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 K Holden—Committee Secretary
Ms A Groth—Assistant Committee Secretary

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

TRANSCRIPT OF PROCEEDINGS

FRIDAY, 11 FEBRUARY 2022

Brisbane

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The subcommittee met at 9.00 am.

CHAIR: Good morning. I declare open this public hearing for the committee's inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system. My name is Aaron Harper, member for Thuringowa and chair of the committee. I would like to respectfully acknowledge the traditional custodians of the land on which we meet today and pay our respects to elders past and present. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander people, whose lands, winds and waters we all share.

The committee has resolved to establish a subcommittee today, as we have the Mental Health Select Committee running at the same time and a couple of our members are on that committee. The arrangements for today are that Trevor Watts MP, member for Toowoomba North, who is substituting for Dr Mark Robinson, member for Oodgeroo, will act in the role of deputy chair. We also have Joan Pease MP, member for Lytton. Stephen Andrew MP, member for Mirani, will be joining us at some point via videoconference. Rob Molhoek MP, member for Southport, and Ali King MP, member for Pumicestone, may also come in during the day.

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. These proceedings are being recorded and broadcast live on the parliament's website. Media may be present and are subject to the committee's media rules.

ALLEN, Mr Jeffrey, Policy Manager, Australian Medical Association Queensland (via videoconference)

BOULTON, Dr Maria, Chair, Council of General Practice, Australian Medical Association Queensland (via videoconference)

CHAIR: I now welcome the representatives from the Australian Medical Association Queensland: Mr Jeffrey Allen, Policy Manager, and Dr Maria Boulton, Chair, Council of General Practice. This is perfect because that is shaping as a recurrent theme this week as we have travelled the state. Would you like to make an opening statement before we move to questions?

Dr Boulton: I am presenting today as chair of the Council of General Practice, as a GP and as an owner of a GP practice in Brisbane. I previously worked in Mackay for nine years as well. GPs have supported Queenslanders every step of the way during the COVID pandemic, caring for patients, answering their questions about COVID, performing more than half of the COVID vaccinations and now caring for the bulk of COVID-positive patients in the community.

Seventy-five per cent of patients present to GPs in the first instance for care of their mental health issues. Our GP members report a rise of between 30 per cent and 50 per cent in mental health presentations due to COVID stress. With long waitlists to see psychologists and psychiatrists, it is GPs who support and care for patients until they can access those services. Queensland hospitals are overstretched and rely on general practice now more than ever to keep presentations to their emergency departments at a manageable level. Our practice doors have remained open throughout the pandemic to care for patients and to support our emergency colleagues.

Australia's primary care is the third best in the world. We should be trying to improve on that. However, Medicare rebates for patients do not reflect the cost of providing general practice services, leaving patients further out of pocket and disadvantaging those in vulnerable populations. Do we want to live in a country where only some people can afford care, leading to poorer health or increased presentations to emergency departments which are more expensive?

AMA Queensland calls on GP practice owners who understand the practicalities and costs of providing medical care for patients to be included in all MBS review panels so that patients are not disadvantaged. Queenslanders in all regions of Queensland deserve first-class, evidence based medical care. We deserve access to fully qualified GPs who have at least 10 years of experience and

training under their belt and who have the experience and training to diagnose, treat and prevent disease. Resource general practice appropriately and more patients will be healthier, have fewer hospital visits and enjoy continuity of care. I will now hand over to Jeff.

Mr Allen: I am the policy manager for AMA Queensland. Thanks very much for asking us to join the inquiry today. AMA Queensland will only be making comments today about primary care. We do have members who are involved in aged care, the NDIS and other areas, but our focus today is on primary care.

We believe general practice is really the lead provider of primary care in the community. If the government fund primary care appropriately and provide them with the resources that they need to deliver quality care, more patients will be healthier, require fewer hospitalisations and presentations, and enjoy continuity of care. AMA Queensland has been working very closely with the Queensland government during the COVID pandemic to ensure GPs are provided with the basics they need to deliver quality care, but we have been frustrated that even after two years of the pandemic GPs still experience delays in the supply of PPE, RAT tests and the processing of PCR results.

AMA Queensland does continue to advocate for patients in rural and remote communities and also vulnerable populations, particularly those in disability care and aged care, to have access to quality COVID care during the pandemic. The abuse that our reception staff and doctors in private practice have endured, both online and in person, has been disturbing including death threats. It has been extremely challenging for some of our members, with some withdrawing their services as a result of the stress and danger to their staff and other patients.

The long-term viability as medical practitioners, as the leading provider of primary care in Queensland, is being regularly tested—even more so under the COVID conditions. This is due to current MBS rebates, GP shortages in regional communities and the strong support which Queensland Health continues to provide to allied health professionals to increase their scope of practice to complete tasks previously completed by doctors such as immunisations, medical diagnosis, treatment, services and autonomous prescribing. This fragmentation of health care is lowering the standards and it will cost lives and the health of Queenslanders.

GPs work collaboratively with allied health providers every day to deliver quality care. This close working relationship should not include allied health professionals undertaking medical diagnosis, treatment services and prescribing restricted medicines. The potential for misdiagnosis and fragmentation of care is just too high. That concludes our introductory comments.

CHAIR: Thank you very much, Jeffrey and Maria. There are some recurrent themes we have picked up in both your opening statements that we have heard throughout the state around the Medicare rebates. Certainly we have heard about access issues to GPs. We were in Far North Queensland earlier in the week where there were 97 GP vacancies. We are seeing the results of that being increased presentations to our emergency departments. That has been reflected all the way through to where we were yesterday on the Gold Coast and in Logan with some stark numbers there.

Jeffrey, you mentioned primary care as your focus, notwithstanding you also mentioned if the government funded appropriately—and you talked about PPE, PCR and RAT tests, and there is a national spotlight on that at the moment in aged care. What relationship do you have with the PHNs?

Mr Allen: We have a good relationship. In fact, Maria Boulton and two of our other high-level representatives sit on the SHECC, the state health emergency control committee, and receive that information. Our relationship with PHNs is a good one. However, there is variable engagement with PHNs. We did a survey with our members last year where members were asked to talk about the level of engagement and the cooperation that occurs. There are high levels of cooperation in some areas of the state compared to others.

CHAIR: Who is responsible for providing PPE and RAT tests to GPs and particularly aged care?

Dr Boulton: Access to PPE for a general practice and general practice staff has been dreadful, and it has not improved much in the last two years of the pandemic. As GPs we are small businesses and we compete on the retail market to buy N95 masks. We are competing with governments like the USA, who are buying N95s for their citizens. We are also competing with large wholesalers. Basically, we are competing for a very scarce resource.

The federal government at the end of last year said that if GPs were having issues accessing PPEs they could approach their PHNs, provided they were caring for people with COVID. Then that changed to 'provided that GPs were caring for people face to face'. The issue we have had is that the distribution networks from the PHN have suffered. The people who deliver them also got sick with COVID and the Omicron variant. We are still having areas where there is not enough PPE.

We have been working with the state government. We are about to announce some initiatives where GPs who cannot access PPE via their PHN can approach their local hospital and health services if they are in a rural and remote region or they can approach the Australian government for urgent supply, but this has been a terrible issue. We are facing the same with rapid antigen tests. We have advocated both federally and state for us to be able to access some rapid antigen tests. Once again we are competing with governments. We are competing with wholesalers. The response so far is that we will not be getting access unless we run a GP respiratory clinic or an ACCHO.

This is really key because, above all, what has stressed us out the most—the entire health system—is the fact that our workforce are getting sick, are furloughed or are close contacts, and we need to get them back to work. If they are waiting to receive a PCR test and they are waiting five or seven days when they could be at work, that is just not good at a time when we are so busy.

CHAIR: We were told yesterday—and it is an observation—that the PHN in Logan had a stockpile, yet I am very aware of GPs and aged care in my electorate in Townsville who are absolutely suffering. The question was: who is responsible for delivering PPE and RAT tests to GPs and aged care? It is the primary healthcare network.

Dr Boulton: Correct, except for RATs. There is no mechanism by which we can access that.

CHAIR: Would you agree that they do not have the logistic capability and capacity to actually deliver this from an infrastructure point of view? It seems to me it goes back onto the public health system, just like if you cannot get into a GP you end up going to an emergency department. Do you have any comments around that?

Dr Boulton: Absolutely. They are not a distribution network. They are working really hard to get it out there, but the issue is that they rely on the PPE arriving at the PHN. They then repackage it and then they deliver it. They are not a distribution network. I have heard, and I have not had confirmation, that they are looking at other solutions for getting PPE from the national stockpile to GPs, but that has not been activated yet. There are many PHNs. Some are superstars. They are amazing. They have done really amazing work supporting GPs, but there are some areas where the GPs have not been well supported.

Mr WATTS: Thank you both for being here. My questions are probably a little broader. I am interested in trying to get solutions for health care in Queensland. I know that the AMAQ has previously called for 1,500 extra beds. I am just wondering why that impacts on primary care. Why would the AMAQ think that 1,500 beds would help primary care?

Dr Boulton: I guess we are the ones that patients present to first. At the moment, the real urgency is in mental health. If there is not a mental health care bed that the patient can be admitted to when they need it, it is GPs who are looking after that patient when some patients desperately need that specialist mental health service. It is more patients, really. We do not want patients to be waiting for a bed. We do not want patients to be waiting in emergency departments waiting for a bed to be available. Above all, it is to do with our patients. We are happy to look after them, but when they need that hospital care it is important that they have access to that, just from a patient safety point of view.

Mr WATTS: Really, it is at the edge of primary care when there is not much more you can do for them in the community? That is when they need that specialist care?

Dr Boulton: Correct. If you have someone who, for example, has stroke symptoms you refer them to the hospital. You want them to be treated rapidly. The last thing you want in a stroke is for someone to be waiting to be admitted to hospital because time is brain. We had a patient who was waiting for two hours to access a bed. Where time is brain, I think that just highlights that point.

Mr WATTS: Just going back to the PPE, in times pre COVID medical practitioners would have their own stock of PPE and that has just been drawn down. Has the issue been that there is not enough out there generally in Australia or in the world, or is it the fact that people did not have enough stock? I understand the distribution problems. I am trying to get some parts for my car engine at the moment and I can tell you that it is not as easy as it used to be. I am just trying to understand what level of PPE holding medical practitioners would have normally had, how you would normally have ramped that up, assuming there is not a worldwide shortage, and how that is happening now.

Dr Boulton: Accredited GP practices are required to hold a level of PPE in stock. It was not ever meant to last us for two years, for example. While we all have some in stock—and PPE is gloves, masks, goggles and gowns, and also hand sanitiser was hard to find at the beginning—the issue is that once that stock runs out you are competing in the retail market. Given that we are frontline, not only do we need the PPE to keep our staff safe; we also do not want to give someone COVID unknowingly. We look after vulnerable people. At my clinic we wear the absolute highest protective

PPE. It takes hours to source it where you can, and I know that many clinics just have not been able to. Even the government is having issues sourcing PPE and it has the big logistics and the big buying power. We do not have that.

Mr WATTS: The inquiry we have at the moment is looking at primary and allied health care, aged care, NDIS and private healthcare systems. Do you think we can fix the health system without having a statewide look at health care from start to finish? We have heard a lot about siloing, and unfortunately this committee is fairly siloed in its scope. Do you think we would benefit from having a wider scope and looking at the whole system?

Dr Boulton: Absolutely. I think for patients to be looked after safely we need to look at all areas of the healthcare system. I think if general practice fails then emergency departments and hospitals suffer and vice versa. I think it is essential to look at the entire system. I think it is also essential to make sure that, in looking at the entire system, the GP peak bodies like AMA Queensland are involved.

Ms PEASE: Thank you very much for coming in today and to all of your members for the great work they do every day. I know that they have been faced with many challenges during COVID. I guess this inquiry is not focusing on COVID; it is focusing on the future and what we can do to improve—as you talked about, Dr Maria, in your opening statement—the health of Queenslanders. Do you still run a general practice yourself?

Dr Boulton: Yes, absolutely. I will be there after this. We are open seven days.

Ms PEASE: You are a seven-day-a-week practice. Do you do after-hours in the evenings as well?

Dr Boulton: We do not do after-hours, but we do seven days a week and we run very big vaccine clinics as well, so it has been a very busy time for us.

Ms PEASE: Well done. I can imagine. Thank you for that. Are your books still open to new patients?

Dr Boulton: Yes.

Ms PEASE: Is there a waiting period for people wanting to see a doctor in your practice?

Dr Boulton: No. Maybe your doctor of choice or preference might be booked out, but you are able to get in to see somebody else. We work collaboratively and we keep notes so that we can see what has happened in previous appointments.

Ms PEASE: One of the things we have heard, and it is in my own electorate, is that people are waiting two to three weeks to get an appointment to see their GP. Can you perhaps enlarge on that? Is there a shortage of GPs and, if that is the case, why? Is there a disincentive for junior doctors to enter the GP space? If so, what is that disincentive?

Dr Boulton: I worked in Mackay for nine years and, yes, some of our doctors were booked out for two or three weeks. It is very difficult sometimes for patients. I think it has been traditionally difficult to attract GPs to rural and remote areas. GPs come with families and those families need to be catered for. I was in Mackay because my husband is in mining. That is how I ended up there for nine years. I think also GP as a profession has been tarnished. It is not what it used to be. We are competing against other specialties when it comes to training. If you are a junior doctor looking at going into a specialty, GP is not as shiny as it used to be. We are losing doctors to the competition. Also, we have been hampered by there not being as many international medical graduates coming. This has been a problem for quite some time. It is not a new problem. I suppose what we are looking at—and I was talking to Michael Clements from the RACGP the other day—is working collaboratively to find local solutions: how you attract a GP to that local area. More often than not you will need more than one, because one GP cannot work 24/7. Every area deserves a GP because all Queenslanders deserve that. We need to get a bit creative, I think.

Ms PEASE: In your submission you made comment around the disincentive around the MBS scheme, the Medicare rebate, and how it has not kept abreast of the actual cost of running a practice and what it actually costs for a GP to consult and see a patient. Could you enlarge on that for me, please?

Dr Boulton: Medicare was frozen for some time and it has not caught up with what it really costs to provide a service. What we are finding is that the fee for a standard consultation to see a GP is about half of where it needs to be. This is according to AMA Queensland research but also WorkCover fees. For example, say you have a skin lesion and you need to have a shave biopsy done, which we all do commonly—sadly, we are all going to get skin cancer at some point—the actual fee that Medicare rebates the patient to have that shave biopsy does not cover the consumables or the

nurse's time, let alone the GP's time to do that procedure. That is why it is important that we review the MBS item numbers and the rebates for patients. Otherwise, patients will face increased out-of-pocket costs.

Some of us, to be honest, have been working with no income, as many of us have during COVID, to be able to continue to provide the services we provide but we do have costs. We have receptionists; we have nurses; we have electricity. I guess the whole MBS needs to be looked at and reviewed and we need people on those panels who actually know how much things cost. If you ask a non-practice owner how much it costs for a local anaesthetic they will not know, whereas practice owners like myself do know. We know how much an N95 mask costs, for example. At the moment it is $7.

Ms PEASE: What we have seen in our public hearings recently is that there seems to be, because of the wait time of people trying to get into a GP—I am a suburb of Brisbane and I cannot see a GP for three weeks so I have to know three weeks in advance that I am going to be sick and need to see a doctor. With that, what we have heard is there has been a very large increase in our public hospitals and presentations to emergency departments of level 4 and 5 patients and if they had been able to access GPs that would have been resolved there. Having been able to access a GP, further to what you talked about as primary care is just that: it is a whole of the patient where you might be able to refer them to allied health services and look after their entire health journey. Part of that problem again goes to MBS because podiatry, OT and physio—all of those other allied health services—are not covered by MBS; is that correct?

Dr Boulton: Yes and no.

Ms PEASE: I know you can get five, but generally a person with chronic disease is going to need five more services. If they have a chronic airways disease, they need to see a physio ongoing to clear their lungs. Five services are not going to actually achieve that. Would you imagine that being able to access those allied health services through the Medicare scheme or some other scheme, rather than private health insurance—because it does not cover the cost either and we have seen a huge drop in private health membership. Do you have any comments on that?

Dr Boulton: I completely agree. We have a lot of emergency department physician members and the truth of the matter is that, with the increased presentations that emergency departments are facing, we are facing the same increase in presentations to general practice. One of our members has been a GP for 40 years and he says that he has never seen the increase in presentations that he is seeing now. I think the system is constipated, to be honest. For example, when we see someone with a mental healthcare issue, the fact that they cannot get in to see a psychologist or a psychiatrist, because many of them are at capacity or have closed their books, means that we look after them longer, which we will do, but that means that that is an appointment that we cannot give to somebody else.

When it comes to allocating resources, I guess you have to see where your resources are best allocated and are they best allocated into allied health or are they best allocated to fund GPs, to perhaps increase the GP numbers. As a GP I am biased. I would say that those funds would probably be best allocated there. The other thing is that we could support those team members within general practice. We could provide funding for our nurses, for example. We do not get that. That way we can work collaboratively, with the GP being abreast of all the patient's conditions but then using the team members to support that.

CHAIR: Doctor, we are almost out of time. I am sorry, we are not going to be able to have supplementary questions. Maybe you can take this one on notice. It is interesting that you came back from Mackay, where the DPA status has changed now.

Dr Boulton: Yes, and that has made a huge difference. Mackay is a brilliant place and I would still be there had my family not needed me in Brisbane. I really enjoyed my time there and I got the best training there. It was amazing.

CHAIR: The focus here is on trying to keep people out of hospital. We have a growing ageing population. Could you please write back to the committee on this as we are out of time: how do we get GPs to practise after hours? We used to have an after-hours service, Doctor to Your Door, in Townsville. I think that was funded federally. That no longer exists. We do not have bulk-billing doctors going to residential aged-care facilities, and I heard that was happening in Mackay as well. For low acuity—catheter changes and things like that—it is another ambulance transport through to the hospital. How do we get GPs into residential aged-care facilities and to practise after hours? Is it around Medicare rebates?

Dr Boulton: Yes, it is around funding. Many of us do look after residents in aged-care facilities and many of us do our own after-hours phone calls. That is a service that we provide. In Mackay we used to do after-hours phone calls for patients as well. It is all down to funding. You need to be able to fund those services. It is going to cost more. Even during the daylight hours, the funding is not sufficient.

CHAIR: Funding by whom, Doctor?

Dr Boulton: It does not really matter where the funding comes from. It is really the patient that needs funding because it is their rebate in the end. I think all levels of government have an interest in this because, say, for example, with the state, if somebody ends up in emergency it is five times more expensive than them being looked after by a GP. We need to look after all of that. In the end, we do not want vulnerable people who cannot afford the gaps to miss out.

CHAIR: Thank you very much to both of you, with Jeffrey in the background. We could talk on this for hours, but we have your submission. Thank you for your contribution today.

Dr Boulton: Thank you very much for the opportunity.

BENEDET, Mr Gerard, Branch Director, The Pharmacy Guild of Australia—Queensland

OWEN, Mr Chris, Branch President, The Pharmacy Guild of Australia—Queensland

TWOMEY, Professor Trent, National President, The Pharmacy Guild of Australia—Queensland

CHAIR: Welcome, gentlemen. You are well known to the health committee from the previous work we have done with the pharmacy inquiry. I invite you to make an opening statement, after which we will go to questions. It will be interesting. You might have picked up some themes there about keeping people out of hospital. I am aware that you have done some work in that space with trials from recommendations that this health committee made in a previous report.

Mr Owen: Thank you, Chair. My name is Chris Owen. I am a third generation Queensland pharmacist and I am also branch president of the Queensland branch of the Pharmacy Guild of Australia. I, too, would like to acknowledge the traditional custodians of the land on which we are meeting today and pay my respects to their elders past, present and emerging. Joining me today are Professor Trent Twomey, the national president of the Pharmacy Guild of Australia, and Gerard Benedet, the branch director of the Queensland branch.

I would like to thank the committee for the opportunity to provide a follow-up opening statement to the inquiry for the provision of primary, allied and private health care, aged care, NDIS care services and its impact on Queensland's public and primary healthcare system.

There are 1,215 community pharmacies in Queensland and 234 of them are classified as rural towns, remote or regional or very remote communities as by the Modified Monash Model. On average, each person in Queensland visits a community pharmacy 18 times per year. According to the Australian Bureau of Statistics, community pharmacies are the most frequently accessed and most accessible primary healthcare destination.

This committee has repeatedly heard at these proceedings that hospitals and emergency departments are stretched and that some of the demand is often for conditions that could have been prevented or better managed within a local primary healthcare setting. Successive health ministers of both political persuasions have highlighted the number, frequency and costs associated with non-urgent emergency department presentations. As recently as last year, Minister D'Ath disclosed the number and type of non-emergency ED presentations. These included supply of repeat prescriptions, vaccinations and common ailments like acne, sunburn and muscle cramps.

This committee has also heard that there are significant shortages of primary healthcare practitioners of all types across Queensland, and this is no different in community pharmacy. Pre COVID, vacancies existed in all primary healthcare industries, but these vacancies have been exacerbated further by COVID. This is not a new problem. In rural, regional and remote areas the shortage is the most acute. In saying that, metropolitan areas are also under significant risk and significant strain.

Consumers have given their lived experience of the doctor block, long waiting times for appointments and the lack of regular doctor in their home town or suburb which has had a significant impact on their overall health and drives up non-urgent ED presentations and preventable hospitalisation. Addressing the shortages of the primary healthcare practitioners like nurses, GPs and pharmacists is multifactorial and complex. This problem is not easily fixed within the short or medium term—two to seven years of training requirements and, frankly, the number of people willing to undertake these professions.

Respectfully, we would suggest that any recommendation put forward by this committee needs to adopt an approach that looks at a diverse portfolio or suite of solutions and not simply focus on one healthcare practitioner group. In other words, the solutions need to be patient-centric, not practitioner-centric. The constant focus of some practitioners on themselves is not in the best interests of the patients.

As primary healthcare professionals, our duty is to our patients and the care that we give them. We come today not to ask for more money, not to take any cheap shots at other professions, not to engage in some ancient turf war or seek to run down the ethics or policy suggestions of other peak bodies; we come with a solution—a solution that is not a world-first, a solution which operates in

countries such as the United Kingdom, Canada and, in part, New Zealand and a solution that is proven to work. We believe that all primary healthcare practitioners should be practising to their full scope.

To this end, community pharmacists support the creation of nurse practitioners and have actively supported other allied and primary healthcare practitioners to practise to their full scope. Full scope indeed is not a new concept. It has been around for decades. The primary healthcare workforce is much more than one profession, and all healthcare practitioners working to their full scope of practice can help alleviate patient access to world-class health care.

When all primary healthcare practitioners are practising to their full scope, we are collectively able to better tackle incidence and management of chronic disease, reduce preventable hospitalisations, reduce non-urgent ED presentations and ultimately deliver better health outcomes to our fellow Queenslanders.

To assist the committee, in 2018 we presented to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee regarding the inquiry into the establishment of a pharmacy council and transfer of pharmacy ownership in Queensland. The committee report stated that there are significant potential community health benefits for extending the scope of practice of pharmacists further. Since then, the guild, on behalf of the community pharmacy sector, has advocated for a trial—the Department of Health calls this a pilot—to evaluate the benefits of community pharmacists working to their full scope of practice, like they are in the UK and parts of Canada. Through a dedicated and broad-based trial, which includes four elements of full scope—those being the ability to prescribe, dispense, administer and review—only then will we get true system reform. The trial will independently evaluate how we, as community pharmacists, are part of the solution for the significant challenges raised throughout this inquiry.

Ernst & Young produced a report in 2020 titled *Scope of Practice Opportunity Assessment* that concluded that community pharmacists working to their full scope would result in $63 million per year in savings in avoidable public healthcare costs, $176 million per year in savings to state and federal governments in avoided costs through better treatment of minor ailments and conditions, and $9 million per year for the implementation of better medicine and treatment practices for chronic conditions.

A forward-thinking Palaszczuk government committed, prior to the 2020 election, to design and implement a pilot of community pharmacists practising to their full scope in North Queensland. The guild, alongside many other organisations—including the AMA; the RACGP; ACRM, which is the rural doctors; the North Queensland and Western Queensland PHNs; Pharmaceutical Defence Ltd; and Health Consumers Queensland—was part of the steering reference group for that trial or pilot in North Queensland. All parties are bound by confidentiality agreements with Queensland Health, but in recent days some groups have deliberately breached these arrangements for their own internal political purposes. This is not putting patients first. Our remarks are constrained to what is in the public domain.

The guild believes that professional training, skill and knowledge of community pharmacists should be acknowledged. Pharmacists have the competency and professional accountability to dispense, prescribe, administer and review medicines. Community pharmacists in Australia are being under-utilised primarily due to legislative barriers and preference. Currently, our scope of practice is limited. By allowing community pharmacists to work to their full scope, with additional university supervised training, we can support our fellow healthcare practitioners to continue the important work that they do.

The scope of practice for community pharmacists in countries and comparable economies and health systems highlights the numerous countries that are more advanced than Australia. As an example, in Canada and the United Kingdom, community pharmacies manage common ambulatory conditions including ailments such as urinary tract infections, back pain and eczema. In Canada and Scotland, pharmacists' scope of practice includes prescription renewal and the management of ongoing supply of prescribed medicines for stable, chronic conditions without the need to unnecessarily return to the prescriber. Most recently, the NHS in the UK initiated a review with a view to make statins available direct from a pharmacist as part of a long-term plan to cut heart disease. It is estimated that two-thirds of people are at risk of heart attack and stroke if they do not take a statin. In further comparisons between the UK and Alberta in Canada, Australia is behind in the areas of administering vaccines and non-vaccine medications, prescribing schedule 4 and schedule 8 medications and ordering and interpreting laboratory tests.

There always has and most likely will be some objection to change. We are focused solely on enhancing patient outcomes. A safe and healthy Queenslander is our interest at all times. However, we should learn from past objections which were unfounded at the time and, in the factor of time, have proven to be incorrect. Scare campaigns based on opinion and not facts are not in the best interests of patients. On 15 January 2014, AMA president Steve Hambleton stated—

Pharmacies have no proven record that they are safe or appropriate locations for such a private and potentially risky clinical procedure as vaccination.

He continued—

It is not in the interests of patient safety for pharmacists to participate in this irresponsible trial. It could even be dangerous.

These statements were in relation to the 2014 groundbreaking Queensland pharmacist immunisation pilot. This was not a world-first but a nation-leading pilot which led pharmacists throughout Australia to be authorised to be giving vaccines. Without the Queensland government support for this pilot, regardless of negative stakeholder feedback received, we would not be in the position where we find ourselves today where community pharmacies had delivered 1.1 million COVID-19 vaccines to Queenslanders. The last two years have taught us that we need expanded points of care and more access to better health services, not less. We need everyone working to their full scope.

Throughout March 2020, the chair of the RACGP, Bruce Willett, said—

This really is an irresponsible effort to buy a few votes in a short-term move with fundamental flaws.

Krystyna de Lange, college training chair said—

This announcement moves into an inappropriate scope of practice.

As recently as January of this year, the RACGP said, 'The pilot's extension of six months risks wideranging adverse health repercussions and making the pilot permanent would be a recipe for disaster.' This refers to the urinary tract infection pilot announced by the Premier to coincide with International Women's Day. This pilot, which had bipartisan support, supports Queensland women aged between 18 and 65 for immediate advice and treatment for uncomplicated urinary tract infections through their local community pharmacy.

To date, 6,300 occasions of service have occurred, saving women from this painful condition in a timely and safe manner. No adverse events have been recorded as a part of this pilot, and pharmacists have referred more complex cases to their local practitioners where clinically appropriate and required without prescribing any medicine. This pilot is yet another example of the system utilising the skills, knowledge and competence of community pharmacists to improve patient health outcomes. Time and time again we have proven that community pharmacists are highly trained medical experts who safely care for their patients.

Due to the COVID-19 pandemic, the community pharmacy full scope of practice trial in North Queensland has not progressed as quickly as envisaged. However, we can see from the extensive testimony to this inquiry that this solution should be implemented as soon as possible. As I said earlier, this trial needs to be broad based and include those four areas of full scope—the ability to prescribe, dispense, administer and review medicines including chronic disease to solve non-urgent ED presentation. This solution costs the government nothing, brings Queensland into line with the UK and parts of Canada and parts of New Zealand, and fulfils a government election commitment.

In closing, I would like you to consider the following truth: patient centred care means we all work to full scope and together for the greater good of patients. I am happy to take any questions. Thank you for your time.

CHAIR: Wow. Thank you very much, Chris. I say, 'Wow,' because they are impressive numbers—6,300. That is 6,300 people who would not walk into an emergency department for a low-acuity case. I think the data we got back in December from Queensland Health was that around 70 per cent of people presenting to emergency departments walk in with low-acuity cases. A lot of it is because of lack of access to a GP.

I would like the committee to have the Ernst & Young report and the UK NHS statin information and if there is evidence based research out there to support scope of practice. We heard about expanded scope of practice yesterday for nurse practitioners. Right now from my observation, with an ageing and growing population, it is not sustainable to have hundreds and thousands of people literally walking into an emergency department when care can be delivered outside.

Thank you very much for the update on that trial. Obviously the former iteration of the health committee did a lot of work in that space and we appreciate it. Also, I say to all pharmacists out there: thank you for the work you are doing, particularly in the COVID vaccine rollout. We cannot do it alone. We need to share the load. I think it needs a whole team approach. I will open it up to questions.

Mr WATTS: I am worried that I am driving up the average because I think I go more than 18 times a year. I am interested in the scope of practice. What are the blocks to this? Is it as simple as dollars—that someone is trying to protect their turf for dollars—or is it that there is true belief on one side or another that the scope of practice should not be enlarged?

Prof. Twomey: There is already a recommendation from your department that is being blocked in Queensland Health from arriving at the minister's desk. It is not the minister's fault. She is waiting on a brief from her department. There is already a recommendation from the independent committee with the representatives of not only consumer groups but also all of those professions that my state president outlined. It is to do three very specific things. It is to allow pharmacists in Northern Queensland, with extra training, to plug the gap in the skills and knowledge they have to perform extra tasks. Those extra tasks, as my state president outlined, are to prescribe, dispense, administer and review.

Most importantly, to the point and the meaning of this particular inquiry of this committee, that will enable pharmacists to do three things for Northern Queenslanders: to help them manage their chronic disease; to help them manage acute occasions of service; and to help them with solutions to vaccine preventable diseases. That is what is in it. It is those three things: management of chronic disease, management and solutions for acute occasions of service, and solutions for vaccine preventable diseases. If the trial does not include as part of its scope all three of those areas, it is not going to provide any system change that is needed. I know that all of us are acutely aware that Queenslanders deserve to have access to these three things from an appropriately trained primary healthcare professional like community pharmacists.

That briefing note is sitting there. There are stakeholders, to the other part of your point, both within the department and those who have probably already given evidence this morning, who believe that the trial should not go ahead at all or, if it is to go ahead, it is to go ahead in some form of scaled-back version. I think it is really important for the committee to understand not only what the trial is but also what it is not. This full scope of practice trial does not go as far as full scope of practice in those other international jurisdictions, and of course we will provide the chair via the secretariat the evidence of all of those things.

The scope of practice that this trial will enable is narrower than a nurse practitioner. A nurse practitioner scope of practice is narrower than a general practitioner scope of practice. This does not enable Queenslanders to access solutions for heart failure from a local pharmacist but it does for hypertension. It does not enable them to get solutions and prescriptions for insulin dependent diabetes but it does for non-insulin dependent diabetes. It does not mean that they will always continually get the cheaper reliever puffer because they cannot, as the member for Lytton said, get a prescription for their important reliever. Even though this is starting in Northern Queensland, I can assure the member for Lytton that medically underserviced Queenslanders are not restricted to regional or remote areas. It could be at a particular hour of the day or on a particular day of the week right here in postcode 4000 and 4001. This is a great thing for Queenslanders.

It is narrower than what the naysayers are saying, but what it does is look at the Australian Institute of Health and Welfare's data and Queensland Health's data. It is targeted towards potentially preventable hospital presentations in the first instance and potentially preventable hospital admissions in the second instance. It costs the taxpayers of Queensland nothing and it does ensure that there has been a robust audit of the skills and knowledge that community pharmacists have. If there are any gaps, university training through the Queensland University of Technology in partnership with James Cook University plugs those gaps before any of those tasks are changed and any of those services are delivered.

Mr WATTS: Just so I understand, there is a report and it has been held by the Queensland Department of Health—

Prof. Twomey: Correct.

Mr WATTS:—and it has not been given to the minister or the executive to be able to make a decision as to whether they want to proceed or not?

Prof. Twomey: The specific answer to your question is that the allied health division of Queensland Health—which is an appropriate place for it to be—has been tasked with this. The minister's office is not in receipt of that report because there are certain forces from other professions,

not ours, that are using their contacts within the department to try to get it blocked. If they cannot block it, they want things removed. They want to be able to water it down so it does not include the management of those things. That is why I think it was so important for us to talk to not only what the trial is but also what the trial is not. I think that is really important for the committee to understand. There has been a robust process done by the department. I know that the minister is eager to receive this report so she can accept the recommendation from the independent committee and accept the recommendation from the allied health branch, but it has not been forthcoming.

Mr WATTS: In relation to those four things in terms of prescribe, dispense et cetera, is someone else getting a Medicare rebate for doing that that would then be missing if it were done by a pharmacist or would the pharmacist get the Medicare rebate?

Prof. Twomey: That is a very good question. Part of your original question was about money and if someone is missing out. Let me tell you that in a demand driven system like the Medicare benefits scheme, which pharmacists do not play in and we are not requesting to play in, this would be a user-pays trial. Those people who cannot afford to pay can still have access to our world-class hospital system. People who can afford to pay are blocking up our emergency departments because they are not allowed, because of regulation, to get it from somewhere that is more convenient and to pay.

To answer your question specifically, this trial does not include mental health. We all know the overwhelming demand for mental health. The appropriate place for that at the moment is through their local general practitioner. I can assure you that, if somebody who was going to present to either an ED or a GP for the management of hypertension or to get a prescription for a reliever puffer was not having to go there, there is a queue all the way down the street of people who want an appointment with that doctor for the management of their mental health. They are not going to miss out on anything. What it will mean is that it is freeing up time for those people who cannot get an appointment who need an appointment for those other conditions that are not part of this trial.

Ms PEASE: As always, it is great to see you and thank you for your great work. I acknowledge the great community pharmacies that I have in my electorate. I am a regular participant and user of those services. I would like to make a comment that often a pharmacist is the first port of call for people who are not well. My son has a condition with his eye. I had a sore eye myself just recently and I needed to get some ointment for my eye. I could not make an appointment with a doctor and I know that I could get that antibiotic ointment for my eye. Therefore, it freed up a doctors appointment. I was able to get that ointment for my eye and my eye cleared up. They are great services that our community pharmacies provide. I would like you to elaborate on that because, realistically, the pharmacist is out of pocket. How likely will they be recompensed for those sorts of services that are coming through in this report that you are trying to get to the Minister for Health?

Prof. Twomey: The report has benchmarked what the MBS item numbers are not only for a local general practice but also for a nurse practitioner. It has a fee for that consult. Remember that sometimes consults result in the prescribing and dispensing of medicines but sometimes they do not, because sometimes it is a lifestyle change that is needed or, indeed, it is a referral that is needed to another element of the profession.

The framework of the trial has benchmarked the cost for a consultation with a community pharmacist that is somewhere between the cost of a nurse practitioner and the cost of a general practitioner. I think that is probably a common-sense approach. If we have a world first, short of going through an MSAC, which is a Commonwealth government cost analyst—there is no Commonwealth government money being spent here—the two relative benchmarks which I think the committee would agree with us that we are benchmarking are somewhere between what a patient is reimbursed for a nurse consult and what a pharmacist is reimbursed for a medical consult. That is what the trial mandates.

Ms PEASE: It is similar to a vaccination—for example, the flu vaccine. I have to pay for my flu vaccine. I would not like to see a pharmacist out of pocket, because it is a hard job they do and they serve the community so well.

Prof. Twomey: Thank you.

Ms PEASE: I would like to acknowledge the hard times that they have had with the delivery of PPE and RATs. It has been hard for them. I acknowledge their patience and kindness to all of the customers who come in.

Prof. Twomey: It has been a rough couple of months for our pharmacists, member for Lytton, and our pharmacy assistants.

Ms PEASE: I know.

Prof. Twomey: They are suffering paraprofessionals as well. For the urinary tract infection trial, my state president has just reminded me that there is a $30 fee that the patient pays. Of the 6,300 occasions of service, guess how many complaints we received about paying $30? Zero. That is because that woman no longer had to be in pain. She no longer had to wait for hours upon hours in an ED or wait weeks upon weeks for a consult with a general practice. That $30 enabled her to go on with all of the productive other things in her life, so she paid and paid with pleasure for it. That fee was there even if it did not result in dispensing or providing a medicine. There is a statistically significant portion of those consultations—I believe it was 10 per cent but I will get you the outcomes of the trial because I do not want to misrepresent—that resulted in referral and non-supply of a medicine because that is consistent with therapeutic guidelines.

Ms PEASE: Thank you very much, Professor. Please pass on my thanks to all of your members for the great work and service they do for our communities.

Prof. Twomey: I appreciate it. I will do.

CHAIR: We are almost out of time, but I wanted to go back to that quote, that it is about patients at the end of the day and should be patient-centric. One only has to pick up the newspaper today. It should not be belted out in the media. This is a time for everyone to work together. I thought that was an apt quote. I have seen it in my own previous clinical world, where paramedics once did not intubate and once did not thromobolyse people. Time is tissue when you are saving someone's heart. I have seen turf wars. We do not need that right now. Right now we need to keep people out of emergency departments wherever possible. Keep doing what you are doing. Could you please provide to the committee any of that information from that UTI trial? Those numbers are pretty impressive.

Mr WATTS: How many years medical training does a pharmacist go through, how many years does a nurse go through and how many years does a doctor go through?

Prof. Twomey: For a community pharmacist, it depends on which program you go to but it is a minimum of four and up to five years of training. In Queensland we have four universities. They are a mixture of a Bachelor of Pharmacy (Honours) and a Master of Pharmacy. The Master of Pharmacy is a three-year bachelor and two-year masters, so five, and then the Bachelor of Pharmacy is a four-year bachelor. Post that, though, there is 12 months worth of postgraduate training which is required under supervision while they are practising. But then, of course, for this trial, as I said before, that delivers a level of skills and knowledge to perform tasks that we are currently performing. There is another 12 months worth of postgraduate training which would be required for a pharmacist which is a combination of not only theoretical training but also practical training and portfolio submissions, consistent with what is happening in other countries, which is for a pharmacist to participate. For a nurse practitioner it is a three-year bachelor and then a two-year masters, so five, which is less. So their scope is broader and their training is less than what we are saying pharmacists would have to do in this particular trial.

Mr WATTS: Thank you. The very last question I am happy to be on notice. I am curious how many community pharmacists there are in comparison to regional and remote towns and even provincial towns where doctors surgeries may not be operating.

Prof. Twomey: I know in the opening statement my state president referred to some Queensland statistics, but nationally there are 450 towns—I can say that as the national president—where the local community pharmacist is the only piece of primary healthcare infrastructure other than that provided by the state. If you do not want them rocking up at your door, the only place they can go to in these towns is ours.

CHAIR: That is a good point. It just reminded me: someone in the submissions talked about medication errors. I think we have had this discussion before in previous committee hearings. If pharmacists could do some work in those residential aged-care facilities, is that something that you are looking to do? I am talking about prescribing within the big RACFs. There was a significant saving, if you get the medication right, to prevent hospitalisations. Can you provide the committee with any information about that?

Prof. Twomey: We will take that on notice and provide it to the committee. What I can tell the 'member for Cowboys' is that deprescribing is actually more important than prescribing in a residential aged-care facility. I know that we spoke when you had that previous inquiry about medical constraint, of which there is—and I love the terminology of 'conflict', because it is obviously thrown in our direction a lot but it is nice for a change to throw it back in the other direction. Somebody who is actually having to care for that elderly individual—many of them have early onset or late onset dementia—is also prescribing the benzodiazepines and the other form of chemical constraint. Therein lies an inherent conflict. The other half of prescribing is also deprescribing. We can make recommendations at the

moment that that person is being overprescribed—they are too docile just because it is easier for you to look after them—but we are powerless at the moment to address the problem and this is something that this trial would actually enable us to address.

CHAIR: Yes, there was some really interesting data. I know that we have gone over time, but we will go into our own break and make that up. We do appreciate your contributions here today. Thank you very much. We look forward to getting any of that information back by Friday, 18 February.

Prof. Twomey: That is why we brought the gentleman at the end.

CHAIR: Again, thank you for everything you are doing in that space.

Prof. Twomey: Our pleasure.

Mr WATTS: I am trying to get my average visits down.

Prof. Twomey: No, don't. We love seeing you.

MITCHELL, Dr Maureen, Private capacity (via videoconference)

CHAIR: Would you like to start with an opening statement before we move to questions?

Dr Mitchell: Thank you. The comments I make are purely as a private palliative care specialist. I am not representing the Sunshine Coast Hospital and Health Service, but I work within that service. These are my personal opinions, which may or may not be supported by the organisation I work for.

I have been in the palliative care specialty now for several decades. I have seen ongoing issues in supplying care for patients in the community. This has come to a head over the last six months. Some of that is COVID related; some of that is just the lack of services out in the community which prevents us from providing good end-of-life care at home for people, which is the preferred place to die for many of my patients. I really just open myself up to the committee to ask questions in relation to my personal experience about this. If I can give some data from my service, because I have had that experience, that could help influence decisions made by the committee. Thank you.

CHAIR: Thank you very much. We may have met. We did some work at the Sunshine Coast when we were doing the palliative care, aged-care and end-of-life care report. We certainly did visit the Sunshine Coast facility. Exactly what you said was repeated wherever we went around Queensland. When people get sick and terminally unwell, they want to stay at home surrounded by loved ones and want care. One of the repeated issues around that was of home care packages for level 4. We have repeated this, but it sits with the committee as a point. In Hervey Bay a lady held up an envelope and said, 'Mr Chair, my husband's level 4 package arrived two weeks ago.' He had died two years prior. That made us look into the waitlists and there were something like 90,000 on the waitlist. There is absolute benefit to providing care. We made 77 recommendations. I do not have the report; it is upstairs. I was pleased to see that the Queensland government responded. We did not get a response from the Australian government in terms of funding, but we certainly know that if you provide care and decent funding you could keep people out of hospital. I will get some general comments around that.

I am sure you know a good friend of ours, Dr Will Cairns in Townsville, who presented on Wednesday in Townsville. We spoke about similar things. It is about establishing that infrastructure around supporting people, because at the very heart of this are people who are suffering at end of life. Thank you for your work in the palliative care space. I will hand it over to you for some general comments around that—I hate to use the word 'infrastructure', but if we got it right do you think that would reduce the burden on the public health system?

Dr Mitchell: I do believe it would have a significant impact on the public health system if we had serious money going out into the community. One of my repeated experiences, both within government and working in the private system, is that, even if there are packages out there, the money is not sufficient to supply what we need. Certainly in that last week or two of life, that is when we need the greatest number of people being involved in the care of that patient. Families do a fantastic job. One of the reasons I work in this field is that how families step up to give care is phenomenal, but they wear out. Even just having a carer overnight such that families can sleep would make a huge difference. The packages really do not facilitate that at the very end. I would support the increase of packages, and I am sure I would be seconding anything that Will said because he is a very knowledgeable man. Besides the care packages, though, is the NDIS access question as well. Are you okay if I go on to that?

CHAIR: Absolutely.

Dr Mitchell: There are a couple of frustrations with NDIS, even though it has been a boon. It has been a fantastic mechanism by which disabled people can be actually cared for with excellent care, with their independence being maximised. Within the palliative care setting, because patients are deemed that they might only have six or 12 months to live, NDIS has been quite hard to get hold of. We really do have to put in a huge amount of effort to try to get patients who qualify under the criteria onto NDIS because they still need that sort of support, especially for those patients who are under 65, which is where the NDIS is focused. That has been an issue trying to access NDIS and then some of the paperwork associated with NDIS is quite onerous.

The quality of the care really depends on the provider of the NDIS package. One of the biggest beefs I have is that I can have two patients with the same diagnosis, one aged 64 years and 235 days and the other aged 65 years and maybe four or five days. They have the exact same disease; they have the exact same disability. I cannot get NDIS for that older individual because of an age cut-off, when the care that they need is equivalent to the cared needed by the person I can get NDIS coverage for, who is slightly younger. That is something we come across quite often. It is very frustrating because the level 4 packages cannot compete with the NDIS packages.

The other issue in relation to the funding of those packages is that NDIS is a much more lucrative program for community services than the aged-care packages. Therefore, we have seen two of our community nursing services up here preferentially take on patients who have NDIS packages over patients who only have aged-care packages or the small amount of money that we have to help support nursing services for the very end-of-life care. That has been another issue for us with the NDIS package. Though overall I am incredibly supportive of this initiative on both sides of government, like everything, you can have the best intentions and things can be working fantastically in one area but they may have flow-on effects in other areas that are unforeseen.

CHAIR: At end of life is when you need that care. We heard yesterday in Logan about a fellow who we know as John with motor neurone disease and the family just needed exactly what you are asking for, but the assessment and the paperwork—everything you have just said—was too onerous. It is ironic that you brought that up and we only heard about that yesterday.

Mr WATTS: Dr Mitchell, I am interested in exploring palliation and whose responsibility it should be and where that should rest and explore how it should be funded. Obviously a palliation bed in a hospital is very expensive; to be able to palliate in the home is much cheaper. The problem is that there is a cost shift here between levels of government, so each is trying to push the other way. Do you have any advice as to whether the state government could save itself money on building palliation beds by providing the service in the community or funding a service in the community and/or should it be a federal responsibility that they take over all of the cost for palliation?

Dr Mitchell: The federal and state divide is very problematic. Having worked as a GP prior to specialising in palliative care, I have (inaudible) so I do understand the difficulties of this state-federal divide and I understand why each pushes back, because health is an incredibly expensive service to provide. I believe that if we had a Hospital in the Home program, which Queensland Health does run, for palliative beds in the community, we might be able to prevent people coming into hospital. I believe that it would be economically sound to do that because it would be a lot less cost. We could have something where we have a package where we can get at least carers in, because we do have access to 24-hour nursing coverage.

We are very fortunate now on the coast, though we were not in November last year. We have a few more players who are joining us up the coast here that are going to specialise in palliative nursing in the private system. We already have access to the private nurses; it is the carers that we need. It is the hygiene and monitoring overnight so family can sleep. If we had a package like that that we could bring into the home to try to prevent an admission where families are a bit burnt out and really just needing to be able to regain some energy in order to continue loving and caring for their loved one, I think that would actually be very cost efficient for the government and would save unnecessary hospitalisation. I know that that would then fall back on the state government when really the community is a federal government responsibility, but I think the state would actually benefit from something like that and it would stop unnecessary hospitalisations.

Definitely some patients do need to come in. There is no doubt about it. We have to bring them in because it is far too complex at home. They have huge pain needs or there are quite complex psychosocial aspects to their care, so those patients do need to come in. We have a 14-bed ward up here. I think that is sufficient, even though we have the capacity for another four beds—when the population does grow enough for those next four beds. I do not think we need to use them for a long while. I do believe, though: if we could concentrate on trying to keep people home for a much longer period of time, we would not need those four beds probably for quite a significant period of time into the future. Currently they are there; they are not funded. We do have that capacity in the future, but I think if I had something where I could manage patients at home with just a carer—a carer is not the cost of a nurse. We already have nurse access. We already have doctor access overnight on call. One of the senior doctors is on call on the Sunshine Coast. By having a package where we could get a carer in overnight so the family members could sleep—that carer could then monitor the situation, contact the nurse if there are any concerns or contact the doctor if there is any concern—I think Queensland Health may actually find themselves in a much better place and not having to admit that patient for end-of-life care.

Mr WATTS: Thank you. That is very constructive. There is another area I am interested in. A large amount of money has gone into NDIS over the last number of years which has then caused a transfer of service delivery from aged care to NDIS, as we were discussing. Do you think we, as a state government and a federal government, are keeping up with training enough people to work in that sector and how do you propose we address the imbalance between aged care and NDIS? The concern is that aged care, from 65 to 100, could prove very expensive for the government that chooses to take it on. That is obviously one of the concerns, but at the same time the cost burden is falling in other areas because they are not getting the care they need.

Dr Mitchell: I agree. There is an argument that it is costly, but the cost has just shifted somewhere else. That is all I see it as—being shifted. It would be far better to use that money up-front for the purpose that it is used for, as opposed to people not being able to manage their old, ageing, frail loved one out in the community and therefore having to bring them into hospital unnecessarily because they just cannot cope. That money could have been up-front straight into aged-care system as opposed to the health system, per se.

Mr WATTS: You would not want to see the federal government pull hospital funding and spend it on aged care, though.

Dr Mitchell: There was a royal commission into this and its complexities.

CHAIR: That is right.

Dr Mitchell: The complexities, I think, were really quite obvious. It is very complex. I understand that there is a finite amount of money. Certainly Health does need to come to the party about making savings wherever it can, but community expectations keep outstripping what the health service can deliver. I do believe that the aged-care system needs an overhaul, as does, I think, everybody, and having increased funding in that area would be particularly helpful. Certainly improving the remuneration for people working in that industry would help. It is far more lucrative to get work as a carer or as a nurse somewhere else than within the aged-care system. We are all going to end up there and so, if not for an altruistic purpose, if purely for a personal purpose, we would all like to have really good carers as we age.

CHAIR: Doctor, I will take you to your submission and then I will ask the member for Mirani if he has a question. In consideration of bulk-billing, including the Commonwealth Medicare rebate freeze, you wrote—

> The … rebate freeze and the level of reimbursement for services provided to terminally ill patients has a significant impact on provision of end of life care, both within the community and in the private health system. GP remuneration for home visits does not cover the cost of service provision …

Can you give us a practical example of that and what is the solution?

Dr Mitchell: Part of the problem is that you might get the same remuneration for actually seeing the patient but you get no remuneration for the actual loss of time seeing other patients whilst you are driving to that patient's home. We find that many GPs therefore stay inside their clinics, where they will see up to 24 patients a day or something like that, whereas if they book an hour or an hour and a half out of that day just to see one patient in order to do a home visit, depending on how far away they were, and to do those kinds of family meetings, which take quite a lot of time—I can find myself in a family meeting for an hour and a half as I have people coming from overseas on the phone who have never understood what is happening to their loved one; I have the poor carer that is being emotional beaten up for the situation that they find themselves in looking after this loved one—the GPs just do not get the remuneration for doing that. Therefore it falls a lot on us to do that. That is part of my job—I am quite happy to do those kinds of things—but there are only so many of us as well.

If there was an improvement in the rate of payment for doing home visits, you may have a lot more GPs do it. The caveat is that medical students are not taught nowadays to go out and do home visits, so it becomes that many of the future doctors have never done a home visit in their whole lives when they come into hospitals, so they do not actually have an understanding of the incredible amount of information you can learn about your patient by going into their house and seeing the conditions under which they live, what support they have, what the condition of the kitchen is—all sorts of things. I keep saying to everybody that it is an area we are so lacking in—that full understanding of our patients—because we sit in white rooms, quite disconnected from their worlds, and they come in and they present themselves in a particular way. That is one of the problems: you never quite get a feeling for that patient unless you go into their turf.

CHAIR: That is a really good point. I am expecting I will get a jibe from the member for Lytton, but as a former paramedic of decades I absolutely understand what you have just said in terms of actually going into people's homes. Member for Mirani, do you have a question at all on the line?

Mr ANDREW: I do not, but I thank Dr Mitchell for appearing today. Sorry, I have been a little bit stuck with some technical issues which I am getting sorted.

Ms PEASE: Thank you very much, Doctor, and thank you for the amazing care, love and kindness that you give to your patients. What a privilege it must be for you to work with the patients and their families during such difficult times.

CHAIR: Hear, hear.

Dr Mitchell: It is a privilege.

Ms PEASE: It is. I wanted to make a comment around that and also to follow on from your comments around young doctors not being trained to go to people's homes. I am really fortunate that I have a fabulous medical practice in my community that does home visits, and many of the doctors do engage with the families at their end of life. One of them has commented to me that they felt, likewise, that it was a privilege that they had worked with this patient since they were young—mothers who had entered the practice; they have had their children; they have watched their children grow; they have cared for their children and now they are at their end of life—however, with regard to the young GP training doctors they have there, once one of their patients becomes palliative they step away because they do not want to get involved. Is there something we could do in that space, particularly around the fact that the college is taking back the training of GPs, to make sure there is some focus given to the benefits of the whole of patient care by encouraging home visits?

Dr Mitchell: Absolutely. I am very happy to hear that the college is taking up the training because that is where my original training as a GP was—with the college—and I had thought that ever since the college was no longer training the individuals we had lost something in that. I think, yes, that would be a fantastic space for junior GPs to start recognising the value of doing home visits and caring for patients who are dying. I know that people get really scared about looking after someone who is dying. I go to parties and I say, 'I am a palliative care doctor,' and people run. It is almost like I am a clinical psychologist and they do a runner. It is such a fantastic privilege, and trying to get that across to junior doctors, I think, would give them an idea that medicine is still an incredibly giving profession—giving back to us, not just us giving to others, as we receive so much from it.

The personal contact you have with your patients is kind of like having more family members, really, sometimes, and that is an incredible privilege. I think it is getting lost somewhere. There is this idea that it is a job and not a vocation. I think we need to bring back the idea that this is a vocation. Politics is a vocation. Medicine is a vocation. There are lots of vocations there. You might not get the remuneration like you do if you join a mining company or something like that, but what you get instead is a better sense of who you are and what your purpose is in life. I think we really need to reinvigorate that somewhere in our community.

Ms PEASE: Thank you very much for your evidence today.

CHAIR: Hear, hear. Doctor, thank you for your submission and your insightful commentary around how we can better tackle the issues that are in front of us, particularly in the palliative care space. It is commendable work that you are doing and we thank you dearly for that.

Dr Mitchell: Thank you for that. As I said in my submission, I am really happy to take questions from anybody. If I can be of use to the committee, I would be very happy to be of use to the committee to help them along. Thank you very much for your time. I appreciate it.

CHAIR: Thank you greatly.

PARTANEN, Associate Professor Riitta, Director, Rural Clinical School, Faculty of Medicine, University of Queensland (via videoconference)

CHAIR: We now welcome Professor Partanen. Thank you very much for your time. Would you like to start with an opening statement before we move to questions?

Prof. Partanen: Yes, for sure. Thank you for the opportunity. As a recap, our submission focused on the beginning of the pathway of the journey to becoming a GP and the importance of educating medical students for their whole medical program in the regions. It is also important to recruit students for these regional based programs from those same regions. We hope that more of them will become the junior doctors and then subsequently the GPs that these communities particularly need.

UQ is certainly working to deliver a new medical program which will have regular generalist clinical experiences in both rural and regional general practice settings and rural hospitals. These will offer longitudinal integrated clerkships. The aim of this—and what we know from other studies—is that this will result in more of our graduates choosing general practice as a career. In particular, we know that rural generalist practice is important in rural and regional areas.

For rural generalist practice to be most appropriate, it needs to be comprehensive care of providing both general practice as well as emergency care and an extra skill base in rural hospitals. For the rural generalist model to optimally serve a community they need to provide general practice based community care, preventive care and chronic disease management—that continuity of care that is so important for general practice—to keep patients out of public hospitals and not just provide care in a hospital setting for that acute medicine that they often do. That is an important part of rural generalist practice. For that to be successful and to meet the needs of our communities and reduce the reliance on the public hospitals in the small rural communities, they need to be able to provide general practice care in the community as well.

The other thing I wanted to highlight is the importance of valuing general practice in these rural and regional communities, in particular so that they can be considered an important part of the healthcare team, and often the central part of that team, to provide that continuity of care in cost-effective way. It has been affected and disadvantaged by the Medicare freeze, as you would know—not that that is a Queensland government responsibility—and it does impact on private practice. It also indirectly undermines the value of general practice in the healthcare system when funding is not appropriate for it.

That can also be reflected in patients' understanding of general practice—that it is not as remunerated as non-GP specialist practice by Medicare. That then inherently sends a message that it is not as important or valuable. We know that strong primary health care is the cornerstone of good health care of communities and individuals. If you do not have good strong primary health care then people need the services of secondary and tertiary care which puts more requirements on public hospitals providing care because preventive care just does not happen.

Finally, I wanted to raise that the pilot of the pharmacist model to diagnose and prescribe in North Queensland concerns me as it might unintentionally undermine the value of general practice just by letting the public know that they can go and see their pharmacist—somebody who has not had 10 years of training that a general practitioner has—to be diagnosed or to be prescribed medications or other over-the-counter preparations and that that can take the place of a GP. That then undermines the value of general practice further, which means that patients might say, 'I can see my pharmacist. I do not need to see my GP.' That might result in poorer health care which results in more people needing to access public hospitals when complications occur due to inadequate care of their chronic conditions and that lack of preventive care that occurs when patients present for repeat prescriptions, for example. The good GP would do that preventive care at the same time. They would check that things are being done and that their cholesterol and blood pressure are being monitored—all those things that need to be done in a comprehensive general practice consultation.

My role at UQ is that we are at the start of that journey, but we engage with our GPs and we need our GPs to be able to provide positive learning experiences and they need to be valued in the community of the healthcare sector so that the students see how important they are in the healthcare team and that they will aspire to become GPs in the future to reduce the reliance on public hospitals.

CHAIR: Thank you very much, Riitta. I want to go to your submission and the two key initiatives around the primary healthcare workforce in Queensland, those being the Wide Bay and Central Queensland regional medical pathway and the Darling Downs and south-west regional medical pathway. Can you give us an update on the progress in that space?

Prof. Partanen: Absolutely. The first one off the ground was the Central Queensland and Wide Bay regional medical pathway. That is the pathway where the students will undertake their three-year undergraduate program with Central Queensland University. Our first students are enrolling right now. They will commence in a couple of weeks with CQU, with their undergraduate pathway program called Bachelor of Medical Science (Pathway to Medicine). There will be 20 students based in Rockhampton and 20 students based in Bundaberg completing that program. It is a three-year degree. Then they will join our UQ MD in 2025 and complete all four years of the medical program that UQ offers in the regions of Central Queensland and Wide Bay—based out of Rockhampton and Bundaberg but involving all of the rural communities that are in those two footprints. That program is to commence imminently with the undergraduate pathway.

Next year, in 2023, before that group of students will complete their undergraduate program, we will be starting our graduate entry pathway. We will be recruiting up to 30 students based in both Rockhampton and Bundaberg to start their four-year UQ MD based out of the Central Queensland and Wide Bay region. That is all in progress. We have a four-way team between the two health services in Central Queensland and Wide Bay and CQU and us at UQ.

In the Darling Downs and the south-west it is about a year behind in implementation. Late last year, in December, a memorandum of understanding was expanded from the two partners that we had in the initial planning, which was Darling Downs health service and UQ, to four partners. In that memorandum of understanding to progress a medical pathway across the Darling Downs and south-west, it now includes the South West Hospital and Health Service, and the University of Southern Queensland, USQ, is also on board.

We can offer a provisional entry pathway through USQ so, once again, students from the Darling Downs region—any student can join these programs but we are focusing on the students from these footprints—will be able to do their undergraduate degree with USQ. That is a body of work that is being done right now and is to be finalised in the first part of this year. We hope that that should be in place for high school students to apply to do their undergraduate program with USQ from next year. That is our current plan. It still needs a few things to be tied up to make sure that happens, but I am pretty sure it should go ahead. Then we will recruit a year later, so in 2024, for our graduate entry pathway to the UQ MD to be based out of the Toowoomba rural clinical school campus. We will have 30 students based out of Toowoomba for their four-year degree. We will be utilising all the rural communities of Darling Downs and the south-west.

What we know is that the longer you train students in regional and rural settings the more likely they are to remain and return. What we also know is that if you recruit students from these communities they are even more likely to remain or return. We want to have a homegrown workforce. It might take a few years to build up the homegrownness, but we know that that is what the evidence shows and that is what we are working toward. That is to make a difference in the communities where the rural clinical schools currently exist, which are Rockhampton, Bundaberg, Hervey Bay, Toowoomba and the surrounding rural footprints. We are passionate about trying to improve access to health care for those communities that we live and work in ourselves.

CHAIR: That is commendable work. We heard very similar from James Cook University. Almost identical language was used: if you recruit locally, you keep them. They had data that shows that about 60 per cent of their students stay in regional and remote Queensland which is fantastic. That is commendable work. One thing COVID has taught us is that we cannot rely on international medical placements. We need to recruit locally. Is there a cap on federally funded medical places and should that be increased?

Prof. Partanen: Yes, it should be increased. It is currently capped. We have been seeking support from the Commonwealth for additional Commonwealth supported places. At the moment they have not provided UQ with any additional Commonwealth supported places so we are moving our CSPs out of the metro site to the regions. We had asked for a fifty-fifty split—that is, we would move 15 of UQ's Commonwealth supported places to the three regional programs, and we were hoping that the Commonwealth would provide the other 50 per cent. All up it would be 45, but initially it would be 15 for Rockhampton and 15 for Bundaberg. That is out of the redistribution pool that the Commonwealth had. Our understanding is that there are still 28 places—I am not 100 per cent sure of that—that had to be redistributed. We felt that our model was a great place for those to go to. We put in a submission and we received a response that that is not going to happen at this point in time.

We will have to fund all of that out of our own CSPs. That puts a strain on our program based out of Brisbane as well as being able to make this sustainable. Obviously there are concerns. There will have to be tight management financially to make it a sustainable model, but we are committed to it and we will make it work. It is going to be a bit challenging, but, at the same time, it is important

work to be done. We hope that there might be other opportunities for funding to support growing that medical workforce in areas where there is acute shortage, particularly Central Queensland, Wide Bay and the south-west, which, as we know, is short of medical staff.

Mr WATTS: I am from Toowoomba and I have a few Darling Downs based questions for you. Do you think that if in regional, remote and provincial areas we provided accommodation for students it would encourage more students into those areas?

Prof. Partanen: That is a really important point. Absolutely, I do agree with that. It is a real issue across our regional footprints, as you would know. It is acute since COVID. The rental rates in these regional communities, being under one per cent availability, impacts on people who have to move from a rural community into Toowoomba, Bundaberg or Rockhampton et cetera. It is challenging.

We also know that student accommodation is a great way for students to be well supported, to be networked—especially when they are leaving home and particularly from rural communities—and to come together with their student colleagues. This is important. We know that it works. The residential colleges that exist at UQ are important ways to help rural kids not feel as isolated when they come to a new environment and leave home. In Toowoomba I think the student accommodation would be important to help advance our program but also potentially help other students who rotate out from other health courses from places like Griffith. If you do not have good accommodation, your learning experience is not as positive and it potentially reduces your ability to think, 'This is where I want to stay.' It does not have to be five-star accommodation; it just needs to be decent accommodation. Students then have a much better learning experience.

We currently provide accommodation for our rural clinical school students at all our sites, including Toowoomba. The students value that. It is subsidised so it does help them financially. It is also a way that they keep connected with each other. With the new model of having the whole four years of the medical program, and obviously coming in for the undergraduate program with USQ, in Darling Downs, there is a risk that some of the students coming from the rural hinterland of that area may not find suitable accommodation. The financial barrier of accommodation could be a problem to start the program. If there were some way of having relatively affordable student accommodation, I think that would be important.

Mr WATTS: As I push harder for our new hospital to be built on the 180 acres we have, I shall mention that it would be good to have a dorm or two there as well. In terms of placements into Queensland Health facilities, both as part of their course and as they go on to be junior doctors, are there enough opportunities for people? Are there not enough opportunities? I am trying to understand the process of how we end up with enough rural doctors. Do we have enough training places for them in the hospitals currently and/or is there something that Queensland Health could be doing to add to that?

Prof. Partanen: At the moment, for the Darling Downs there are enough intern places. If all of our graduates from the UQ medical program at Toowoomba wanted to become an intern at Toowoomba, they could. That is great. They can remain. At the next level, when they want to join their speciality programs at our regional hospitals, including Toowoomba—certainly in the Wide Bay, Bundaberg, Hervey Bay and Rockhampton—if they are wanting to do physician training, surgical training or obstetric training they cannot remain in those regions. They have to return to Brisbane, because the colleges have not accredited those places. I understand that obviously for these you need to see certain experiences and have certain time, but I think we need to work with our colleges—and Queensland Health could perhaps help support this—in looking at different models of supervision.

With some of the barriers, they say that in the regional hospitals there are not enough different specialists so you do not get the variety of senior specialists providing that support or supervision. Maybe we need to start looking at different remote models of supervision where they can still be supervised and supported by some of those other sub-speciality specialists based out of the tertiary hospitals rather than always having to say that the trainee has to go back to the city. Once you leave, life happens and there are chances that you may not return because of life. You find partners; you do this; you do that.

The more we can keep our trainees for longer in the regions, while making sure they can still meet the learning outcomes to be a fully qualified specialist and gain the skills, the better. I think our specialist colleges colleagues need to start thinking a little bit outside the box about supervision and support for trainees in the regional hospitals. There could be some work that could be done that Queensland Health could support in that way.

If I can just go back to the Wide Bay for a moment, if all of our students who graduated out of our new regional medical pathway wanted to remain in the Wide Bay, they could not. There are not enough intern places. Our program will fall down from our graduation. There are not enough intern places. There are 17 state funded intern places and we will have 30 graduates, so we are going to lose 13 students. Even if they want to remain in the Wide Bay, they will not be able to. There is a hurdle that we hope to work through, to be able to increase that number of interns in the Wide Bay in time. That is not immediate. That is not going to be required until 2027, but we need to look at that if we want these pathways to work. We need to work with Queensland Health. Queensland Health is involved in our steering committee; Keith McNeil is on that. It is just being aware that, for those pathways to work as best we want them to, they need to be able at least to start as an intern in these hospitals.

Mr WATTS: In terms of specialist training once they go into an intern and/or registrar role, I know that in Toowoomba different categories exist for different types of service. A lot of our services are category 3 and 4, so people get packed off to Brisbane and you end up with a person from the region being seen by a regional based doctor in a capital city, simply because there is no provision for that in that regional setting. Particularly as we build a new hospital in Toowoomba and at Bundaberg, is that something that you think would be helpful for maintaining the workforce in those regional areas?

Prof. Partanen: For sure. Increasing the capacity of those regional hospitals to be able to manage higher acuity and complex cases is really important. If we are building new hospitals, we need to be able to have higher quality. There will always be certain things that people have to be transferred for, where it does not happen often. Having worked in regional areas for almost all my medical life, I think we can have more of those slightly higher acuity and complex cases being managed in the regions but we need the resources. We need the physical resources that are required. We need the human resources both in medical specialities and in nursing, and then the other health team, to be able to provide that ongoing care and expertise in those regions.

I do not think Queenslanders should be deprived or need to always go to Brisbane and metro settings to have that if we can improve that and increase that. Our population is growing. I think we will have a need for that in the regions. It would take the pressure off. There would be a huge saving in cost in the long run from all of those transfers that occur if we could leave people in the regions for more of their care. They just need the expertise and the equipment and all that goes into that. I am not the expert on all of that, but I am sure it can be done.

I remember hearing a stat that everyone in the United States is only two hours away from a cath lab, just about. It is doable that you can set up these things with remote resourcing and helping regional people be able to remain closer to their families and their communities when they are at their most vulnerable in life.

CHAIR: I do not know if I would compare Queensland Health to the States, where you need medical insurance to actually get into that cath lab; otherwise you die on the street.

Prof. Partanen: True. There are a few discrepancies, absolutely. We have a much better system overall, do not worry.

Ms PEASE: I just wanted to reflect on the statement you made around the 30 undergraduate places and there not being positions available for them when they complete. How did you determine how many places you would be offering? What was that based on?

Prof. Partanen: The number of 30 decided for the Wide Bay was in consultation with the CQ and Wide Bay health services and with CQU. CQU needed a certain number of undergraduates to make their program viable. Twenty was deemed to be the minimum that they could have in Rockhampton and Bundaberg. That would be topped up by 10 graduate entry students, because we want to also make sure that local people who may be working in other professions who want to become doctors are able to join the medical program as well as graduates. We wanted to still have the mix. It is partly that as well as the capacity in the hospitals to be able to service and teach our student body.

Ms PEASE: I am just trying to get an understanding about providing the training where there is not necessarily space for them at the end. Why was that not a consideration?

Prof. Partanen: That is a good question. I guess it was a consideration. Personally, I was not actually involved at that point in time. I was not the director of the rural clinical school when numbers were decided, but my understanding is that that was the request by the health services and that, in time, they would look to see how they could potentially increase those numbers of interns. It does not

mean that these students will not be able to get a job, because they will—Queensland Health, as you know, guarantees that all domestic students get an intern position—but it just may not be that they remain in the Wide Bay. We are not going to probably expect that 100 per cent of our graduates will remain in Wide Bay, Central Queensland and Darling Downs—we know that students and graduates for various reasons will move to other locations to get different experiences—but we want to be able to offer that if they could stay that would be great, and that is something we would work toward with Queensland Health. That is something that Queensland Health will consider, but I am not sure how that works from that perspective.

Ms PEASE: The students who come through and do the regional training are not bonded to stay in the area?

Prof. Partanen: No, they are not bonded.

Ms PEASE: They can go wherever they want to go?

Prof. Partanen: They can.

Ms PEASE: In terms of selection of the students who want to participate in this, is the entry weighted towards people from the regions? Is the entry level lower than for access to UQ medical school at St Lucia?

Prof. Partanen: The academic rigor needs to be the same. The university is very clear that to enter the program the hurdles are the same. Having said that, students who come from CQ-Wide Bay through the provisional entry pathway are receiving an extra bonus point to their ATAR. I am not sure if you know: with the ATAR system, UQ's requirement is 95 but then there are adjustment points. You get two already for rural background, so if you have a 93 of ATAR and you are rural background—so 93 plus two makes 95—you now meet the criteria. CQ-Wide Bay residents have an additional one-point bonus to their ATAR, so they could get in on a 93. There are other ATAR bonuses which are subject based—if they do specialist maths and language other than English—up to a maximum of five. At this point, that is the weighting for CQ-Wide Bay. They get an additional bonus point there.

The other hurdle they have is the UCAT, the undergraduate clinical aptitude test. Often those with rural background will get in under a lower UCAT and will be offered an MMI. It is dependent on the spectrum, but they do usually get in on a lower score to be offered an MMI, a multi-mini interview. The final hurdle is the multi-mini interviews. The students from the Wide Bay and Central Queensland have a slightly more rural flavour to some of those questions. If you are a rural and regional resident, you will naturally understand the context a lot better and should be able to perform better in the MMIs as well. There are 20 places for CQ-Wide Bay residents. There were 37 students who applied through this provisional entry pathway this year from that region.

Mr ANDREW: A lot of students come up to me saying that they are going to leave the profession through the mandates. Are you seeing issues with that for future employment, stopping these young people coming into the hospital system?

CHAIR: I have ruled on this previously. It is outside the scope of the inquiry. Professor Partanen, in your submission you state—

Medicare support is essential …

and—

Medicare rebates increased by 1.2 to 2.5% … between 1995 and 2021, at a time when the Consumer Price Index increased by 3% per year, until they were frozen completely. This has undoubtedly compromised the viability of many general practices …

Can you summarise the importance of that?

Prof. Partanen: Obviously an important part of general practice is the funding model. If practices bulk-bill and direct bill rather than have an additional fee, it is just not viable practice. It then runs the risk that access to health care becomes not universal, particularly in lower socio-economic communities, when practices—GPs—have to charge gap fees to be able to provide the service that they want to provide.

When your income does not increase and your costs increase, it simply just makes it hard. Having students in the practices when they are seeing the stress that general practices are under from a financial point of view does not help to inspire them to consider careers. We need more of our graduates thinking about and wanting to choose general practice. When they see general practices struggling, it is another added negative to thinking, 'I'm going to be a GP.' We all need more GPs in our community. Even in Brisbane I understand there is a GP shortage—let alone in rural and regional areas, where it is really acute.

CHAIR: That is a good point. It is a theme we have picked up on this week. We started in Far North Queensland, where there were 97 vacancies for GPs. It is an absolute point. I thank you for your contribution today. There are some good initiatives happening in local areas. Well done to UQ. Thank you very much for your contribution today.

Proceedings suspended from 10.59 am to 11.16 am.

ROWE, Mr Geoff, Chief Executive Officer, Aged and Disability Advocacy Australia

WILLIAMS, Ms Karen, Principal Solicitor, Aged and Disability Advocacy Australia

CHAIR: I welcome Geoff Rowe and Karen Williams to the hearing. You are great contributors to the health committee. We certainly welcome your contribution. We have your submission in front of us. Did you want to start with an opening statement before we go to questions?

Mr Rowe: Thank you, yes, I would. Firstly I would like to acknowledge the traditional owners of the land on which we meet and pay my respects to their elders past, present and emerging. I will take our submission as read. I want to congratulate you on the complex task that you have taken on. The interface between particularly aged care, disability care and the health system has been something that has probably kept Karen and me up at night for many years now. I want to also, during the course of the presentation, bring in another system that also is a contributor. ADA Australia, as you know, supports about 5,000 Queenslanders each year with information, education and individual advocacy services. We deliver those right across the state. The organisation has been delivering those services over the past 30 years.

In respect of the aged-care interface, as you will see from our submission we talk about the concerns that we see about older people being prematurely admitted into residential aged care. Going back a step, the aged-care royal commission report, which I would hope that you would reference in your considerations, said pretty clearly that the aged-care system is broken and made, as you know, many recommendations to try to improve it. While the federal government has started taking some steps on that, thus far they are only small steps.

ADA Australia often receives approaches from older people who suddenly find themselves in residential aged care. Karen no doubt can elaborate on this as we go through. When I talk about ADA Australia, as you may recall, Karen is the principal solicitor for ADA Law, our community legal centre, that specifically works with people who are deemed to have a cognitive impairment and are aged from 18 years really to 105. We will probably even go higher if we get an older client than that, but I think that has been the oldest client we have had thus far. Karen's team often find themselves approached by people who have had a medical issue and found themselves in the health system, but the health system has deemed that they are no longer appropriate to be kept there and they are fast tracked into aged care. At times the guardianship system is engaged and supports that transfer into aged care. We find, I guess, on many occasions that the older person's deemed impairment has been a short-term impairment but once they find themselves in the residential aged-care system it is extraordinarily difficult to come back from there.

We are also happy to talk about our experience with hearing from older people who have found themselves marched out of the aged-care system and into the health system because either their behaviour is deemed to be difficult or the aged-care system has not deemed themselves to have the adequate skills to provide those services. I would like to share what came as a bit of a revelation for me. A couple of years ago I was doing a presentation. I looked at the demographics of people entering residential aged care from 10 years prior to now. We are probably going back 12 years now. In time gone by about 20 per cent of people who entered the residential aged-care system had high or complex health needs and 80 per cent had low or none. Fast forward 10 years and now we are seeing that 80 per cent of aged-care residents have high or complex health needs and only 20 per cent have low or no health support needs. That has been at a time when the aged-care system has tried to step back a little bit from the medical model where they are seeing that the need for RNs et cetera is reduced, but I do not think the aged-care system has kept up with the change of demographic. That change is also, I suppose, exacerbated by the desire of many old people to age in place, to continue to live at home with supports. Many of the people we see who have been fast tracked to aged care we would deem that they would been far better placed to be supported to return to their home, the difficulty being the lack of home care places, which has been outlined in the aged-care royal commission report.

In respect of disability, we support both people with a disability and older people. I want to go back probably 14 years now to when the Productivity Commission made its recommendations to establish the NDIS. The Productivity Commission was very clear at the time that it would cost governments more to do nothing because what we would see is that people with a disability would be inappropriately supported in the health system, the child protection system, the criminal justice system, et cetera. That was certainly part of the momentum at the time for both the federal and the state governments to invest in the NDIS. What we are seeing during the rollout of the NDIS is that many Queenslanders with a disability, particularly marginalised groups such as Aboriginal and Torres

Strait Islander people and people in remote communities, have found it extraordinarily difficult to access the NDIS because of—for want of a better way of putting it—the hoops that the individual has to jump through to access that scheme.

About 18 months ago the Queensland government, in consultation with the federal government, set up the Targeted Outreach Project or TOP. TOP sought to identify people with a disability who were hard to reach and to support them to access the NDIS. That program is due to finish in late May this year. I think it has been very successful in identifying those hard-to-reach people. We as non-government organisations and the Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships have found that the outcomes for those individuals of getting access to appropriate support has meant there has been less demand on the health and other systems. I guess I would encourage you, as you consider your response, to look at whether there is perhaps some ground to continue the Targeted Outreach Project, to continue to reach out to Queenslanders with a disability who do not have the ability to negotiate the entry into the NDIS system, which is jointly funded by the Commonwealth and the states. If people do not make it into the NDIS, the state government pays twice: they pay for the NDIS and they pay for the health services, the criminal justice services, child protection services or whatever.

I have probably been a little bit long in my opening remarks but the final comment that I would make, and I do not think we made it in our submission, is that one of the key roles that Queensland Health plays within the aged-care system is in the delivery of the ACAT assessment. Often we see that the ACAT team will tick all of the eligibility boxes so they only have to do one assessment, which makes some sense at one end, but at the other end we find that it means that providers go to residential aged care because that box has been ticked. That is another contributor to that issue of being fast tracked.

The other real concern I have is the waiting list. One of the clients that I alluded to earlier was fast tracked into aged care and wanted to get out. When they approached the ACAT team to get a reassessment for a home care package they were told, 'You've got a roof over your head. You're a low priority and it might be nine to 12 months before we get to you.' I have to say that is completely unacceptable in terms of the outcome for that individual. I understand the ACAT teams will be looked at as part of that broader reform, but I think in the short-term there is some work that needs to be done around training, particularly around exploring the options that might be available for older Queenslanders. Thank you.

CHAIR: Thank you very much. You pick up on some themes that we have heard about this week in relation to accessing NDIS in the disability space. We just had a doctor who delivers palliative care talking about people at the end of life, such as a person with motor neurone disease who is in a wheelchair, and the inhibiting onerous task on families and carers, who are already stressed, trying to access funding. It is a blocker when people need it at that very critical point in time. Aged care is in the national spotlight right now. Coming from regional Queensland I am used to seeing the Army assist communities following floods and cyclones. I never thought I would see the day when they have to roll out to residential aged-care facilities. That is the reality of where we are at.

There are some key themes we have picked up around the home care packages. I know you quoted the previous work we did in the former iteration of this committee, making recommendations to get people care in the home as quickly as possible. The consistent theme this week is about the lack of access to GPs in residential aged-care facilities. We are seeing lots of movement of people. QAS gave us a figure of about 35,000 transfers from residential aged-care facilities to emergency departments. If there was a care plan in place and if there was access to GPs, would it be your view that you would stop some of those transfers for what could be low acuity? I get that people with long bone fractures from falls need to go for scans, but have you got any comments around low-acuity care before we go to questions?

Ms Williams: I am happy to answer that. There are a few factors. We talked in the submission, and also note the Public Advocate's submission as well, that people in aged-care facilities often do not get to choose their GP. It is not just a matter of a GP for the facility. If people do not feel comfortable in the facility, if they felt they did not have a choice in going there in the first place—and this is just experience from working with older people—they do not feel they can trust the GP so they are not going to confide in the GP about a whole range of things. Assisting them to find access to a GP they can trust is extraordinarily difficult and timely and sometimes we do not have a solution for that. It is the starting point to being able to disclose concerns about health, mental health or other chronic conditions. It is a starting point. If you don't have that position of trust—that is a key systemic thing about people accessing GPs—then you have a whole range of other care planning that falls from that or does not fall from that if the person does not wish to engage with the GP whom they consider is the aged-care facility's GP. It is a key issue.

CHAIR: It is a trust issue, isn't it? I have had the same GP for 20 years. We are all getting older.

Ms Williams: So many of our clients say, 'I'm now in a different suburb or a different area and they cannot come.' There are a whole lot of things. The care does not flow because the key relationship has been broken. We tend to gloss over that time and time again.

CHAIR: That is a good point. Deputy Chair, did you want to start?

Mr MOLHOEK: No. I am happy to defer to the member for Toowoomba North.

Mr WATTS: One of my interests in addressing the health crisis that we are having in Queensland and the impacts that it might be having on aged care is the transition into and out of hospital and how that is being managed—what we might be able to do better from a workforce point of view, from a treatment point of view and from a communication point of view to try to make sure that when people need hospital care they go to hospital, but when they do not need to be stuck in a hospital they are rightly processed efficiently and effectively, and that they get out with all the appropriate notes so they can then go back into their community. Would you be able to share some comments around that?

Ms Williams: Yes. It is a key topic close to my heart. Yes, there is no management or planning. The interim report of the aged-care commission was called *Neglect*. They talked about how entry into hospital is often the result of a traumatic event. They are the unplanned admissions, whether it be from a fall or an infection or the like. There is no management of that transition. As a cohort we can look at all the data—the people who are utilising health services and look at various ages—but there is no incentive for individual planning, which probably starts with a well-known GP.

I am pulling thoughts out of the air. You can look at mental health plans where people can approach their GP and get a referral, but there are no wraparound planning services about what their care needs are. Where is the incentive to have those discussions when they are not in crisis mode? Those only happen now in crisis when the person has that traumatic event or when they are in aged care. Their mind has not caught up with everything that has just happened. They are often assessed as not being capable at that point and there is no reassessment and focus on reablement. It is, 'Okay, this is what has happened to the person,' but there is no continued monitoring of the person's ability to make decisions and refunctioning. It is all crisis management from that point onward rather than a planned transition. The word 'transition' unfortunately does not even apply to the experience of people. Having a planned process would be fantastic.

Mr WATTS: Access to specialist appointments and getting the waiting lists down is one factor. Evidence that has been presented is that if you get to see the specialist early enough and you get the right kind of treatment you can potentially avoid a critical situation that requires more hospitalisation. We have had some evidence given to us about the transition out of hospital and how someone might be sitting in a hospital bed sometimes for a long time—a couple of months—waiting for the appropriate document to be prepared to release them. Is that your experience from the hospital service?

Ms Williams: Yes. It can take some time. In this interface, which is often hidden as well, there are often legal problems around decision-making and the like. What has been very useful in the amendments to the guardianship act are the capacity assessment guidelines that are now out there. There is not enough done to educate health professionals so that capacity assessment guidelines link to a human rights approach and a supported decision-making approach, including people along the way. I have gone off track. I have forgotten what your question was.

Mr WATTS: The issue is bed block in hospitals or, as the AMAQ will say, 'We are 1,500 beds short.' Either way, the critical component is when someone is in a bed when they should in fact be either back in their community or in an aged-care facility, but they are waiting for the handover documentation from the hospital so that they can go back under the care of a GP. The other side of that is when someone is under a GP's care but they need specialist input and the GP is trying to manage that because the specialist input may take years.

Ms Williams: There is also the multidisciplinary approach that people often get in hospital. You get the physio overview and the speech OT and the social worker overview, which can be lacking if someone's problems are chronic and there are lifestyle impacts as well. There is no management of the process in or out really. It is also linking with the Commonwealth data. Someone may be on a home care package waiting list in hospital but who would know? I do not know how people know that in hospital. They could be third on the list.

CHAIR: I know that the member for Toowoomba North will come at this from a different political angle. This is not just in Queensland; this is a national issue. That is why we had a national royal commission into aged care. In terms of the long-stay patients the member for Toowoomba North

spoke of, we have figures from Queensland Health that 550 or 600 are either waiting for an NDIS package—there are huge delays in accessing it—or waiting to access an available bed in a residential aged-care facility. Are you are hearing things like that from your members?

Mr Rowe: They are certainly things that we are hearing. At times we see the focus of the health system is about clearing the bed rather than looking at the outcome for the individual. That is about pressure on the system. I do not think that we always, as a community, look at what Karen is touching on. We do not look at what are the available options. Do we need to invest a little bit here or a little bit there so that we get a better outcome for the individual? Certainly the issues that we are raising are not peculiar to Queensland. They are national issues. I think Queensland has an opportunity to take the lead, as we often do, to show how it can be done better and that doing things better is about a better outcome for the individual.

If I go back to the Productivity Commission, sometimes when we look at how we do things and whether we can do things differently we actually save money as well as get a better outcome. It is very easy to keep doing what we have been doing. What we know is that the incidence of disability in our society are increasing, particularly those who have high and complex needs. At times really good medical intervention has stopped people from dying who may otherwise have. We also know that the population of people over the age of 65 is moving. By 2050 it will be 25 per cent of the population, whereas at the moment it is about 15 or 16 per cent. The issues we are talking about today are going to continue.

What may be different—and I always have to throw this line in—is that we often talk about the older people we support at the moment being the 'grateful generation'. They are a generation that grew up during through the war. They do not complain and are grateful for what they are getting. We know now that the baby boomers are coming into aged care. No-one has ever described them as 'grateful'. They are a generation who will want things to change. I think we have the opportunity to be on the front foot.

CHAIR: We do. We have lots of opportunities.

Ms PEASE: Thank you for your great advocacy for your membership, those across Queensland in that age bracket and people living with a disability. I would like to explore a little bit further what you were talking about in terms of access to health care for the people you represent. We have been hearing a lot about people's inability to access GPs and allied health services. I understand that people can apply for a package where they can get five appointments to see an allied health professional. If you are a person with a disability or an aged person with a chronic disease, those five appointments are not sufficient. For example, if you are someone living with a chronic airways disease, those five physiotherapy appointments to clear your lungs are not sufficient.

Can you maybe elaborate on the issue around access to affordable allied health services? Currently you have to pay for a physio or a podiatrist or an OT if you do not qualify for those five appointments. I am not talking about people with a disability or people who have private health insurance. I am talking about the aged sector. How does that impact on your clients who are aged and are trying to access allied health services?

Ms Williams: It is very difficult. I am thinking of people who have had to enter respite services or aged care because they have broken an ankle and the fracture has not healed quickly enough, and also the number of days funded in respite and accessing rehabilitation services after that. Unfortunately, residential aged care, if you think of it that way, is very institutionalised, which means that getting people going in or out, even if they could afford the services, is difficult. People often find there is a lack of mobility of the services because of the difficulty of transport.

Ms PEASE: I am not talking about people in residential aged care. I am talking about the general public who are still living at home and would be seeing their GP but do not have access to or cannot afford to visit a physiotherapist because they are outside of that package and they do not have private health insurance. We have heard some evidence that what is happening is putting a strain on the public system. Rather than go through their private GP, people who might need to visit a physiotherapist or a podiatrist for their condition are entering the public system. In fact, we heard from one of the HHSs that 700 people a month were doing that. Do you have experience of your membership having those problems and how do you help them? What do you suggest we do to fix that?

Mr Rowe: Just to clarify, we do not have a membership as such.

Ms PEASE: Sorry, not a membership; the people you represent.

Mr Rowe: In terms of our aged-care advocacy, anyone in Queensland can access our services who are users or potential users of Commonwealth funded aged-care services. That limits who the cohort we support may be, although disability is a bit broader than that even though we are focusing on geographic areas. That said, we know that the people we support are amongst the most marginalised and disadvantaged in the state.

You are right: many people do not have private health insurance. I think one of the other issues is that many of the people we support do not have—I am trying to think of the right word to use—the skills or the capacity to negotiate what at times is a complex health system. I think we do see people turning up at EDs because—it is a bit like aged-care facilities—that is the easiest place to go to get help. Whether that is about education or whether that is about the system being broken, I do not know that I have put a lot of energy into really considering that.

Ms Williams: It is certainly an issue—prevention focus. Having a focal point is not that easily identifiable for the general community apart from having a GP to go to—the old-fashioned outpatient type approach that is also very segmented for the older person. It needs to be more cohesive and coherent and more easily identifiable.

Mr Rowe: The Commonwealth does fund some reablement programs—that is probably their word. They are services for people who have had an injury or been unwell and who are trying to get their strength back and get their skillset back. They are often community based. I do not know that they are necessarily well known enough. They are not seen as an option. Again, you will see ED as being an option rather than saying, 'Well, service X has a reablement program. You can go there. You can get access to physio. You can get access to physiologists who will put you through an exercise program to help you get mobile again.' I would suspect that even within the hospital system the options that are available are not well known and therefore are not used.

CHAIR: We are just about out of time and we need to keep to the program. I do apologise. Before we go, member for Mirani, do you have a brief question?

Mr ANDREW: It was heartbreaking to hear the stories about aged-care residents being locked up and not allowed near their families. What do you think can be improved? Is the government listening with regard to what is going on?

Mr Rowe: ADA Australia along with the Council on the Ageing and a number of providers have come up with a visitor code to support access to aged-care services during lockdown. The recent revision of the code has acknowledged the fact that we are now seeing aged-care facilities locked down for many weeks, if not, months and that there is a significant mental health impact. I think it is both a Commonwealth and a state responsibility. It needs to be reflected within the Chief Health Officer's health directive for residential aged care. We are really wanting the health directives to support partners in care—they are the families who have been involved daily in the person's life—to have access. Ideally, we would like all older people to have access to a visitor who is appropriately vaccinated and trained in the use of PPE.

COVID is certainly going to have some significant impacts for the health system not only in terms of long COVID or the impact of COVID itself but also in terms of the impact on mental health. I agree: the aged-care population is a very key group when it comes to that impact.

CHAIR: Thank you very much for that.

GABBERT, Mr Paul, Project Officer, Community and Stakeholder Engagement, COTA Queensland (via videoconference)

POWER, Ms Stephanie, Research Assistant, COTA Queensland

STALKER, Mr John, Policy Coordinator, COTA Queensland (via videoconference)

TUCKER-EVANS, Mr Mark, Chief Executive Officer, COTA Queensland

CHAIR: Welcome to those online. Mark, would you like to start with an opening statement? It is good to see you again. You are a regular contributor to the health committee much like ADA.

Mr Tucker-Evans: I would also like to acknowledge the traditional owners of the land on which we are meeting and their elders past, present and emerging. I thank the committee for the opportunity to appear before you today. As you have said, I am joined by a number of my colleagues.

Our submission to this inquiry was comprehensive and this reflects the importance of older Queenslanders in terms of the issues being examined by the committee. My opening statement will highlight some of the key points raised in the submission as well as a number of the COVID related concerns that have arisen following the lodgement of this submission.

COTA Queensland has been advocating for an integrated health system that places people at the centre of care. This approach would ensure equitable access no matter a person's age, diagnosis, location or resources. Health is seen as interconnected to other areas of the community including transport, housing and participation, and the Queensland government needs to encourage tests and embed integrated models that connect those domains. There are clear and navigable pathways to services for diverse and changing needs throughout the life span. The Queensland government leads collaboration across federal, state and local government responsibilities including co-design with consumers to work towards an integrated system.

This vision for an integrated health system reflects actions and areas contained in the United Nations Decade of Healthy Ageing action plans. These are changing how we think, feel and act towards age and ageing, developing communities in ways that foster the ability of older people. In Queensland we talk about an age-friendly Queensland and have been working with the state government since 2016 on this. It is about delivering person-centred integrated care and primary health services that are responsive to older people and providing older people access to long-term care when they need it.

Health services, disability care and aged care within Queensland are provided in multiple settings through a combination of state funding, federal funding and user-pays approaches and eligibility criteria. The interface between these settings and funding systems is frequently poor, particularly in an environment where an older person is likely to see multiple providers for a variety of conditions and vulnerabilities. Information breakdowns may occur: for example, between GPs and hospitals, between specialists and GPs, between allied health providers and GPs, between community care providers and medical practitioners, and between residential care providers and hospitals.

The COVID pandemic has highlighted numerous examples of poor planning and coordination between the federal and the Queensland governments. The Omicron outbreak and its unpredicted rapid spread elevated points of contention. Issues such as border closures, mask mandates, the timely provision of booster shots to residential aged-care home residents and access to RATs and PPE have all been points of dispute between governments. For older Queenslanders, this has often caused confusion and alarm. Who do we believe and how much danger are we really in? It has certainly confirmed the fears that aged-care facilities are not places you want to reside in. The stories that emerged during the royal commission into aged care were scary enough. Add to that the high number of deaths that have occurred in aged-care facilities since the Omicron outbreak commenced: earlier this week, 160 of the 308 were in residential aged care.

The Commonwealth has failed on multiple fronts with respect to the standard of care provided in aged care. It has not acted quickly enough on the recommendations from the royal commission, particularly in respect of workforce issues and the healthcare provision. It has not acted quickly enough in this current outbreak to fill the gaps in care staff, ensuring that contractors will quickly fulfil their obligation to provide residents with booster shots and more readily enabling providers to access desperately needed supplies of PPE from the national stockpile.

Older people believe that the Queensland government was also caught short by the rapid spread of Omicron after the border restrictions were eased. I am sure the question of whether the border restrictions were lifted prematurely will be given more consideration in the future. However, older Queenslanders were not impressed by the insufficient numbers of testing centres that were available and the long waiting times involved on extremely hot days.

The announcement earlier this week of the international border opening to international visitors will also cause concern within the older community given their propensity to become infected with the various COVID strains. Being fully vaccinated, including boosters, may lessen the severity of the symptoms experienced. However, if you are over 60 and have pre-existing medical conditions, you are still facing a high risk of serious illness.

To help prepare for future pandemics, COTA Queensland strongly endorses the United Nations recommendation that person-centred, non-discriminatory, accessible, integrated primary health care and social care should be increased to support the communities in developing or maintaining the capacities of older people both during the pandemic and beyond. Scaling up integrated care for older people will require investment in and reinforcement of health systems involving older people in clinical trials, developing new technologies and telemedicine, and working with non-health sectors to create opportunities for people to build and maintain their capacity. More personalised and inclusive services will meet older people's needs, further reduce demand for hospital beds and lower the risk of morbidity and mortality.

To better understand how the person-centred approach can be achieved, it is vital to gain an accurate insight into local community access to and availability of health services and support, particularly in regional, rural and remote communities and in diverse cohorts that historically are underrepresented or experience disadvantage—for example, culturally and linguistically diverse groups, First Nations communities, those suffering inequities with housing or transport or who are from a low socioeconomic background, under- or unemployed, bereaved, living on their own or experiencing elder abuse. This will require consultation, coordination and collaboration with communities and networks on regional responses, in addition to making the most of existing community resources and opportunities to expand upon, for example, the volunteer network for needs such as transport, running errands, home and yard maintenance, social connection and similar activities. I will now pass over to my colleagues to answer any questions that the committee might have.

CHAIR: You were in the room previously. Did you ever think you would see the military in residential aged-care facilities?

Mr Tucker-Evans: No, we did not and we do have some concerns about that. Geoff, in fact, has also raised the issue that many people who are in aged care come from a culturally and linguistically diverse background such that they have a fear of the military. We have certainly said to the government that the deployment of the military to assist is welcome, but we do have our reservations and that will need to be well managed.

CHAIR: I agree.

Mr WATTS: In your submission one of your recommendations was that the Queensland government increases current expenditure into areas that are greatly needed such as palliative care. Is the government listening to you?

Mr Tucker-Evans: We have been pleased to see that investment has been made in palliative care in recent budgets. However, we would say that there is still a need for further investment. Often when people think of palliative care they think very much of the end of life. We actually believe that palliative care needs to start at diagnosis. It is about having people on a path to die well, and it also involves the family and the broader community around that individual. Often palliative care has been seen, particularly in regards to cancer, as very much an end-of-life issue rather than as helping people to die well.

CHAIR: I am sorry to interrupt, but I have the recommendations from our inquiry into aged care and palliative care, which you contributed to. The Queensland government responded to our recommendations. We also asked the Australian government to respond, but we have not had a response. I want to point out that a whole-of-government solution is needed in that space.

Mr Tucker-Evans: Absolutely.

Mr WATTS: Do you think further investment in that area would take pressure off the Queensland health system if the Queensland government put more money into palliative care?

Mr Tucker-Evans: It is not just the Queensland health system that would benefit; it really is enabling people to die well, as I say. People want to die at home. From the point of view of enabling people to not occupy hospital beds, it would certainly help the individuals.

Mr WATTS: In relation to the people you represent, I am interested in understanding about their access to elective surgery and whether that is causing them more difficulties and potentially more acute problems that see them admitted to hospital rather than getting the surgery they want. Is the blowing out of the surgery lists causing a problem for people in aged care and other facilities?

Mr Tucker-Evans: It is certainly a concern at the moment because COVID has placed some of those surgeries on hold. Whilst we understand that, the longer it is delayed, obviously, the more concern and potentially serious conditions there will be. COVID has actually shown up a whole lot of weaknesses not just in our state but across the nation and, in fact, the world. That is why the World Health Organization has produced a number of papers around COVID, particularly in relation to the Decade of Healthy Ageing, which is 2021 to 2030. One of the four action areas for that decade is actually integrated health care. It also looks at long-term care. As has been recognised by the royal commission that was conducted recently, that has highlighted a number of issues. Some of those recommendations were being worked on, but then COVID came along. Whilst we obviously need to respond to the pandemic, we cannot take our eye off the long-term ball either.

Mr WATTS: Do you think those waits and taking the eye off that long-term ball are costing people their lives?

Mr Tucker-Evans: Invariably if people are not getting the surgeries they need it can limit their life. We have also recognised that the Queensland government has actually responded positively. Along with ADA and a range of other organisations including Palliative Care Queensland, Health Consumers Queensland and a range of other not-for-profit organisations, we work with the state government. In fact, there is a meeting with the director-general this evening. We are having input and we are helping to shape the response, but we are in unprecedented times.

Ms PEASE: Thank you to all of the COTA board for the great work that you do. I know how hard you work and how well regarded you are. I would like to follow on from a line of questioning from the member for Toowoomba North with regard to the delivery of services and making sure that it is patient centred. Ensuring that the care is patient centred would, certainly for the people that you represent, make a huge difference to their quality of life, whether it be at the end of life in palliative care or just with their day-to-day living. Earlier today we heard from a palliative care specialist about the great work that she does and you have talked about palliative care not just being at the very end of life. I was on that previous inquiry with the member for Townsville. One of the things that we have heard is that there is not a great deal of access in the community for people to see a GP in their home, whether their home be where they grew up and raised their family or a residential aged-care facility. GPs are not visiting people in their homes. Also, there is also not a great deal of support for or growth in GP numbers, or an interest among junior doctors who are training to become GPs in visiting and providing care for residents through home visits or at end of life. Can you comment on what we have heard, which is that there is a disincentive because, sadly, there is no cash incentive for the doctors to actually provide that service? Do you have any commentary around that?

Mr Tucker-Evans: It certainly has been discussed at length that general practices have called for appropriate reimbursement for their visits, particularly to residential aged care. We are certainly aware that there are fewer GPs going to residential aged care. Even people who have been long-time providers of services are really questioning their commitment to that and that has been highlighted again by COVID. I might turn to Steph to see whether she has anything to talk about.

CHAIR: And the people who are online as well.

Mr Tucker Evans: Paul is one of our community engagement officers, particularly focused on regional, rural and remote areas. Steph and Paul might have something to add.

Ms Power: As the research assistant I sit across multiple areas of data that comes into the organisation. Unfortunately I am not on the ground as is Paul, who is out in the communities, but I do collate all the insights that we get from individuals, from inquiries, in public consultations—all different forms of engagement, basically, through our engagement officers and the advocacy that we do.

We did highlight in our submission that I did an analysis of the comparison of health professions in Australia, which decrease in numbers according to areas of remoteness. We really found we were drawn to the data around what we refer to as the RRR community, that is, regional, rural and remote. It was quite interesting that—just revisiting this this morning—it is basically Aboriginal and Torres Strait Islander health practitioners who come up ahead of the game in terms of seeming to be meeting that need. You can clearly see from our table 1 on page 25 that there is quite a bit of a gap, particularly

between the outer regional and remote areas, and you can kind of follow that down. There is a clear pattern—not in every single profession but across most of those professions, and particularly the key professions that we hear from RRR communities are most needed. We are speaking about dental health, GPs and allied health professionals, and also across aged-care services. That is not included in this table, but elsewhere in the submission we highlight that there is a great need for people to have support and assistance to navigate the aged-care system and assistance with health literacy and digital literacy in order for them to access those services. I am sorry: I have gone off on a bit of a tangent here, but I might, Paul, if that is okay, throw over to you for some deeper insights.

Mr Gabbert: Maybe I can draw on one example. I remember taking a call from a woman who was trying to get a GP to see her husband who was in residential aged care. She really struggled with that. Luckily we were able to connect her with the local PHN, which was able to connect her with a list of GPs who were visiting the residential aged-care facility. I think there is plenty of evidence that indicates there are less GPs interested in doing that kind of work. I know of this from personal experience with my mother-in-law and trying to get her GP to come and visit her. She had severe dementia. The comment was, 'Well, if she can't come to the surgery she shouldn't be at home.' It was a really unfortunate situation. Those are just some examples of the complexity.

Certainly we should have a system where if people are at home and they are not able to get to a surgery then they should be able to access a GP, whether it is in residential aged care or in their own home. As we move to supporting far more people to age in place in their own home, then I think our system has to evolve a little bit more to ensure that that can happen.

Ms PEASE: Can you shed any light on why GPs are not visiting people at home or in residential aged care, such as your mother-in-law for example?

Mr Gabbert: Personally, no. I suggest you probably need to talk to the medical colleges which could probably give you far more insight into that—the AMA and those places. It looks like John might have some insights.

Mr Stalker: The only comment I was going to make was that the AMA does do a survey of GPs. I cannot exactly remember which year, but fairly recently they undertook a survey and one of the questions they asked related to servicing aged care. While you would need to look at the results for exactly what they said, the cost of servicing aged-care facilities was a major barrier.

CHAIR: We will take that on notice to get that report.

Ms PEASE: Do I have another question?

CHAIR: I think we might go to the member for Mirani and then if we have any supplementaries we will go to my left.

Mr ANDREW: The deaths in aged-care facilities in Queensland have been fairly shocking. What are the failures that your groups have identified concerning that?

Mr Tucker-Evans: One of the things that we have certainly seen is that there has been a very slow rollout of vaccinations in aged care and that is being replicated with the rollout of the boosters. Aged care is one of these challenging areas where parts of the health system are funded by the Commonwealth government and parts are funded by the state government, there is a multitude of players within the health system and trying to actually get it integrated is no mean feat.

We have been concerned that the rollout of vaccinations to people in residential aged care has been much slower than was planned. We have also been disappointed—and there are elements of elder abuse in this as well, or potential elder abuse—that currently about 30 per cent of people in residential aged care in Queensland have not been vaccinated or fully vaccinated. Some of those decisions have actually not been made by the resident themselves but, in fact, by their family. One of the things that we have been looking at, and we have been talking to people such as John Chesterman about this, is actually reinforcing the role of the Attorney, that in fact they are there to make the decision that would have been made by the resident and not their own take on this. It is a combination of, I think, misinformation—the residents do not have the right information—and also a very slow rollout of the vaccination.

CHAIR: On the back of your question, member for Mirani, I would not mind getting a number and you can take this on notice. You said 30 per cent have not received the vaccine. What does that look like in a practical sense? How many people are in the state's 459—I think; I should know that—residential aged-care facilities?

Mr Tucker-Evans: There are about 440.

CHAIR: Approximately how many residents are we talking about? How many residents does 30 per cent make up? Who is missing out? What do the numbers look like?

Mr Stalker: I cannot say off the top of my head. You are asking the oldest person sitting here.

CHAIR: We will call it a potential senior's moment. Can you take that question on notice?

Mr Tucker-Evans: We will provide that information to you.

CHAIR: Do we know how many residents are in residential aged-care facilities? Then we could subtract 30 per cent.

Mr Gabbert: Not off the top of my head. It is fairly easy to get though.

Mr ANDREW: Pre December 2017 there were a fair few deaths and there was no COVID in the state. I am trying to work that out too. We had a lot of people in the Mackay area pre December 2017—

CHAIR: We are getting some background noise. I will go to the members on my left for supplementaries.

Mr WATTS: I will go to a couple of your other recommendations. One is—

The Queensland government adopts a strong framework to ensure diverse older consumers, as partners, co-design an integrated system of care (including services, health promotion activities, information and supports)

The next recommendation is about telehealth and an integrated model. Could you expand a little bit on how you think that would address the health crisis we are seeing here in Queensland?

Mr Tucker-Evans: COTA Queensland is the seniors' peak organisation. We are a registered charity for purpose and our purpose is to advance the rights, needs, interests and futures of people as we age. Our cohort starts at 65 and goes through to people over the age of 100.

One of the things that we certainly see amongst the older population is that they grew up in a time when they did not question their doctor. Whatever their health professional told them to do they just did. What we are seeing amongst the younger age group is that they actually really want to be partners. They actually want to be well informed and actually work through solutions with their health professional. We would certainly encourage that. We think that that is the basis of a person-centred health system. We are recommending that that happen. Often older people are excluded from that, partly because of what I said earlier, but what we are seeing is that people in their fifties, their sixties and seventies now want to actually be part of the solution rather than part of the problem. Steph might like to add to that.

Ms Power: An item popped into my head actually, which we did not put in the submission. I mentioned digital literacy before and the converse is that there is great interest from the cohorts aged from 55, 65, 75. Latest reports such as the ADII report—the Australian Digital Inclusion Index report I believe the title is—clearly show a pattern of increasing digital literacy and unfortunately once again it is in the RRR community areas where it is lacking. Gender wise females—very generally—have a lower digital literacy rate than males. Something else I find we need to keep in the background when we are interpreting the data coming through is how people are interpreting the huge amount of information that is coming in at the moment and how they are processing it, not just at a digital level but also the overwhelming nature of information overload. If you like I can also include the ADII report because that is particularly telling for those cohorts.

CHAIR: Thank you. We are out of time for COTA Queensland. We do thank you for your contributions. I very much thank the gentlemen online as well. Can we have the answers to any questions taken on notice by Friday, 18 February. We certainly appreciate your contribution and the great work and advocacy you do. Thank you very much.

FRKOVIC, Mr Ivan, Commissioner, Queensland Mental Health Commission

CHAIR: Welcome, Mr Frkovic. You have been a very busy man. We know that the Mental Health Select Committee is also undertaking hearings today. I watched online your opening, and there is some stark evidence there. I see some significant crossover to what we are doing, which you might talk to. Please make an opening statement when you are ready and then we will move to questions.

Mr Frkovic: Good afternoon. I start by acknowledging the traditional owners of the lands on which we meet and pay my respects to elders past, present and emerging. At the outset I would also like to acknowledge that we can only provide quality care through valuing and respecting but also drawing upon the lived experience and expert knowledge of consumers, their families and carers as well as the dedicated staff that we have in the general health, mental health and alcohol and other drug sectors. The Queensland public health system is facing enormous pressures in the face of the rising demand for health services. We see this especially now during the current Omicron wave, but even before the pandemic some Queenslanders struggled to access the health services they needed in a timely manner. We welcome this inquiry to achieve better outcomes for Queenslanders, including those living with mental illness and drug and alcohol problems.

Easing the pressure on the public health system is complex. We have touched on a range of issues in our written submission to this committee that I would like to expand on briefly. Issues we believe need to be considered by this committee include improving funding approaches between the Australian and Queensland governments, with a clear delineation of roles and responsibilities. There is no doubt that more investment by federal and state governments is urgently needed to address the long-term chronic underfunding of both the mental health and alcohol and other drug sectors.

The mental health system has been referred to as a patchwork system that is failing to meet the needs of many Australians rather than being a comprehensive and integrated service. It is well known that the current approach is unbalanced and oriented towards a hospital-centric and crisis-driven system. Australian government investment is especially necessary to build a diverse range of community based services including resources to assist what we refer to in mental health as the 'missing middle'. Those are people whose mental health challenges are too complex for the primary healthcare system but not complex enough to meet the criteria of the public acute system.

The impact of the currently unbalanced system can be seen through pressures in our emergency departments and bed occupancy rates by people experiencing a mental health crisis. Inappropriate reliance on emergency departments can be considered a sign of system failure. Community based responses are required to prevent and intervene early when mental health challenges first arise. Under the current system there is limited access to general practitioners, especially in regional Queensland; long wait times for private psychiatrists and allied health professionals; and also gap payments are restricting people's access to services. Primary health care, an Australian government responsibility, is the frontline of Australia's health care system, including in the area of mental health.

Queensland is the most decentralised state in the nation and needs particularly Australian government support to expand the GP and allied health network in the regions and increase bulk-billing generally. It is suggested that there would be greater bulk-billing for mental health services—and this picks up on some of the discussions you just had earlier—under the MBS if rebates were increased to reflect the complexity, particularly when GPs, private psychologists and social workers are working with people with mental health and drug and alcohol problems. People who are unable to access GPs who are trained and qualified to undertake mental health assessments and/or provide treatment or care are at greater risk of getting worse and needing costly hospital care. This is why entry points to primary health care are critically important to reduce emergency department presentations and also the inappropriate utilisation of expensive hospital beds.

Additional factors impacting on our tertiary state funded healthcare system include delayed access to aged-care support and the National Disability Insurance Scheme. The Australian Medical Association of Queensland recently indicated that people waiting to access aged care, home care packages or disability support were taking up hospital beds, and it was a statewide problem. Timely access to such services provides better outcomes for the individuals, the people and their families but also for the state operated health system and our economy. The rollout of the NDIS has brought many benefits to those who are eligible but continues to present significant challenges such as access barriers, complexity of need, thin markets and also sector sustainability. Again, these issues are exacerbated when we talk about regional Queensland.

As we know, the Australian government is primarily responsible for funding residential aged care, community aged-care support and also the NDIS. We need to prioritise the resolution of some of these issues to be able to ensure that people with mental health problems and alcohol and other drug problems have access to these services in a timely manner. The integration of Australian government and Queensland government services is critical to reducing duplication and service gaps, and also to enhancing consumer outcomes. We need all parts of the system to be talking to each other and working together to ensure all parties are developing a seamless mental health system where people are not falling through service gaps.

There is also a significant unmet demand for alcohol and other drug treatment and support services in Queensland. AOD treatment and care services meet an estimated 28 to 48 per cent of demand in Queensland. Again, the lack of these services and unmet demand is particularly critical in regional Queensland.

On top of these issues there are critical workforce issues in the mental health and alcohol and other drug sectors that we all collectively need to urgently address. The commission supports reforms to take the pressure off an already stretched public health system that is also dealing with the challenges of the ongoing pandemic. We also and finally acknowledge the work and sacrifices of a committed and dedicated health workforce that is dealing with enormous pressures, health risks and often associated mental health issues. Thank you. I am happy to answer any questions.

CHAIR: Ivan, clearly at the core of this is trying to keep people out of emergency departments. There has been an initiative where the QAS—and I have one in my own patch in Thuringowa involving the Kirwan Ambulance Station—is running a co-responder model. Can you talk to the benefits of that? We might need to ask the QAS what the data looks like, but can you give us an understanding of that initiative and how it might keep people out of EDs?

Mr Frkovic: The co-responder model in Queensland has been funded both with the Queensland Ambulance Service and the Queensland Police Service. There are two different types of models. This primarily means that you have a mental health clinician embedded within the police service and they go out into people's homes or they are embedded within the Queensland Ambulance Service. Also, in their communication centres there are people with mental health backgrounds who support both the ambos and the police when they go out. Some of the evidence is really overwhelming, to be quite frank.

I spoke at the select committee inquiry about, for example, the evaluation of the West Moreton co-responder model that has some really good data. It is linked more with the police but has similar types of outcomes as the chair's question around ambos. In some instances—and I am just trying to recall the data—there has been a 70 per cent reduction in people needing to be brought back into Queensland Health services, emergency departments et cetera. This enables particularly the resolution of what we could call in mental health 'situational crises' where people may be experiencing a mental health problem but it is as a result of having experienced domestic violence, drug and alcohol problems, financial problems, instability in their housing et cetera. The combination of those things is what causes some of the crisis. Providing options where we can proactively go into people's homes and try to resolve those issues in situ is the way to go.

I will mention some data from my discussions with the Queensland Ambulance Service. In terms of mental health call-outs, as a result of all of these supports that we have put in place to support the Queensland Ambulance Service, 60 per cent of mental health call-outs are dealt with in situ, in people's homes; they are not brought into an emergency department. Of the 40 per cent that are brought in, if we as a state had alternatives to ED and other options where the Ambulance Service could take those people, probably only between five and 10 per cent of that 40 per cent would need to go to an emergency department. There are clear opportunities but also clear evidence that, if we provide services such as a co-responder model and we support and also provide alternatives for people who may need a level of support rather than ED, we can do that successfully.

CHAIR: I spoke to some of the clinicians when we announced it in Kirwan. The language they used was about going to the 'appropriate' place of care.

Mr Frkovic: Correct.

CHAIR: That is an initiative we certainly welcome.

Mr MOLHOEK: Ivan, you touched loosely on the shortage of alcohol and drug support services. Could you elaborate a little more around what services are available and what additional services we may need to keep people away from our hospitals and provide greater supports in the community for those wrestling with these issues?

Mr Frkovic: We have a range of services already in place. Obviously there is a whole range of both government and non-government services providing individual, group work, counselling, brief motivational interviewing—a whole range of services. There are also some residential services where people can come in for rehabilitation services, detox and a whole range of things. We do have a range of those services available in Queensland. The challenge with that is that we do not have scale.

Mental health is the poor cousin, if I can use those words, in terms of funding in the general health area. Drug and alcohol is really a poor cousin in mental health in terms of the funding level. Our biggest pressures seem to be—and I do not have the data specifically in front of me here now—really around some of the beds that we need, particularly in drug and alcohol so detox and rehabilitation beds. I know the government has funded a range of those and they are starting to roll out, but the numbers of additional beds we need are probably in the hundreds to meet some of the demand for some of those services.

If we can provide some of those services, as I said in the other inquiry, we can provide options to divert people who have an addiction, who have a drug and alcohol problem. They are not criminals in the main; they have an addiction, a health problem. Can we get them into treatment? That is an option as long as we have those treatment options available to refer them to. The options are that we need to grow the drug and alcohol sector in Queensland, providing a whole range of community and residential services—public and non-government. Again, drug and alcohol is not just a state responsibility; it is funded by both the federal and state governments. We have to look at that in a holistic way but we have to grow that sector to be able to divert people who have a health problem into treatment rather than them ending up in the criminal justice system.

Mr MOLHOEK: Further to that, I understand that the nature of alcohol and drug addictions has changed significantly. I am told by some of the providers on the Gold Coast that when people were using, say, marijuana or less complex drugs it was a lot easier and the time required in rehab was shorter. The issues now are far more complex because of the ice epidemic. Can you comment around the challenges of that epidemic and whether that actually requires a greater focus on service provision and greater time frames?

Mr Frkovic: I will try to break that down a little bit. Certainly the change in the availability of a whole range of substances has impacted on individuals and their health in terms of how they are experiencing their health. For example, there are a range of substances on the market that are obviously being utilised and that do cause psychotic responses in individuals. That is certainly enhanced, but that is not to say—if I can try to unpack this—that any substance is better than the other. I think they all have negative impacts in terms of quality of life and a whole range of outcomes. Supply will change from time to time depending on a whole range of markets and what is available.

Whether the situation is worse now than it was before, I think the data would indicate that we do not have this huge blowout of drug and alcohol problems. There has been a gradual increase. I think what we are seeing at the moment is that there are pockets, and certainly some of the more harmful substances are getting much more media attention, particularly in some of our regional areas, which then gives the impression that we have this massive problem across the state. That is not to underplay the level of problem that we do have, but I think we have to take a balanced view on this and try to understand what some of the factors are that lead people to use some of these substances.

Please keep in mind that the most damaging substance is alcohol and not illicit substances, and that is something we can legally buy. The social impacts of alcohol are huge. These are some of those nuances within the alcohol and other drug sectors that we need to understand to be able to impact on what is happening. Yes, illicit substances are a problem. Yes, we have to deal with them. Unless we also tackle alcohol at the same time, I think we are always going to be grappling in this area.

Going back to my point around investment, unless we start to invest in this area in a serious way to be able to respond to these needs then I think we are going to see more problems. We are going to see more people facing the police and facing the courts but we are also going to see higher rates of incarceration.

Mr ANDREW: It has been devastating to hear about the aged-care residents being locked away and unable to be with their families, how the lockdowns and mandates have affected people right across the different demographics of Queensland and how alcohol and drugs all work in with that. What does your organisation's research say about this? How is the mental health of Queenslanders generally at the moment? How are they dealing with the loss of jobs and the loss of income? So many people call us every day. It is obviously affecting every single person at the moment and not just in terms of their mental health.

Mr Frkovic: From the information that we have and the data that is available and even some fairly large matter research that has occurred around mental health, there has probably been about a 25 per cent increase in depression and anxiety during this COVID period. That is not just Australia; we are looking internationally. We can also see that translate locally. For example, we have seen an increase in demand for our services and for some of those support lines like Beyond Blue and Kids Helpline. We have seen an increase in young people particularly—young people with eating disorders. We have seen increased presentations to our emergency departments. We have seen the translation of the impact of some of the things that you are talking about starting to manifest themselves in people reaching out for supports and services, which is a good thing, but also we have to have the responses there.

When it comes to drug and alcohol services, similarly we have seen an increase in people—obviously, as a result of lockdown, there are a whole range of reasons—also reaching out particularly to some of the phone lines we have in Queensland. Our ADIS line has seen a massive increase in people looking for support and assistance to deal with some of their drug and alcohol problems. I think some other commentators have used this: the second wave of the pandemic will be the mental health wave. I think there is some clear indication particularly of the long-term impact on people who have lost businesses and people who have lost lives as a result of this.

I was really pleased that the Queensland government—it was probably the only government—recognised that you cannot have economic recovery without human and social recovery. The government, as part of the economic recovery plan, made a commitment of dollars for mental health. Other jurisdictions have probably invested more money, so I will not go into the quantity and into their mental health systems, but they did not recognise it as part of their economic recovery which I think is a critical aspect. As I say to people, you cannot have economic recovery without human and social recovery. I think there was a great recognition from the Queensland government at that particular point in time that we have to invest in the mental health of our society if we are going to come out of this at the other end. More is needed, can I say.

Mr ANDREW: Are there any impact investment vehicles around mental health that are being used here in Queensland or in other states? If so, can you give us an overview of how they work and what role the private sector entities play in funding desired outcomes?

Mr Frkovic: Could you clarify that for me again just to make sure I got it right?

Mr ANDREW: Are there any impact investment vehicles around mental health—as you say, it needs them—that are being used here in Queensland or in other states that we could look at? If so, could you give us an overview of how that would work and what role the private sector entities would play in funding desired outcomes?

Mr Frkovic: I think there are probably a range of areas where we could hopefully attract additional resources to be able to deal with this. Taking it from that service delivery component, again, Queensland is one of the lowest per capita spenders when it comes to mental health but we also have some challenges in terms of people getting early to some of our services that are funded by the federal government. For example, we need people to be able to access, as I said in my intro, GPs at an early point et cetera. Otherwise, the roads all lead to inpatient care or emergency departments. As I said in my opening statement, we need a general investment in mental health across governments to be able to meet the existing demand and then on top of that the increased demand we have seen as a result of the pandemic.

Where I think some of the impact investment can have is really about supporting people like some of the work that we have started to do with the Office of Industrial Relations and the Small Business Commissioner in Queensland, looking at how do we support small business in this particular process to be able to continue to operate, to be able to continue to employ other people, to be able to continue to provide services but also to be able to understand that this pandemic and its economic impact is having an impact on their mental health and they need to deal with that. Again, I have to say we have done some fairly good work through those two organisations and also with local chambers of commerce. We are working through those to try to assist the community.

What the private sector can do is support some of these initiatives that are happening more broadly in the communities where they operate. One of the things that I think is the most important aspect is about how we look after the mental health of the workforce. The workforce, both in the public system and in the private system, is critically important because again we are not going to get through this pandemic and the economic impact and all of those things unless we look after the workforce. That is where I see some of those bigger picture investments where things can happen to help us get through this and also ensure that we come out the other side psychologically much stronger.

CHAIR: I will make a couple of observations before I move to the member for Toowoomba North for final questions. We were told that 60 per cent of Queenslanders do not have private health insurance, so even accessing the private sector is a barrier, and for the 40 per cent who do the gap is so much that they end up going to the public system. I have often said that you cannot have an economy if you do not have your health. We know how vital mental health is. I was visiting a Lifeline call centre in Townsville a few months ago and their significant call-ins over the last couple of years from people seeking help blew me away. It is a real issue affecting our local communities.

Mr WATTS: In your submission you talk about a $2.3 billion investment from the federal government over four years. I am interested in exploring what match funding is coming from the Queensland government to go with that. My particular interest is in detox beds and residential care beds around drug and alcohol affected people who are trying to recover from addictions and how that can impact. Someone can get an acute bed in a hospital; that is really not the place for them but there is nowhere else for them to go. Often they then bounce out of there and back into the home and the whole thing magnifies and then they are back in hospital again. I am seeing this in my community. We have two residential facilities—no detox beds though. Can you talk about that in relation to the funding and match funding? What more do you think we should be able to do?

Mr Frkovic: I do not have the details about the bilateral negotiations that are happening between the states and the jurisdictions and the federal government in relation to that $2.3 billion. I can certainly give you some insight into my understanding of what is required. The federal government has obviously made a $2.3 billion investment into mental health. Remember that that is nationally. I would never say no to any money, but I think when you divide it between eight states and territories the investment is relatively low.

It is a great start. I think what is the best around the federal government investment is their focus on what I talked earlier around the 'missing middle'—trying to establish particularly some of what they are calling Head to Health hubs, which are to support people in a community context in situ before they end up in the public system—which is all the discussion we have just had. Those community centres will also deal with mental health and drug and alcohol. From my understanding and what I have been made aware of, there will be a contribution required from the state and territory governments to be able to get that funding from the federal government. I think that is a good, very small first step in the right direction because we need to build that infrastructure. That is a critical aspect. I do agree that is a Commonwealth government responsibility.

Where the state government comes into that is the state government funds beds and community clinical services. Those services, particularly the community clinical services, need to be integrated with these new Head to Health hubs and they need to be the new front door of mental health—not our EDs and not our hospital services, as you say. Within that, I do not have the details but I am not sure how much of that new national partnership agreement and those bilaterals will cover drug and alcohol. In fact, I suspect very little apart from those areas where there is a comorbidity between drug and alcohol and mental health. It will pick those up. It is not specifically around drug and alcohol services, even though there will be some overlap where people have both a drug and alcohol problem and a mental health problem.

The other good thing around the Commonwealth investment is that for the first time, apart from what the state does in this area, we are seeing more investment upstream targeting—and Queensland should get a number of these—called Head to Health Kids, which is for zero to 12. An area where we do not have a lot of services generally is those early years. If you give a kid the best start in life then your trajectory changes and then downstream your impact on child safety, your impact on youth justice, your impact on mental health services and public health services will reduce. I am really glad to see that some of that money has gone upstream. Again, the state will have to co-contribute to that to be able to attract that funding to Queensland.

Mr WATTS: I have a very quick supplementary: what should we be doing as a state government for drug and alcohol and detox in our community?

Mr Frkovic: There are probably three things—and I could spend quite a long time talking about this. The first thing is that we as a state government, but also the federal government, need to increase our investment in drug and alcohol services—the things you talked about: detox, residential rehab, community services. That is a fundamental start because drug and alcohol is excessively underfunded at this particular point in time.

There are some clear, easy wins in the harm reduction area that we can do quite easily—I can certainly provide you with that information—where we can make a huge difference to keep safe people who have an addiction. Finally—and probably the biggest system change that we need to achieve when it comes to drug and alcohol—we need to have a clear focus on diversion. Divert people

who have an addiction, who have a health problem, into a health response rather than the criminal justice response, and let our law enforcement agencies focus on those people who are traffickers, manufacturers, suppliers.

CHAIR: That is a good point. Ivan, we have come to the end of our time with you. We very much value your contribution. Thank you very much for making time to be with us today. You were probably at the other hearing.

Mr Frkovic: Yes. I am going back there now.

CHAIR: As usual, your insight into this valuable space is welcomed.

Proceedings suspended from 12.45 pm to 1.30 pm.

POWER, Mr Darren, Mayor, Logan City Council

CHAIR: Welcome. We were in your area yesterday for a public hearing. It was very insightful, with some good contributions. We welcome you, Mayor Power, to make an opening statement and then we can move to questions.

Mayor Power: My name is Councillor Darren Power, Mayor of Logan. Good afternoon and thank you for the opportunity to speak today. The City of Logan, as you know, is one of the fastest growing areas of South-East Queensland, expected to jump from a population of 350,000 to half a million in the next 15 years. Combine this growth with the national trend towards an ageing population and the increased demand for health care, aged care and NDIA services, and the problem is significant.

In 2018, council commissioned research to look at the demand for healthcare services in the city and the gaps in delivery of service, of which there are many. The study also looked at the main drivers of investment. As someone who has lived in the city for over 30 years, this research confirms some of my own life experiences. Unsurprisingly, it found major gaps in Logan's healthcare infrastructure.

As a city, we are experiencing significant shortfall in acute hospital care. This is despite the current expansion of the Logan Hospital, which by the time it is built will be already overwhelmed, with a significant flow of patients to hospitals and facilities outside of Logan, to both public and private; significant gaps in specialist outpatient care and medical imaging services; and specific gaps in allied health services. As mayor of a city of 350,000 people, I am extremely frustrated by this. Modelling shows that there will be a shortfall of 604 beds and places in 2030, despite planned upgrades to the Logan Hospital. This is not good enough. Logan residents are being left behind by a health system failing to cope.

The same study also found that, as a city, we lack a long list of medical specialists: paediatric medicine and surgery, obstetrics, psychiatry services, geriatric specialists, urology, cardiologists, orthopaedic surgeons, trauma, eye surgeons et cetera. These are services that a city this size should be able to access easily and quickly, without the extra burden of battling peak-hour traffic to Brisbane.

As a council we want to be part of the solution and, with a strong track record in attracting major investment, council made it a priority to focus its efforts on the medical and health sector. Through the right planning settings, infrastructure and investment incentives, council has contributed to attracting a pipeline of more than 30,000 square metres of private health medical services to the suburbs of Springwood, Meadowbrook, Loganholme, Crestmead, Park Ridge, Greenbank, Flagstone and Yarrabilba. This might sound like good news, but I have lived in this city for a long time. I know how difficult it is to land these projects on the ground. A private hospital in Logan has been talked about. I am yet to walk through the shiny glass doors of one.

What we need to see is government thinking outside the box when it comes to traditional health and care models. Now is the perfect time to develop private-public partnerships in our city. We would like to see partnerships where Queensland Health subcontracts services to the private industry, creating additional beds and boosting the services available to Logan residents. This has the potential to ease the strain on the health system, deliver critical public health services and reduce waiting times for residents in Logan.

Recently I was approached by an eye surgeon who runs a clinic in Loganholme. He has an existing clinic and would be able to accommodate 300 outpatients a week and perform over 100 eye surgeries, both elective and urgent, with the addition of a double operating theatre day surgery co-located with the clinic. He could be up and running within four months. This is an ideal opportunity for public-private partnership and could significantly ease the burden on the public system in Logan. Logan residents could then access these critical services in their own city, rather than being referred from the Logan Hospital to the PA Hospital 25 kilometres away, or to Redlands, which is the current arrangement. I spoke to this surgeon at length. He works in the public system as well as providing to the general public. He says that he can do a cataract operation for $2,500, yet in the public system it is $4,000. He says that if he was up and running he would be prepared to put in the $2.5 million to put up a clinic that he would pay for, and he would obviously be working for both public and his own practice. That would be a great outcome, because at the moment we have nowhere in Logan to have a cataract removed; we have to move outside of Logan. This is crazy. I had a cataract operation about four years ago and I witnessed this firsthand.

There is already a precedent for arrangements like this in other local government areas, such as the Queensland Health Metro North Surgical Treatment and Rehabilitation Service hospital project and the new Mater Health Services project which is about to deliver a 174-bed hospital in Springfield. We believe there are other opportunities to subcontract elective surgeries to new private health facilities that are set to be delivered in Springwood, Park Ridge and Yarrabilba.

Council is in an ideal position to provide insight into the current and future private health investments in the city and also to help facilitate discussions between Queensland Health and private sector investors on potential partnerships. We believe that the public-private partnership model is a practical solution with significant benefits to both the Queensland government and the Logan community. I would urge that this committee and the Queensland government give it due consideration.

That is my presentation. I must say that my frustration of living in the city for over 30 years is that we have over 110,000 people who have private medical insurance and they are always travelling out of the city now. It is congesting our roads. They are obviously competing with Brisbane people for these services. The frustration of having a city as big as Logan without these services is a huge embarrassment as well. I am constantly reminded in my community of these failings, and that is why I decided to make myself present here today.

CHAIR: Thank you very much, Mayor Power, for your passion for your community, like all of us. We all care about our community greatly. I wanted to take you through the terms of reference for this inquiry. Just bear with me for a moment. We are asked to inquire into the provision of primary and allied health care, aged and NDIS care, the private healthcare system, which you have touched on, and the impacts of availability and accessibility of those to the Queensland public health system. We are asked to look at bulk-billing policies, including the Commonwealth government's Medicare rebate freeze, and the Commonwealth's definition of 'distribution priority areas', which is workforce around GPs. What we have heard to date—and clearly you have an ageing and growing population—plus the data we received from Queensland Health, is that it is just not sustainable.

Mayor Power: No.

CHAIR: We are a city—I am sure you know Mayor Hill in Townsville, where I come from—of 200,000. Along with the outlying district, we are 245,000. We are seeing 250 people a day through our emergency department. That is not sustainable. The theme we have picked up this week, whether we have been in Cairns, Townsville, Logan or the Gold Coast, is: how do we better—and you have come up with a proposal, and I see that as part of your submission—and divert away from the public healthcare system people who should not be there, for low-acuity issues.

We have heard right across the state that people cannot get in to see their GP. I think you said it well this morning, member for Lytton: 'I can get in in three weeks. I will just book myself to be sick in three weeks.' Seventy per cent of those people turning up to emergency departments are walking in—a fair degree of them—with low acuity. The question is: how do we better tackle that issue with the current private system as well? You have touched on that.

The data we received in our first hearing last year was that some 60 per cent of Queenslanders do not have private health insurance. Whilst the private organisation that you are referring to and want to get off the ground sounds great, what about the affordability for people in your area of paying thousands of dollars for private health? I see it in my patch, too, and it is reflected across the state. The 40 per cent who can afford it are still going to the public health system because the gaps are so big in delivering care. How do we tackle those primary areas that I am trying to touch on and draw out in your area?

Mayor Power: I concur with your thoughts. It is not sustainable the way it is going, and with an ageing population the problem is going to get worse. The experience I have had is—I have lived in another state; I lived in Melbourne for a long time—that the availability of clinics after-hours was there. There is nothing of that type in Logan.

CHAIR: That is right.

Mayor Power: Once you get to after five o'clock, you then go to the Logan Hospital, and the Logan Hospital is full. If you go to the after-hours emergency, you can be up for four or eight hours or such. It is full of people with private health insurance. The problem is that it is not just the gaps; it is the drive to, say, Mater Private Hospital which I do occasionally because I want to get seen to. Yes, it is a $250 excess, but I want to be seen and, on a mayor's salary, I can afford it. I see people from my constituency in that emergency area at Mater Private, but I have also gone to the Logan Hospital with a son with two broken arms, and I see people from my area. My area is generally the wealthy area that has private health insurance—that is, the eastern side of the Pacific Highway. It is frustrating

because they all say look, 'My son broke his arm. I have to get him to a hospital straightaway.' They are not going to get in the car and drive all the way to Brisbane; they want to see someone straightaway. Those partnerships I talk about with the eye surgeon—that is an opportunity. I am pretty sure there are a lot of specialists who think that same way. There was an endoscopy centre that wanted to do the same thing. Somehow we have to get doctors to open up after-hours.

We also have another issue. A lady councillor spoke to me today about an issue. They represent the Woodridge-Logan Central area and they are finding it very hard to attract doctors to that area. As such, we get overseas doctors. For women it is really hard, because when they go there the doctors will not see them for women's issues and they refer them on to specialists in the city. I do not know whether it is for religious reasons or what, but they refuse to go there. That is another impediment for these women to get treatment in Logan and it therefore puts more pressure on the state public system. They will get referred to the Mater Hospital or somewhere like that. These are issues that could be easily dealt with.

To be honest, I will just give you my contribution. I am sure you would have got a lot of other contributions and I am sure there are a lot of ideas that you can put together. I will be putting a letter to the health minister about this eye surgeon because he wants to go; he is ready to go. I think it is crazy that there are so many old people—it is funny, because I was at the practice last week and it was full of old people. They were all probably over 75 and they were all there for cataract, but once they are referred there for cataract they have to go to Brisbane to have it operated on. That is crazy. They have to go to the hospital the day before, the day of and then the day after surgery. For old people, it means getting a lift in or getting someone to drive them in, but also it is competition for the services in Brisbane. It is just crazy in this day and age.

Mr WATTS: Thanks very much for coming along and presenting, Mayor. The Queensland health crisis is real. As we know, in this committee we are not allowed to talk about it.

CHAIR: Hang on—

Mr WATTS: The government has stopped listening so much so that—

CHAIR: Member for Toowoomba North!

Mr WATTS:—there is a set of references that we cannot even talk about.

CHAIR: Member for Toowoomba North! Order! Member for Toowoomba North, there is absolutely no need for that commentary. We are allowing people to come before us and talk to the terms of reference. Don't let me go to the warning side of things. Let's keep this civil. It has been like that all week. It is Friday afternoon. We have the mayor of Logan here. Can you just rethink your language, please? I do not want to have to—

Mr WATTS: Sure. I have read the submission and the submission talks about the lack of health services in Logan and the fact that people have to travel outside of Logan to access that. I see that as a failing of the state government and we are not allowed to talk about it. Do you find it peculiar that we are not allowed to talk about that in this hearing into the health services in Queensland?

Ms PEASE: It is an opinion, Chair.

Mayor Power: I am not in any political party. I acknowledge that it is a growing problem in Australia. We are ageing, we do not have six or seven kids anymore—we have one or two—and we are living a lot longer. I am not in the blame game; I just want to fix the issue, and that is what I am here for. I feel very passionate about this because I have lived in this city for a long time and I know it is a big issue. When I saw this come up, I thought this was a great opportunity to talk to someone who will listen and take notice of it. I have given you a few hints. We are here to help the government. We will assist you in getting some of these things done, but it will help everyone if we get some of these things right.

Mr WATTS: I could not agree more. One of the terms of reference is private health care, so we can talk about that. I do not think private health care should fill the gap when there is a failing of state health, and it would appear to me that if people are travelling outside of Logan to have their healthcare needs met the first thing that should happen is they should be provided state health in the city they live in. The proposal is that private health will fix that gap. Do you think private health should have to fix that gap?

Mayor Power: To me, private health is about working up the list. There is a waiting list for so many operations. If you have health care, you avoid that list and you go straight in. I feel that that is what it is for—and you get to see the doctor of your choice, you get to go to the hospital that you want to go to and you know that you are going to get great care. On the same foot, some people that I know use the public system and they are very wealthy. I get annoyed with those people because I

think they are creating an extended list for those people who obviously do not have the resources that they do, but I understand why they do it. The fact is that they feel they are paying for something so they should get something as part of paying their tax. I think the bigger problem is the travel part of it. If we can get people off the freeway and if we can get people seeing their doctors and getting medical services in their own city, I think that will go a long way to addressing the problem.

CHAIR: It goes back to your commentary about after-hours care and 24-hour access to GPs, and we have heard that right across the state. There is a barrier—it does not matter whether we are in Cairns or here—for GPs to practise after-hours, and that sits around that Medicare rebate freeze. We have heard that time and time again. What would be your message to us to make recommendations in terms of addressing that Medicare freeze?

Mayor Power: With regard to the allocation of doctors from overseas, Logan has also been disadvantaged now. I am getting doctors who have had doctors from overseas and now they cannot get them because they are in the Logan area. That also is a disappointment to the residents of Logan. Let us take, for instance, a skin specialist who does skin cancer removals. You have two doctors. You remove one of them. They cannot get a replacement doctor. The list to see that doctor goes up by a year. That is not acceptable in a state like Queensland for skin cancer.

CHAIR: Yes.

Mayor Power: So I do not know how you can do it. I do not know how Melbourne and Victoria can achieve getting doctors to work after-hours, but obviously they must have some sort of incentive. If we had that, there would be a great release from the Logan Hospital and the public system. There are a lot of people who want to pay for medical services—they have medical care—but it is not available to them. You have people who are managers, doctors, dentists, solicitors—whatever. If they get sick after five o'clock, they have two choices: go to the Logan Hospital or drive all the way into the city.

Mr WATTS: You said that by 2030 there will be a shortage of 604 beds—

Mayor Power: Yes.

Mr WATTS:—and there is a lack of speciality. There are two issues there for me: the built environment and whether those beds should be filled by private or public; and then the speciality is the level that the hospital is approved to conduct in specialist areas. Can you tell us a little bit more about that in terms of whether what is required is a second hospital, an expansion of the existing hospital or an increase in specialisation and whether that should be private, public or a partnership or how best to achieve that outcome?

Mayor Power: The best way to express that is: the growth of the city is 10,000 people a year, compared to Ipswich's 6,000 new people. We do not have any private hospitals in Logan at the moment. We are entertaining a couple at the moment in Meadowbrook, our medical precinct, but at the moment—approval is fine. When the first brick gets laid, we will start to celebrate. Obviously in the city there are 110,000 people with private insurance. If they have a private hospital, there is a choice for them. You can imagine being an elderly person and you have private insurance, but you have friends and family in the local area. You are not going to go to the private hospital in Brisbane; you are going to go to Logan Hospital because your friends and family can visit you. So the requirement to have a private hospital is of utmost importance for the Logan council at the moment, and we are entertaining two possible hospitals. Hopefully that will fix the problem, but we obviously need some incentives for them to land.

Mr WATTS: Yes. What did you say was the population of Logan City, sorry?

Mayor Power: Our population is about 350,000 at the moment, so we are a large city, and we are growing by 10,000 a year and our PDAs—that is, Flagstone and Yarrabilba—have not really taken off yet. This is mainly our infill between our suburbs and the PDA areas—they are filling up very quickly—but we obviously have a lot of green space and we are going to have a lot more people land there in the near future.

Mr WATTS: In Toowoomba, with 110,000 or 120,000 people, plus the surrounding areas, I have two private hospitals, both excellent, and it does take a lot of pressure off the state system.

Mayor Power: Absolutely.

Mr WATTS: It is not a reason it should replace the state system, in my opinion. With regard to the provision for ambulance removal, say someone is ill in Logan—and I am not sure what the ramping situation is in Logan—do people get transferred up to the Brisbane hospitals? How is that assessment made?

Mayor Power: Okay. I have had firsthand experience with the ramping. I have been in the hospital a number of times when there is ramping. That does exist. I am aware that they do transport people to Brisbane for certain things that are not available in the Logan Hospital, but we are undergoing major development at the hospital, so I am hoping that some of those provisions will be fixed.

Mr WATTS: So that is an increasing category of service for particular specialists at the hospital?

Mayor Power: I could not say.

Mr WATTS: Okay. Thank you.

CHAIR: That is an interesting point, because when we were there yesterday they gave us some figures. Are you aware of the long-stay patients? Some people stay, I think they quoted, 12 months to 14 months—up to 400 days. These are beds that are occupied by—and, again, this is reflected across state—people who are awaiting an NDIS package or home care package or to go into a residential aged-care facility. Actually, they said that staying in a hospital for such a long period of time is really unhealthy because it just does a number of things to the person. So it is about addressing that as well. Were you aware of the long-stay patients that you have at Logan?

Mayor Power: No.

CHAIR: Okay, so that information was given to us yesterday by the—

Mayor Power: But what is a growing issue is that we are getting a lot more retirement homes now in Logan because we have the greenfield sites, so we are going to have an ageing situation—and we already have. As you know, Ruby Gardens has obviously experienced all of those traumatic issues in the last week or so that you have seen on the news. That is in Logan. There are a number of retirement homes in Logan and obviously not having a private hospital removes the choice of these people.

CHAIR: Again, reflected right across the state is getting care in place. In Townsville we do not have a bulk-billing doctor who goes to residential aged-care facilities for a catheter change or for a low-acuity case, and I will just give you some figures here. For, say, a catheter change, they will get an ambulance to go to the public system. Some 35,000 people were transported by Queensland ambulance out of the state's 400 residential aged-care facilities last year. Again, we need to fix that. It is becoming clear and apparent to this committee that care in place with the right delivery model of care will reduce the impact.

Ms PEASE: Thanks for coming in, Mayor. Can you tell me how many general practitioner clinics you have in your city?

Mayor Power: No, I could not tell you. I honestly could not tell you, but I do know that the centre part of Logan struggles to get GPs, and most of them are from overseas, and that is why some of our residents are experiencing some issues there, particularly women.

Ms PEASE: You mentioned that there has now been the removal of overseas doctors.

Mayor Power: Yes, as their designation is not as important as it used to be. Practices that were relying on overseas doctors to keep the numbers there are finding it very hard to attract doctors to work there.

CHAIR: Yes, DPA.

Ms PEASE: So that DPA has impacted on your city and the ability of your city to provide primary care?

Mayor Power: Absolutely.

Ms PEASE: Have you had any engagement with your local PHN around that?

Mayor Power: I am not aware.

Ms PEASE: Okay. The primary healthcare networks manage primary health care and the delivery of it in the place, and you would fall under, I am assuming, the Metro South PHN.

Mayor Power: Yes.

Ms PEASE: Have they reached out to you at all with regard to what services they provide you or what they do?

Mayor Power: No.

Ms PEASE: Okay. Do you know what sort of a wait time there is for people to get in to see a doctor in your city?

Mayor Power: That obviously can be very tricky, because some practices are more popular than others. I could only detail to you what I am experiencing. The frustration is that you ring up for an appointment because you are sick and they say, 'We can't fit you in until probably Friday week,' or something like that. I said, 'I might not be sick by then, but I need to see someone now,' which is really frustrating. I do know that that depends if there is a flu epidemic going around or the doctors get very sick. I know one in Daisy Hill who offers a very good service but he is trying to sell because of his mental breakdown of actually keeping the service and keeping the patients happy and providing that. He is working around the clock. He is starting at something like 6.30 in the morning and he is operating late at night. Some practices are obviously experiencing that, and of course then you have those non-family practices where you have a contracted doctor service, which seems to be a little bit more efficient. Obviously they do not spend as much time with the patient as someone who has a family practice who has been around for a long time. Obviously residents want to see their family practitioner who they have seen for the last 20 years, but they are frustrated because it might be two weeks before they can see them.

Ms PEASE: Thank you. We have actually heard a fair bit of evidence around the fact that there is a huge demand on general practitioners and the only way they can actually afford to continue to run their businesses, particularly bulk-billing with the rebate, is to see a high turnover of patients. Have you heard of that? You mentioned it a little bit earlier when you talked about the burnout of the doctor in terms of the Medicare rebate at the moment if they are only bulk-billing, and I am assuming that many of your practices in some parts of your city would only be bulk-billing.

Mayor Power: And the reason for that is the people cannot afford it. That is why they go to these places, because they just cannot afford that extra bit—the family might be sick, they have prescriptions, they have a lot of things to pay for. If people do not have that bulk-bill, they will not go there.

Ms PEASE: And that puts a huge strain on the GP being able to deliver that service, because they get such a small rebate from the MBS.

Mayor Power: Yes. I am aware of some doctors on the eastern side of the freeway who offer the services and do not bulk-bill but there are not too many of them.

Mr WATTS: Do you think a private hospital would reduce the ramping at the Logan Hospital—which at the moment is at 58 per cent and the highest in the state, an increase of 22 per cent. If you had a private hospital, do you think that would reduce that ramping?

Mayor Power: Absolutely. There are 110,000 people who have private insurance. They do not want to go to the Logan Hospital and queue up and sit there for four hours. They want to go and get medical treatment there and then. They pay the money. For some reason they might not be able to get to Brisbane. That is why the council is really trying to get these two private hospitals to land.

CHAIR: That is commendable work by your council and by you. Whatever you do land, make sure it has an emergency department that can take people 24 hours. Ours is a bit limited in the Mater in Townsville. The ED there closes at 9 pm. Make sure that you get a 24-hour model to share the burden of people who get sick. Thank you so much for your contribution. We are out of time for this session. We dearly appreciate your contribution here today.

Mr WATTS: It was a very thorough submission as well, thank you.

WARD, Professor Kylie, Chief Executive Officer, Australian College of Nursing (via videoconference)

CHAIR: Welcome. Would you like to make an opening statement before we go to questions?

Prof. Ward: Firstly, I apologise that I am not able to be there in person. The Australian College of Nursing welcomes the opportunity to present to the Health and Environment Committee as part of the 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. I am speaking to you today from the lands of the Eastern Maar and Wadawurrung people and on behalf of ACN. I would like to acknowledge their roles as traditional custodians of this country and pay my respects to elders past and present, and I certainly extend that respect to all First Nations people present today.

The Australian College of Nursing is the national voice of the nursing profession focused on policy, advocacy and education to advance the status, recognition and respect for nurses. Through our corporate and individual membership, we represent over 150,000 nurses Australia-wide. We are the largest provider of postgraduate education for nurses. I note that there are over 99,000 nurses in Queensland. Our membership events, institute of leadership and higher education qualifications allow nurses at all levels to be leaders in their profession. We are excited to lead change and create a strong collective voice for our profession by bringing together thousands of extraordinary nurses from across the country.

The past two years has seen devastating bushfires, the global pandemic and major social and economic upheaval for millions of Australians. In Queensland alone, more than seven million hectares were burnt during the bushfires of 2019. This was swiftly followed by the impact of COVID. Of course, people have required care during this time and nurses have been there to deliver that care. The effects of the pandemic on Queensland cannot be underestimated. A report from the Queensland Council of Social Service found that Queenslanders have experienced a greater level of financial impact from the pandemic compared with those in other jurisdictions, including a higher loss of employment and a greater number withdrawing from their superannuation. We have also yet to fully appreciate the societal consequences of the pandemic, though research from groups such as the Queensland Family and Child Commission suggests there are increasing rates of mental health issues, emotional wellbeing concerns, sexual abuse and suicide attempts.

Throughout these challenges, nurses have remained on the front line and experienced the totality of these circumstances. Nurses work tirelessly to ensure our most vulnerable and marginalised are safe and well cared for across their lives, as well as deliver evidence based health promotion and prevention. Certainly in Queensland, as in the rest of the nation, they have been key in getting Queenslanders vaccinated.

Australian nurses provide highly skilled, trusted care in a range of settings and their leadership and expertise has been crucial—not only in the pandemic but also in the day-to-day healthcare settings. I would like to reinforce that nurses are a fundamental and often under-utilised source of positive disruption and innovation for healthcare systems. Nurses can provide agile, affordable care for individuals in the community whilst maintaining and extending existing high standards of safety and quality.

As Queensland enters a new phase of the pandemic with the opening of borders, it is more vital than ever to reimagine how the interface between state and federal services should look. There are no silver bullets for issues such as hospital capacity, elective surgery backlogs or the service inequity between urban and rural areas; however, there are some effective nurse-led solutions that are ready to be activated and deployed. Chief among these is to allow nurses to work to their full scope of practice, particularly by empowering nurse practitioners and advanced practice nursing to help fill the gap that doctors are unable to bridge.

The Royal Commission into Aged Care Quality and Safety and the COVID-19 crisis in aged care have also revealed systemic failures in funding, regulation, workforce planning and risk management in the aged-care sector. Nurses are best placed to address many of these issues, with their ability to provide much needed leadership and coordination of care, to ensure there are streamlined and holistic services. We are certainly committed to supporting nurses to drive reforms in these areas to allow older Australians to have greater autonomy, dignity and access.

These crises also strike at the heart of future challenges for the nursing profession. Australia is expected to experience an estimated shortage of 100,000 nurses by 2030. However, the World Health Organization recently released that there will be a minimum of a nine million global workforce shortage by that time, so we may experience more numbers. Whilst we are seeing a significant number of students study to become nurses, new graduate employment security is often

unpredictable and cyclical, with great variations in transition to practice programs. These problems will only be amplified over coming years, and there are many others that I could speak to, as nurses approach retirement age.

We have delivered six key recommendations to help tackle this, and I am going to go through those quickly now: firstly, revamping existing models of primary care to focus on an integrated, person centred and values based system, looking at seamless pathways within a multidisciplinary team—and telehealth can have a key role here as well; secondly, enabling nurses to work at the top of their scope, supported by education, training, skills development and, of course, appropriate remuneration; thirdly, reforming our current funding system that is outdated and not sustainable to support the models of care needed, particularly providing access to MBS item numbers for nurses and advanced practice nurses; fourthly, retaining current telehealth MBS funding, with appropriate regulation and allowing a range of telehealth stakeholders, including nurses, access to telehealth item numbers; fifthly, improving aged care through the implementation of the recommendations of the royal commission on aged care and further investment in nursing scholarships for education and training; and, lastly, abandoning the age criteria for the NDIS as it is inequitable and creates barriers to accessing services that best meet individual needs, particularly for people from culturally and linguistically diverse backgrounds.

The Australian College of Nursing looks forward to providing this committee with more information about these recommendations and answering any questions you might have on the central role of nurses in working with governments and other health stakeholders to improve quality, equity and sustainability of our health, aged-care and disability sectors.

CHAIR: Thank you. That was a great overview. Those six recommendations have pretty much nailed everything we have heard around the state this week—the last one being the DPA, the Medicare rebate freeze. I am hugely interested. The QNMU yesterday mentioned the ACT trial of the walk-in clinics that were established in 2010. In your submission you talk to the benefits of that. Can we get a practical understanding of how many people they might have kept out of public hospitals in the ACT because of the establishment of those? The second part to that question is who funds them.

Prof. Ward: We can certainly look to get you information. We do not run them so I will not look to give the data, but I will see if my team can source that for you. They are incredibly innovative. They are funded by ACT Health. The jurisdiction has taken on the responsibility of that. It decreases the burden of care in the acute sector because the people who are attending the walk-in clinics would otherwise be more than likely attending emergency departments. There are waiting lists in Canberra. It is very hard to get into GP practices and the primary care model obviously does not have extended hours for all residents. The only alternative for people is to sit and wait in an ED.

CHAIR: That is exactly what we have heard. It sounds like a good model and we will look at that data.

Prof. Ward: It is a great model. The evidence for the nursing workforce says that the most satisfied nurses are those who are able to practise autonomously, and that is often in primary and community health. If they can work to their scope of practice, let them get on and do their jobs, which they do extraordinarily well. They can treat many ailments and illnesses. Nurse practitioners can diagnose and certainly write up scripts, and it just avoids that double handling of the system which is a waste of money. There is also the time resource of waiting for access that is not available.

CHAIR: I have looked at some of the data very briefly and they have kept thousands of people out of hospital emergency departments with really low acuity things such as suture removals.

Prof. Ward: Correct, wound management.

CHAIR: I am of the view that the Commonwealth could potentially fund, as an example, a clinic and the nurses are provided by the state. I imagine some kind of arrangement has to happen. I would like to hear your views on that.

Prof. Ward: We would be happy as a national organisation to definitely participate in any interface to encourage the Commonwealth and the state. It is a gap that is putting a burden on the acute sector and the states, and I absolutely acknowledge that from our members' feedback. We will do anything we can to facilitate that. I think it is a great collaboration and a desperate area of need.

In our position statement on advanced practice nurses, we very clearly state that nurses are not only the largest profession in the country, with 400,000, but also the most geographically dispersed profession. You of course have a fly-in fly-out model that is expensive and difficult to maintain in terms of consistency for consumers in isolated areas, but nurses often live in the postcodes that they serve and work so it is a sensible solution to actually empower and enable the nurses who are already living and servicing communities to do what they want to do and work to their full scope.

Mr WATTS: Thank you for being here. I have a couple of questions but I am particularly interested in rural and regional areas. I come from Toowoomba. I did spend a long time in hospital and the nurses were the main interface I had and they certainly made my days brighter. In your second recommendation of having a 'workforce fit for purpose', you spoke about legislative changes to improve incentives and employment conditions. I do not need the answer today but I would love to get that fleshed out in detail. I realise there is a bit more in the submission. I think the nurse practitioner model is something that is worth considering, and it would be interesting to understand what would make that viable from the nurses' point of view.

I am also interested in the training of nurses and the positioning of nurses in regional and remote areas. What are your thoughts around accommodation and/or making suitable arrangements around travel and distance, and trying to encourage people to work in those areas, particularly if we end up with a model of increased scope of practice?

Prof. Ward: Thank you for your comments about the care that you received and the difference nurses make. We really do appreciate that. Of course, most people get to know us when they are a consumer of the service, unfortunately. Of course we are highly respected, but it then gives a greater understanding of who is the profession that is observing, monitoring, assessing 24/7. We will get that information that you requested. There is a lot in that that we can provide and we are happy to do that around workforce. There is no easy or quick solution, but I think you are touching on some important areas.

The last thing that somebody needs to do, even if you are only going to get them for six weeks or two years—maybe not everybody is doing a permanent relocation to rural and remote areas. Not leaving any clinician or any expert who comes into a community isolated in any way is very important, otherwise they will want to go back to where they came from. It is accommodation, the support, the integration into communities. We have even been talking in the past week that you can throw a certain amount of money but that only lands in so many ways. Can we package opportunities for partners or families to actually make a move and is there any way communities can support the employment of a family to get a nurse or a clinician in? I think we have to now start looking a little bit differently at how we embrace not only the individual clinician and nurse who can come but also who they are bringing and look at how they want to fit into that community for however long they are there.

I am happy to provide information but also discuss that we have to do something differently. We cannot have the people in rural and remote Queensland or Australia disadvantaged just because they choose to live there. The postcode determines your health outcomes in Australia and we will do whatever it takes to change that.

The other factor is that you do not have the numbers necessarily so there is a certain burden when people know—and I talk about this as in a moral injury or an emotional burden—who the nurse or the local doctor is. You are not often off duty in a way, even though you might not be getting paid. I think that, even with time out, it might actually be about giving them pay to go somewhere else and have a holiday because they are giving so much to their community.

We would welcome the opportunity to be really innovative in solutions, apart from what we have seen, or packages. The accommodation and the sense of community will be vital, and the reality is that not everybody will move forever so we have to look at whether we will have someone for two years but also have a good healthy turnover in a short period, and that is okay. We need to remodel how we onboard, how we transition and how we support. Then when they go off and talk about how wonderful it was, more people might come.

Mr ANDREW: Thank you, Kylie, for your expertise in the nursing field. Thousands of nurses exercised their rights and never got vaccinated. How did that actually translate to patient-nurse ratios to be able to provide care? So many are stood down at the moment. Is there a way for those people to get back into employment? Obviously it puts a lot of pressure on you to turn out trained nurses to fill the void. How is that all looking for you?

Prof. Ward: It is complicated. It is something we never thought we would have to face but we did. Apart from the functionality and the practicality, it certainly has affected people's moral judgements and values. Not every nurse who is not vaccinated is an anti-vaxxer; there are different reasons. Nursing is not just what we do; it is who we are. There is a lot of identity when you choose to be a nurse and train and give so much. It is more than just a job; it is implicit in who we are. The profession and those who have not chosen to or been able to get vaccinated for different reasons are really struggling with their identity or are feeling excluded.

We completely understand and support all governments' position on that. We do have to have an arbitrary line. My suggestion certainly would be to let us think about how you have talented, capable individuals, some of whom might be vaccinated but immunosuppressed and cannot be in a

clinical area. Let us look at direct care. Let us look at virtual care. Let us look at nurses on call and nurses answering a hotline. There are certainly different ways that we could mobilise expertise without really disadvantaging trained clinicians while also not putting others at risk. Again, it is in that innovative space that we never thought we would get to that we could create a positive outcome for everyone without arbitrarily disadvantaging or getting into fear and divide.

You mentioned ratios. One of the things we have seen is that we already had pretty lean staffing. We are a huge health workforce, the clinical workforce. We are a big investment for government. We are a big percentage of GDP, but because we aspire to give the best care it has not taken much—we have seen this in aged care—to be quite fragile. What we really come out of this with is: rather than a ratios concept, we need a baseline of a good workforce model, rather than saying four-to-one, which has not worked with the donning and doffing of PPE. When people have a baseline of a particular number of patients to a nurse, it just means that we are not identifying the skill set of the nurse and the complexity and acuity of the people we care for. In fact, there have been times when for one nurse it may be appropriate to have one patient who is deteriorating or dying or has very complicated care.

We would say that we need to come out of this and look at a strong workforce model that considers skills and skills mix, because we have just pushed the workforce far too far around the country and that elastic has stretched to the point of breaking. How do we attract the next generation without those who have all of that clinical experience and expertise to mentor and transition and share their knowledge if they leave?

Mr WATTS: I want to explore what you have listed as sustainable funding reform. We have heard a lot of evidence about the federal government and its primary care network and the failings of some of the Medicare allowance. From a nurse practitioner's point of view, what can they claim at the moment and what would you propose going forward? Obviously that needs to be tied in with skills, qualifications and experience.

Prof. Ward: We will get you the list of what they can claim. There are not many items that a nurse practitioner can claim. Let me take it from a different perspective. They are not able to claim the same amount as their allied health colleagues or their medical colleagues, even though they will do the same intervention of care. This is not about the nurse practitioner. I will give a very basic example: a doctor, a nurse and a physio can all take blood pressure, so it is not about the actual procedure that we are doing because we can all do it. Say a doctor gets paid $100, a physio gets paid $60 and a nurse gets paid $20 to take that blood pressure, which is what is happening with the MBS item numbers. The nurse practitioner is not getting paid the same for providing the same care to the patient.

The reason we are so far behind as a nation is that that nurse practitioner cannot work independently. We have gender inequality because we are female dominated. They are not getting paid their worth. They are having to get supplementary jobs in health services or elsewhere to be a nurse practitioner at the top of their game and work one or two days in what they want to do. We would say that it is not only the access to MBS item numbers. Certainly nurse practitioners need the opportunity to give referrals. If I want to go to a nurse practitioner and they are not able to give me a referral, I have to go back to the GP to get the referral, even though the nurse practitioner can easily tell me to head to a dermatologist or head to a cardiologist. It is a crazy waste of the healthcare dollar.

We then would say that we have a couple of thousand nurse practitioners in the country. When you look at the UK, Canada, the US and many other nations, we should be looking at at least 25,000 nurse practitioners. We have dishonoured the highest level of clinical nursing by not giving them access to earning an income, and that is a detriment to the people who could care for them. It then means nurse practitioners are not to be able to earn a full-time income but have to find other employment. Often the acute sector picks that up.

I think this is something the Queensland government should lobby the Commonwealth government on because then they employ in the acute sector, where they are very valued, but they are highly effective in primary care or the interface. A nurse practitioner looking after residents in an aged-care facility, interfaced with disability primary care in a coordinated care model, would take a significant burden off the acute sector and be very effective for chronic and complex disease management, preventive health, population health. It is such an obvious under-utilisation around that funding. I hope that example helps to say how basic it is that that is fundamentally the issue.

The other thing that nurses and nurse practitioners are asking for is a bundle. Rather than being charged for getting an MBS item number for everything we do, we would much prefer to be paid in time allocations. The reason is that a nurse never does one thing at a time. If you know a

nurse, you know that we are looking at you, we are doing this and we are doing that. If I give you a vaccination I am also checking your wellbeing, maybe doing a mental health assessment, looking at a wound. We do not do just one thing in a 15-minute period. You would actually get a better use of taxpayer dollars by giving a nurse six minutes or 15 minutes or 30 minutes. We would get an enormous amount of healthcare delivery in that time, rather than trying to say, 'I have done an ECG and I have done a mental health assessment and I have done a temperature and haemodynamics,' as an example.

CHAIR: Kylie, in the ACT clinics do the nurses refer? Do they have a broader scope of role?

Prof. Ward: Yes. The ACT government, to be honest, has been very brave, I will say. I have been really impressed with the minister because, of course, there is a bit of backlash initially with medicine. It is just our sibling rivalry through the years.

CHAIR: It is a turf war.

Prof. Ward: It is a turf war. It is the worry that 'they will take money from us'. I am based in Canberra and I cannot get in to see a GP because I am actually well. When I need one for an odd thing, I cannot get in because they are booked out for months. I wait until I go to New South Wales. Realistically, the GP in the primary sector is already struggling. There are not enough, certainly not in regional and rural Australia. In a supply-and-demand model there is plenty of business. It should not be about the money ever, but it always is.

The minister and the government were, I would say, brave. We supported them most certainly and it is in the best interests of the communities. The communities walk in and out; they love it. Yes, the nurse practitioners there are able to. Because the local government has taken carriage of it and it is not an MBS item, that payment is an offset of what is saved. They get greater flexibility and the ability to then prescribe and save that double handling.

Mr WATTS: I want to clarify the figures. Kylie, you said there were 400,000 nurses in the country—

Prof. Ward: Almost, yes.

Mr WATTS: But only 2,000 nurse practitioners.

Prof. Ward: There are approximately 2,100 nurse practitioners. About 1,500 of those now work clinically because others have not been able to get the work. I will give you an example. I was in South Australia a couple of years ago. There was a nurse practitioner who was trained in a particular area but there was no job for her. She had work as a registered nurse—unless she was prepared to relocate her family, but that was their home. I had to work with the health service: create a job, for goodness sake! Have a little bit of insight. As the MBS item numbers do not give people the opportunity to earn an income—certainly one that is above the poverty line but certainly not commensurate with their investment, education and training—then they need to look at other employment. Out of the approximately 1,500 nurse practitioners who are working clinically, there would only be around half of those again working in primary and community health or aged care because of that. You have the other half working in the acute sector. You have some brilliant nurse practitioners in Queensland who are impressive, I must say.

CHAIR: We certainly do and we are very proud of them.

Ms PEASE: Can you provide me with the level of study nurse practitioners have to undertake to become a nurse practitioner?

Prof. Ward: It is considered the highest clinical level. It is a separate authorisation with our Nursing and Midwifery Board of Australia. Nurses do undergraduate qualifications. Then they do postgraduate certificates and degrees. They would need a minimum of five years clinical expertise as well as a masters degree in an area of speciality before they would be considered eligible to be a nurse practitioner. It is years of experience and further education and qualifications.

CHAIR: I have a paramedic background and that is very similar to the critical care model. Out of 4,000 paramedics, we might have a couple of hundred of those. Not everyone is going to be able to achieve that.

Prof. Ward: Not everyone is going to get there. Not everyone wants to. You have 400,000 nurses and, as you said, 2,100 are nurse practitioners. They would also be registered nurses. The bulk of that number are registered nurses. Within those hundreds of thousands of registered nurses, 44,000 have been identified as advanced practice nurses. They are registered nurses not able to work to their scope of practice. They are living in Queensland now and could be optimised very quickly.

CHAIR: We have certainly heard about scope of role. Thank you for your submission. We can always write to you if we need any more information. Thank you for your contribution; we appreciate it. If we could have the answers to anything you have taken on notice by Friday, 18 February, that would be appreciated.

ARMSTRONG, Mr Philip, Chief Executive Officer, Australian Counselling Association

RYAN, Mr Isaac, Policy and Government Relations Officer, Australian Counselling Association

CHAIR: We now welcome representatives from the Australian Counselling Association. You have probably picked up on a few themes over the last hour or so that you have been here. Would you like to start with an opening statement and then we will move to questions?

Mr Armstrong: Yes. Thank you very much for allowing us to speak and to introduce ourselves. As a profession we are the new kids on the block, when it comes to mental health particularly. It would be a big mistake to try to separate mental health from physical health. It is a bit of a chicken and egg, that one. Did somebody get physically ill first and then have a mental health issue or did they have a mental health issue that led to them becoming physically ill—or possibly both, depending on the person's background and their exposure to trauma type situations, such as first responders?

My opening statement is primarily a bit of education. People are still a little confused what a counsellor is. I use the terms 'counsellor' and 'psychotherapist' interchangeably. When I refer to counsellors, I am also referring to psychotherapists. We are a self-regulating industry. The Australian Counselling Association is the peak body for counsellors and psychotherapists in Australia. We have a registration and accreditation process for counsellors. That accreditation and registration process means that to be able to register with ACA as a counsellor you need to have a certain qualification, and that qualification has to be accredited through us even though those qualifications are accredited through government authorities. Counselling educators have to go through a double accreditation process.

When they join ACA they have to provide certain documentation. If they are in private practice they must have insurance. They must also undergo professional supervision or clinical supervision, depending where they come from. There are also annual mandatory requirements for professional development that they must go through. If you wanted to do a comparison between the counsellor registration and ongoing processes and the processes for others, you would find that we are equivalent to general psychologists. The difference is that psychology is a government regulated profession and counselling is a self-regulating profession.

As far as education is concerned, here in Queensland we have undergraduate and graduate programs through UQ, QUT, Griffith, USQ, James Cook University and Central Queensland University. Every university in Queensland has an undergraduate program. All those of programs are accredited through ACA. That is where we stand in the system. The universities come to us to make sure their courses are accredited through us—even though they are accredited through the higher education process—to ensure their graduates can get full registration with us.

We have a complaints mechanism. We work with the state and territory governments through the ACCC in some states, and here in Queensland it is through the ombudsman. We work in conjunction with state authorities as well as having our own complaints process.

Counselling is probably a unique profession in that we work in the entire continuum of mental health. We have counsellors who come through the vocational sector and they work in the early intervention services. They come from TAFE, for example. We have counsellors who work all the way up to a PhD level who work in a clinical setting. We are unique in that sense. We tend to work primarily within primary care and secondary care. A lot of counsellors do not work in clinical care, even though we are certainly qualified to do so. Counsellors generally are not attracted to clinical care.

I will give you a profile of counsellors. The average profile of a counsellor is somebody between the ages of 45 and 65. We are a mature age workforce; we are not a young workforce. That means that the average counsellor comes into our industry having already completed one or two careers. We are talking about mature age people who come in with significant life experience, which is something a lot of social workers and psychologists do not have. They go through high school, university and then register. The majority of our members have brought up families, have maybe been through divorces, have been exposed to trauma, have high resilience, know what paying a mortgage is all about and know what working in the workforce is all about. Something significant that we bring to the workforce is that experience.

Being mature age workers, we have a lot of teachers, nurses, people from the police service and veterans. I am a veteran myself. We have people who have spent a lot of time in other types of industries that are congruent with working with mental health, and their interest in mental health is because they have been exposed to mental health issues within those workforces. It also means that

our members have a significant affiliation with people. For me, being a veteran myself, working with veterans makes it that tad easier to understand their issues. We have a lot of nurses who are able to work with nurses. We have a lot of police officers and firies—the whole gamut.

When it comes to the dispersion of counsellors, counsellors are found more readily in rural and regional areas. The reason for that is found in the profile of our workforce. When people study, graduate and register as a counsellor, they generally do not move. I have a young daughter who is going to university now. When she completes university she will probably move to another city to get work. Counsellors, because of their age, are already settled so when they graduate they stay where they are and work with their local community. That is another big plus when it comes to counselling and working in mental health in rural and regional areas. I am a country boy; I am from country Victoria.

CHAIR: Cowboy country.

Mr Armstrong: I choose to be a Queenslander. When I was discharged from the military I asked to stay in Queensland. Being a country boy, I am well aware of what happens in the country. Nothing annoys me more than when people say they know what being in the country is about or they understand rural and regional issues. I say, 'How do you understand rural and regional issues?' Doesn't it depend which rural or regional area you come from? Each rural and regional area has unique issues. Whether they be an agricultural, mining or manufacturing area, each one has individual issues. Therefore, having local knowledge, particularly when working in a sensitive area like mental health, is very important.

Unfortunately, what happens in Queensland, particularly up the east coast, is we have fly-in fly-outs or locums. We have mental health specialists who fly in from the city to maybe Townsville, Cairns or Cooktown. For a start, there is a very high turnover of people working under those conditions. They are very trying conditions to work under. Also, when they go into these communities they do not understand them.

We embrace technology. We are advanced in how we teach and train counsellors, particularly at university, on the use of telehealth and those sorts of services. We are also painfully aware that a lot of people prefer face-to-face services. It concerns me when I see some other disciplines over-embracing technology. If you go to an Indigenous community you find that Indigenous people do not respond to telehealth. Indigenous people respond to face-to-face services. So do a lot of other people who come from different cultures and different backgrounds. We have a lot of immigrants and lot of refugees. They do not respond to telehealth. Telehealth is certainly better than nothing; however, embracing telehealth to be a primary service I think is a bit of a mistake. It should be in addition or an add-on. Again, the benefit counsellors bring to services, particularly here in Queensland, is that we have a greater spread in rural and regional areas.

CHAIR: Thank you very much. Something that has been highlighted to date is accessing mental health support. I do not think you were here when the Mental Health Commissioner gave evidence just before lunch, but he certainly highlighted the significant increase, particularly over the last two years of COVID, in people suffering mental health issues. For this inquiry it is determining how we keep those people out of hospital. How many people do you have in your organisation?

Mr Armstrong: There are over 9½ thousand people registered with the association. We are growing by around 150 people a month. In Queensland we have extremely high growth. I can come to you as a good news bearer and say that we do not have a workforce shortage. We are totally and utterly under-utilised within most mental health systems, possibly because we are the new kids on the block. We do not have a workforce issue. We have one of the highest rates of growth in Australia. As a comparison, if we continue to grow the way we are growing now, within five years there will be more counsellors and psychotherapists than social workers and within 10 years there will be more counsellors than psychologists in Australia.

CHAIR: Who funds you?

Mr Armstrong: We are self-funding. We are funded by our members. We are totally self-funded. We get no money from the federal government—not a zip. We do not get anything from the state government. We do research. Right now we are doing some work with First Nations peoples looking at curriculum for mental health in First Nations peoples. We get funding from private organisations. We have funding from Bupa. We have had funding from the Queensland government. That is the only type of funding we get outside of our membership fees.

Mr WATTS: I am interested in trying to understand exactly where you fit into the mental health area. Obviously there is acute mental health—someone who has admitted to hospital. There is someone who has seen their GP. I have heard anecdotally from various GPs over time that

sometimes someone is just coming in for a 15-minute consult and they do not have any real health requirements but just want the reassurance from someone that they are well. I am trying to work out where the counsellor fits in. Let us pick a couple of topics. Let us talk about someone who is struggling with drugs and alcohol but has not yet had an acute episode and someone who is struggling with issues around COVID, whatever they might be. Where would you plug into the system there compared to a psychologist, acute health worker or GP?

Mr Armstrong: Particularly looking at drug and alcohol, a lot of organisations, like Drug ARM, use counsellors. The traditional services, services that are supported or come through the church system or religious type organisations and the not-for-profits—Relationships Australia, headspace—all hire counsellors. Counsellors are hired within those organisations. A lot of counsellors are in private practice. The biggest challenge in private practice in Australia for counsellors is that we are not part of the Medicare Benefits Scheme. We are fighting very hard to become part of that. You would have heard that argument. The fact is that the majority of psychologists are in private practice. If you are fortunate enough to live in an affluent suburb in Melbourne, Sydney or Brisbane you will probably find one, but if you are like the rest of us—middle income Australia—you will struggle. Most of the books will be closed or you will not find one. The books are closed, yet we have an equal spread of private practitioners and we cannot offer rebates against MBS. The tragedy with that is: we surveyed our members, and over 80 per cent of our members responded saying that they would actually go into bulk-billing services.

Darren was here before. I served with Darren in the Army. I cut my teeth in Logan for the first four years working in mental health. I am well aware of the challenges in places like Logan. In Logan you will not get a psychologist. It is very difficult, unless you are fortunate to go through the hospital system or something like that. Certainly in private practice, there are very few who do bulk-billing. The gap fees are enormous if you can find one. We know statistically that in Australia the large majority of private practitioners of psychologists and psychiatrists are in the affluent areas of Melbourne, Brisbane and Sydney—certainly not in rural and regional areas. They are also very difficult to find there.

Private practice is a very popular area for counselling. Most counsellors undercharge and a lot even will do pro bono services because they feel a responsibility to the local community. The problem with that is: that is not a career path for young people or to attract people into the profession. You do not go to university for three or five years to look at working pro bono. That is just not why we do it.

Counsellors can be the first port of call but they are generally not. Before Better Access under Medicare came in in 2006, the majority of GPs referred to counsellors. Since the Better Access service came into being, they all now refer to psychologists because they get paid to do a referral to a psychologist and psychologists can offer Medicare rebates. Counsellors do have private health funds—Bupa, Medibank Private. We have 15 or 16 private health funds. Again, if you have private health that is fine; otherwise, again into private practice it can be very difficult—and offer a reasonable service.

Mr ANDREW: It sounds like it is a very grassroots, on the ground, in-your-face service which we desperately need. Thank you for that. Are we seeing a lot of issues with mental health in the regions, even in the cities? No-one is talking about suicide just recently. Everyone has been locked down. As I said earlier, a lot of families are locked away from each other. It has been critical that we get back and reconnect. You guys obviously do a great job within that space, helping people do that. What are you seeing out there?

Mr Armstrong: It is very interesting. Contrary to common myth and what some people say, statistically suicides are down during COVID. One of the reasons for that is that it is probably more—I should not use the words ‘more difficult’. People think twice about suiciding because they are locked in, particularly with family and friends and other people. We tend to feel that it might not be that suicidal ideation is not as prominent or prevalent; it is just that, because of COVID lockdowns and so on, movement is a lot more difficult. That could have something to do with it. One thing we have absolutely seen is significant increases in domestic violence—absolutely.

Mr ANDREW: I have had people come to me with injuries, are sick from vaccine sometimes or have unknown sicknesses. They are really suffering and they say that no-one wants to talk about it. Are you seeing any of that?

Mr Armstrong: Yes. People are dying at home with COVID and nobody knows until they are dead. We know that we have a lot of people in the aged population. COVID has had significant issues. There was an article in today’s paper about people who are waiting for what they call elective surgery. Where did the word ‘elective’ come from? If you need a hip replacement, you need a hip replacement. You do not choose to need a hip replacement. Anyway, they call it elective surgery. People are

bumped. I know a bloke who has been bumped. He is now two years past the date. He has now lost all his muscle. It has all atrophied. He is now on morphine. He now has a problem with addiction to prescription medication and he is totally and utterly depressed. Can he get services? No, and he lives in Brisbane. This is someone living in Brisbane. A lot of that is happening now. People are suffering at home and you are not hearing from them, but they are making calls. Lifeline cannot handle the demand. I know that headspace—I was talking to Patrick McGorry a couple of weeks ago—absolutely cannot handle the demand. The tragedy is that we have over 5,000 tertiary qualified counsellors in this country who are under-utilised that the government will not use and offer Medicare services for. We are here today to let you know that there are several thousand in Queensland who are waiting to be brought into the system. When it comes to the definition of 'allied health', counsellors are not there. That is just atrocious.

CHAIR: If you had a Medicare rebate, do you think we could service a lot more?

Mr Armstrong: Absolutely.

CHAIR: That is really good.

Mr Armstrong: It would make a big difference. The highest usage of BAI services is by GPs, not psychologists. GPs are inundated. If they have a patient there who is depressed or wants to talk, what are they going to do? They cannot send them home. They spend an inordinate amount of time servicing people who have mental health issues whom they cannot refer to counsellors. They are the highest users of Better Access provider numbers. If you go and look statistically under Better Access, look at the provider numbers and see who are our biggest users—GPs.

Ms PEASE: Thank you very much for the great work you do in the community. I know how dedicated you are, so thank you. I am interested to hear about the qualifications of counsellors. Could you elaborate on that for us?

Mr Armstrong: Probably 75 per cent of counsellors will have a minimum of a bachelor degree. We actually have more masters degree qualified counsellors than we do bachelor degree. About 20 or 25 per cent of our members would be counsellors who come through the vocational system, as I said. There are a lot of counsellors who work in early intervention. There is no need to get a degree to work in early intervention. That is another under-utilised area and, again, it is a tragedy. Why do we wait until people need clinical services before we then bring them into the medical system? Again, I do not get it.

We should be using counsellors in early intervention and stopping people moving. Only around 10 per cent of people actually have a clinical condition, but a lot of people who have clinical conditions move into clinical condition as they move up the spectrum and get neglected throughout the system. You do not wake up with clinical depression; it is something that happens over a period of time. People do not wake up with burnout. You do not just burn out; it is something that is cumulative and works over time, because people are not given access to early intervention and early services. We can do that at in a vocational setting. We do not need to be paying people hundreds of thousands of dollars as clinicians with PhDs to be working within this sector. We can be using people who come through the vocational sector. We have counsellors who come through with accredited diplomas. They are the ones who should be utilised. The mentality we have in this country that everybody has to have a degree? There is no science and no research—I am a researcher—that supports that you get better outcomes.

Ms PEASE: Thank you for that. I know that there are a lot of workplace and employment programs where they refer their staff on to counsellors. Is that a service that your counsellors provide?

Mr Armstrong: Sometimes. It is a bit like working within the school system. We have a lot of counsellors who work in the private school system but not in the state school system. In the state school system they primarily look at psychologists. We know that there is a shortage. The irony is that counsellors get trained in psychological focus therapies, which is exactly the same as what psychologists get trained in. Our training is the same. The same lecturers at university train counsellors, social workers and psychologists. Again, when you look at the training, there is very little difference between what we can and cannot do. The school system is one. Actually, the hospital system is one where counsellors are totally under-utilised. You would be well aware that, particularly within the emergency departments within the hospitals here in Queensland, the clinicians themselves are burning out because they are trying to support their staff. They are not trained to do that in the first place, but who is going support them? They are working in emergency departments. Why is there not a counsellor attached to each emergency department? They are the ones who should be taking that burden.

Ms PEASE: You mentioned that you are covered through private health insurance. Where do your clients or patients come from who are claiming through private health insurance?

Mr Armstrong: It is primarily middle income Australia. They are the ones who cannot get access to the psychologists with the closed books.

Ms PEASE: So they would find you in the phone book, or what?

Mr Armstrong: We have a national register. We have a register that you can go to online and you can type in a counsellor's name. If their name comes up, it means they are registered. They are safe. It means they are appropriately qualified and everything else. That is what that national register is for. You can find a counsellor. It has a 'find a counsellor' facility on it. All of that is done through us. It is all the normal things that peak bodies do.

Mr WATTS: You said that some people might be masters qualified, some people might be degree qualified and some people might have come through a vocational training program. Are there different categories of membership—sort of like a fellow associate or what have you?

Mr Armstrong: Absolutely. We have a scope of practice which goes out to every state and territory health department. It also goes out to the federal government. It defines the scope of practice of each level. We have four levels of membership. Each level has a scope of practice of where they can work within that scope and cannot work within that scope. Obviously, somebody with a diploma would be limited. Obviously they cannot work in clinical areas. They would do a lot of referral work. They would do intake or they could be working in early intervention, whereas if they are masters qualified they could be working in multidisciplinary groups with psychologists, psychiatrists and social workers. Take away all the interdisciplinary rivalry. If you want a medical system that works, you must have interdisciplinary teams. Counsellors work very well in interdisciplinary teams.

CHAIR: There is a bit of turf related stuff we have heard over this inquiry, I can assure you.

Mr Armstrong: Absolutely. When you limit the dollar and then you tell everyone they have to fight over it, you will always get that.

Mr ANDREW: I have businesses ringing me every day. They are suffering. I just hope you guys are seeing that and helping as many as you can.

Mr Armstrong: Absolutely. We have 12 primary employee assistance programs that all use counsellors. Counsellors are probably at the highest demand right now through those employee assistance services. EAPs are pretty affordable now. Businesses that have those can use those and get access to counsellors.

Mr Ryan: We would like to add to the recommendations that we be included as allied health professionals in Queensland. Music therapists and art therapists are. We have members who are music therapists and art therapists in the ACA.

CHAIR: That is an important point. We have oversight of the Office of Health Ombudsman—all registered paramedics, nurses and psychologists. What governance do you have in place?

Mr Armstrong: Like any other peak body, we have an elected board. We have an AGM every year. Members vote people in and out. As the CEO, obviously I am in charge of policy and policy direction. We have quite a significant team of other people who work with us. All are highly qualified.

CHAIR: It would be great if you had a Medicare rebate. Do you think that would have to come under more of an Ahpra-style registration?

Mr Armstrong: No. Social workers do not. Social workers have access to Better Access. Exercise physiologists, dieticians—they all work under the MBS. None of those are regulated. It is an absolute myth. There is absolutely no research that there is any correlation between regulation and standards or accountability. There are more non-regulated allied health professions in Australia that get access to Medicare rebates than regulated.

CHAIR: Okay. That is interesting. We welcome your contribution because, going back to the core of this, it is about keeping people out of hospital—upstream prevention, of which counselling obviously forms an important part. We have heard how hard it is to get an appointment with a psychologist because the workforce is so short. Go to regional and remote Queensland. I am from North Queensland. I have worked in Charters Towers, Hughenden and Cloncurry over the years and those smaller places just do not have those types of services. I can see the importance of this and the work that you and your members do. We thank you very much for that. You have given us some food for thought in terms of recommendations, too. Thank you for your time today. Enjoy the rest of your day.

Mr Armstrong: Thank you very much. Have a good weekend and stay safe.

BANGE, Associate Professor Ray, OAM, Private capacity (via teleconference)

CHAIR: Welcome. I was very interested in your submission, given my former career. We have heard about expanded scope of role. We have had the nursing profession in front of us talking about what they might be able to do in terms of nurse practitioners. Would you like to make an opening statement before we move to questions?

Prof. Bange: Yes, I have a brief statement, if you do not mind me reading it. Thank you for the opportunity to appear before the committee. I acknowledge the traditional custodians of the land on which we meet and pay my respects to their elders past and present. I extend that respect to Aboriginal and Torres Strait Islander people present today.

My name is Ray Bange and the views I express are made in good faith. I appear as an individual and declare no direct conflicts of interest. In common with other members of the community I aspire to good health and, when needed, I rely on being looked after by health professionals, supported by a health system that enables them to perform to the full scope of their expertise.

Queensland is a vast state with a widely distributed population. My evaluation of the submissions to the committee and the hearings to date is that it is clear that the health and care system is in dire straits. It is a tribute to our hardworking staff at all levels that they have maintained services under the pressures occasioned by the COVID pandemic, for which support my wife and I are personally very grateful. We have been looked after very well by the health department.

Shortfalls in staffing and maldistribution in the health workforce has seen too few practitioners in our rural and regional communities to meet patient requirements. In many regions, access to GPs, specialists and allied health practitioners may be limited, and appointment wait times are excessive or simply not available. Practitioner shortages have had a profound impact on an ageing population. That population is at times distant from tertiary facilities and hardest hit by a lack of primary healthcare resources. Long travel distances are common, while unfilled vacancies abound for GPs and allied health practitioners, and many practitioners are reportedly working well beyond the normal retirement age.

CHAIR: Ray, you are dropping in and out. It is important that we can hear you. We are going to ring you and speak to you via teleconference. We keep losing you via this video link.

Prof. Bange: I can see and hear you fine.

CHAIR: We are getting every second word.

Prof. Bange: The COVID-19 pandemic has brought these issues of access and equity into sharp focus. At a national level, more attention is now being placed on primary and preventive care. These developments need to be considered in framing the use of the health workforce and the investment in services. If there is one persistent theme that I would raise, it is that the health system needs more people at all levels across the state to provide the care our communities need.

The provision of expert health resources to service those needs is the underlying theme of my submission, which you have, called 'Creating Pathways to Better Health'. The submission highlights the interconnected nature of health care and the gatekeeper role played by the Ambulance Service operating as part of an integrated health system. I draw attention to the benefits of preventive and primary care and the untapped potential of the paramedic workforce working across both the ambulance and the private sector.

My submission provides a snapshot of the QAS and suggests that perceptions of the QAS need to go beyond the role of a limited pre-hospital emergency care provider. An appropriately funded ambulance service that is widely distributed across the state is uniquely positioned to respond to population based health initiatives, health promotion and community based health management needs aligned with the social determinants of health. With the use of appropriately trained and empowered paramedics and other strategies, I suggest the level of patient conveyance to hospital emergency departments may be reduced, with a potential decrease in the incidence of ED presentations.

Separately, there should be wider mobilisation of paramedics in primary care and in other clinic, hospital and care settings, with the capacity to modify and potentially reduce the immediate demand on hospitals. This view is not a simple view. It is based on well-founded local and international evidence that judicious use of the paramedicine workforce in primary care roles can improve the health and wellbeing of community members while simultaneously reducing the overall demand for more advanced interventions and services.

With that background, one might ask: why haven't we been more proactive in mobilising the paramedicine cohort of more than 22,500 registered health practitioners who already are universally respected and trusted for their expertise? Some 70 per cent of those practitioners are already working

for ambulance services but there are many more who could be deployed across the health domain. Part of the reason for their omission is that governments, especially at a national level, have been slow to recognise paramedicine as a discrete generalist allied health workforce. Various mechanisms are available to support allied health engagement. They list 18 to 20 professions but surprisingly commonly omit the significant paramedicine cohort.

The documentation, legislation and regulations relating to paramedic practice have not kept pace with the rapid development of the profession and expanded practitioner capabilities. To put it another way, that is like having documentation and legislation that recognises registered nurses and doctors who work in public hospitals and ignoring them if they work elsewhere in health. This restricted focus creates uncertainty regarding the legal status of private paramedic employment and inhibits the use of paramedics in primary care and in other areas of health.

My submission thus addresses the lack of workforce utilisation through a range of policy options and more direct actions intended to drive the active engagement and deployment of paramedics across the health and care sector. The underlying premise is simple: if the expertise is there then facilitate its use. I will not go through the various initiatives, but I would be pleased to respond, to the extent I may, to any questions that members may have.

CHAIR: Thank you very much, Ray. Thank you for your considerable research in your submission. You have made 13 recommendations. There has been some discussion today of expanded role. We have the co-responder model now in the mental health space. You would be familiar with the LARU, the low-acuity response unit.

Prof. Bange: Yes.

CHAIR: They are now able to do things like suturing and all of those types of things—expanding the role. Ray, I recognise your name. I am not sure whether you had anything to do with paramedic registration when we kicked that through.

Prof. Bange: I began the paramedic registration exercise.

CHAIR: I thought so. I remember speaking to you 20 years ago with NCAU.

Prof. Bange: You are absolutely correct. I became deeply involved in 20, 30 or maybe 50 submissions. I travelled Australia and spent about 20,000 hours or more of my time. Yes, I am familiar with registration.

CHAIR: We are really proud that Queensland was the first jurisdiction to have passed that legislation for paramedic registration. It is something privately that I wanted to see over my three decades of work. Now that we have had registered practitioners only for the last couple of years—prior to that the paramedic profession was seen as the poor cousin to nurses and doctors—the role has expanded greatly, from thrombolysis to intubating and providing all of those additional levels of care. People call an ambulance when something acute is happening. How do you think the scope of role can be expanded in a rural community where you have an ambulance station? Are you saying open up a walk-in clinic? What is your proposal in that regard?

Prof. Bange: There are two ways to approach this. The first way is the one you have mentioned which is via the Ambulance Service, by having people in rural areas where there may be an ambulance station such as in my own home town. The ambulance station became a hub for people to go for minor issues. I am now going back to the days when there were people called ambulance bearers. That might strike a chord or a memory.

CHAIR: It certainly does.

Prof. Bange: My brother was an honorary bearer. My father was involved in the QATB. We can use those resources both directly and in downtime. We can also use them to help support a local hospital if there is a hospital. There are places throughout Queensland where there is a clinic or a hospital that does not actually have a resident doctor. That means that the nurse practitioner or the paramedic, whether it be an ICP or whatever level of paramedic, is often the most qualified person in that community.

The second way, however, is that paramedics do have a wide range of skills. I refer to them generally as a generalist allied health practitioner. A well-qualified, experienced paramedic may have done anything from helping to birth a child to looking after a trauma incident to looking after somebody having a mental health episode. Paramedics have a broader skillset than is often appreciated. This has been taken up internationally in the UK, Canada and in other areas by having paramedics work in the hospital and also in clinics or in GP practices. The second mechanism that I have suggested is that we should take advantage of those same options and make sure that the impediments to practice are removed so that paramedics can work directly in or with GPs and clinics.

CHAIR: I met with paramedic practitioners in Townsville at JCU, and I am familiar with a couple who are working in the hospital from an older program some years ago now. Are you aware of that one?

Prof. Bange: Yes, I am. I am aware of a number of those programs around Australia. For example, there is a community paramedics program in Ceduna in South Australia. That is slightly different in that the individual there is funded through a range of funding mechanisms. The paramedics work independently of the South Australian service, but at the same time they work with, say, the local Aboriginal health service and with other community groups. The paramedic practitioner role is what you can see developing.

There is another one in Victoria known as the health community group. The problem with that is that they do not have the option to directly bill for reimbursement through Medicare and the like, so this is one of the impediments to the wider use of paramedics in normal primary care. There is yet another program supported by the federal government called the Workforce Incentive Program, the WIP, and this enables a practice to employ allied health practitioners and be reimbursed—that is, the practice—to employ those people and be reimbursed for their employment. The interesting thing is that the list of allied health practitioners contains 18 or 20 listed professions and they simply do not contain paramedicine. The doctors that I have spoken to said, 'I didn't know I could employ them.' I said, 'Well, have a look.' They said, 'But your name is not there.' That is one of my concerns. Perhaps through the Queensland government you can also talk to the federal government to make those programs more readily available.

CHAIR: Ray, I am going to go to questions from others. Very quickly, could you take on notice and provide the committee with some of the data around the South Australian model and the Victorian model and even any international jurisdictions? I love it when we can get some evidence and data.

Prof. Bange: Yes, no problem.

Mr WATTS: Thank you and thank you very much for your time today, Ray. I had a couple of questions out of your submission. In your submission, one of the recommendations is the enactment of a contemporary legislative and regulatory framework covering the QAS. I might just ask you the three things I am interested in and get you to comment on them as a whole. I would be interested to understand a little bit more about what that framework might look like. The second one is that on page 15 of your submission it says that, looking at Queensland, the time trend of ambulance service response shows that most patient attendances are not acute emergency cases demanding a lights and sirens response and less than 40 per cent of responses are classified as an emergency. I would just be interested in your comments around the growing demand on transportation. You make a comment in there about the service commitments of the UK ambulance service. I would be interested in that. Then the last one is the Queensland Audit Office report which spells out the extent of the Queensland ambulance ramping crisis, with paramedics collectively spending 112,000 hours ramped outside 26 of the state's top public hospitals during 2021, a 76 per cent jump from the previous financial year. I am interested in the regulatory framework, what we are doing in terms of transportation when it is not lights and sirens and how much time we are losing with these highly qualified professionals standing out the back of a hospital.

Prof. Bange: That is quite a lot. The regulatory framework is essentially based around a system where QAS, the Queensland Ambulance Service, is the primary emergency service in Queensland. I greatly support that because I think some overseas experience, particularly the US, is that the services are far too fragmented. I like the idea of a primary service that supports the state. At the same time, though, the recommendation I have made is that the ambulance service—the paramedic service as another term—should be accredited and that should apply to everybody, both state and private sector groups. If that were the case then private sector services could be utilised both as NEPT, non-emergency patient transport, and for surge capacity where it was necessary. This is what happens in the UK—not a great deal, but it would be there.

Obviously I am conscious of the time. On the percentage basis, one must look at this with a little bit of care because the percentages of emergency and non-emergency and urgent responses are based on the Report on Government Services, the RoGS. These percentages are reported by the QAS to the Council of Ambulance Authority, which then goes to the Productivity Commission. Some of those distinctions are fairly broad and they do depend upon the protocols which apply when people classify them as emergency or urgent or non-emergency. However, what is causing the growth in the areas outside of emergency?

I make the point that emergency responses are increasing, but they are not increasing as much as the other classifications. One of the reasons for that, in my view, is the fact that the Ambulance Service is a 24/7, 365-day service. In the community, if somebody has a crisis and wishes to have

some form of support or service, the first thought that comes to their mind is, 'I tried the GP or the clinic or the health centre and they are not answering'—and that may well be true, because health crises can occur at any time of the week and not just Monday to Friday, eight till eight or the like. The ambulance services tend to be seen as the universal portal to care, and that means people ring up because they know that there is a very high probability they will be looked after within a reasonable time frame and so you get a growth in those kinds of conditions. The other thing, of course, is that with an ageing population we are getting more people with comorbidities and with chronic conditions, and their particular requirements may not demand lights and sirens but they are still relevant and therefore they need to be catered for.

On the last one, the QAO, I cannot be too precise on the QAO because all I have done is use the QAO figures to illustrate the kinds of ramping issues and the kinds of delay issues which are independently reported in Queensland. I do not have access to the depth of granular information that would actually tell me who and when and where those paramedics are being occupied. That is something that is quite detailed, first of all. Secondly, we are in a state of flux right now because of the COVID pandemic. We need to look at what is the longer term demand and how we cater for that.

CHAIR: On that point, part of this inquiry is looking into that primary care space, to take people out of the emergency department. The data we were given from QAS is that 40 per cent of their people going into ED need to go in there via transport but the rest are walk-ins, low-acuity cases, that could be managed. We have heard from QNMU and the Australian College of Nursing on other models of care not too dissimilar to what you have presented here today. We have also been given data of 550 people taking up long-term beds when they should be going into residential aged care or NDIS packages. There are a lot of causative effects. Our aim is to get as much data as possible. I am happy to go into the break a little bit because this is something right up my alley. I have the member for Lytton and the member for Mirani who might want to ask a question. Member for Mirani, can you hear us?

Mr ANDREW: I can hear you, Chair. Ray, it is a great prospect that you put forward there.

Prof. Bange: I can only just hear you, but carry on.

Mr ANDREW: You have thought this out very well. It would be interesting to go into some of the answers to the questions on notice to get a bit more understanding. I do not have a question at this time. I will leave you with one of the other members.

CHAIR: Member for Lytton?

Ms PEASE: Thank you very much for coming in, Mr Bange. It is a great submission. Likewise, it is very thought provoking. Like you, I remember the days when it was the QATB that operated. I am fortunate enough to have the ambulance museum in my electorate in Wynnum, on Tingal Road. We have some wonderful old pieces of history stored there, very carefully, well looked after by our local LAC. What I am interested in is this program and how it might work nationally, because each different state operates their ambulances differently. They run their services very differently than we do here in Queensland. Would you imagine that there would be the capacity to take this up at a national level?

Prof. Bange: What is it that you were looking for at a national level?

Ms PEASE: Your proposals, your recommendations.

Prof. Bange: Generally, yes. I have given you—Queensland—13 proposals which are essentially broadbrush policy proposals. The reason I did that was that I think you have to look at broadbrush policies. You can get the details from individuals and submissions, but at the end of it you have to come up with proposals which are constructive and well based. Most of these proposals are very similar to the proposals that I have made to an inquiry in South Australia which is underway at the moment and similar to proposals I made in Tasmania six months or more ago. For example, the idea of a chief paramedic officer to be able to provide on-the-spot experience input at a senior policy level is a recommendation that I have made right across every state. The recommendations for looking at ways of diversion to other forms of care,—mental health, palliative care, local urgent care centres—are the same as I have recommended elsewhere.

Perhaps one of the things where you can do something independently but also would benefit from a national approach is simply making the health system aware that paramedics do more things than ride in the back of an ambulance. It is almost amusing: when I have spoken to people across the board in the medical profession and in the nursing profession I am sometimes met with the response, 'Oh, can you do that?' or, 'Do you do that?,' because they may not be aware that for the last 25 years or so paramedics have been educated through the university system. Paramedics have masters degrees; paramedics have PhDs. They are health professionals and a lot of people do not realise that they are registered health professionals. That realisation would help to facilitate the

employment of paramedics in non-traditional roles or in roles where you would see multidisciplinary practice, perhaps in emergency departments or in clinics and GP services. Generally the recommendations could be applied nationally with, obviously, distinctions in each state. Western Australia and Northern Territory do not have an Ambulance Service Act so I have recommended that they have an Ambulance Service Act in a submission which I made to the Western Australians. It is horses for courses, but a great deal—maybe 60, 70 or 80 per cent—is common.

Ms PEASE: From my understanding, many of the remote mine sites and those sorts of communities employ paramedics who have completed their training to actually undertake those roles that are the first port of call for primary health care.

CHAIR: You are speaking from direct experience.

Ms PEASE: Yes, I know that that actually happens. It is not dissimilar to what you are talking about.

Prof. Bange: I am not really sure what response you need.

Ms PEASE: Nothing.

CHAIR: We just know that we have paramedics performing that role in mine sites.

Ms PEASE: That primary healthcare role.

CHAIR: They have to be registered under Ahpra as well. Ray, we have taken a lot of your time. I would be interested to see that submission to Tasmania and South Australia.

Ms PEASE: And Western Australia, he said.

CHAIR: Western Australia is about an act. If you could provide any more information that is currently underway.

Prof. Bange: Do you mind if I send you a copy of those submissions? That might be an easier way.

CHAIR: That is exactly what we are after.

Prof. Bange: They are in the public domain so I have no problem with that. I do not want to flood you with too much information.

CHAIR: Paramedics like to read a lot of stuff. There is one last question.

Mr WATTS: It is a very quick question, and I will declare a conflict of interest. You talk about an appointment of a chief paramedic officer. That would create a vacancy here in the parliament if Mr Harper took that role. I am just interested in why you see that as necessary when you have a commissioner for the ambulance service and how you would propose funding that?

Prof. Bange: The suggestion is similar to that of a chief allied health officer. I believe you have one of those.

CHAIR: And a chief nursing officer.

Prof. Bange: The chief nursing officer in Queensland, the chief health officer in Victoria and an allied health and nursing officer in Tasmania. It would be funded, in my view, by the health department. It need not necessarily be a full-time appointment.

Mr WATTS: I need it to be full-time so I can get rid of a member of parliament! I appreciate your answer.

CHAIR: I won't apply then. Ray, thank you so much. We have taken a lot of your time. You should be incredibly proud of what you have achieved in getting paramedic registration across the line. I know that a lot of former colleagues watched that with great interest. We fought for it for many years. Many thanks for the considerable work that you have put in to that. We thank you for your contribution here today.

Prof. Bange: Thank you very much. It was a pleasure. If I did achieve something, it was only with the help of many.

Proceedings suspended from 3.33 pm to 3.43 pm.

MAXWELL, Dr Ross, Chair, Health Workforce Queensland (via videoconference)

MITCHELL, Mr Chris, Chief Executive Officer, Health Workforce Queensland (via videoconference)

CHAIR: I now welcome Health Workforce Queensland. Welcome, gentlemen. I invite you to make an opening statement and then we will move to questions.

Dr Maxwell: Good afternoon. I am a general practitioner based in Dalby. However, today I am in a suburb of Brisbane on Jagera and Turrbal country and I wish to acknowledge the traditional custodians of the lands on which we meet today. I am joined by Chris Mitchell, Chief Executive Officer of Health Workforce Queensland. Thank you for the opportunity to be at today's hearing. Health Workforce Queensland is a rural workforce agency. It is a not-for-profit agency funded by the Australian government. Its singular focus is on ensuring remote, rural, Aboriginal and Torres Strait Islander communities have access to highly skilled health professionals when and where they need them now and into the future.

We have a track record and experience of more than 24 years in supporting communities and working with stakeholders to address health workforce shortages and assist the rural primary healthcare workforce. Our work includes conducting an annual health workforce needs assessment to support and target our work to develop place based workforce solutions for thin markets and market failure in remote and rural communities. We work with communities and all interested stakeholders to develop these solutions to deliver improved services to the community or improved support services for the health workforce, in this case general practitioners. This is done within a range of Commonwealth grant programs. RWAs are at the coalface of the implementation of federal government funding and policy and see firsthand the collective impact of government funding and policy and the realities of lived experiences for rural health practitioners and the communities they serve.

Health Workforce collaborates with PHNs, the Queensland Health Office of Rural and Remote Health, Queensland Health at multiple levels and rural health and hospital services, other non-government organisations and various stakeholder groups. The inquiry is aware of the considerable challenges facing rural and remote communities, specifically in relation to access to quality primary health care, allied health and private health care as well as aged-care and NDIS services. Maldistribution of general practitioners remains the single major barrier to access to services for remote and rural communities. I would like to hand over to Chris to highlight themes of the way forward. Thank you, Chris.

CHAIR: Welcome, Chris.

Mr Mitchell: Thank you very much. As the Chief Executive Officer of Health Workforce Queensland, in addition to our formal submission which we submitted, there are four key points we would like to press today. One of those is a need for a shared Commonwealth and state vision for primary healthcare services that focuses on the needs of the patients in the communities. The second one is a single funding arrangement that supports and drives the agreed vision. Thirdly, we need a system that supports allied health nursing professionals and their medical workforce to make sure that there are sufficient supports. A joined-up approach to support students with early career exposure to rural and remote health care is particularly important at the beginning of a graduate's career. They are the four key points we would like to make today in addition to our submission. Thank you.

CHAIR: Thank you both very much. It was very apparent early in our travels in Far North Queensland this week when we heard there were 97 GP vacancies up there—we were in Mossman at the time—and people are driving literally hours from Mareeba to Cairns to see a GP, so access is a problem. That takes me to the first point around that distribution priority area. My home town is Townsville. When you do your annual assessments what success have you had? I know Mackay got a DPA status change recently. There are communities crying out for more GPs and better GP access to take the burden off the public health system. There are a couple of parts to this question. When you do that annual workforce assessment, you report back to the Commonwealth and you have done that for 24 years. In Queensland how successful are you in changing the DPA status to address these issues and what kind of funding do you receive from the Commonwealth to do this?

Mr Mitchell: Would you like me to cover that, Ross?

Dr Maxwell: Yes. Presumably you will speak about the Health Workforce needs assessment and then I might pick up on the DPA stuff?

Mr Mitchell: Yes; thank you. The Health Workforce needs assessment has been conducted for the last four years. It is a multidisciplinary assessment. It is done in conjunction with the primary healthcare networks, and they do a health assessment. I understand the HHSs are beginning to do

health assessments as well, so that will need to come into the mix, but the focus—the lens—is on primary health care. We also do a service analysis, survey based, from the viewpoint of the practitioners that identifies what the priority professionals are and what the priority services are, so we actually develop a service gap. None of that will be news to you. You would know the professions, you would know the gaps.

In preparing for today, I was looking back. I have been in this role for just on 21 years and when we started we had 820 GPs in rural and remote Queensland. As at November we count 2,609. A couple of things have changed over 20 years—not only the colour of my hair, but a lot of things have changed. Consumer expectation and demand for service is up; health care and chronic disease have increased; and we are more aware of our health care. We have all of that happening beautifully, but it is still insufficient. It still remains maldistributed, and there are some causes for that. Ross, do you want to speak to the next piece and we will come back to that?

Dr Maxwell: Yes; thanks, Chris. Just to pick up particularly on a couple of points there, before the Health Workforce needs analysis we were not acting blind but we were probably targeting the general practice workforce number in a different way and, as Chris said, we were following the growth of the general practitioner workforce. At the moment Australia has I think the worst shortage of general practitioners that it has had in my lifetime and it is around some of those things that Chris has talked about, but it is particularly around the fact that Australian graduates are not particularly interested in coming into general practice. This actually goes to our first point about the need for the country to develop a really robust primary healthcare strategy that will get the right workforce into delivering primary health care for Australians no matter where they live, whether in metropolitan Brisbane or in rural and remote or in Doomadgee. So I think there are real challenges.

Why do Australians not want to become involved in general practice? I think the remuneration gap between specialists and general practitioners is worsening. The remuneration gap and conditions gap between doctors working in a salaried position compared to general practice is worsening and smart, young people are smart. They look at what is the best opportunity for them to have a good life and it is probably not in general practice in Australia at the moment. General practice has plenty of problems. There are plenty of things it does not do well. Particularly, it does not pick up people coming out of hospital very well and it does not keep people in nursing homes and out of EDs very well. It does do some other stuff amazingly well. We have one of the world's best health outcomes and I think that is because of a lot of the very good work that is done in general practice. We have to try to convert this in the future into something that people are excited about and want to be part of. At the moment general practice feels like a cinderella in the system and young Australians are voting with their feet.

The other thing that has occurred is before COVID there was a winding back of our long-term international recruitment. In Australia—we can see it at the moment; it is really hitting us in the face—every industry almost has been reliant on international recruitment to keep their workforce numbers up, and very much so in health and very much so in general practice. That entry of people into our system has stopped dead obviously with COVID and it was wound right back before that. What you are seeing across the country and seeing in every one of your members' communities is there will be constituents complaining about lack of access to general practitioners, because I would believe that the shortage of general practitioners is bad almost everywhere in Queensland and everywhere in Australia but because of the maldistribution: what is a couple of days wait in Brisbane is a three- or four-week wait in rural and remote communities and the community quite rightly say that this is not good enough.

CHAIR: Thank you for that. That is exactly what we have heard all week, actually, but you have summarised it very nicely.

Mr WATTS: Thank you both very much for your time. I live in Toowoomba, so wave as you drive home.

Dr Maxwell: Yes.

Mr WATTS: We heard earlier today from UQ about how they are placing 30 trainee doctors into Central Queensland and Wide Bay and they are looking to do the same in Toowoomba where they do their undergraduate program through a partnership with another university and then they do their medical qualifications as their postgraduate in that location. Do you think that something like that should be expanded or are those two numbers roughly where we should be?

Dr Maxwell: I think what we can say is that we know that this is a good thing to get people to live and work in a rural and remote community. There appears to be good evidence over the country that if we can get students to train in place and finish their training and have their internship in

Toowoomba or Rockhampton then there is a much higher chance that they will stay there. The other thing that is very important is to select students from rural and remote communities who have an interest in health and try to make sure that the universities have a commitment to bringing rural and remote students into their cohorts to make sure that that is actually happening. I think a cohort of students training in Toowoomba is a really good idea. Toowoomba has trained students for a very long time, as you are probably aware, but they have usually been UQ students and Griffith students. They have often been there for a year.

Mr WATTS: Yes, and they rotate through.

Dr Maxwell: This is the first time there will be a whole-of-course approach to training in Toowoomba, and I think it is a good idea. Are the numbers enough? We would probably like to see 90, because then if we keep 30 that is great. If we train 30 and keep 10, that is probably still not enough.

Mr WATTS: In relation to the hospital facilities and specialists practising in those hospital facilities—and Toowoomba is a good example in that we are level 3 and 4 on a lot of things and I think we have an occasional level 5 in terms of specialist delivery—do you see that that should be moved out of the CBD a little bit more so that we actively get more specialists into regional and remote Queensland and operating in hospitals such as Toowoomba?

Dr Maxwell: This becomes a personal opinion because we do not traditionally deal with specialists. I think it is really important to try to have carers as close as is reasonably possible to the community, bearing in mind economies of scale and sustainability of rosters and those sorts of things. I think Toowoomba has been extremely successful in improving the service. Broadly in terms of consumer services—I am referring to Toowoomba both publicly and privately—the range of services available in Toowoomba in the last five years has just exploded, and full credit to probably the public and the private hospitals there for driving that development of services. It is an example of how leadership in the Queensland Health service has provided a very good range of services in Toowoomba. I think the leadership at St Andrew's and St Vincent's has also provided a complementary increase in the range of services at those private hospitals, which is also supporting the public system because a lot of those people have VMO appointments and work part time in both systems. It has required a commitment of all three of those parties.

Mr WATTS: I have one other question and then I will let some others ask some questions and then if there is time maybe come back. In terms of training people for regional and remote in particular, as opposed to provincial, do you see accommodation for nurses and/or doctors as they are going through their training and potentially as they are going through the junior doctor process being helpful in encouraging more people west?

Dr Maxwell: The answer to that is definitely yes. I think it is really important that people, if they are going to a remote community, know that they are safe at night, know that they have access to reasonable facilities and that they have access to the internet, which is really important because that is how everybody is connected these days. I think accommodation is really important, particularly for allied health and nursing who have often not had access to that. Probably medical students and junior doctors have had a better cut of the accommodation that is available. It is trying to get those other groups included in that.

Mr WATTS: Thank you.

Mr Mitchell: Do you mind if I add to that? The issue extends not only to those in training. This is extremely important, and Roma is a good example. They are simply growing their own little suburb adjacent to the hospital, which is a beautiful new hospital. The issue then is that for those coming to town, from across the professions, accommodation needs to be secured. There are a number of towns where the accommodation asset is low and therefore stops the recruitment.

CHAIR: Fair enough. That is a good point.

Mr ANDREW: Down the track or in the near future are there any plans to re-employ some of the nurses who are currently unemployed or are waiting to see if they are going to be terminated? They are in limbo. Is there any plan to do that?

Dr Maxwell: They are nurses who were employed by Queensland Health?

Mr ANDREW: Correct, yes.

Dr Maxwell: It is not a box we have any vision into. We hear war stories and that sort of thing, but I am not aware of the situation you are talking about.

Ms PEASE: I would like to go back to the conversation that you were having with my colleague from Toowoomba about the shortage of GPs in the communities. Can you comment on whether it would be worthwhile for the Commonwealth government to look at increasing the cap that is currently in place on Commonwealth supported positions at university to increase homegrown doctor participation in undertaking a medical degree?

Dr Maxwell: It is a good question: should we just train more? That is certainly one response. It sounds as if nothing has been tried before but if I wrote down every strategy that had been tried we would be here all day. They actually did try. In fact, there is something called the Medical Rural Bonded Scholarship where a number of medical students have signed up to do medicine and have a full year return of service in an area of workforce shortage in their eventual craft group area. This is interesting. Human beings are such fascinating creatures. I know of one person from my town who was one of those scholars. He did anaesthetics. He was very clear: he does not want to go back to Dalby, for good reasons. He is now trained as a super specialist anaesthetist because in his craft group the Queensland Children's Hospital is an area of workforce shortage. It is interesting to see the rules that are made about these things.

To be serious about that sort of approach, if we want to do that then we have to be much better at joining the dots and making them feel part of something. I think where that process has not paid off is that there are a lot of 17-year-olds who have to make a commitment about what they are going to do when they are 27 or 30-something, and it is a very long time. We have not made them feel part of anything other than they know they have this sword hanging over their necks the whole time. It would be our belief that we get the students involved and motivated about the difference they can make and the great rural life they can have. We do that really well nationally up until they get into a hospital. There is a real gap then once they spend their first couple of years in a hospital because everything new and shiny looks like an interventional-cardiologist sort of thing. We tend to have a lot of difficulty trying to maintain their enthusiasm through those couple of years. That is why the training in Toowoomba is great because if those guys stay in Toowoomba they are much more likely to stay regionally whereas a fair number of the people who go into the PA or the Royal will get seduced by all of that.

Yes, training more is an important thing. The Queensland government did that when the Rural Generalist Program was being set up. The then Beattie government purchased 50 medical school places from Griffith University, which they initially paid for entirely themselves. The idea was to try to create a bigger cohort of medical graduates to drive into the Queensland Rural Generalist Program, which in many ways has been one of the standout successes in the whole workforce arena.

CHAIR: On a similar line of questioning as that of the member for Lytton—and you talked about the decline in international medical training placements pre COVID—in their submissions the training universities are calling for an increase in the training places that the Commonwealth funds. Can you speak to that so we get clarity?

Mr Mitchell: I might add to that. There are two pieces of evidence that JCU would give to you. They would say that at an OECD level we have a sufficient number of medical practitioners compared to other OECD countries. Your question is: how is that so? Ours are maldistributed and, as Ross just outlined, we have significant growth in our subspecialties. There is a conglomerate group arrangement. Say we have 20 medical schools and if you look at the output it has been quite incredible to see the number who have come through. However, we can look back not too far in this state and see one or two of the teaching hospitals in a single year absorb in excess of five to 10 per cent more staff. There is that subspecialty attraction. As a previous health administrator, I can say that you need as many specialists as you can get. The issue is always, where are they? Are they too close to the seaboard, in our case? Are they further out?

The other strategy that has been in place for about four years now is a regional teaching hub arrangement. There is one through UQ and one through JCU. It is really important that the thinking changes: it says you do not train in the city and go to the bush; you start in the bush and if you need a particular piece you come to the city to get it and then go back. That way you and your family are established in your regional centre. It is just a flip on the idea. It is not my idea; it is out of JCU. Its study also showed, as Ross said before, that if you train locally and stay, from the evidence from Darwin, Cairns, Townsville and Mackay—I might get that wrong—the odds ratio was about four to one. You are four times more likely to stay in that geography; end of story. There is plenty of evidence to support that.

Ms PEASE: We have heard, particularly with the JCU model, that the college is going to be taking back that GP training and it is going to be delivered from wherever, not necessarily in those areas where JCU is currently delivering it.

Dr Maxwell: The College of Rural and Remote Medicine will obviously be delivering training nationally, as will the College of General Practitioners. One of the challenges is that we make sure that, however many doctors we train, we attract them into rural and remote practice.

I have been around way too long. I had the fortune, or misfortune, to be on the AMA branch council when JCU first graduated. At that stage there was a serious conversation going on about whether or not JCU graduates would be quarantined to North Queensland. To the credit of the minister of the day and to the credit of the professional organisations, we actually said no, that is not the sort of world we want to create for young people. If you come from Longreach and all your training was at Longreach and you are a world beater and the community is going to be best served by you becoming a neurosurgeon, then we should not be trying to create artificial barriers around that. There is always a bit of a downside to anything you do, but I think we can train in rural and we can increase the number of people who are of rural origin. I think that is all good. I am really concerned with the dramatic decline in the number of people who want to do general practice out of the mix. I am concerned that we would continue to put lipstick on a pig here. We have to try to work out why it is that young people are making that choice and make changes around that.

Things which are obvious to me include: partly level of remuneration; partly professional respect; but I think a lot of it is around choosing to be a salaried versus a non-salaried person. I think a lot of people value very highly the supports that a salaried position creates. That is a real negative in attracting people into general practice. Also I think where governments can really play a part is in championing primary care as a way to try to manage the extraordinary burden of chronic disease that we are experiencing. This is a good story. Australians live a long time because we have good food, good housing generally and good nutrition and so people live a long time. When I was a junior doctor, if somebody came in with five diagnoses on their history list they were a really complicated patient. Now, if somebody comes in with 15 diagnoses then that is almost run of the mill. There is this huge burden, which is why it is a bit of a black hole. We are continuing to create people who need a lot of services and support, but they are our brothers, sisters, parents, uncles, aunts and they are good people; we feel quite rightly that we are a wealthy country and so we should look after them.

Ms PEASE: I want to understand who decides what positions are available when junior doctors are making the decision about what to specialise in. Does somebody say, 'We need 25 anaesthetists and we might need some osteopaths, orthopods and oncologists'? Is there a governing body that says, 'We need these extras'? Given what you have just said about people having 15 underlying conditions, GPs need quite specialised skills to provide that service. What happens in that regard?

Dr Maxwell: My understanding—and it is complex—is that Queensland Health is responsible for providing specialty training. Almost every specialist will be employed during their training by Queensland Health. If you want to become an anaesthetist, for example, you would apply to the training program that is supervised by the College of Anaesthetists. If you want to become an orthopaedic surgeon, you would apply to that training program. Each program has its own entry criteria about university grades and research papers to be done.

Ms PEASE: Are those positions capped? Who decides how many? One year they might have a thousand people who want to become an orthopod. Is there a body that says, 'No, we only need two this year'?

Dr Maxwell: I suspect it is a complex negotiation between the colleges and the hospital system broadly. If you take accident and emergency medicine, it sucks in a whole lot of medical graduates. Part of the reason is that staffing all of the accident and emergency units in Queensland with high-quality doctors requires a lot of people in that training program. That is a sort of Faustian pact almost between the hospital system and the training colleges. How many people they have to have to cover their rosters is an important consideration in all of that. At the other end of it, they have always been able to say that if they graduate them and they become fellows of, say, anaesthetics and then are not needed in the hospital system they will go private and that will soak them up. It is complicated and it is muddy for the people applying to the system and for the people trying to understand it.

Ms PEASE: In terms of the Royal College of General Practitioners, where do their graduates go? Do they go into GP practices in the community to get their training?

Dr Maxwell: Yes. Once you have done two years in a hospital then you can apply to join the Australian General Practice Training Program, which has a selection criteria. I have done interviews for people coming on to that program and that sort of thing. The Commonwealth government supports that training whereas the state governments support the specialty training.

Ms PEASE: Have the numbers for GP training places increased or decreased?

Dr Maxwell: They have increased over time. I think on the current figures they are slightly undersubscribed at the moment; Chris, am I correct?

Mr Mitchell: Yes. There is a total of about 1,500 new entrants a year. It plateaued at that for the last few years. Prior to that it was 900, then it was 600 and then it goes further down. It is 1,500 at the moment per annum, and that is, as Ross has said, paid for by the Commonwealth government.

Ms PEASE: Did I hear you correctly that it is undersubscribed?

Dr Maxwell: It is undersubscribed, yes.

Ms PEASE: Yet we have a shortage of GPs?

Dr Maxwell: Yes.

Ms PEASE: What is happening in that recruitment? I know you have touched on it, saying it is not fashionable and is not considered to be highly regarded, but that seems to be where this gap is coming from, that people are not being picked up and going into the colleges. What can be done to improve that?

Dr Maxwell: There are things that are talked about. One of them would be to have some sort of a continuous employer model. By the time all those people are coming out of the hospitals, they have entitlements; they have maternity leave and holiday leave and all that sort of thing. They lose all that as they kick into general practice training, so that is something that might be helpful in that space. Other than that, I think it is about trying to make the underlying professional prospects more attractive. I think that is the rock that we do not seem to get around. People are clearly voting with their feet because of a strong perception that general practice is not well supported.

CHAIR: On that note, thank you both very much. Your contributions today have been greatly appreciated by the committee.

LITTLEWOOD, Dr Robyn, Chief Executive Officer, Health and Wellbeing Queensland (via videoconference)

MUNRO, Ms Joanna, Director, Health System Partnerships, Health and Wellbeing Queensland (via videoconference)

CHAIR: I welcome representatives from Health and Wellbeing Queensland. We are very excited to hear from you because it was the health committee that made recommendations to establish Health and Wellbeing Queensland.

Dr Littlewood: Absolutely, and I am so grateful that you have done exactly that.

CHAIR: I was really keen to hear from you today. We will go straight to an opening statement and then move to questions.

Dr Littlewood: Thank you so much for inviting us today. I would like to acknowledge the traditional owners of the land on which we meet today and pay my respects to elders, past, present and emerging. We are all here for the same reason: to improve the health of Queenslanders. Please let me set the scene by quoting a Queensland consumer who lives with chronic disease every day—

It is challenging. Diabetes is the worst thing that could happen to anyone. Once you get it, the fun is over. At one stage I was on the borderline, but I didn't understand it. I wish I could go back to the borderline. I've accepted that I now have diabetes. I've accepted it and that's it and there is no way out.

There are several issues here that really need focus. Problem No. 1 is long-term high obesity rates. In Queensland, we know that being overweight or obese impacts two in three adults and one in four children. Obesity alone is now impacting 32 per cent of all adults. If current trends continue, more than 40 per cent of Australians are going to be living with obesity over the next 10 years, yet one-third of the disease burden in Australia is potentially preventable. That means that we can actually do something about it.

Problem No. 2 is pressure on our hospitals. The impacts of obesity and chronic disease on the system are enormous and continue to rise. These conditions place pressure on a healthcare system that is under incredible demand already. According to the CHO report last financial year, there were close to 90,000 hospital admissions that were for lifestyle related chronic conditions in Queensland.

Problem No. 3 is the enormous healthcare costs. Nationally, the costs of obesity are estimated at between $1.5 billion and $4.6 billion every year, with additional costs arising from lost productivity every year, yet Australia spends only 1.34 per cent of the health budget on prevention—that is, 1.34 per cent—which is much less than countries such as Canada, the United Kingdom and New Zealand. There is very clear evidence that many preventive health models are very cost effective.

Problem No. 4 is inequity. Poor health from chronic disease is much more common in the most vulnerable of communities, as we know, and they are the ones that need help the most. That is why we need to be precise in our work.

What is the solution? Gain, there needs to be more than one but we have to be very good at thinking about them because they need to be connected. No. 1 is getting clinical prevention right, that is, prevention and treatment working hand in hand. Every day, thousands of Queenslanders connect with the healthcare system. Every connection is an opportunity to promote healthcare change and identify risk factors for chronic disease. Clinical prevention is all about connecting, prevention and treatment, rather than supporting a patient once they have a chronic disease because then it is too late.

No. 2 is educating staff. Our workforces are not trained well in this. We need to upskill, empower and support clinicians in prevention and refer to the programs that can support them well at the right time. Student training and student-led clinics are the key to building a future workforce that is prevention focused.

No. 3 is to always have a place based and consumer-led approach. Our health services need to operate as a seamlessly connected network, placing our consumers and our communities at the centre and sharing everything that we have across the board to provide care closer to home. This is the basis of the Logan health hub, which we are very excited to come and speak to you about today.

No. 4 is using outcomes based funding models because they simply drive outcomes. The current Australian government funded chronic disease management plan does not support those living with chronic disease well and it does not support those at risk of developing a chronic disease. Funding reform is needed to support prevention focused models of care, rewarding engagement and uptake by Queenslanders as they reach their own goals. That is what we absolutely need.

The last one is the right support and governance. We have been set up at exactly the right time. Health and Wellbeing Queensland is perfectly positioned to drive such an important and amazing connected agenda and we have already started. Why? Because the model works. To quote a patient from the new connected Logan health hub—

I had just about given up on the health system. This is the first time I feel like I matter in a long time.

Thank you.

CHAIR: It is very clear from your opening statement and submission that if we get the health prevention right—and that diabetic example was a great example of that—then you are going to save thousands of people by investing upstream in the prevention space. I wanted to get clarification of the CHO data. I think you said there were 19,000 ED admissions.

Dr Littlewood: Nine, zero—90,000 admissions.

CHAIR: Ninety thousand. Wow!

Dr Littlewood: I know. I double checked that as well. That is enormous.

CHAIR: It is. All week we have heard about the millions of calls to the Ambulance Service for what is categorised as a lights-and-sirens case versus a low-acuity case. We need to look at how we can solve that and, again, it is about prevention. It is about GP access and good monitoring of a person's health to prevent the types of examples you have given, be it around cardiac, respiratory, diabetic, endocrine—whatever. I think we need to visit you, given the work that we have done to see this happening to get a better understanding of it. At some stage we will get the committee to come over for a visit and have a face-to-face meeting. Before we open to questions, I want to thank you so much for what you have established. We know it is going to be important.

Dr Littlewood: Thank you.

CHAIR: I imagine we will be able to get some data from you at some point on initiatives. For how long have you been set up? Is it just over 12 months?

Dr Littlewood: No, it is almost 2½ years.

CHAIR: There you go. Another inquiry that has taken three years of my life.

Dr Littlewood: This is two years and we have not stopped. We have been exceptionally busy.

CHAIR: Thanks, Robyn. I will open up for questions.

Mr WATTS: Thank you both very much for joining us. I am interested in the entire journey: if we start at prevention and we go all the way through to palliation and the scope of practice that happens in there. We have heard a lot this week about siloing of funding, siloing of responsibility and integration. From a prevention point of view, who is providing that information and then, as someone moves along, who should they be handed over to? Where does a nurse, a nurse practitioner, a paramedic, a chemist fit in when, as I said, you are starting at prevention and finishing at palliative care?

Dr Littlewood: That is a great question. I think it is a really important one because prevention has to be a part of the entire life course, so absolutely everywhere. We have to start at the beginning. We have to think about maternity, the babies, the kids, the adults and then the seniors as well. We have to be in every single part of the health system. I will ask Jo to talk a little bit about the programs we have and the things that we are doing to support and train staff so they know exactly where they can refer to.

Ms Munro: We do see all the touchpoints that you mentioned as an opportunity for clinicians and health professionals to be prevention focused, address healthy lifestyle behaviours and refer on to prevention programs. We have established the clinical prevention agenda here at Health and Wellbeing Queensland because we really do see that every touchpoint that Queenslanders have with the health system is an opportunity.

Having been a clinician myself and not having been prevention focused, I see that there is an opportunity for the education and training of clinicians to be more prevention focused and also to raise the profile of the fabulous prevention programs that we have. Currently we have six prevention programs and we are very keen to drive referrals and Queenslanders to those. We really have our job cut out for us to upskill health professionals in the prevention space and also to raise the profile of the fabulous prevention programs that we have. I agree: across the whole life course we are looking at all those various touchpoints—

Dr Littlewood: Every single one.

Ms Munro:—every single one of them and providing some skills, tools and resources. We are working with the health professionals across the system to really understand what they need to be more prevention focused and to have all those tools. We know they are busy and we know they have a million things to do in a very short time, so we are trying to work with them to give them what they need.

Dr Littlewood: And that is going along exceptionally well.

Ms Munro: It is.

Dr Littlewood: We are certainly supporting the system now.

CHAIR: What are the six programs? Could you very briefly talk to those?

Ms Munro: Currently we have My Health for Life, 10,000 Steps, the Healthier Tuckshops support program, Jamie's Ministry of Food, Deadly Choices and QCWA Country Kitchens.

Dr Littlewood: The number of Queenslanders who used those last year was 575,000, which is absolutely amazing.

CHAIR: That is fantastic. I am familiar with Deadly Choices. Some of the Cowboys players are engaged with that in the schools in Townsville.

Dr Littlewood: That is such an important one of ours.

CHAIR: I like it—Queensland driven.

Dr Littlewood: Absolutely. We are doing lots of work. Our First Nations agenda is one of the most important for us.

CHAIR: Excellent.

Ms PEASE: It is great to see you again, Dr Littlewood. In the past you and I have spoken at length about prevention programs, which are very important. One of the things that we have been hearing around accessing primary health care is the problem people are having accessing a GP. I know that GPs are responsible for encouraging people on their health journey. Do you work with GPs?

Dr Littlewood: That is No. 1 on the radar. Absolutely we do. Jo, do you want to talk a little about that and include the Logan health hub?

Ms Munro: We have a couple of great partners. We have been working with a number of PHNs. We currently have a partnership with Brisbane South PHN doing a PIP QI, a practice incentive program for quality improvement, to support GPs better prevent and manage childhood overweight and obesity. That is an exciting project that we are piloting with them. We are hoping to scale that up across Queensland. We are waiting for the evaluation report for that to come in in April. They are working with general practices and GPs to support them with that. That is one piece.

The other big piece that we are doing that involves a PHN is the Logan health hub, which Robyn mentioned in her opening statement. It is a fabulous alliance of universities—so UQ and Griffith University—the Brisbane South PHN and Metro South. That is bringing all the key players together in an integrated model of diabetes care. That is down at Logan Healthy Living. We are supporting that at UQ Health Care as well.

We are very much involved with GPs and we also do education and training through Project ECHO. I am not sure whether you are familiar with that, but that is targeting GPs as well to upskill and train them in the paediatric obesity space.

Ms PEASE: Much of the evidence we have heard is that there is a lack of interest from junior doctors to practice as a GP. With the GPs that you have worked with, have you come across any pushback from them or found that it is a second choice for them? Have you considered doing any work with junior doctors who have not yet made their decision around what they are going to specialise in to possibly consider general practice? Is that something that you would do or are you at the end of the coalface?

Dr Littlewood: At the moment we are starting to work across the universities as well so that we can change curriculum around this. We can now look at making it glamorous for them as well so that they understand that this is so important. Once we started with that we found that there is so much interest in that. Jo, have you found that outside the university sector?

Ms Munro: No, I have not looked at that.

Dr Littlewood: We found that the GPs are very keen. I must say that it is because they have been in an established centre and they are so incredibly busy. They are keen for this. Universities and those established ones as well are the most important for now.

Ms PEASE: The programs that you are delivering are a great support to people who are thinking of going into the primary care world. If junior doctors who are trying to decide where to go were made aware of the great support packages and programs that are out there it would be of benefit to them. Given your knowledge and expertise in those areas, you could buff up the role of the GP to make people more interested in considering that as a career.

Dr Littlewood: Exactly.

Ms PEASE: You can contribute greatly. I know that you both come from different backgrounds as practitioners so you see the benefits and reap the rewards of the work that you do in the community because you see how it changes people's lives. It would be good if you could encourage more people to do the same. Thank you for your great work.

Dr Littlewood: Thank you.

Mr ANDREW: I am familiar with 10,000 Steps and Deadly Choices and they have made a difference to a lot of people. Thank you very much for the work you have done in that area.

Dr Littlewood: Thank you. That program is amazing, isn't it? It is a great one, whether you are a child or an adult.

Mr ANDREW: There are a lot of people up here who support it. I see a lot of people wearing the shirts and I hear people talking about it.

Dr Littlewood: That is great. Thank you for that.

Mr WATTS: I am just trying to clarify this a little bit—and forgive my ignorance for not knowing enough about it; I am new to this committee and I am still getting my head around several aspects of it. Are you mainly delivering, using economic terms, B2B? Are you training the medical practitioners or are you delivering B2C—straight to consumers—or are you doing both in terms of the program's implementation?

Dr Littlewood: Your question is a great one. I know in the first year of establishment we looked at this so many times, but absolutely B2B and B2C. We have to be there for those consumers as well. Our programs have to be there for every age and every place across the state—so B2B plus B2C.

Mr WATTS: In terms of your budget split and/or focus as an organisation, there are a lot of different types of practitioners who can multiply the effect of your program. I am trying to understand how that works for you and how we might be able to enhance that. The purpose of all of this is to drive down the need for medical services. Particularly in aged care and the NDIS, how can we look at some of your programs and invest in them to try to drive those things down?

Dr Littlewood: I will start by talking about the training and then Jo can talk a little about the work that we might want to do with the health boards. First of all, in terms of the training, the universities are so keen to partner. We now work and train nurses and doctors. I trained tuckshop staff as well and spoke about chips versus chicken nuggets et cetera. They are so important to this agenda. To me it is about the training. The training is the most important, absolutely. Jo, do you want to talk a little about how we do that?

Ms Munro: I might refer back to the example of Logan. That is a student infused allied health clinic. They run a lifestyle management program. We are using it as a bit of a test bed for training in clinical prevention. Hopefully that will impact the emerging workforce to be more prevention focused. All the staff involved in that will then raise awareness of all the programs we have.

The other thing we are looking at is integrating referral pathways into the system. Like you were saying, how can all the health practitioners refer quickly and easily into these programs? A big project that we have on our radar for this year is to look at digitally integrating—it is a bit like having one front door for all of these prevention programs to help clinicians navigate where to refer consumers to. That is another piece of that as well.

CHAIR: I am very keen to get the committee to visit you after this inquiry is wrapped up. The secretariat will be in contact at some point. Thank you so much for the important work you are doing. It is literally saving lives with early prevention, particularly for youth. I imagine that you have very wide stakeholder groups from GPs to Diabetes Queensland and all of the other organisations. I think it would be valuable to come over and see what you are doing to keep across it.

Dr Littlewood: We would absolutely love that. We would love to show you the Logan hub as well. That would be very good. We will put that in place.

CHAIR: We will organise something in the next little while. It has been a big week. We have had lots of people giving their contributions to this important inquiry. We value deeply the work you are doing. Thank you for your contributions today.

Dr Littlewood: Thank you for asking us and for finishing with us. It is wonderful.

CHAIR: You were always going on there once I saw the list of stakeholders.

Dr Littlewood: That is fantastic—music to my ears.

CHAIR: It has been a big week. We have travelled the state from the cape to the Gold Coast and I thank the secretariat for their support. We have had a couple of different people helping us. I thank people like Stephen, who is online, for their patience. Thank you all for coming along. We have two members involved in the Mental Health Select Committee that is on today. It is a big load. I thank Hansard. I declare the public hearing closed.

The committee adjourned at 4.41 pm.