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 (virtual)

Staff present:
Mr R Hansen—Committee Secretary

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

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 10 FEBRUARY 2022

Logan Central

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The committee met at 9.30 am.

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

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

This hearing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Only the committee and invited witnesses may participate in the proceedings. I remind members of the public that they may be excluded from the hearing at the discretion of the committee. These proceedings are being recorded by Hansard. Media may be present and are subject to the committee's media rules. You may be filmed or photographed during the proceedings. I ask that phones be turned off or switched to silent mode.

I acknowledge the member for Jordan, Charis Mullen. It is good to have you here. Today's program goes for a couple of hours, but if there are other people who want to speak, please see Rob Hansen, our secretariat, and we will allow some time at the end of the registered speakers for people to make comments if they wish to.

PHILLIPS, Ms Rachel, Executive Director, Allied Health, Metro South Hospital and Health Service

CHAIR: Rachel, thank you for attending. Would you like to make an opening statement before we move to questions?

Ms Phillips: Thank you for the opportunity to come and answer questions and to speak before the committee. Alongside the chair, I would like to acknowledge the local traditional land custodians of the Brisbane South region on which the Metro South health service now stands, the Yugambeh, Quandamooka, Jagera, Ugarapul and Turrbal peoples. I also acknowledge their enduring connection and that they were the first true clinicians of the provision of health services in Australia.

Metro South Health, alongside Mater Health, is the provider of public health services in the Brisbane South region, and those services are provided to 1.2 million Queenslanders. Metro South also provides a suite of statewide services and quaternary services including our brain injury unit and our spinal injuries unit and also transplantation services for the state and northern New South Wales.

While the region's growth rate is on par with Queensland, we know that Brisbane South has some unique characteristics that increase some of the challenges of the provision of public health services. We have a higher number of Aboriginal and Torres Strait Islander peoples within the Brisbane South region, sitting at about three per cent, or 40,000 people. We also know that we are a culturally and linguistically diverse community, with 21 per cent of our community speaking a language other than English at home. The other really important thing to note is that 4.5 per cent of people live with a profound disability within the Brisbane South region. That equates to about 45,000 people. This comprises about 21 per cent of all people living with a disability in Queensland, so we are certainly higher than the state average.

The other important recognition of the health service over the last 12 to 18 months is that we have established an interagency domestic and family violence reference group to try to increase the momentum of social change within health workers in their response to ensuring that we reduce the likelihood of harm to women and children and we also support families to be able to heal. We are committed to listening to our consumers, our patients and our communities in terms of how they experience their care but also how to improve the care they do receive.

Finally, we also know that we are not an island and that it is really important for us to be able to work in partnership with our other health services including the PHN, private hospitals and other agencies that provide different types of services to people who might come to our services. It is really important that we recognise that it is not easy to navigate health—even if you are a health worker, which I have found personally—and that we need to work towards making it as easy and timely for people when they need us most. Thank you, and I am happy to answer any questions.

CHAIR: Thank you. It will be interesting to contrast where we have been over the last few days—Cairns, Mossman and Townsville—where there were reports of lots of GP vacancies. People were finding it difficult to access a GP and ending up presenting to an emergency department. I want to start by getting a feel for what it is like down here in terms of GP access. The follow-up question would be about GPs in residential aged-care facilities. We heard from the Queensland Ambulance Service that there were some 35,000 transfers last year of people from residential aged care. If care was in place, would that stop the burden of transports to emergency departments? Can you give us an idea about that issue?

Ms Phillips: We would be the same as other areas of Queensland, where ED presentations for what we would consider preventable hospitalisations—things like cellulitis, for example, or a UTI—have certainly increased. They are non-acute/subacute type presentations. The largest proportion are in people aged over 65. What Metro South has done, alongside some other areas, is establish a program called CAREPACT, which actually liaises with aged care and Queensland Ambulance to try to provide timely health advice so that aged-care facilities can provide in-home care. One of the great achievements has been how to keep people in aged care who may be COVID-positive but otherwise okay, otherwise well, but also then to monitor their functioning so that we can admit them as soon as possible. It is reducing the time they may otherwise spend in hospital.

I think it is recognised that access to general practitioners is a challenge for aged care. I know that the PHN is talking after me so I might defer to the CEO to give a bit more specific information. While Metro South has a high population density compared to perhaps some of the other areas of Queensland which are more geographically diverse, we probably experience similar problems but maybe not as extreme because there is just much more diversity and depth of service provision.

CHAIR: I will open up to questions.

Mr MOLHOEK: I have plenty of questions but I wonder whether we should defer to our online participants first.

CHAIR: We can start with the member for Mirani.

Mr ANDREW: You can go with Trevor first.

Mr WATTS: One of the things I am interested to understand is how things interact. The example that was spoken about before was aged-care transfers. I am trying to understand how you can improve that. If someone in aged care is ill and needs an ED then obviously you would transport them—the same as if they were in their home and they were ill.

Ms Phillips: Correct.

Mr WATTS: So that is a necessary transfer, versus a service that could be provided in an aged-care setting and avoid that transfer. Given the number that was quoted, I am trying to understand how many of those would be transfers that would be happening if they were living in their own homes.

Ms Phillips: The service that we have established to centralise the advice and act as a conduit between the Queensland Ambulance Service and the particular aged-care facility is to really do a triage and screen. If, for example, there was a concern about someone, we have both medical and nursing advice that is provided, and my understanding is that that is around the clock. That can help to say, ‘Yes, please bring the person in as soon as possible to the closest ED.’

CAREPACT is also closely integrated with what we call the patient flow service. Patient flow across Metro South keeps an eye on bed occupancy of each of our five facilities and also ED status in terms of capacity. We can actually make sure that the person goes to the right hospital at the right time. That information around their status is handed over to ED to try to expedite their movements through ED.

If on the other hand the advice is that the care could be provided to the person in their residence—whether that is home or in their aged-care facility—CAREPACT can liaise via general practitioners who provide the services to that particular aged-care facility. That seems to be working incredibly well. It is incredibly busy because of the need that exists, but I think it has been an absolute improvement and I know Metro North have also commenced something very similar.

Mr WATTS: For the people who have to wait a long time for various categories of specialist visits and other things like that, would they normally be transported in an ambulance if they were going from an aged-care home to see a specialist, or would other transportation be arranged after they have waited that period of time to see the specialist?

Ms Phillips: It probably depends on their mobility, so how safe they are at transfers. If someone is a high falls risk or is bedridden, for want of a more contemporary term, they would be transported by ambulance. However, if they are able to walk, even with assistance, they could use private modes of transport. I know with the Department of Veterans' Affairs there will often be taxi services that will bring them up to the specialists. It really depends on their health status. Certainly, for people who are frail and elderly and not able to walk there is no option other than an ambulance transfer.

Mr WATTS: That would be much the same if they lived in their own home as well.

Ms Phillips: Correct. I would say for people living in their own home it is actually more difficult because usually they are more reliant on private transport than QAS transport. That can be prohibitive in terms of getting access to the specialist appointments.

Ms PEASE: Rachel, thank you for coming and for the great work that Metro South does. You cover my electorate and I acknowledge all of the great staff who work within the Metro South area and I acknowledge the outstanding work they have been doing during COVID. During our inquiries we have heard some statistics around residents being able to access various services. I am particularly interested to hear about the Commonwealth home care packages and whether you have any involvement or understanding about the delays for people being able to get access to those packages at this time.

Ms Phillips: If we start right back at the start of someone's journey, the most common scenario is where someone comes into hospital and there is a change of their health status that means they may need a different type of support. That can be as least restrictive as home care all the way up to specialist level dementia care. What we find is that the assessment process is pretty swift. As soon as someone is identified and the referral is made to the aged-care assessment team, there is usually an outcome within 24 to 48 hours within the Metro South region. The delay then ensues in terms of establishing those cares, so finding either a placement for the person or the in-home support. We find that the in-home support tends to take the longest, and that is a trend that has been observed over quite some time. The Department of Health has requested weekly reporting since about November on barriers to discharge that are identified by clinicians, and the greatest barrier is securing an aged-care service, whether it is a placement or it is home care. That is the highest in terms of volumes of people. There is, I would say, a shortage of home care support, but also there is a delay in establishing the right support when it is needed.

Ms PEASE: We heard within this inquiry, but also in other inquiries, one particular incidence in Hervey Bay. A woman spoke of her husband who had been on the waiting list for two years but had died by the time she received it. Staying at home, getting and receiving care in place, just did not happen. You talked about the situation being that these people would possibly be retained in a hospital setting.

Ms Phillips: Correct.

Ms PEASE: Do you have any figures around those sorts of numbers? What is the length of stay potentially for those residents?

Ms Phillips: On a weekly basis in Metro South we will have between 40 and 50 people awaiting discharge who are medically ready. These are people who are predominantly awaiting an aged-care facility. Their barriers to discharge are determined by clinicians. It is usually that everything else has been done and tried and we cannot do anything else. Clinicians find themselves in a really difficult position because they do not want someone to go home if they think it will be unsafe, but equally we know that the longer you stay in hospital the more likely you are to decondition and pick up another complication or infection. There is a lot of agitation that goes on to try and expedite.

The other challenge really is the delay between the approval for home care and then the implementation. There are other services that can be put in place, dependent on the person's condition. There has been an increase in transition care packages in Queensland because of the need. They provide up to 12 weeks of support for rehabilitation and reconditioning.

Probably where things are the most difficult is more the activities of daily living, so assistance with transfers, showering, cleaning—some of the more deep domiciliary type care. That has been a gap for probably the last four to five years as a result of the change with the National Disability Insurance Scheme—not so much the aged-care sector, because a large non-government organisation such as Blue Care is so used to providing both, so they did not discriminate based on patient diagnosis or condition. It was just a case of what they needed. Because those funding models have changed, it has meant that the viability of continuing those services by those NGOs has been more challenging.

Ms PEASE: That is interesting. Thank you for that. On that, we talked about the number of potential aged-care residents who are staying within the facilities. Would the same apply with NDIS clients, and what would the numbers be around that?

Ms Phillips: What we find is that, when talking about the number of days a bed is occupied, we have a higher number of people waiting for aged-care beds but a lower number of days they wait, so the volume is important. It is the reverse for people who are National Disability Insurance Scheme participants. There is a lower number but they wait much longer. We have some who can wait—it is very uncomfortable—a year.

Ms PEASE: We have heard that.

Ms Phillips: Eighteen months to two years.

Ms PEASE: We have not heard that.

Ms Phillips: Part of that is because of the market forces associated with specialist disability housing in Queensland in particular, but also quite lengthy processes in terms of people who have challenging behaviours, who need quite specialist level interventions—a willingness to accept those participants. It is very difficult and so they stay with us.

CHAIR: I acknowledge Linus Power, member for Logan. It is good to have you here and it is good for the committee to be in your patch.

Mr MOLHOEK: You said that in extreme cases some people can stay up to a year. What is the average length of stay for people waiting on aged care?

Ms Phillips: Usually it is between seven and 14 days. The volume is an important thing. We have a high number of people waiting, but their length of stay is usually seven to 14 days longer than what is required medically, whereas with the NDIS it varies. The range is quite significant.

Mr MOLHOEK: Longer or shorter?

Ms Phillips: Much longer.

Mr MOLHOEK: How many beds are there in total in the Metro South Hospital and Health Service?

Ms Phillips: There are probably close to 2,000 beds.

Mr MOLHOEK: In terms of the demand, would you say that it has become worse, is about the same or has improved on, say, five years ago?

Ms Phillips: This has always been a challenge for the public health service because we are a provider of last resort. We were a provider of aged-care last resort and now we are national disability last resort. I would say that the problem has been exacerbated because of the lack of available interim care type beds, for aged care but now for people with a disability. If they are a new participant to the scheme it can take time for the plan approval, and then if they are waiting for a new house to be built they will stay in hospital until that house is ready. We do not have—

Mr MOLHOEK: That is in the disability sector?

Ms Phillips: That is right. We do not have interim care type beds where they could go and wait and be looked after by, say, the same provider. During 2020, when the COVID pandemic started to hit Queensland, there was what they called a medium-term accommodation option that was developed by the Commonwealth where we were able to discharge quite a lot of people. That was short term, but that really showed that people were able to transition out into supported accommodation and then wait until their plan got approved and was established, rather than sit in a hospital bed.

CHAIR: What was that program called?

Ms Phillips: I can get you the exact title. Could I take that on notice?

CHAIR: Yes, please.

Ms KING: Thank you, Ms Phillips, for your very clear submissions today. I want to turn back to the aged-care sector and its specific impact on our public health services. I notice today—and you may or may not have seen it so far—that the ABC has published an article about the fall of a resident in a residential aged-care facility, Jeta Gardens—a fall from a balcony which has been attributed to lack of staffing. In particular there are comments made about one nurse being available to administer medication to 160 residents and the lack of timely medication potentially contributing to that person's fall. Is it your view that there are enough aged-care beds in the Metro South region?

Ms Phillips: There are about 10,000 aged-care places in Metro South, probably just under. I think it is the type of aged-care bed that is important, and that depends on the level of service that a patient or a consumer or a person needs. We know from the aged-care royal commission that there is not enough of these specialist dementia type beds available nationally, and there have been plans underway to establish more specialist level services. I think the challenge around the provision of health care in aged-care facilities is a significant and troubling social problem from which then unfortunate and very distressing situations like this sometimes occur.

The challenging situation is: what would 'right' look like? If we think of our own loved one in hospital and needing a place in an aged-care facility, how do we make that as easy as possible? But how do we as a family feel confident that when we are not there they will get the care that we think they need and that they will be safe? I think everyone in aged care—just as in national disability, just as in public health—goes to work to do a really good job, but system factors often play a role in preventing us from doing that, and I suspect that that is probably part of what has happened in this very distressing event.

Ms KING: I will acknowledge the incredible work that nurses and aged-care workers do in our aged-care facilities, providing that care when they can and to the extent that they are able, particularly during COVID.

You are the executive director of Allied Health, so I want to turn specifically to allied health. We have received submissions during the course of this inquiry about difficulties following changes to the funding model for the provision of allied health services into aged care. I am wondering if the public hospital system is seeing an impact on that, derived from that lack or difficulty in providing allied health services. Do people present at hospital following exacerbation of their conditions where allied health care provided earlier may have been of assistance?

Ms Phillips: Probably the main allied health professions that would be involved are the same as what would be involved in hospitals: physiotherapy in particular to maintain mobility; occupational therapy in terms of pressure injuries, management and also assistive equipment needs; podiatry for foot care, especially if the person has diabetes; and speech pathology in terms of swallow assessments and trying to prevent people choking.

I think the challenge is timely access. The arrangements are often between private facilities and individual providers, very similar to what happens with the Medicare Benefits Scheme as well. I think one of the challenges for that is the capacity of a team approach in terms of provision for care. Often, if someone has a chronic disease, or they are approaching the end of their life, they need a team to be coordinated around their care, and I think that is a real challenge which has probably been exacerbated.

Mr MOLHOEK: Earlier you mentioned some of the barriers to discharge and, I guess, the access to those services. Is the lack of services an issue of funding or is it simply that the demand has increased so much and there are not enough services, case managers and allied health services available to meet the increased demand because of new funding arrangements and opportunities under the NDIS and aged-care packages?

Ms Phillips: There are probably three parts to my response. The first is that I think the level of need in the community was underestimated. For 90 per cent of people with a disability the NDIS has been absolutely wonderful. It is the complex and severe end of the spectrum where we are always going to have difficulties, not only physical need but psychosocial disability in particular. That is people with enduring mental health or acquired brain injuries.

The funding model is very much provider led. Even though it is about reasonable and necessary supports, it is still dependent on those providers being available and being able to provide that response. When you talk about a provider, that could be anything from the delivery of a specific intervention such as communication all the way to housing. That is incredibly confusing for people and they need a lot of support. I do think the model does make it difficult for the people who probably need it the most. They would have been participants of our state disability services, where they were the providers of last resort. That has shifted to Health in a lot of ways. I think it is a very complex scheme to navigate, both within and externally, but probably the most complex for people who need it the most.

Mr MOLHOEK: We heard from one of the providers on the Tablelands, for example, that they have gone from 40 to 150 clients in the past two years. They cannot access the allied health carers and specialist services because the demand has increased so much because there is so much more money in the system.

Ms Phillips: I think the challenges are that there are not enough allied health professionals in some of the professions. That has been well established for a very long period. In prosthetics and orthotics, for example, there are severe shortages and in podiatrists. I am a psychologist so I know that for psychologists there has been an increase in the number of MBS sessions in response to COVID. That has been great for people already under the care of a psychologist, but it has actually been a huge barrier to access for new referrals. There are severe shortages and professionals now can pick and choose.

CHAIR: That summarises your contribution. Thank you very much, Rachel. We have heard in other hearings the term ‘providers of last resort’. With an ageing and growing population, there are significant challenges to delivering care. Our job is to hear from people like you and others on what opportunities there might be to tackle some of the challenges there. Thank you very much for your contribution today.

BOSEL, Mr Michael, Chief Executive Officer, Brisbane South Primary Health Network

CHAIR: Welcome, Mike. Thank you very much for being here today. Can you start with an opening statement? Then we will move to questions.

Mr Bosel: I take this opportunity to acknowledge the traditional owners of the land on which we are meeting today and pay my respects to elders past, present and emerging. My name is Mike Bosel. I am the chief executive officer of the Brisbane South PHN. With some degree of nervousness I will also admit to 30 years experience of aged care both here and in the UK, given the number of questions that came about for aged care previously.

I thank you for taking the time to come to Logan. It is a really diverse community base. As my colleague Rachel has said, the Brisbane South region has a population of about 1.2 million and we serve to plan the community needs of that population. It is about 23 or 24 per cent of the population of Queensland. As already said, it is probably the most diverse in the country and certainly in Queensland. We are the third largest PHN in the country and the largest one in Queensland.

In terms of issues and concerns—PHNs were funded specifically to support primary care and to look at the community needs—particularly the majority are around mental health. We elected to look at three areas specifically. The first area I would like to talk about is our advance care planning. We recognised that many older people in residential aged-care facilities were being admitted to hospital in the last few days of their life. We initiated a pilot about three years ago that worked with Metro South to work with residential aged-care facilities to train the residential aged-care facility staff to be able to accept and work with not only people going through their last few days but also the families concerned. A third of our residential aged-care facilities participated in that pilot, and at the end of 18 months we saw a reduction from just over 40 per cent of residents in one-third of our residential aged-care facilities being admitted to hospital to just over 22 per cent. That is a significant drop. We also saw that the average length of stay in those last few days dropped from just over nine days to just under six days. That was for a third of our residential aged-care facilities. Imagine, if you would, the impact it would have on all 96 of our residential aged-care facilities and their 8,156 residents, as of last week.

The second initiative—and I am cognisant that yesterday at the Press Club there was a focus on family and domestic violence—is that for the past two or three years Brisbane South has been running a program called Recognise, Respond, Refer. It has been recognised by both the Commonwealth and the inquiry report last year. To put it in its context, statistically Southport leads anywhere in Queensland for the number of applications for domestic violence orders. In terms of breaches of those violence orders, Townsville leads the way and Southport follows in third place. Just in terms of incidents of family and domestic violence, those two—Townsville and Southport—are way ahead of everyone else. That puts in context, I hope, to this committee that it is something that we need to address. It is not something that the PHNs were specifically set up to do but we elected to focus on that area.

The final program I would like to talk about demonstrates the way in which my PHN approaches working with our health partners—and you have seen my colleague today—which are Metro South, Children's Health Queensland, the Mater Hospital and a number of members across all of the peak providers such as universities et cetera. That is our Child Development Program. We identified in two- and three-year-olds that there was an opportunity to go through our childcare centres—currently in Logan, Beenleigh and surrounding areas 83 are part of this program—to identify children who may be at development goal risk. I am pleased to say that since June 2020 over 2½ thousand children have gone through that program. I am also cognisant that six per cent had never been made aware to the health system before that. Again, they are programs that I would like to say do not necessarily underpin what we do as a PHN but look at those opportunities that we will respond to. Given that time is short, I am happy to take any questions.

CHAIR: Thanks, Mike, for your opening statement.

Mr MOLHOEK: I should put on the record that Southport is where the courthouse is, so every DV order that gets lodged the length and breadth of the Gold Coast, from Beenleigh to Coolangatta, goes through that court. Just in case the media are listening, I do not want them to misreport the fact or infer that it is the suburb of Southport where the problem exists. It is actually a city-wide issue.

Mike, I am interested in some of the funding arrangements and the crossover between PHNs and Queensland Health. I note that in your submission you talk about the need for greater collaboration around co-commissioning services. Could you unpack that for us a bit?

Mr Bosel: Certainly. If you take the Queensland Health set-up, we have Queensland Health itself and then we have the hospital and health services. Again, the PHN's problem is navigating between those two institutions, if I can call them institutions. I think as a PHN we work very closely with Metro South. The relationship is really good. We have a joint mental health strategy and we have an older persons health and wellbeing strategy, which we have both worked at.

I would say we could go a few steps further to look at those services that we commission that are often services that both Metro South Hospital and Health Service commissions as well as Queensland Health. If I look at mental health particularly, the branch that sits under Clinical Excellence, the Mental Health Alcohol and Other Drugs Branch, will commission services independently of the HHS. Therefore, often we find ourselves in situations where we are commissioning a program that in essence could have been more effectively and efficiently commissioned if we came together. We have an opportunity with that, with the bilateral agreements that are underway. We also have a mental health strategy that is being adopted and rolled out throughout the entire state. I think those are some of the examples where we can avoid duplication and cost in the system by actually mandating that we do come together and look at areas where we are commissioning and jointly commission.

Mr MOLHOEK: Are you saying, essentially, that Queensland Health is commissioning the running of services and that perhaps they have not actually consulted with the local health service and PHN or they are running more of a regional program of services in some areas that perhaps do not interface well with the local hospital and health service?

Mr Bosel: I will probably go far deeper than that. PHNs are tasked every three years to do a needs assessment across our entire population. That is a long document. We look at and engage with the community, so I think we understand the community need far better than any health system in Queensland. Our commissioned programs respond to healthcare needs. What we then find is that potentially there is the commission of other services that do not necessarily reflect the needs of that community but are there as an additional facility or prospect to a service that is already there.

The other part that we would say is very clear is that, in order to respond to health needs, we need to build capacity. To build capacity we need to work with providers—not necessarily have the expertise in-house, which is the approach most hospital and health services and Queensland Health would use. Rather than building the capacity in the community, they will actually look to retain the services themselves.

Mr MOLHOEK: Has the PHN covered any of that in detail in their initial submissions or is that something we could perhaps ask for a bit more information on and some examples?

Mr Bosel: Yes, we are more than happy to provide additional information.

Mr MOLHOEK: I will put that as a question on notice, Chair.

CHAIR: Sure.

Mr MOLHOEK: Could we have some further information? Basically, you are talking about duplication in some circumstances.

Mr Bosel: And it is not just about Queensland Health; it is a number of different portfolios. For example, disability sits within Communities and not necessarily with Health. In our correctional communities, hep C is a prevalent condition. Because of the location of Wacol we have the highest prevalence of hep C of anywhere in the country. We are struggling between whether it is a hospital and health service, a Health service or indeed a community problem. It is not just within the health system; it is across those portfolios.

Mr MOLHOEK: I am assuming that the mental health strategy that you just referred to is being submitted to the Mental Health Select Committee?

Mr Bosel: Indeed.

Mr MOLHOEK: Great. I will not ask for it here then.

Mr Bosel: Hopefully we will see you again in a couple of weeks.

Ms KING: Chair, if I may, I will defer to the member for Lytton because these questions have been on funding and I know that she has some funding questions.

CHAIR: We might do that, but that was a good reminder. A number of submitters were vocal about the funding streams. They have just set up a pilot program for prevention in the primary healthcare space and that pilot might go for 12 or 24 months. There were some themes in the submissions to the committee about those funding streams. I do not know if that is similar to your question, but, Mike, can you start with that and then we will go from there?

Mr Bosel: The PHNs are funded across probably three main streams. We have what we call our governance and core funding, which allows us to be flexible and respond to community needs. Basically, it funds us to open our doors. We then have a number of other schedules that are specific to that funding stream. Mental health, for example, would be a large schedule and within that there will be programs that have been there for some time and those schedules can only fund those particular activities. Currently we have mental health, we have alcohol and other drugs and we now have also for the first time in the PHN's history—and, indeed, in divisions of practice for Medicare Locals—aged-care funding. That came through for the first time this year.

There are opportunities where, for any number of reasons, particularly given COVID it is more apparent, we have things called underspends. Those are commitments that we have made in programs where, particularly through COVID, that face-to-face meeting activity did not take place so there are underspends. Those underspends we have used at our PHN to fund pilot projects to establish a response to a particular need and to show that it actually works for that particular need. As an example, our PHN has recently, as of yesterday, commissioned a pilot into eating disorders, which is a fast-growing aspect we are seeing here in Brisbane South. We have also commissioned an extension of a community nurse practitioner into the correctional communities. Those are funded out of underspends. The purpose of underspends is to prove that something works, but it does not necessarily guarantee that that program will continue beyond the end of the pilot.

I mentioned the after-hours program, which is a schedule that has been around for about eight to nine years. That came through divisions of practice and Medicare Locals to PHNs. That is scheduled for discontinuance by the end of this financial year, despite the fact that we as a PHN use it to fund our multicultural health team—and we are the only PHN that has a dedicated multicultural health team—as well as to fund our homeless program and to fund some of our domestic and family violence response. Every couple of years we see that the program is scheduled for discontinuance. In most cases it either continues for a further two years or morphs into something else. As with anything, our schedules at the moment will generally go two to three years in advance of what we are doing at the moment but, in all honesty, this time I am looking at potentially three programs that are due to cease from 30 June. We are obviously advocating for those to continue. They are the kinds of parameters we operate under and our providers do as well.

Ms PEASE: I would like to explore a little further the matter we have been discussing already. I would like an understanding of your funding streams. You mentioned in your submission that you have to deliver better place based local responses; however, you are restricted in what you can deliver. Do you have control over the funding as to what you can deliver? What percentage of your budget can you use to deliver place based programs that are researched and determined that each separate community within your very big area needs? How much money do you have in your budget to spend on that? I suppose I am trying to find out what your discretionary spending is.

Mr Bosel: Before I answer that directly—I cannot give you a set percentage—a number of the programs that we currently fund have been in operation for some time, so a large chunk of our funding goes to headspace, and we have five headspace facilities. That is a huge chunk of the $45 million we get every year. That is a program that has been in place for some time. The PHNs have just continued that from Medicare Locals. Another large part of our funding goes to after hours. That is about $2 million. That has been around for about eight or nine years.

Ms PEASE: Could you elaborate on that, please?

Mr Bosel: After hours is a program designed to work with community needs to fund programs that would allow people to use alternatives to emergency departments and give them access to primary care beyond social hours—typically eight o'clock in the evening till five o'clock in the morning Monday through to Sunday and then Saturday afternoons and Sundays. It was there as a supplement to our primary care. That is what it was set up to do when it was first envisaged about eight or nine years ago. That has continued. PHNs are five years young.

There is a large part of our funding that is already in place. In terms of that flexible part of our funding, other than our governance costs, I would say we have between $3 million and $4 million a year of flexible funding where we designate or believe there is a place based response or a particular community need. The problem there is that if you do fund something then that is continually funded for the foreseeable future, because you cannot work in the community and build expectation that there is a program that responds and then cancel in two years time. Typically a large part of that flexible funding is committed.

I would not say that we are usual or unusual, but for my PHN we have committed about $600,000 to $700,000 in new initiatives. I have mentioned the eating disorders. I have mentioned the hepatitis C outreach program for correctional communities. We have invested over $250,000 in

Beaudesert for a particular place based response. We have probably invested just short of $200,000 in Southern Moreton Bay Islands, building an advocacy committee there to ensure we can respond to health needs. That is the flexible bit that we would not normally have been scheduled to fund.

Ms PEASE: What is your total budget per annum?

Mr Bosel: Our total budget is about $45 million.

Ms PEASE: Per annum.

Mr Bosel: Per annum.

Ms PEASE: And $3 million of that is flexible for you to determine discretionary programs that you think might suit public needs. What is the governance expenditure for the PHN?

Mr Bosel: We have about $4 million worth of governance.

Ms PEASE: How successful has your engagement with our local primary care organisations been to promote these great programs that you are running and how do you go about doing that?

Mr Bosel: The response from our primary care has been excellent. With Recognise, Respond, Refer we have currently just over 40 per cent of all GP practices on that program out of a GP practice total of 360. That is a significant involvement from primary care over and above their usual day-to-day business.

Ms PEASE: Can I explore that further, particularly with the domestic violence program that you are running—the RRR. Have you had any feedback from your GPs around the amount of time that is available for consultation with their patients? A six-minute appointment time frame is not a great deal of time for them to assess that their patient is actually in need of a referral to the RRR program.

Mr Bosel: The first point I would make is that we have not had any adverse commentary back, but it is not just the GPs that are involved in this program; it is everyone from the receptionist through to the practice nurse through to the administration. It is the entire GP practice. Often practice nurses are involved in the treatment of patients who may be suffering from family and domestic violence, rather than a GP directly. It is the whole practice.

I would say that from GPs generally, particularly where we have seen recently with COVID, we have not seen the level of adverse comments that we would expect around other programs that we have run. As an example, after some GPs raised issues about being able to visit all of the patients face to face, the Commonwealth funded us—about $600,000—to put in a deputising service, which is a GP referral service, if a GP was not able to visit that patient, whether it was a patient in a residential aged-care facility, someone with disability in their own home or accommodation or an older person in their own home or generally anyone in their own home. The take-up of that service has surprised me. It has been less than I would have expected given that certainly the MBS item payment for someone visiting someone in their own home is probably not what it really reflects.

There has not been as much adverse comment about our programs. I think they are under pressure. I attend the usual morning briefings. There is a lot of confusion about what is happening. For us, we looked at it and said, ‘How do we support our GPs in primary care?’ As of last week we launched the first GP support line in the entire state. A GP can ring at any time and ask for directions: ‘Where should I be referring to? I have a particular patient who has this particular symptom,’ and they can escalate it up to the Hospital in the Home and virtual care wards. Again, we as a PHN are not seeing the level of adverse commentary that you may get in other areas. It has been very positive and very supportive.

CHAIR: I asked the North Queensland PHN what their budget was over the last five years, so if we have a look at that for your PHN—and it can be taken on notice. I am interested to hear whether any of that underspend is returned to government if it is not used.

Mr Bosel: Typically it can be. There was a program that ceased about two years ago for which the money was returned. It was not used for any other program. Generally the process is: if you have an underspend, you apply to the department giving the reasons that underspend occurred and what you intend to use it for in the next financial period.

CHAIR: Can you give us an idea of how much was returned?

Mr Bosel: I could not tell you. From our point, none of it was returned.

CHAIR: Obviously we are really interested to take the burden off the public system. PHNs are responsible for the delivery of primary care. Can you provide the committee on notice with the results of that after-hours funding program?

Mr Bosel: Yes.

CHAIR: My observation is that if the money is being returned it should be put into that. That is something that you could work on in that primary health space to remove the burden on the public system. Can you move those moneys around to fund something like that after-hours access, which I think is a brilliant initiative? Do you have the capacity to boost that funding program?

Mr Bosel: The only capacity we have at the moment is increased funding, or we take the funding from another program that we have already funded. It is kind of like a Peter-and-Paul situation. I chair the after-hours working group for the department.

CHAIR: Good.

Mr Bosel: That is changing and morphing, so I think it is unlikely that it will discontinue, but it will change and morph into something that is fully focused on supporting the avoidance of an emergency department.

CHAIR: That is an excellent initiative. We would be really interested to see how that is progressing.

Mr MOLHOEK: I just want to clarify one thing. The figure you quoted earlier—$45 million for the PHN—would not include all of the money that is rebated to doctors through Medicare and other payments?

Mr Bosel: That is not something that comes through us.

Mr MOLHOEK: That is just a figure for special needs or local programs and services that are identified as requiring extra support or finances to establish on an area-by-area basis?

Mr Bosel: Yes.

Mr ANDREW: We have seen a lot in the regional areas about siloing and access to funding and things like through silos that complement your area. Can you tell me about that? Do you see that as much in the cities as they see in regional areas?

Mr Bosel: I could not compare it to the regional and rural areas. I can only talk about my particular region. I can say that when I joined this organisation three years ago I was amazed at the siloing that exists across the health system. Every week there is another anecdote that comes to me that demonstrates how disconnected our entire health system is, not just at the Commonwealth and federal level but also across the different portfolios. I can give you anecdote after anecdote but it is frustrating. As someone who is new to primary care, although I have a masters in primary health, this is the first experience where I have seen a system that is designed to complicate and confuse.

Mr ANDREW: Thank you very much for that. It obviously does not help anyone, especially the people trying to provide care or the people seeking care. That is one of the main things that comes up in some of the country areas so thank you for that.

Mr WATTS: Referring back to the siloing, we have a situation where somebody in a GP setting then has to send someone to a specialist outpatient service. There was an Auditor-General's report on this late last year. The report said that a few key projects as part of a specialist outpatient strategy remain unfinished. They included the clinical prioritisation project and the referral service directorate. I am interested in how delays in these kinds of projects might impact GPs and PHNs more widely in being able to provide care at the right time to the right patients.

Mr Bosel: I can again respond only from the perspective of my Brisbane South region. We have had to work with Metro South to ensure those referral pathways are clear, and I am pleased to say that Metro South have been instrumental in ensuring that that work together has resulted in clearer referral pathways.

I think the main thing is that I am less concerned about the primary to tertiary connection. What concerns me is the other social determinants that we tend to ignore, or it sits in a different portfolio. Disabilities for me is a prime example that I have seen over the last couple of weeks. The health response to disability—which was quite clear across rapid antigen testing and supporting people with disability to attend their GP practices—did not fall at the feet of the health department but actually sat within Communities. I am not blaming either portfolio for that, but wouldn't it be great if we actually got together and did a system-wide response to be able to attend to that? That is probably the biggest example of siloing that I have seen recently.

CHAIR: That is interesting going into that area, particularly around RATs. Does the PHN have the capacity, capability, logistics and infrastructure to actually deliver PPE and RATs to residential aged-care facilities?

Mr Bosel: We have and we have done that. Basically, up until more recently, the PHNs were tasked with the emergency stockpile for PPE for all GP practices and residential aged-care facilities.

CHAIR: Where is that stockpile?

Mr Bosel: It is currently sat with an organisation that is just a little bit south of here. It is sat there. They have the distribution skills.

CHAIR: Is that the only stockpile? Having come from regional Queensland, we are hearing about the difficulty in accessing PPE and RATs.

Mr Bosel: Up until Christmas we were very much across that logistics control so it was not as much of a problem as it has become recently. I think what has happened is you have now changed from each PHN being responsible for its logistics to a national logistics approach, which covered also the rapid antigen testing.

CHAIR: In Townsville is goes back to the public health system to provide those needs to aged care and GPs. Certainly in Townsville during COVID the GPs and the PHN were all talking together, but the actual delivery of those required RAT tests or PPE was delayed significantly. In North Queensland and Far North Queensland, where we have been, is there a stockpile there for you to roll out to those residential aged-care facilities?

Mr Bosel: I know that up until quite recently Robyn, the CEO up there, would have had her own stockpile up there—whether it could have been delivered and the logistics. We did have some supply issues just before Christmas. Even with the hospital and health services that was clear. I think the perception that everyone has their own stockpile and jealously guards it is probably a valid response here, because there are a number of stockpiles that I am aware of across this region that are all jealously guarded.

In essence, for PPE from a PHN perspective, we are the lender of last resort. The responsibility for the GP practice is still to order their own PPE, but in the event that that PPE is not there or they cannot get hold of it the PHN will supply it. Likewise at residential aged-care facilities, the responsibility is always in the first instance for that residential aged-care facility to get that PPE. If there are any problems or issues we can supply that, and that has certainly been the case up until quite recently.

Mr WATTS: My question relates to the transitioning of patients from Queensland Health into primary care and/or the other way around—from Queensland Health back into an aged-care setting. What can we do better in terms of onboarding, communicating and making sure the right care is available for the right patient at the right time—whether it be an outpatient service, an aged-care bed, disability support or an emergency service requirement? As we are talking about siloing, I want to try to understand how we might be able to break down those barriers so that the right patient gets the right care from the right agency at the right time.

Mr Bosel: This conversation could last days. I would be happy to take this offline but I would like to make one point if I may. I heard previously about the delays going into home care packages. I had the honour of running probably the largest private home care company in the south-west of the UK 18 years ago. The static population that I serviced in terms of both staff and patients was about 18 million and I could drive to each of my five offices in one day if I chose to. We had a staffing pool of about 500 staff. I struggled to find the staff day in, day out, and those provided home care packages.

I would pose this: in a country the size of continental Europe with a population not much bigger than the population I served, we are going to struggle to find the adequate and appropriate staffing to provide those home care packages. The reliance on home care packages as the answer to all of our ills I think is incorrect. I think we need to work across the entire system.

If I could just make a plug, we have an unpaid, focused care workforce in terms of family members and carers. If all of them decided tomorrow, ‘I’m not going to do it today,’ we would be in crisis. The health system does not support those unpaid carers sufficiently or at all.

Ms KING: I want to go back to in some ways the core of what this inquiry is about and ask for your understanding from your participating GPs within the PHN area and from the people who go to them for care. What is the GP landscape like here in the Metro South area? How long are people waiting for appointments? Can they get onto the books of a GP? Are GP practices thriving or failing based on the viability of their businesses?

Mr Bosel: Our primary care goes beyond GP practices so it is all allied health; it is mental health support services.

Ms KING: I understand that.

Mr Bosel: I think there are a number of issues we are seeing. We do not have the records to show how long someone is particularly waiting for a GP. What we do know is: being the third busiest primary care network in the country, there are certain areas where we are seeing a degree of difficulty.

Bulk-billing psychologists is one, and certainly our response in Beaudesert resulted from the fact that waiting times were up to six months, if you could get in there at six months. Therefore, we had to build a community response that attracted people who wanted to practise as psychologists. We have specialist areas where the bulk-billing nature is one that is causing the issues.

What is specific to Logan and the surrounding area is: we do have some cultural framing aspects that cause difficulty. For example, I have been concerned that our female patients who speak Farsi—that is, the northern Iraq and Afghani populations—will find it difficult to go to a male GP and someone who does not speak Farsi. Trying to find the appropriate GPs at the right time and the right place is also a difficulty.

The other part is that we have an approach where GPs will practise. Some of the areas we have—the Southern Moreton Bay Islands—are very challenged. We rely on the Aboriginal medical service there, the Yulu-Burri-Ba, to support that. I think there are some distinct areas that we need to tackle but it is not in my perception relevant to the whole primary care.

CHAIR: Thank you for your contribution today. I am really interested in that after-hours information. I think it is a benefit. We used to have an after-hours GP you could ring in North Queensland, a mobile service, but it no longer exists. I am wondering if other PHNs are doing what you are doing here in that after-hours sector.

Mr Bosel: We all have the after-hours program. However, we choose to use it a little differently because it responds to our population needs. You will not see the same service potentially in every PHN but added together it is a formidable program.

CHAIR: Thank you for that. There are questions taken on notice. If we could have responses by 17 February, that would be greatly appreciated. That was very informative and the committee appreciates you being here today.

JOHNSON, Ms Tracey, Chief Executive Officer, Inala Primary Care Ltd

CHAIR: Welcome. We look forward to your contribution. Would you like to start with an opening statement? Then we can move to questions.

Ms Johnson: I provided this statement to the secretariat for future reference because there are a whole bunch of graphs that I will be referring to but I will not bore you with talking to those graphs in my presentation. Thank you for this opportunity. I too would like to acknowledge the traditional owners of the land on which we meet.

General practice where I am from involves over 7,000 clinics, with revenues exceeding $14 billion annually, representing a declining share of government expenditure, meaning half of GP practice owners are concerned about practice viability. Sector revenues are predicted to grow by just 2.1 per cent in 2022, despite the growth in demand generated by the pandemic, ageing and chronic disease. This is a figure well below inflation and exacerbating the more than 26 per cent cut to real incomes that practices have faced over the decade.

One-third of practices are indicating revenues are down since the pandemic began, with 39 per cent reporting a fall in profits and 64 per cent noting vaccination rebates do not even cover costs. Profit outlooks are bleak, with 68 per cent of practices seeing as their top challenge the Medicare schedule lagging and the increasing costs of running practices, resulting in 36 per cent proposing to increase consultation fees.

Our practice at Inala operates in one of Queensland's poorest suburbs. Patient poverty limits our ability to use mixed billing to cross-subsidise bulk-billed operations. However, in November we introduced a $20 fee on Saturday mornings. We need to aim for five per cent mixed billing by the end of the financial year and 10 per cent within 18 months to even be able to pay our rent. Our practice bulk-bills in an area with above state and national prevalence for every condition—with 32 per cent of our patients using five or more medications and 53.5 per cent having two or more chronic conditions. This is not a six-minute-medicine cohort. Prior to the Medicare freeze, it was common for GPs to schedule four patients per hour. The majority of practices have moved to six, with many in our immediate catchment routinely seeing 10 to 12. Six-minute medicine is a direct response to the financial pressures practices face, meaning we can no longer spend time with patients.

Pressure to bulk-bill telehealth and COVID vaccinations has put general practice under further stress. Our doctors often seek input from the hospital via phone—if you can get a specialist to answer. In that time, another patient could be seen and income earned. Many practices simply refer to hospitals without seeking that advice. Secure email support services in some units are more convenient, but the effort still remains unpaid for the GP. Real gains could be made in the areas of orthopaedics and urology, just to name a few, if GPs could ring the hospital and make a request of the specialist to issue an MRI order form, just as their private equivalents will do. GPs could also be given scope to order MRIs via Medicare, saving outpatient appointments at hospital.

GPs have absolutely no incentive to work extended hours. Penalty rates apply for nursing and reception staff but the bulk-billed rate remains the same. We ran Saturday morning clinics at a loss before we introduced a moderate out-of-pocket expense. GPs operate from sizeable premises, meaning occupancy costs have been impacted by rising property prices. In addition, staff working under awards receive regular pay increments. These are still insufficient to attract highly qualified skilled nurses to perform the chronic disease and care coordination work to keep patients out of hospital.

Nurses can earn 40 per cent more in the public system. Without chronic disease support, more patients are referred to public services. Bundled payments, which reflect patient need, or chronic disease care planning payments, which reflect patient complexity, are long overdue. Increases to the workforce incentive payment—which pays practices for their nurses—are urgently required to ensure general practice is a career path that nurses will embrace.

If sending a patient privately, the level of detail required is limited. If sending to the public system, health pathways need to be referenced. GPs resist this time incursion, which is why letter quality can be poor. More recognition of the detail of this work would allow Queensland Health to sift through better referrals and determine which ones need to be followed up by a visit and which could be addressed by a phone call. For example, if we provide a well worked up patient they might not need an OPD appointment, but they could go straight to a surgeon for skin cancer removal. Public referral usually involves ordering tests to accompany that referral. This means two visits to the GP: one to order the required test and the second to send them, with their referral form, to the hospital. Sadly, more often than not these tests are repeated at the hospital, costing the system twice.

The use of interpreters also takes enormous time. In our practice the accumulated cost of working through interpreters is over $400,000 a year. Whilst the interpreter is free, the additional time involved is so poorly compensated it affects our very viability. That is why most practices create barriers to access for non-English speakers, leading to their above-average use of emergency departments.

Practice incentive payments do not reflect patient complexity. The SWPE count used by the Commonwealth rewards practices with large groups of easy-to-serve patients who visit only very occasionally. Our practice has 40 per cent more patients aged over 65 than the regional average and more than 800 patients with complex and chronic mental health conditions. Such patients visit frequently and almost none are privately health insured. More than 29 per cent of our patients visited more than five times in 2021, taking up 54 per cent of all of our GP consultations. In Brisbane South just 15 per cent of patients have those characteristics. Consequently, we receive half the incentive payment of a practice with similar patient volumes.

Upskilled GPs, like those who work in our complex diabetes service or our HEPREACH service, reduce the flow of patients to the hospital system. We cannot charge more despite replacing hospital activity, meaning some of our most competent and skilled GPs are paid the least. The MBS should reflect special interests and hospital funding should be easier to shift to where the activity actually occurs. This is where our award-winning Keeping Kidneys Service fell down. Despite positive evaluation by Deloitte and the hospital system, moving money from our hospital partners to our practice proved just too hard so it closed.

Just 15 per cent of medical graduates are interested in working in general practice due to income disparity. GPs are choosing to work part-time to avoid burnout. In disadvantaged catchments like the one I come from, income differential is so stark it is hard to attract staff, just as it is in regional areas; hence, practices in marginal catchments are heavily reliant on registrars, who are junior doctors, as their core workforce. However, junior doctors are more likely to order tests and refer patients to hospital. Turnover of trainees also compromises care, often leading to late referrals. The bulk-billing incentive in catchments like mine should match the bulk-billing incentive applying in remote areas.

Ongoing failure by government to address the social determinants of health and fund equity of access to health services results in what Sir Michael Marmot terms silent mass killings. In Inala the median age of death is 72, versus the Australian average of 81. In neighbouring Goodna, which we also serve, it is 67. Our patients spend an additional 15 years in poor health, compounding the health and social care costs. We need funding and we need it now—reformed funding that aligns with the 10-year health reform plan that has been in draft at the Commonwealth level for some time and the recently launched preventive health strategy. Delay will be counted in ramping, patient deaths, burnt-out GPs and practices closing just like mine. Thank you.

CHAIR: Thank you very much. Some things we have heard previously in Cairns and Townsville. One thing I picked up on was private health insurance. You said very few would have it.

Ms Johnson: Two per cent of our patients have it; 48 per cent, and falling, of patients have it across the country.

CHAIR: We heard data that around 60 per cent of Queenslanders do not have it. For the 40 per cent who do, the cost and the gap are so big that they go to the public system.

Ms Johnson: Yes.

Mr MOLHOEK: Thank you, Tracey, for the commitment that you have to your local community. It sounds like there are certainly some significant challenges there and we certainly appreciate the work that you do. You touched on an issue around efficiency of service. You mentioned that it would be better to order an MRI via Medicare rather than send the patient to the hospital for an outpatient service where they are seen by another doctor and then are able to go and get that. We heard a similar comment from Dr Michael Clements in Townsville.

Ms Johnson: I know Michael.

Mr MOLHOEK: He talked about the New Zealand system, which basically provides for more information sharing and greater responsiveness between the public health system and the private health system. Would you talk a little bit more about that and perhaps about what you think the impact of that is, firstly on patient outcomes and secondly on cost?

Ms Johnson: It is very real. It takes on average 15 to 20 minutes for our doctors to locate a specialist they can talk to. It might take over the day to get that conversation occurring. If we could have more immediate access to people to help us triage, treat, titrate medications and things like that, we would not be sending as many people to outpatient activity.

My bigger concern is actually discharge. Queensland Health has a target to send us a discharge summary within 28 days—28 days—of the patient leaving hospital. Patients often leave hospital with medications that they might only need to take for three days, five days or 10 days and then they are supposed to discontinue it. If we do not even know they have presented to hospital, been admitted and had a medication change, and we do not get the discharge summary back for 28 days—and let me tell you, it is often more like three months—how do we know to contact that patient, get them in, educate them about the new medication they are on or take them off a medication they are only supposed to take short-term?

In every other modern country in the world, including New Zealand, hospitals are measured on their 30-, 60- and 90-day return rate of patients, because typically patients will return because there has been an adverse outcome surgically, they might get an infection or something, or a medication-error-triggered kind of representation. If we actually had discharge summaries available to us before the patient left the hospital, or within a day or two of them leaving the hospital, we would see dramatic reduction in re-presentations, bed days, emergency department access et cetera in the hospital system. How do I know that? I was part of a research program that employed pharmacists to liaise with the hospital pharmacy before the patients were discharged. We got a 33-as-to-one return on that money.

Mr MOLHOEK: Just say that again?

Ms Johnson: We had hospital pharmacists liaising with pharmacists in general practice before the patient was discharged to let us know what medications the patient was on, because often the discharge summaries are not complete, they do not contain all of the medications and they do not contain enough instructions when to take patients on or off medications. By having pharmacy-to-pharmacy linkage, for every dollar spent on that project we got a $33 return to Queensland Health of that project.

CHAIR: What was the project called?

Ms Johnson: Remain Home. It has actually been written up in peer reviewed literature.

CHAIR: Can we get a copy of that sent to the committee?

Ms Johnson: Sure.

Mr MOLHOEK: With the introduction of My Health Record I assumed, perhaps wrongly, that that actually provided for sharing of information around patients so that, if I had presented as an outpatient at the hospital and then I came to see my local GP, when they called up my records they would be able to see all of that if I had consented to that.

Ms Johnson: Queensland Health now—recently—does put all of their pathology and discharge summaries and things like that onto My Health Record. We cannot actually see anything in there about what is happening to the patient whilst they are in hospital and if the discharge summary is not written for eight weeks, which is often what happens, or it is not even written, there is nothing to upload. Once it is uploaded it is on My Health Record. The problem is the delay in actually getting that discharge summary written.

Mr MOLHOEK: You probably do not know, but maybe you can surmise: why does it take that long? I would assume that when you see a doctor probably by the end of day most comments and notes have been made and pathology reports reviewed. I am amazed that when I go and do blood tests my doctor goes, ‘Well, here is the last six years of them and here is what has been happening.’

Ms Johnson: That would be in the private system rather than in the public system, which is under so much pressure. Normally a discharge summary is written by a junior doctor, often not even the doctor you saw, looking at the notes that are contained in the hospital record and they will just produce a summary. That is often why there are so many errors and so much incomplete information: because the person who is writing that is a freshly minted doctor who was not actually involved with that episode of care.

Mr MOLHOEK: When you look at My Health Record, are you going to see everything that has been prescribed in the last few years and blood tests?

Ms Johnson: As of the last 12 months you can. You can see the active script list. That is a real innovation. We can actually see when medications are dispensed from the pharmacy—hospital pharmacies as well as community pharmacies. That is a revolution. From a treatment perspective, when you have a patient sitting in front of you and they just do not seem to be responding to the management you have applied, and they will often tell you that they have taken their medication, you can now go on to the active script list and go, ‘But you haven’t actually had the script dispensed in the last three months. Maybe that is why your blood pressure keeps going up.’ It does create more accountability and transparency in the system, but that is a fairly novel thing.

Mr MOLHOEK: You mentioned a need for a shift in hospital funding to programs like Keeping Kidneys. If you have some information around some of those programs, that would be helpful. Could you take that on notice?

Ms Johnson: Sure. Hospitals are funded with weighted activity units. If the activity does not occur in the hospital system, the activity gets moved to us because we collaborate with them. GPs are a lot cheaper than hospital specialists, as are our nurses. It then becomes hard for them to move that money that would have gone to an outpatient appointment to us. Sometimes it can be done, but it is a pretty sticky area and an area ripe for innovation.

Ms KING: Thank you so much, Tracey. Your presentation has been really compelling. The shocking disparities in lifespan in your community makes the care that your members provide all the more important. I wanted to ask a couple of questions about some points you mentioned around the financials of running GP practices. Since the GP freeze on Medicare payments in 2015, how much would you estimate the costs of running a GP practice have increased on average in your region?

Ms Johnson: In my region directly, I actually had a $170,000 a year rent increase alone and then on top of that salary increases. In our practice, 86 per cent of my budget goes to salaries. Our practice turns over over $4 million. We are a very large practice. We are a charitable practice. In terms of the direct impact to us, if you look at the 26 per cent cut that we have taken to our income over the last decade, and you are turning over $4 million a year, that is the sort of income we are looking at.

In terms of what I am constantly chasing money for to be sustainable, every year I start my budget process looking at a $350,000 deficit and then have to go out and find grants and ask staff to take pay cuts. My GPs are some of the most poorly paid in the region and yet they do some of the most complex work. We have a national reputation for the work that we do. A full-time GP with me earns $280,000, so they are not the working poor, but if they went and worked elsewhere, where they could mix-bill and use their skills, they would be earning $450,000 to $500,000 a year. That said, a radiologist earns $1.2 million, a gynaecologist earns $2.5 million and an ophthalmologist earns $6 million. How is it fair that GPs earn what they earn when they did the same training as their much more highly paid private specialists? That is also the opportunity we have in our health system: to move care that does not need to be done by a superspecialist in a very expensive hospital environment back to primary care, but our funding does not support that.

Ms KING: Do you see a lot of burnout from your GPs—a lot of turnover?

Ms Johnson: Absolutely. A GP in my environment tends to work for us for about four to five years and then they become part-time because our work is truly hard. Our patients go to the public system. They sit on waiting lists in the public system for months and years at a time, which means as a GP you are having to learn and upskill and support them as best you can. In the private world, they would be seen by a private specialist within two to three weeks—maybe six, eight weeks—and you would get that advice back and you sort of feel relaxed about what is happening with that patient. Beyond that, our GPs tend to turn over within seven to 10 years because they are like, ‘I have done my hard slaving. I have done my public work. I am going to go and relax and earn easier money somewhere else.’

Ms KING: You mentioned incentive payments that mean that with your patient mix you are only receiving half the benefit compared to a less disadvantaged patient mix. Can you explain that to us in a little bit more detail, please?

Ms Johnson: Sure. The standardised whole patient equivalent is a Medicare algorithm that basically says that if you are under five or you are elderly you are equated to being one person and if you are a woman you have a better chance of being equated to one person, because we tend to attend the doctor a bit more often for pregnancy and other issues, but in those middle years, particularly the middle adult years, the algorithm does not count you as a whole person. The total number of active patients that we have in our practice versus the SWPE count is actually quite a different number. The government is trying to reflect the complexity of the patient group. That is their attempt to do it. It just does not work very well. For us, incentive payments are all triggered by that SWPE number and multiplied out. At the moment our SWPE number is sitting at 3,000-odd—3,200 patients. Everything we do is multiplied by that, yet my active patient group is like 7,800. It is worth hundreds of thousands of dollars a year in payments to us now. If it is actually doubled, all of a sudden I do not have a budget deficit that I am always chasing grants and other things for.

Ms KING: In fact, what you are expressing to me is that your patient mix is much more complex in the middle years of life and they should appropriately be considered to be the whole person in terms of account?

Ms Johnson: Absolutely. We work in Queensland's largest housing commission suburb. We support the largest group of refugees in Queensland. We support the biggest group of patients with mental health needs in Queensland. This is the patient group that we serve and we do it because we know it is needed, but the Commonwealth funding model, and indeed things that the state could do, does not reflect the support that our patients need.

Ms KING: I think we all join in thanking you for that work and that service to your community.

CHAIR: Hear, hear.

Mr WATTS: You said that sometimes a patient might be able to be seen by a GP as opposed to waiting for a specialist but, because of the funding model from Queensland Health, that does not happen. What advice would you have for the committee about that funding model and allowing GPs in the less complicated speciality consultations to be able to access that?

Ms Johnson: I think there are two solutions. If I look at the Keeping Kidneys model, we took 287 patients out of Princess Alexandra Hospital's nephrology outpatient list and saw them in our community closer to home. We are doing the same thing with our HEPREACH model. We have taken patients off Mater's public list and we see them in the community for their hepatitis. It is the same with the diabetes model that we run. With one of those models, Queensland Health has been able to give us a subsidy to cross-subsidise that service. For HEPREACH we do it for no subsidy whatsoever, but we do it because hepatitis is so endemic in our community. With the third model, Keeping Kidneys, which was a more expensive model to run, initially the hospital service was subsidising that model, too, but then when it came to taking it out of an innovation grant and putting it into mainstream funding the funding was discontinued, despite it being significantly cheaper and producing better outcomes, as independent evaluation showed.

There are two solutions. One solution is to have different Medicare item numbers that the GPs can bill that reflect that they are doing higher value, higher skilled work, particularly in the areas of chronic disease, which is rising and killing the hospital system just like it is killing us. No. 2, we can work with Queensland Health to make sure that activity is not about having to have it in the hospital; activity is about where it happens. If the hospital wants to reallocate some of their activity based funding to a community partner like ourselves, we can in fact get that money but the hospital system does not feel like it is being disenfranchised in the process.

Ms PEASE: You mentioned a term 'SWPE'. What does that stand for?

Ms Johnson: Standardised whole patient equivalent. That is the government figuring out how many patients we have. If you are younger than five, you are a whole person. If you are over 60, you are a whole person. If you are in the middle, you might be a 0.5, a 0.7 or a 0.2.

Ms PEASE: Thank you. You try to engage the GP with a specialist at the hospital. You then said that one of the ways you might be able to resolve that situation would be a Medicare funding model so that the doctors could claim the time. At the moment I understand they cannot. What can they claim?

Ms Johnson: Nothing.

Ms PEASE: Nothing?

Ms Johnson: That is why doctors do not do it.

Ms PEASE: Just a normal short consultation?

Ms Johnson: Yes. While the patient is with you, you can claim that time. Typically, if you then try and phone the hospital in the middle of that consultation (a) it is a bit awkward for the patient—they are sitting there bored—but (b) the chances of getting the right specialist on the end of the line when you might need them are low. You put in a call to the hospital. Typically they will ring you back at some other point. You then stop whatever you are doing and take that phone call but, because there is no patient in front of you, you cannot bill.

CHAIR: Thank you very much for your work and that of your practice. How many GPs do you have?

Ms Johnson: Sixteen.

CHAIR: It is remarkable, commendable work. Thank you for your frank assessment of what is going on and for the solutions as well. We dearly appreciate your contribution.

MASTERS, Ms Robyn, Child Health Pathways Program Lead, Salvation Army

CHAIR: Good morning.

Ms Masters: Good morning. Thank you. I, too, would like to acknowledge the land of the people on which we meet, the Jagera and Yugambeh people, and the elders past, present and emerging. I work for the Salvation Army as a program lead for the Child Health Pathways project, which covers the area of Logan. The Child Health Pathways Program is funded by the Brisbane South PHN. The primary focus is to support families with children aged 2½ to 5½ to navigate the health system. We are at the other end of the spectrum. The CHP project was developed in response to the overwhelming need for support for families to access and navigate the complex, multiple health systems that exist for children who do not follow common developmental trajectories. The unique and individual experiences of the families we are working alongside have highlighted common gaps as well as unique and specific barriers for different cohorts within the community, including support for children from culturally diverse backgrounds like Aboriginal, Maori and Pasifika and those from a refugee background. In order to better support cultural diversity, we have developed partnerships with other services in Logan including Gunya Meta, Access Community Services and Village Connect who employ cultural workers.

The system is complex and not responsive enough. Intervention takes a long time. For children who do not receive timely support, this can change the trajectory of their entire life. The need far exceeds the resources available. The processes in place to allocate the limited resources available can disproportionately disadvantage certain population groups such as those in crisis, including domestic violence; those without access to financial means and additional resources like transport, reliable phones and technology and basic levels of education; those whose first, second or even third language is not English; those who are not citizens; and those who cannot advocate for themselves and do not have anyone to advocate for them. These barriers are especially relevant for children.

The arguments for early intervention in the lives of children have been made time and time again and the overwhelming evidence to support this approach speaks for itself. The perspective, appetite and courage for long-term investment still appears alarmingly absent at systems, governance and decision-making level. We all recognise that zero to five is the most critical time of brain development and therefore we have the best opportunity to make a difference to the life outcomes for children during this time. By improving the outcomes at this age, research such as the longitudinal Dunedin study will show that you lessen the impact on many government services in the long term, including the health system, the justice system and employment outcomes. This project has highlighted the opportunities for change.

We need to share our learnings for the betterment of the systems that exist, some of which are simple and being promoted, like building basic relationships between local service providers and co-locating therapy services within community-based settings. Different parts of the system rely on each other, yet there is often a lack of interface between Commonwealth and state based programs, with limited communication or shared processes between them. The onus is on the individual or family to be making complex decisions about their health systems, which is likely not their area of expertise. Where our programs have been able to build and maintain relationships between service providers, services and families across different systems, we have seen life-changing interventions for children and their families. Information is very difficult to obtain and understand, pathways are not clear and the array of options is not clear.

There is a lack of recognition of the impact of trauma on children’s development. Without this recognition within the system, and at the diagnostic level, these behaviours are often lumped under more accessible diagnoses such as ADHD and autism. However, the treatment for trauma related behaviours and developmental concerns on children is vastly different from those that are the result of ADHD or autism.

Having access to resources, information and education puts you at an advantage to engage in and navigate the system, but it still does not make it any less complex. There are wait times of up to 12 to 18 months to see a paediatrician in the public and even the private system. This is half their lifetime for some children we are working with. Without a diagnosis, some children are missing out on gaining the additional supports they need at a time when this would have the most impact on their development, as these diagnoses are a requirement for children to receive support for many services such as the Early Childhood Development Program. Listening to and adjusting the systems in response to feedback from families is desperately needed.

This is a pilot project and we are only just beginning to see the tip of the iceberg. We need to continue to support families to make these health pathway connections, to highlight opportunities to improve communication between services. What could it look like if we act now? What a life-changing difference it makes for children when they get early access to therapies, when children are better able to integrate into education settings. What a difference it makes to families, with reduced stress and tension. It even means some parents can return to work. What a difference it would make if children can participate in programs that require a diagnosis, such as the Early Childhood Development Program, and not have to wait 12 to 18 months for that diagnosis.

CHAIR: What a commendable program. Thank you so much for all that. How do we pick it up and put it in Townsville? Seriously. This is exactly what we need in communities to help communities thrive. It is a pilot program. You said that it was funded by the PHN. Are you able to get continued funding? You might have picked up some of the observations of people who have made submissions that funding streams end at two and three years. Is there certainty in this, because it needs to keep going?

Ms Masters: There is no certainty at this stage. It is only funded until June.

CHAIR: Are you talking with the PHN about outcomes?

Ms Masters: Yes. We also have a research component that sits alongside the work that we are doing.

CHAIR: How long has it been running?

Ms Masters: Only since May last year.

CHAIR: How many children have you seen?

Ms Masters: We work with the 83 early childhood centres that go through the TOTS program. We are only working at the moment with about 33 children, but it is quite intensive work.

CHAIR: That is a good research model. We would love to be across the outcomes of that. Please continue to work with the PHN. I wish you all the very best. It sounds like a scalable program.

Mr MOLHOEK: The Mental Health Commissioner, Ivan Frkovic, recently made a submission to the Mental Health Select Committee. One of the issues that he raised was the higher need for early intervention. He talked at length about the fact that those formative years, from about nought to six I think they said in his report, were really critical in terms of long-term outcomes and better social outcomes. That submission would actually be available online on the parliament's website. It would be worth having a look at that. I thank you for raising the issues with us today. It is very interesting.

Ms KING: You are working intensively with about 33 children. What does that look like? What does that support involve? What might a child's journey alongside your service involve?

Ms Masters: Part of the early stages of the program has been developing those partnerships. We have an Aboriginal worker at Gunya Meta, a Pasifika worker at Village Connect and another multicultural worker at Access Community Services. We have coordinators who are based in these different services. We work alongside the early childhood centres and also the hubs. Each of those centres has a hub as well. That is our main referral base. It takes some time to build trust with families. Then we work alongside them to identify what pathway they are wanting with their child.

As you say, often you are unveiling multiple complexities. For example, we have children who have had NDIS plans but there has not been any action. It is not the fault of NDIS; the fault is that the phone number is not working anymore or that person is no longer caring for that child but extended family are now caring for the child. So you have a child who has missed out on a year of therapies at a critical time in their life.

You may want to get them into the paediatrician but it is another 12 to 18 months and you can see that the stresses on the family are so extensive that you cannot wait 12 to 18 months. We do have a small amount of brokerage. In extenuating circumstances we have been able to speed that up. We have been able to get a paediatrician in place, which has then meant that we have had a diagnosis so that child can now be enrolled in ECDP. They can get some medication because they are bouncing off the walls and that is having a huge impact on their family. Telehealth appointments often do not work, so we can sit alongside the family with the technology to help that happen, which has been particularly useful in COVID times.

In the last quarter we have had three families experience domestic violence. One of those families was on the phone to me. She had rung the police. She was bailed up in her bathroom with her two-year-old, not getting a response from the police. The trauma that that child went through during that period was exacerbated. A number of children have speech delay, and I do believe that sometimes that is trauma related.

We have a number of families from diverse cultural backgrounds. The paperwork can be very difficult to understand to complete the forms. I have difficulty myself sometimes. To use an interpreter to go through the paperwork can take twice as long and it can be very confusing.

For speech therapists there are very long waitlists. We have developed a database of the length of time for speech therapists. We get feedback such as for this coming year they can only take on an additional five clients in total. That is how full their books are. You are waiting a long time to get those therapies in place.

Many of them do not have extended family. We do not have the village anymore that is looking after people. Quite a few parents have mental health issues themselves. To have a child with additional needs, the stress on that family, I think, can be a tipping point. A lot of it is emotional support also for those families, to see them through that diagnosis.

Ms KING: Very briefly, through the delivery of this service or the coordination of this service, how user friendly is the NDIS application process for the families that you support? Presumably some of the assistance you might occasionally provide is assistance to make applications or to deal with reviews. Can you tell us your views and thoughts on that?

Ms Masters: I think the beauty of this program is that we have been able to build a really good relationship with the Benevolent Society, which manages the ECA locally. I think what is really good is: when you have programs like this that are working on the ground, you can build that relationship with the service providers. We do work alongside families to make that application. The forms themselves are a little complicated, particularly when it is not the parent caring for the child; it is an extended family member caring for the child but there is no formal arrangement in place. You have to manage all those complexities within filling in the forms and getting all the permissions to be able to act as a third party.

I think with our support they can manage that process, but on their own families find that very difficult. They get a package and they do not always know what that means. I have sat alongside families in the interviews with the NDIS and my experience is that those have been really productive. I am working alongside families that are from different cultural backgrounds. I think having that support person in the meeting with them is good.

We have another family where the parents have an intellectual disability, so we can advocate for them with the NDIS and make sure they have an advocate sitting with them too. The ability of that family to speak up and ask for that sort of process would be very difficult.

Mr ANDREW: Thank you for coming in today and giving the information that you have. The children are a very interesting quandary. Does kids accessing technology such as phones, games and tablets interfere with you providing care? I ask that because I know that most kids are dependent on technology. Does that inhibit the way you can deliver care to those children?

Ms Masters: Our role is not so much in delivering care; it is really that we are helping to make connections to the care. We are working with children who are 2½ to 5½. For me it has been more about the family's ability to access technology, because so many of these systems rely on the family's ability to access technology to submit forms. I think with COVID so many things have gone online. Autism Queensland has some fabulous information sessions, but for a lot of our families to access those can be really difficult. It is probably outside my area to be able to talk about the impact of technology on the children.

Ms PEASE: Thank you so much for coming and for your obvious dedication. You have a real passion and a vocation that is lovely to see. I understand from your submission that you take referrals from a community hub or a childcare centre or something like that; is that correct?

Ms Masters: The program actually aligns with the TOTs program, the Thriving and On Track project, which is operating in the 83 childcare centres plus in Gunya Meta, Kingston East Neighbourhood Group, Access has five hubs and Village Connect. Those hubs are amazing places, particularly the ones in Village Connect and Access, because you have occupational therapists and speech therapists onsite, so it is community based. Yes, our referrals come from the TOTs program.

Ms PEASE: That sounds fantastic. It is a nice soft entry for many of those families as well in a setting that is comfortable and safe for them. In terms of access to the local GP, are they aware of the services that might be available to their patients? Do you know if the PHN has worked with the local GPs to let them know about your service?

Ms Masters: The PHN did have a GP working group. I sat on that working group for a while as well, so there was definitely promotion through that working group, but possibly more needs to be done in terms of that. We have had quite a bit of work with ATSICHS so that they are aware of the program. We talked the other day about going and visiting the GPs at ATSICHS as well.

Ms PEASE: It is a great program and it would be wonderful if it was more accessible to the community. Not everyone would have access to those childcare centres or those community hubs.

Ms Masters: No.

Ms PEASE: Potentially, GPs may be in a position where they could do that. How do your clients who are participating manage navigating a GP service? How do they pay for it? Do you have any commentary around that? We are hearing a lot of stories that people cannot access GPs. Often they might need a referral to see some of the services but they cannot get to see a GP. Are you aware of any of those?

Ms Masters: We get mixed reviews on GPs. The child will see the health nurse at the childcare centre. We had one example where the health nurse recommended a referral to the Child Development Service and that needs a GP referral. She went and saw her GP, who disputed that the child needed a referral and would not do it. That particular family had to then go and find another GP service that would do that. I think there was a lack of understanding from the GP.

Ms PEASE: I imagine your clients have complex needs and would no doubt have medical needs as well. Are you aware of them having delays in being able to access GPs within the system in the area?

Ms Masters: It has not come up particularly, no.

CHAIR: Thank you very much, Robyn. As I said at the beginning, your work is commendable and it is a great program. I wish you all the very best in continuing that.

Ms Masters: Thank you for the opportunity.

CHAIR: I would like to see it scaled right throughout Queensland.

Ms Masters: Yes, I will come up to Townsville.

CHAIR: Please.

BERESFORD, Mrs Lenore (Wendy), Private capacity

HALL, Ms Jocelyn (Jos), Private capacity

TURNBULL, Mrs Anne, Mental Health Advocate, Care Army

CHAIR: Thank you very much for being here today. Jos, would you like to start with an opening statement and then we will move across the table for contributions?

Ms Hall: Thank you. My name is Jos Hall. I have attended previous inquiries and hearings, but I am well aware that this is very different. I have a separate question to my main reason for wanting to speak today. I am particularly referring to some information that I received only last night so I have not had any time to do any research myself. How does someone who, in my opinion, needs a package but is not eligible financially actually get that healthcare package or that assistance? Their GP has not been apparently much help. I think that all of you know the person I am talking about. His first name is John. John's wife is not coping. She has been in hospital with hypertension, which is possibly stress related. She is absolutely exhausted. Their daughter is having to take time off work. They understand that they are not eligible. I will do some research myself, but I would have thought this is something that the GP may have been able to assist with.

CHAIR: You would think that would be the starting point, yes.

Ms PEASE: Is this about gaining an aged-care assessment package through ACAT?

Ms Hall: Yes, it would be.

Ms PEASE: They are not assessing him?

Ms Hall: Financially—they have already made some application and they are apparently not eligible. There must be someone who can do this sort of thing.

CHAIR: Thanks, Jos. We might take that one offline and come back to you.

Ms Hall: Okay. The reason that I wanted to come to speak today once again is a little bit different. It does relate to a federal issue of Medicare. I do not currently live in this area but I have in the past, so I know the area still quite well so some of my information may be a little outdated.

I am absolutely appalled at the number of people, particularly in this area, who have appalling dental hygiene. This has major impacts in a number of ways. It exacerbates other medical conditions and, in an area that is somewhat socially disadvantaged, it really impacts on people's ability to find a job. Possibly now that they can wear a mask they might be on equal footing, but when you smile at someone and you have a mouth full of brown and rotting teeth it is very difficult to find any sort of employment at all.

Many of those people—and I have spoken to a lot of them—are relatively young women who have small children. At the time I am talking about there was a free dental clinic run at QEII Hospital. No appointments were able to be made. It was first in, first served. Many of those women would have already dropped a littlie off at school. They then go in with a toddler or a baby and they sit around until it is their turn. Some of those people said they would sit there until three o'clock, when the clinic is due to close, and then be told, 'I'm sorry, we haven't got time to see you today,' and so they would go home. I am asking, as there is some overlap, hopefully, with this inquiry into the federal issues, that perhaps it could be recommended that dental care be at least considered for inclusion in Medicare.

CHAIR: Thank you, Jos. That is excellent. Thank you very much. That is a good point. It does lead to other presentations to emergency departments with ongoing complications and things like that. Wendy, would you like to make a contribution?

Mrs Beresford: Good morning. I am coming today to talk about my husband's last journey with his health and the very mixed assistance we received in the public health service. It was very sad, because my husband was a microbiologist who worked in the health system for many years.

In August/September 2019 my husband started to be quite unwell. Our GP, who was an absolute brick, may I say, organised an ultrasound: 'Oh, there's something there on the pancreas, this shadow here. We'll send you for a CAT scan.' There were so many errors in the report: saying he had something on his thyroid, which it turned out was just a repeat on the pancreas which they then decided was a cyst; that his kidney that was not working, totally black, had a growth—though how it was to grow without blood confuses me; and a gall bladder that was classed as porcelain. After much toing and froing—very much what Tracey Johnson from Inala was saying—the doubling up, the tripling up, of tests when really you only need one—they sent for another CAT scan. Finally, they sent him to the QEII. Then they wanted three different types of people to be seen. By now we are starting to get COVID, aren't we? During this time, not once was an MRI mentioned. I know they are available. My sister has to have them regularly once they are sure that all the screws in her head are not going to fry her brain. Not once did they do that.

They kept shifting appointments. Then they decided they would not operate and he could just die. I actually rang my local member here in Woodridge, who was a brick who stood up and organised that they would 'bloody well treat him'—his words, not mine. I was abused by the surgeon at the QEII Hospital for daring to go above his head and to inform me that 'politicians don't operate'. I said, 'No, but they make sure people like you do. It is my right to go to my member of parliament.'

Unfortunately, it goes on. They finally decided they would do the MRI on the last Saturday in March 2020. They were just looking to remove the gall bladder because, 'Once that rotten gall bladder is gone, his pancreas will recover.' We had the MRI. We turned up on the Monday to the clinic at the QEII to be told, 'Oh, look, the specialist is not here. I'm his registrar but I can't give you the results.' They are going to give us a death sentence, aren't they? They made us wait another week. We come back: 'Oh, it's too far gone. If it had been diagnosed earlier. You have pancreatic cancer—it was never a cyst—and it is now in your liver.'

If they had the foresight to do the MRI in the September it might not have changed, but we will never know because of the way the system works—the toing, the froing, the triple checks, going by what one says when they already had an underlying suspicion. Why was the MRI not done earlier? Then we go on: 'We wish to put him in hospital. Which hospital would you like—the Mater or the PA?' I said, 'I'll have the Mater, thank you very much, for better pastoral care.' The PA saved both my mother and my sister when they had brain haemorrhages—do not get me wrong—but I prefer the Mater and the Logan. They went in. They did the biopsy. Yes, there was nothing they could do; it was too far gone.

The treatment was appalling by the system. Do not get me wrong: apart from that dreadful surgeon who I wouldn't let operate on a dead duck, the nursing staff and the specialists were brilliant with what they have. It is the funding that is not there. We now are fully in lockdown and we are doing interviews over the video—someone had to teach me how to do that. When it was decided there was nothing anyone could do, I asked for us to be transferred back to the palliative care at Logan. They need to wear wings, because I was in there with my mother for 10 days, and they are the best. I said to Ian, 'Well, we won't hear anything now for a couple of weeks.' That was the Tuesday. They rang me Thursday. They came out to the house on Monday. You could not have wanted better people to come to your door, a doctor and a nurse. They apologised for what had gone wrong, but that is never going to change. They gave me a 24-hour number to ring and I had to use it. On Thursday, Ian was taken into hospital and died the following morning.

While I want to castigate the system and how it treated Ian, I also want to give accolades to the Logan Hospital. They looked after my mum. They let me sleep there and let me hold her hand until she passed. They looked after Ian. Recently I was taken in, even though there was no ambulance for me, two or three weeks ago. There were 30 critical ahead of me. I was screaming and screaming. It turned out I had passed a kidney stone. There were no ambulances. I am a volunteer driver. I am in and out of hospitals. I see the ramping. Really, you need more people and you need more beds to be opened up. When they talk about no beds, I know the beds are there; you just do not have the nursing staff. It is the same in aged care. It is a system that is dying while we look at it. I can remember that as a child I was in Toowoomba Hospital for near 12 months. My mother was treated in the public system in Toowoomba General in the 1960s and you got much better treatment for what was available then and there than you do today. That is what I wish to say today, and thank you for your time.

CHAIR: Thank you very much, Wendy, for sharing what must have been very difficult, very personal. Our deepest condolences to you on the loss of Ian and having to go through that. As you have highlighted, we have some wonderful people in palliative care doing some extraordinary work and supporting you. We thank you for sharing what is a deeply personal story.

Mrs Beresford: Thank you for listening to me.

CHAIR: Anne, welcome.

Mrs Turnbull: Good morning. I just have to raise a few issues. Wendy has had a loss. I lost my Vietnam veteran father back in August. With border closures, I was not able to go to the funeral. On September 11, 20 years ago, I was actually living in a nursing home. I was supposed to be doing the ABS Census at the time. I thought the last lot was a total joke, but because I was a resident at the nursing home I was not able to do the Census, which I had done back in 1991 when I was carrying my son after being retrenched as a dental nurse because they could not give me enough hours in private practice. I registered with the Care Army as soon as I could and I found that available. I am a retired dental nurse by trade and also a very active mental health advocate.

My issues are mainly about mental health hospitalisation and the lack of allied health, like Jos raised before. I was on a temporary contract through the Logan Hospital in the dental hub. I did theatre as a dental nurse. There would be kids coming in who were supposed to have 20 teeth but whose teeth were rotten to the gum line. They would have all bar four teeth removed. I am a very proactive dental health advocate as well.

I am also mentioning chiropractic because that follows on from where I am going. The PHN had a fair bit of input with the way that Ryan's Place at 22 Mayes Avenue closed on about 19 March, pretty much as soon as COVID came about. People were then having to work from home or isolate at home. My partner was a chronic alcoholic. We would be lucky if he went through six cans a week. It took me a while to keep my routine of going to Ryan's Place as I was on the Logan mental health consumer action group in 1996 and wanted to pursue mental health, because that goes hand in hand with general health as well. The changes of staff were always rolling. The executives were paid big bikkies and wasting money on tangible things that were not even included for the client care. Then Ryan's Place got on to the Hospital in the Home system. I know of clients who phone up the ambulance because they want somebody to speak to. That is adding to the ramping. The cost of the medication is also an impact.

I would like to find out if 13SICK is still available. My GP has after-hours cards at his clinic but I have not had to use them. I have an alternative health directive that basically says if I am feeling unwell to stay in bed for two days but to call the doctor after the first day. From the COVID, I actually lost 2½ kilograms as a side effect of the injection. With the other two Pfizer jabs I have had leg cramps. In 1996 I was at TAFE doing a certificate III in communities and part of my project was identifying the working poor in Beaudesert.

With the errors in the mental health system, I have just recently obtained my medical records. Initially, I tried to do it about five years after I was hospitalised with mental health. It was costing me so many dollars per page, but I was getting a page. I would be lucky if I could read three lines that were not blanked out. I was at the Mater Hospital when I had my youngest son, who I think was born in 1991. He is 30-something this year. The Mater Hospital gave me the wrong age of the baby on the papers they sent me through to an email. I have actually downloaded them. They said that he was born at 42 weeks. He was actually born at 38 weeks. He was premature by two weeks. I am thinking, 'Are these my records?' The only thing that I can identify that was real for me was the actual name of my children's father. I used to do the dental records when I was dental nursing down in Canberra.

As a consequence of being—this is with my mental health experience—put into Wolston Park and also the Logan Hospital, I have spinal damage. I was at Wolston Park in 1998 and 1999—17 December and discharged about 17 March 1999. It cost me $800 in out-of-pocket costs for my children to be in day care. At Logan I was refused a prearranged chiropractic adjustment. I had $3½ thousand of out-of-pocket expenses to rectify the force they used to sedate me. That force was used three times. This was at Wolston Park and also Logan. The physical thumbprints are still embedded on my ankle. I used Synapse just to be able to walk and talk. This was before Christopher Reeve was even put on his ventilator. I had had major falls. I had postnatal psychosis but it was also caused from cortisone and adrenaline when I had my son. When he was 11 months old, I was actually put into the mental health ward at Logan and there was no mum and bubs. I had to dry up my milk, which is as painful as mastitis. I asked for assistance. I said, 'Can I have a cabbage leaf?' 'No, just go and have a shower.'

As a consequence of my background, I also sought out kinesiology and getting counselling through that. That was $5,000 out-of-pocket expenses for counselling costs. Then I pursued kinesiology. Before my admission in 1998, I had my level 2 kinesiology exam the day before. While I was there, I got burgled. I had a psychiatrist and an OT rock up at my doorstep on that Friday saying, 'You have four hours to get to Wolston Park.' I then thought, 'Okay, I'll talk to my counsellor for her to be able to take me to Wolston Park.' I was unaware of how long I would be going, so I just packed a port and away I went.

CHAIR: Thanks, Anne. We are nearly out of time.

Mrs Turnbull: Just hold on. I refer to the holistic health approach and the growth of people coming to Logan to try and get better medical or away from domestic violence. I just found that the Care Army could refer appointments for those people getting jabbed. There is more information on aged care in this week's seniors newspaper. It has at least five pages of things that are relevant. Women, housing and health issues involve a lot of advocacy with sexual assault and DV. Also, there is the lack of menopause education in the community. I consulted YFS legal team and they did a summary of what I just told you, but they told me that, because the issues I have raised are older than three years, I have to go through the Mater, Metro South and West Moreton to retrieve my medical records. For the last 20 years I have seen my children for 165 hours.

CHAIR: Anne, thank you very much. That was very brave to come up and share all of that personal experience with us. We really do appreciate it. Good on you for doing the Care Army volunteer thing as well. That has been something that has been needed.

Mrs Turnbull: In two weeks I will be helping out with the Gunya Meta.

CHAIR: Good on you.

Mrs Turnbull: I also found out that I am part of the Indigenous community as well. My brother let me know.

CHAIR: Okay. Good on you, Anne. Thank you all for being here today and sharing all of that with us. That does conclude our time. I now declare this public hearing closed.

The committee adjourned at 11.50 am.