HEALTH AND ENVIRONMENT COMMITTEE

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

Member in attendance:
Mr SA Bennett MP

Staff present:
Mr K Holden—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

WEDNESDAY, 2 MARCH 2022

Bundaberg

WEDNESDAY, 2 MARCH 2022

The committee met at 2.32 pm.

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

With me today are: Rob Molhoek, member for Southport and deputy chair; Joan Pease MP, member for Lytton; Stephen Bennett, member for Burnett—and we thank Stephen for being here as I know that a lot of people from his area are here; and joining us via videoconference is 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. However, after we have heard from the formal registered speakers we will open it up to members of the public. If you want to speak, please say hello to Karl, the secretariat, during the break. We will make sure we hear from you.

I remind members of the public that they may be excluded from the hearing at the discretion of the chair. The proceedings are being recorded. Media are be present and are subject to the committee's media rules, so you may be filmed or photographed. Please turn off any mobile phones or put them onto silent mode. If any witnesses have documents to provide to the committee, please ask to table the documentation while you are speaking and we will deal with that in a procedural way.

BELL, Mr Stephen, Executive Director, Allied Health, Wide Bay Hospital and Health Service

CHAIR: We will start with an opening statement.

Mr Bell: I would like to thank the committee for the opportunity to provide information here today. I would also like to acknowledge the traditional owners of the land on which we are meeting in Bundaberg today, the Taribelang Bunda, Gooreng Gooreng, Gurang and Byellee peoples, and pay respects to elders past, present and emerging. I am the executive director of allied health services for the Wide Bay HHS. I have been in this organisation for the last 10 years in senior roles across Bundaberg and the Fraser Coast and North Burnett regions.

I want to make a quick statement thanking our staff in all areas of the health service for their efforts during COVID-19 and in particular during the two flood emergencies we have had in the last six weeks, particularly in the Fraser Coast region, and that continues to be a challenging time for not only our staff but the community as well.

Just to give you a bit of an overview of our service, we provide health services to the North Burnett region, Bundaberg, Fraser Coast and also a part of the Gladstone local government area, in the Agnes Waters-Miriam Vale area. We cover around 37,000 square kilometres and 220,000 people. We have hospitals in each of the major centres—Bundaberg, Hervey Bay and Maryborough—and also a number of multipurpose health services in the North Burnett region. In addition, we provide a lot of community health services and we also provide health services to the Maryborough Correctional Centre, which is a 650-bed prison in Maryborough.

I want to give a bit of demographic information, because I think it sets the scene for some of the challenges we face in the health service here. The provision of health services in any context is challenging but particularly in regional areas. In order to understand some of these challenges a bit more, I want to let you know about our population in the Wide Bay region. Twenty-six per cent of people are over the age of 65, which is significantly higher than the Queensland average of 15 per cent. Eighty per cent of people in the Wide Bay region are in the bottom two quintiles of the most socially and economically disadvantaged people and 26 per cent of our population earn less than $33,800 per year, compared to 17 per cent for the rest of Queensland. That has some flow-on impacts

for families as well. One in three children in the Wide Bay region has developmental challenges—they are developmentally vulnerable—and eight per cent of our community live with a profound disability. That is some relevant information.

In terms of some activity statistics, in the last 12 months we have had 132,000 presentations to our emergency departments across Wide Bay. That is an eight per cent increase on the previous financial year. We have had 31,000 patient admissions from our emergency department. That is a slight decrease on the previous year. We have had over 350,000 outpatient occasions of service, which is a 7.3 per cent increase on the previous year; and 4,831 elective surgeries, which is an increase of 0.6 per cent on the previous year.

In terms of some of our challenges in relation to allied health, GP and primary care issues, one of the things I want to mention today is workforce; it is a significant challenge for us. I am not going to talk too much about the GP situation because I know we have another speaker coming to do that and I do not want to speak on behalf of GPs. I will say that Wide Bay has a lower rate of GPs per 1,000 compared to the rest of Queensland. I think one per 1,000 for Queensland is the average number of GPs. Maryborough is as low as 0.5 per 1,000 and Bundaberg is 0.9. In terms of our dentists and allied health workforce, we have four per 1,000 compared to 5.7 per 1,000 for the rest of Queensland; and 26 per cent of our population has private health cover compared to 35 per cent of the rest of Queensland.

In relation to our aged-care places, we have 48.1 per 1,000 for the Fraser Coast compared to 56.3 per 1,000 for the rest of Queensland. That is a significant challenge. We also routinely have complex NDIS clients admitted to our hospitals for extended periods of time when a placement is complex and challenging or perhaps has been unsuccessful. We have a limited amount of primary care and allied health community referral options for patients, and that can create challenges for us in terms of our length of stay in hospital and increased hospital admissions as well.

We do have some close collaborations and partnerships with a number of other health services and organisations around the Wide Bay including our private hospitals across Fraser Coast and Bundaberg. Our First Nations health equity reform planning process is well underway. We have some close collaboration happening with our Aboriginal and Torres Strait Islander primary healthcare services. We have also been working closely with the primary healthcare network specifically on projects around end-of-life pathways for care and then the Healthy Ageing strategy as well as COVID-19 collaborations. They are probably the main points.

CHAIR: Thanks very much. That is a good start to the proceedings. We were in Hervey Bay with a former aged care, palliative care and end-of-life inquiry and it was heavily subsidised—and in Bundaberg, from memory. The member for Burnett will remember that; he was there. There is a significant ageing population in that area. I want to find out, as we start, how many beds in total you have throughout the district in terms of capacity.

Mr Bell: I do have that information. It is approximately 600 beds across all of the hospitals. I can get you the exact number.

CHAIR: We will take that on notice. I will move to my second question, which is relevant to that. You mentioned in your opening statement that you had some issues with NDIS participants in the hospitals. How many long-stay patients would you have—and you can take this on notice—over, let's say, the last of years particularly? Do you have a figure today? When I say 'long stay', what does that mean to you?

Mr Bell: People who are in hospital for longer than they are required to be in terms of their health requirements. In other words, they are not required to be there for their health or for treatment, but they are there because there is an unsuitable care placement for them.

CHAIR: Or not available residential aged care?

Mr Bell: Yes, residential aged-care facilities—I can get you the exact numbers over the last two years. I would say that every day we would have patients in our hospital who are awaiting a residential aged-care facility bed—not necessarily an NDIS placement but certainly a residential aged-care facility bed. There would be patients waiting daily for that.

CHAIR: The reason I say that is that we have picked up some themes. We have held hearings in Mossman, Cairns and Townsville and we have definitely picked up some themes about people who cannot get out of hospital for up to 12 months—some three months—and what that does to them. We will open up to questions.

Mr MOLHOEK: Thanks for joining us today. I would pass on my thanks, along with those of the chair and others, to your colleagues and all our frontline workers. It has been a fairly trying couple of years for everyone in the health system and probably nowhere more so than in some of the regions.

I am sure you are dealing with the shortages of staff and complexities of finding allied health support. We certainly do appreciate that. Looking at some statistics, it is quite pleasing to see that in terms of elective surgery performance Hervey Bay and Bundaberg are doing pretty well.

Mr Bell: Yes.

Mr MOLHOEK: In terms of outpatient appointments and waiting lists, again, these are some of the shortest waits in the state so you must be doing something right—although for some reason gastroenterology comes up as a bit of a spike but it is not hugely alarming. You said there has been an increase in ED. Ambulance ramping times are at the lower end of what has been said around the state, but the actual number of patients seen within the recommended time frames is perhaps not what it ought to be. I am interested to hear about some of the challenges with ED and some of the flow-on issues that are happening within the health service as a result of that.

Mr Bell: I think our presentation rate levels at our emergency departments are related to a number of things. There are very limited after-hours health services available at GP practices and things. That is quite limited, so the only place to go is the hospital and that certainly leads to increased presentations. In addition to that, we have quite limited what we call post-acute services. Once people are discharged from hospital, they might need follow-up care by allied health services in the community or other primary health services. That is quite limited in the Wide Bay region as well and that can result in people becoming unwell and re-presenting to hospital sooner than we would like.

Some of the other challenges just relate to the fact that we have, like I mentioned before, a significant ageing population. We have the highest proportion of people who are overweight and obese compared with any other hospital and health service in Queensland, with 68.4 per cent of our population being overweight or obese, so we have a lot of chronic health conditions. The majority of people who would be presenting to the emergency department would be due to the exacerbation of chronic health concerns. Those are some of the reasons.

We have limited rates of private health cover as well compared to the rest of Queensland. I think it is a combination of things. We have a lot of socio-economic challenges for our community and significant health and chronic disease challenges, with limited primary health and community services available to address some of that. The hospital is obviously there for people to come to and receive care and treatment, which is what we do every day. Those would be some of the reasons.

The COVID-19 pandemic has certainly played its part as well in that. I think it was a fairly well-known phenomenon early in the pandemic that a lot of people stayed away from hospital for an extended period of time because of concern about COVID-19. Subsequent to that, we had a much higher rate of presentation. My understanding is that that has been seen right across Queensland. There are a range of factors, really.

Mr MOLHOEK: You spoke about people re-presenting at ED—so they have been released and there has not been the follow-up with their GP or the ability to find other allied health services. One of the issues we have heard a bit about is that the information sharing between public and private practitioners has been typically fairly limited across the state and there have been significant issues around the timeliness of discharge summaries and that information being available. If people were to go to their local GP or an allied health specialist, they perhaps would not have any access to information about what has happened so that is why they are back at ED.

Mr Bell: I will say that definitely we could have better integration between the primary health sector and the acute hospitals. That is probably a general statement that would apply right across Queensland once again—certainly it is relevant to us. We do work hard to build those connections, build those linkages, through projects that we are undertaking with the PHN. We have a general practice liaison officer who works for the PHN who works closely with our organisation as well. That certainly could be improved, yes.

Mr MOLHOEK: The other thing we have heard a bit of discussion around is the term 'six-minute medicine' and that local GPs are having to churn through patients. On the other side, we have heard that within the public health system there tends to be duplication. In smaller communities away from the south-east, there are not those other allied health specialties so GPs will often have to refer people to the health service for further tests and then the duplication comes because they have to go and get an appointment to see someone and then that person orders a test and that information is not always shared back with their local GP. Would that be a common issue in this area?

Mr Bell: I probably could not comment on that specifically. We certainly do take referrals direct from GPs to our specialist outpatient department, but they are generally very specific referral reasons that they are sending their patients through. I would not necessarily say it was duplication as such.

CHAIR: Can I just add something here. I spoke on the Health and Other Legislation Amendment Bill last week, and I think you did as well, Deputy Chair. It talked about the Viewer and sharing of information between primary health, GPs and the hospital. Hopefully, with the passing of that legislation, that will assist in the sharing of information like the member is talking about. We only just passed that last week.

Mr Bell: Great.

Ms PEASE: I would like to echo the words of the member for Southport and thank you and all of your staff for the great work you have done looking after your community during COVID. I guess you might have felt you were a bit removed from it, but the great work you have done has meant that you have kept COVID out, so congratulations. I really acknowledge the great work that everyone has done.

Mr Bell: Thank you.

Ms PEASE: I am really impressed with the figures you have given in terms of the presentations. You have said there has been an increase in presentations to the emergency department. Do you have any figures around those presentations that were category 4 and 5 who could have accessed a GP rather than come to the emergency department?

Mr Bell: I do not have that information with me today, but I can take that on notice and find out.

Ms PEASE: Would that be okay, Chair?

CHAIR: Yes.

Ms PEASE: We have heard across all of our public hearings that many of these presentations that make up the significant increases could have been attended to by their GP. You talked to the member for Southport about those sorts of gaps, and there have been some submissions from other people in this area about shortfalls in areas where you do not have access to services. You have said how low your ratio for GPs is compared with the rest of Queensland. Do you know what the wait times are to try to get in to see a GP?

Mr Bell: I do not, actually. I could not tell you that off the top of my head. I could try to find out.

Ms PEASE: That is okay. Do you know if there are many bulk-billing GPs in the area?

Mr Bell: I could not answer that either. There are some but I could not give you a definitive number.

Ms PEASE: That is okay. Further to the statement you have given is that you have a very high percentage of the population that are low socio-economic, so they are low income and probably cannot afford to go to a GP where they have to pay unless they are bulk-billed. They then present to the hospital in an emergency department where they get what they hope to get from a GP, with that wraparound holistic service. They get their health, and then they can get referred to an allied health service, whatever that need might be. They cannot really afford to do that because, from my understanding, they are only eligible for five allied health services, while First Nations people get 10. Do you know the number of patients who might present to the emergency department and then have to access the other outpatient services, like your allied health services, but who would normally have been picked up and serviced by the community?

Mr Bell: With our outpatient allied health services, we usually take referrals direct from GPs or from patients who have been treated within the hospital. Those are our normal referral sources for those outpatient clinics. What was the question again?

Ms PEASE: Some people who cannot afford to see a GP also might need to see a physiotherapist or a podiatrist, so they might present at the emergency department as a category 5. They then get referred on to a podiatrist, dentist or physiotherapist because they cannot access a GP or cannot afford to see a GP and they cannot afford to pay for that allied health service.

Mr Bell: I am sure that would be the case for some people. I do think also, like I mentioned before, that a lot of the after-hours services are quite limited, and that includes weekends, Friday and Saturday nights, those sorts of things. I think that also adds to the demand.

Ms PEASE: Thank you.

Mr BENNETT: Can I just bring you back to the 2018-2022 strategic planning document. I have done a complete review of it and I would say to you that the statistics are not quite as glowing as what our community expects or deserves. I want to ask specifically about the community based services that were meant to be introduced to reduce pressure on our hospitals. You mentioned in your introduction about recruitment and trying to find these specialists, with respiratory medicine,

rheumatology, neurology, diabetes and breast screening failing currently. What can we do to try to improve the recruitment and selection of these professionals, because all of those have not been delivered under that strategic plan?

Mr Bell: In relation to recruitment, often our medical specialists are coming from outside the Wide Bay region. Recruitment from overseas was a significant source for medical specialists, but that has obviously been a challenge since COVID-19. We have run into some challenges as well with just simple things like accommodation, trying to find housing for some of our new doctors. We have certainly lost not medical staff but other health professional staff who have not been able to take up positions in Wide Bay because they could not find somewhere to live. That is another factor that has been affecting us. There are a range of issues. COVID-19 has certainly played a big part, with all of the border interruptions—

Mr BENNETT: Without interrupting, but just because of the time, is there anything the federal or state government could do with a new program of incentives to try to get these professionals here willingly?

Mr Bell: As we speak, I think the Department of Health is looking at undertaking an international recruitment drive in the near future for clinicians from all areas—nursing, medical as well as allied health. That is just quite recent.

Mr BENNETT: It has been four years since we have had a pain specialist here as well, since the last retirement, so it is true and present. Thank you for your response.

CHAIR: Mr Bell, I thank you on behalf of the committee for all of the workforce that has done a remarkable job with some very big challenges, with the floods and COVID. We have already heard right across the state the impacts of those international borders closing. JCU, which is before us today, has made a very good submission about the restrictions that have been put on training places. The international graduates are heavily relied on right across the health spectrum. It is up to the committee to make the recommendations going forward. There were a couple of questions taken on notice and the secretariat has taken note of them. Could we please have them back by 9 March? If you need to confirm them, you can speak with Karl. Thank you for your contribution today.

KOHN, Dr Alicia, Medical Director, Indigenous Wellbeing Centre

MULVANY, Mr Wayne, Chief Executive Officer, Indigenous Wellbeing Centre

CHAIR: Thank you for an excellent submission. It really paints a picture of the challenges. Who would like to start?

Mr Mulvany: I will give you a brief rundown. We are quite an innovative organisation. We are the largest provider of primary health care in the entire region and we are the largest Indigenous health organisation for many regions. We are an organisation that receives funding from both state and federal government departments. However, in our organisation we generate a large proportion of our own funding. We are very much what you would call a public-private partnership and we operate under a business model. It is very successful. We have over 140 staff. We have 10 doctors and a range of many other different health professionals. We have over 15,000 clients across the regions. We generally produce around 150,000 to 160,000 episodes of care a year.

At least one or more of our services is provided to around 92 per cent of the Indigenous population. I would have to say that in general, for the purpose of today, normally mainstream general practice would have somewhere between 15 per cent to a maximum of 25 per cent of their patients with comorbidities, whereas we are well in excess of 80 per cent. We do not even use the word 'comorbidities'; we talk of multiple morbidities. We service very vulnerable, disadvantaged and Indigenous people throughout the community. Our work is difficult, but we do achieve very good results.

CHAIR: How long have you been established? We did not pick that up.

Mr Mulvany: We started in late 2006.

CHAIR: That is an impressive service that you and the team provide. You said 10 GPs and about 140 staff?

Mr Mulvany: Yes.

CHAIR: And you look after 150,000 clients?

Mr Mulvany: 150,000 episodes of care per year, yes.

CHAIR: That is incredible. Well done. Your submission is quite detailed. The committee is looking at how to stop people going into hospital or, as we have heard throughout the state, the door of last resort when you cannot get care at, let's say, a residential aged-care facility, if you do not have the model of care there right. Some of your submission goes around the home care packages. If someone had the model of care right in their home, if they were very unwell and needed level 4 care, would that take the burden off your health service, would it make it easier and would it take the burden off the public health system? What is the right model of care in that space? Can you talk a little bit about that?

Mr Mulvany: Simplistically, it is not just to do with home care. When you are talking about getting a model of care right, I think it is across the board. The problem is that the healthcare services and framework as they are, I think, are out of date; they are well behind the times. They are not necessarily responsive to what is required in regional areas. The previous speaker spoke about trying to recruit people, and that is part and parcel of it as well.

To answer your question in short, if we could review and change the model of care, we would definitely see the results. We ourselves speak volumes of that in what we have achieved in the short time we have been around. It is not difficult. I mean no offence to some of the people who may be in the room from the cities, but the problem is that mostly the models of care and everything about them are typically designed by people in the cities sitting in ivory towers and not knowing what is required in the regional areas. They are spread out across the state, whether it be state or federal government, in that manner, and we are at the challenge sometimes to break that down and try to make it work within the community, hence the funding requirements and meeting the limitations there. That is the real problem, whereas it should have been really, basically, designed heavily with community input and you would get the better response.

On top of that, you have a number of layers that sit within health care that, I have to say, do not achieve anything. There are projects and programs out there that the government throws hundreds of thousands of dollars at that achieve nothing. We see the results of that day to day when we see people in need.

I will summarise it as this: the real problem is that we have so many programs and projects out there where people are funded to do management and coordination, so they bring the people in, they do an assessment, provide them with some information and then refer them on. This happens from

place to place, and it ends up a vicious circle. The question really is: who is actually going to do the work? It is very limited. We ourselves often become the default service of that, but there is only so much we can do.

Mr BENNETT: For the benefit of the committee, can you talk of the some of the challenges that we have faced over the decades in mental health and the work you have tried to achieve there? Could you really hone in on a similar question I asked previously about no pain specialist being here and patients having to go to Nambour, so the committee can get a feel from your experience at least?

Dr Kohn: I speak from a general practitioner point of view. I think it is important to realise that, in normal settings, general practitioners perhaps would not have even been aware of this. I am only aware of it because in an organisation there are people who are aware of funding measures and politics. We tend to keep away from that.

We are a salaried position where we are whereas, with normal general practice, if they are coming to a meeting like this they are not getting paid; they are not seeing patients. I think that is important to recognise when you are looking at the situation.

I come from Brisbane. I did my training at the University of Queensland. I moved up 8½ years ago. I have been at IWC for seven years. I have certainly seen the disparity between the larger cities and this region. Sadly, it has actually not gotten any better, it has gotten a lot worse since I have been here, to the point of burnout in the general practitioners that I am aware of. Mental health is a very good example of that. We have one private psychiatrist accepting patients. It is still a long wait time to see him. We do not get correspondence. If he is changing medicines for our patients, we do not get any correspondence. Perhaps he is very busy. I imagine he is, as he is seeing the bulk of patients in this area, and that is because it is very difficult to get the Mental Health Unit to manage our patients. We can certainly refer to the acute mental health team, get a one-off opinion, but we have patients that we have to manage as general practitioners who really should be case managed; they are on depot antipsychotics, on concoctions that are very dangerous, and we should not be doing it.

We are a training practice. I have taken on the majority of the training of these mostly overseas trained doctors because of that need to recruit doctors to the area. It is a frequent conversation, how to manage the rejection of referrals to the mental health service. We have looked at telehealth options as well, where we get rejected saying, 'This patient is too complex.' We should be referring that to our local mental health, but they obviously are not taking them on, so we have full responsibility of these patients. That is really inadequate. It is putting us at medicolegal risk, it is putting us under immense pressure and stress, and it does lead to burnout and to doctors leaving. We recruit, we train; they leave.

CHAIR: We have heard that throughout the state—the passion of those many people who stick around because it is their people in the community that they are looking after. You can tell that from your own—

Mr Mulvany: I would like to add to that, briefly. The question is a very important one and very pertinent. The problem is that, again, we run into problems here with framework. We have people who are unwell, whether they have mental illness or mental wellbeing issues, they go and see the doctor, the doctor does what they can, and if they are not eligible to get support from the Mental Health Unit or other places they get lost completely in the wilderness. You have people who sit in the Queensland health system who do not understand primary health care. I am saying that in goodwill. The GP's hands are tied because, whilst other organisations out there may think they should be on this program or they should be eligible for this, they fail to understand that the client does not meet the eligibility criteria. This is where the problem lies. There is very little there to support everyone who falls through the gap, and there is a large proportion of them. When we do have some programs out there that support mental health referral support, again they are very limited and they are restricted.

Dr Kohn: To add to that, that is our psychology services in this area—do not get me started—but it has been a few years of sagas with the provision of psychological services for patients who cannot afford any gap. Even if they can, it is an enormous wait anyway to see psychologists in the town, but if we have referred them onto whatever program at that time has the funding—Artius was a group that had the funding for some time. It did not last. I had patients who were suicidal and were never seen, were phoned and told ridiculous stories about having to pay.

CHAIR: Where do they end up?

Dr Kohn: Back with me—back in my office, often refusing to ever be referred again. I have so many patients who say it has been a waste of time and they are not doing it again, and so they are back in my office.

Mr MOLHOEK: For clarification, are you talking broadly about across the board in Bundaberg and the Wide Bay region, or are you talking about inaccessibility of services for Indigenous patients?

Dr Kohn: All.

Mr MOLHOEK: I just wanted to be clear.

Dr Kohn: The bulk of my patients are not Indigenous. I came from another practice and they mostly all followed. We are open to all people. In a similar way, they are very disadvantaged and suffering multiple morbidities. We certainly treat them similarly. That is one dimension. Then we have moved over to the PHN. I recently received a letter to say that the funding has been cut. I have patients who finally found a psychologist and now they are being told, 'You have two visits left. Funding has been cut. You are going to have to pay $150.'

CHAIR: That is not the first time we have heard about PHN short-term funding. You literally now have people for whom those services will be cut?

Dr Kohn: They have stopped accepting referrals for psychology. They are stream 3, which is the only reason I refer, to be honest. I can refer to a lot of these other services myself. I am utilising the funding for psychology services and they have stopped funding, so I cannot refer a patient for bulk-billed psychology.

CHAIR: What PHN is that up here? Are they coming in front of us today? No. We will explore that a little bit more. That is terrible.

Mr BENNETT: Wayne, you should make a pitch the next time the committee is in town and they have half an hour to spare. They should come out and have a look at IWC. It is a wonderful service and a great facility. That is my plug for today.

CHAIR: Member for Burnett, that is a good call. We would be very interested. You do some fantastic work. It is commendable.

Mr MOLHOEK: Is the funding cut for that service happening because it is being replaced with funding for people with mental health packages?

Dr Kohn: No. They did actually send us a letter explaining that they were unsuccessful in getting more funding because they have run out of funding.

CHAIR: This is the PHN, the primary health network?

Dr Kohn: Yes.

CHAIR: Would you share that letter with the committee, on notice?

Dr Kohn: Yes.

CHAIR: We would be interested to see what that program is and why it has been cut.

Mr Mulvany: The problem is that the PHN has little to no traction with general practice. It is supposed to be out there representing primary health care. The cornerstone of primary health care is general practice. They refer to everyone else and work in conjunction with everyone else, whether they be specialists or allied health. The PHN saga has failed dismally. That is where a lot of the problems lie. There are so many general practices out there that could be doing so much more and working so much better. There is a whole range of problems. That is one of them. Another one is bulk-billing, which you asked a question about earlier. I can answer that for you. There are about three bulk-billing practices in town.

Mr BENNETT: Wait times are weeks.

Mr Mulvany: The waiting time is a minimum of three to four weeks. The majority of general practice in this region have their books closed; even we do. At the moment we are only seeing Indigenous people, but we are only taking on limited numbers. GP numbers have been down here for years and they have never recovered. You only have to refer to the average number of patients a GP would see. In this region the last time I read about it there were about 1,030 patients per GP. If you were in the city, that could be 1,400 or 1,500. Part of the reason for that is what my colleague said earlier about the large proportion of the community being unwell and the low socio-economic status. You only have to refer to the SEIFA, the Socio-Economic Indexes for Areas. That will tell you the story. All of that gives the reason for the problems we have, among others.

CHAIR: The deputy chair is also on the Mental Health Select Committee. I would ask that perhaps they consider taking a submission on the mental health issues that you have raised.

Mr MOLHOEK: I think we are back here next week actually.

CHAIR: There you go. If you are here, turn up again. Maybe they will turn the room around and face that way.

Mr Mulvany: We are invited next week, yes, but I will not be here. I am actually on holidays today as well, but I decided to come along.

CHAIR: Thank you for coming in.

Dr Kohn: I think I will be here.

CHAIR: I know there is a little bit of crossover with both.

Dr Kohn: That is why we are trying not to focus too much on mental health today, because we realise that will be covered next week.

Ms PEASE: Thank you for coming in on your holidays. I know the feeling. Also, thank you very much for your passion. It is obvious. I can see it from all of you. I am really interested to hear from you, Alicia, about why you chose to do GP work.

Dr Kohn: In the first instance?

Ms PEASE: Yes.

Dr Kohn: I chose general practice for a balanced life. I wanted to be a mother. I wanted to be a doctor. I wanted to have spare time. I wanted to do it all. I did not want to do shiftwork.

Ms PEASE: I can imagine that many of your peers when you were going through university would not have chosen to go into general practice. You talked in your submission about bulk-billing policies. I will go back to that if I get time. I am interested to hear about your comments around the Commonwealth distribution priority areas and the problems there. You mentioned in your submission that previously there were financial incentives for doctors to come to regional towns. That is not the case anymore, I take it, from your comments. Do you have any other suggestions on how we can improve the Commonwealth distribution priority areas?

Dr Kohn: The financial incentive has obviously been removed, whether or not it was successful at the time. At the moment there is nothing, apart from for very rural areas. They are not recognising the disparity. We are only 4½ hours from Brisbane. Despite that distance, I feel that we are very disadvantaged here in terms of support and financial incentives.

Ms PEASE: Are you considered to be a priority area here?

Mr Mulvany: That would depend on what priority list you look at.

CHAIR: How it is categorised.

Mr BENNETT: I think we are for Medicare provider numbers but, for example, Gladstone is not.

Mr Mulvany: Those lists chop and change. I have seen them chop and change over the last 20 years.

Ms PEASE: Given the nature of the population, that makes it very problematic with the MBS. That takes me back to what I wanted to ask about your bulk-billing policies around the ability to charge the patient only the co-contribution fee instead of having the patient cover the full cost and then claim it back. So that does not happen at the moment?

Mr Mulvany: No. You cannot do that. It is illegal under Medicare. We have been banging on about it for a long time. We are probably the largest practice in the area. We bulk-bill Indigenous patients and we bulk-bill under-16-year-olds and pensioners, but everyone else pays because we only receive limited funding and the rest we generate. Realistically, in today's society no-one in this region is really going to survive on bulk-billing and trying to provide a quality service. I will put it that way. Yes, there is a six-minute service that you spoke about earlier; that is correct. That is the way Medicare is designed. It is not necessarily designed to compensate quality. That is what is missing and that is what is required for this region.

Ms PEASE: That is the holistic approach to health care.

Mr Mulvany: That is correct.

Ms PEASE: You have to have that whole wraparound health service. You went further on to talk about the IUD insertion rebate and how that is not funded. That is just one example. I am sure there are many. Thank you for sharing that. I think it is a really interesting point. Have you raised this with your local PHN? What is their position on that?

Mr Mulvany: We have raised an awful lot of things with the PHN. Does it go anywhere? That is the question. Furthermore, there is a huge lack of capacity of people in the PHN who understand primary health care. That is part of the problem as well.

Ms PEASE: Finally, you mentioned that there are a number of obsolete and ineffective projects that are run—that it is a circular process. You end up being referred back to where you started from. Who is involved in those projects? Is the PHN involved in that as well or are you finding that happening everywhere?

Mr Mulvany: No. I would say it is everywhere. It is not just a PHN problem. They are projects funded by both state and federal and/or by the PHN.

Ms PEASE: Thank you for your great work and dedication.

Mr ANDREW: The Mayor of Bundaberg, Jack Dempsey, gave an official apology to the Australian South Sea islanders recently. Do you see a lot of elderly Australian South Sea islanders in the Bundaberg community?

Mr Mulvany: Yes, we do. The South Sea islander community is mixed in with the Aboriginal and Torres Strait Islander community—very much so. There are a number of linkages through family relationships as well.

Mr ANDREW: Do they receive similar treatment and service? Do they fit into that service or are they outside of that service?

Mr Mulvany: The short answer is that they can access a large proportion of our services but they are not regarded as Indigenous under the terms of Aboriginal and Torres Strait Islander, so they cannot access any programs or projects that are specifically for Indigenous community members.

Mr BENNETT: Dr Kohn, you talked before about training and the work you are doing training specialists. I am on some of the training committees. How is that working across all sectors—the private and the public sectors? With our aspirations to work strongly with the public hospital system, how can we improve our training?

Dr Kohn: How can we improve our training?

Mr BENNETT: We are going to hear from JCU in a minute. The other universities have a key role. UQ are here. JCU are here.

Dr Kohn: I am very happy with what JCU are doing with their training program. I think it is wonderful that CQU is getting a medical degree. To answer your question earlier about how to get doctors here, I think you need to train them in this town. There is not enough incentive to get someone who has already settled and had kids in Brisbane after years and years of training. There is nothing that you can do, really, to get them up here. You have to train them up here, integrate them into the community, get them to fall in love with it and get passionate about it, and they will stay. But you are going to lose them if they are burnt out, if, as general practitioners, they are not supported by the public health service, by the mental health service, by the specialists. Without the ability to refer adequately to specialists, it is then all on your shoulder as a GP, and that is not what I signed up for.

Mr BENNETT: That is why I mentioned the public sector. Obviously they have a big hospital and there are opportunities for those doctors to learn through their years of service. We all have aspirations and hopes for our new hospital, being a training hospital. Is work going on there strongly now? What you are telling me is what I wanted to hear—that there are positive things to come out of training locally.

Dr Kohn: I am very happy with all the registrars that have come through those programs.

Mr BENNETT: It is good for the committee to hear that.

Dr Kohn: I see a lot of overseas trained doctors. That is very different. Because we have had a lack of doctors, we have had to recruit from overseas and doctors who are already working in hospitals or general practices in Australia. They are coming to programs that are not supported, not funded. We are not funded. We are not given any reimbursement for the time that we are putting into these doctors. There is no obligation on us to do that. These doctors can be working in practices unsupervised. We have taken them on and we have gone, 'Whoa. This isn't cool. We are going to have to take a step back. We are going to have to be supervising and training to make sure that what they are doing is safe because we have an obligation to the community and our patients.' That is the difference. That is what I am getting at. We have more overseas trained doctors who are not trained like—

Mr BENNETT: We have a bad history here, haven't we, in Bundaberg for exactly those reasons?

Mr Mulvany: IWC has taken this on with no help or incentive from anyone else. We have taken it on because we see the worthwhile investment. We put the time and effort into it. In terms of the benefits of what we will see, I will probably be pushing up daisies. These are the holes and where

money can be better spent. In a nutshell, that is what it is all about. We need to stop wasting money in areas that are a waste of time, showcasing or doing little. We need to be putting it into the right areas and we will see the outcomes. That is what it is about. For years and years, too many people have been measuring outputs. That is just an absolute waste of time. To answer your question, a level 5 hospital is a clear answer here as well. That is what is required for the region. That also engages the university and other planning and support services.

Mr BENNETT: And the specialists and all the professors we need.

Mr Mulvany: Yes. We have lost a lot of those specialists over time.

CHAIR: Thank you, Wayne. You are the CEO of IWC?

Mr Mulvany: I am, yes.

CHAIR: Can you make sure the good doctor gets a good break at some point this year? Thank you very much for the work you do in your community. It is commendable. We would love to come back and see it firsthand at some point. It is something for the committee to think about. On behalf of the committee, I thank you very much for your contribution today. It is much appreciated.

Mr Mulvany: Thank you very much for having us.

ILETT, Ms Sandra, Director and Nurse Continence Specialist, Community Nurse Service

CHAIR: Thank you, Sandra, for your excellent submission. I always cop it from the deputy chair when I talk about this—and no doubt the member for Burnett will say something—but in my former career as a paramedic I can tell you: the number of times we transported people just for a catheter change was remarkable. If we could have you times 469 in every single one of the state's residential aged-care facilities, we would probably stop a lot of those transports.

Ms Ilett: We have a curriculum written for the nurse.

CHAIR: I see that. Your submission is fantastic. Before I go any further with general comments, thank you for being here today. Would you like to make an opening statement before we move to questions?

Ms Ilett: Thank you very much. I, too, want to begin by acknowledging the traditional custodians of the land on which we meet today and pay my respects to elders past and present. I extend respect to Aboriginal and Torres Strait Islanders here today. Thank you so much for the opportunity to present to the committee. I am not presenting my whole submission, of course. I was asked to just give a small introductory statement.

As a brief overview, I work as a nurse continence specialist. I am also the director of a very small nursing service. What I do is just so insignificant compared to the huge health system out there. I am just the tiniest little part of it. My little service provides a range of nursing services to people with bladder and bowel problems. This includes catheter care and catheter changes, continence assessment and care planning with conservative management of continence issues. I employ three other nurses and have admin help—and this is all casual work.

One in five Australians have bowel and bladder problems across the lifespan from birth to death. It affects all genders and it affects people from all socio-economic backgrounds. It does not spare anyone, really. People with incontinence can often suffer many negative emotions related to the issue including guilt, embarrassment and shame. Just as an example, I saw a little 92-year-old war veteran yesterday who has never told her GP she has a continence issue—ever. She is extremely incontinent. These people are unlikely to share the problems they have accessing assistance with mainstream media or with their local member of parliament. I am not sure, Steve, if you have ever had anyone come to you and say, 'I cannot get help with my continence problem.'

Mr BENNETT: I have not.

Ms Ilett: No, there you are! They are more likely to suffer in silence. To respect and work with these emotive issues, the service I provide is a home visit service. Our cars and uniforms are not branded and my company name does not include the word 'continence' or 'incontinence'. That is to provide that confidentiality to the people we see. The service is not advertised. Some targeted marketing has occurred, but mostly it is word-of-mouth. That is how people find the service. People with incontinence who must use disposable continence aids also have a considerable financial burden. The average cost of a packet of 14 adult sized pull-ups is $30 and, based on a usage of three per day, this could cost $45 per week, which is a huge amount out of a pension.

Queenslanders can access two government schemes. There is the Medical Aid Subsidy Scheme, which is a Queensland government scheme, and the Continence Aids Payment Scheme, which is Commonwealth government. These schemes both require the client to have had a continence assessment and a continence care plan created. Registered nurses are not the only health professional who can make these applications, but whoever makes them needs to have a sound understanding of continence issues and management. In actual fact, GPs are not eligible to make applications to the Medical Aid Subsidy Scheme. A nurse in a GP surgery can, but there is no Medicare item number to cover that. An assessment, the review process and the application process could take anywhere from three hours upwards.

Emergency departments across Queensland are the backstop for anyone in the community who needs an emergency or a planned catheter change if they cannot access this elsewhere or cannot afford privately for this to be completed.

The Queensland public health system is affected by the lack of continence services, because these people or their carers eventually find the workload or expense of dealing with these problems too much of a burden, resulting in an admission and possibly eventual residential care. Continence issues also increase the risk of falls in older people significantly. Then the whole scenario of being admitted to hospital happens. Support and care for people discharged from hospital with an indwelling catheter is crucial to prevent them from returning to the emergency department.

My intention in making a submission was to advocate for people with continence issues who are unable or unlikely to advocate for themselves. I also wanted to make the committee aware of services such as mine that do exist and are playing a part in providing health care to Queenslanders. I am happy to answer any questions.

CHAIR: Thank you very much Sandra. It is a really important service that you provide. I want to commend you on that. Where did you do your training?

Ms Ilett: I trained at Bundaberg Base Hospital.

CHAIR: Well done. You stayed here and you started a company?

Ms Ilett: Yes. I have worked at the Bundaberg Base Hospital. I am a registered nurse and a midwife, I have a Bachelor of Health (Child Health), I have a postgrad in continence and I am actually doing a masters in nursing at the moment.

CHAIR: That is quite incredible. I was looking at the total of 1,222 referrals received for continence assessment and catheter—

Ms Ilett: I actually went to see Steve, when I was first thinking of working as a sole provider, to ask about the funding. Steve could not help me at the time, but I just ploughed on anyway.

CHAIR: You talked about the Medical Aid Subsidy Scheme. What was the title of the Commonwealth scheme? How do people access it?

Ms Ilett: Continence Aids Payment Scheme, CAPS.

CHAIR: On page 6 of your submission, the very bottom line states—

Some RACF's have a policy where they will not allow their employed nurses to change urinary or suprapubic catheters.

Ms Ilett: I got that information because a friend of mine actually works in one of the palliative care specialist programs at the Sunshine Coast. She did a little survey for me: when she went to those residential care facilities she asked them about catheter changes. In some of the facilities she goes to, their registered staff are not allowed to change catheters.

CHAIR: Why?

Ms Ilett: I have no idea.

CHAIR: That is insane.

Ms Ilett: Yes.

CHAIR: Because there is a cost to transporting that person.

Ms Ilett: Correct—a huge cost.

Ms PEASE: Not just financial but also on the patient.

CHAIR: Exactly. The burden there is moving the person just for a simple procedure.

Ms Ilett: Yes, and if that person is wheelchair bound they have to go via QAS. Once they get to the hospital, there are no hoists for them so they have to stay on a bed or be transferred to a bed and then they stay on a bed for a long time. There are no pressure-relieving mattresses. It is quite a significant issue.

CHAIR: You might have heard me earlier talk about models of care. If the models of care were fixed to actually do that, what would that model of care look like?

Ms Ilett: That model of care to me would look like a nurse run service that does provide that service and it is advertised so that people can access that without a referral. People can access me at the moment without a referral, but I always work with a duty of care and within my scope of practice. I involve the GPs if I need to, and Dr Cindy will attest to that. I can see a model of care being a nurse-led service that is referred to, and those nurses do the assessments. That will take the pressure off the GPs as well, because people go to GPs to get these forms filled out. For the Medical Aid Subsidy Scheme, they need an initial application and then they need a reapplication once every three years.

CHAIR: Good grief.

Ms Ilett: GPs cannot fill them out. The nurses can, but the GPs cannot. A lot of nurses in GP practices do not have the skills to do that.

CHAIR: It is just quite incredible. Just to put it in context, we received information from QAS that there were 35,000 transports from the 459 residential aged-care facilities in the state. I do not know if they actually—

Ms Ilett: Can you tell me that number again?

CHAIR: 35,000 transports last year.

Ms Ilett: Wow.

CHAIR: That is what I said. They were category 4s and 5s, of which some would fall into this. These are not falls from bed. It is quite incredible.

Ms Ilett: I do not have the prevalence data for how many people. That is just residential care. I have 15 regular catheter clients already.

CHAIR: In home?

Ms Ilett: In home. Half of them are completely privately paying. They do not claim my fee from anyone. They just pay for me to come and do it so that they have the same nurse who does it and they are happy with the skill level et cetera. We turn up at the appointment time when it is made.

Mr BENNETT: Thanks very much, Sandra. It is such a comprehensive report. It did surprise me. It blew me away, actually. On this funding issue, which is an amazing story for us to become aware of, I am just wondering about the Commonwealth home care package issue. How do you qualify for those packages? It is for catheterisation, isn't it?

Ms Ilett: If they have a catheter in and they have a home care package, the home care package provider may pay me to do that catheter change—or another nursing service. That will be funded as part of their home care package, yes.

Mr BENNETT: But later in your submission you talk about funding barriers between Commonwealth and state. Could you expand that out for me?

Ms Ilett: Tell me where on the submission you are referring?

Mr BENNETT: It is the last page, second last paragraph. You talk about funding borders between the state and Commonwealth funding.

Ms Ilett: What I was referring to is that aged-care funding is Commonwealth and Queensland Health has funding, but I do not sit anywhere in any of those. I sit well outside of those, because 25 per cent or thereabouts of the people I see have no ability to access any of those funding buckets. I had a phone call from a nurse in Kingaroy last Friday who was chasing a continence assessment for a 13-year-old boy whose parents cannot afford to pay for any assessments. He needs that assessment to get on to NDIS. He has not even got to NDIS. He needs to get on to it, but the parents cannot afford it. The people I see do not have any funding or any ability to pay.

Mr BENNETT: This might be a really naive question, but as a practitioner, especially in your field, you will never qualify for a Medicare provider number?

Ms Ilett: I actually did start a nurse practitioner masters. When I started my masters, that is what it was for. As I went through the program I realised it really just did not fit with what I do, so I swapped over to an advanced nurse practice masters. I am happy doing that.

Mr MOLHOEK: Thank you for raising this issue. It is the first time I have ever heard of this particular issue. It is another issue to add to the melting pot of issues that we need to wade through in the coming months as we look at our report back to the parliament. I never cease to be amazed at the areas of health care that do not get considered or thought about.

Ms PEASE: Thank you so much, Sandra. What a great submission. Most importantly, thank you for the great work that you do in the community. You talked about it being a tiny bit, but what you do is give dignity and support to families who really need it. My father suffered terribly from incontinence at the end of his life. It fell to his three daughters and my mother to look after him so I know how valuable this service is. You talked about dementia patients. It is a huge challenge. It is about providing dignity for those people, because people of that age are so private. You talked about the 92-year-old woman who had never spoken to her GP. Can I ask: how did she have the courage to speak to you?

Ms Ilett: Her referral came via another health professional.

Ms PEASE: How lovely, and you were able to help her. What a beautiful thing to do. Congratulations. Do not belittle what you do. It is a really big and important part, and it is something we do not talk about.

Ms Ilett: No, we do not talk about it.

Ms PEASE: The member for Burnett spoke about applying for MBS and the ability of your clients to claim. My understanding is that quite often nurse practitioners, even at GP clinics, are not eligible to make many claims through the MBS.

Ms Ilett: That is right. There are only four item numbers. There was a review recently, within the last year and a half, but I do not think anything changed much with the item numbers.

Ms PEASE: Who can sign off on incontinence, given that you have said that the doctor cannot sign off on it? Is it a nurse practitioner? The time of a nurse practitioner at a GP clinic is not being paid for through Medicare, so that is a fee for service. Are you eligible to sign?

Ms Ilett: Yes, I do them all the time.

Ms PEASE: Do you mind me asking what cost is involved for a service like that?

Ms Ilett: I charge $130 an hour as a home visit service. For most people it would take me around an hour and a half to do a visit. Honestly, usually it takes me three hours but I only charge for an hour and a half.

Ms PEASE: You are a very good human being, Sandra.

Ms Ilett: It is fine for me, but for the nurses I employ that is very hard.

Ms PEASE: That is right. You talked about the Commonwealth home care packages. We in a previous committee did a bit of work in that space and heard that, while people could apply, there was a very long waitlist.

Ms Ilett: There is a huge long waitlist.

Ms PEASE: Does that continue today?

Ms Ilett: Yes.

Ms PEASE: Do you have any idea how long that wait time might be?

Ms Ilett: No, I do not.

Ms PEASE: We have heard some horrific stories—two years or more.

CHAIR: There was a lady in Hervey Bay who came and held up her husband's level 4 package, which had arrived. He had died two years previous.

Ms Ilett: Yes, actually I can tell you another story exactly the same.

CHAIR: Tell us.

Ms Ilett: There is a lady at Bargara who I assessed, and her home care package information turned up when her husband had been passed for six months.

Ms PEASE: If those home care packages were assessed and delivered in a more opportune manner, would you be able to assess those particular clients and provide that service under the package?

Ms Ilett: Yes, if that provider wants to broker my services. They do not have any obligation. The home care package is a choice which the person makes.

Ms PEASE: If they are assessed as needing some continence investigation?

Ms Ilett: I certainly do have brokerage arrangements with quite a few home care package providers.

Ms PEASE: Do you deal with many GPs locally?

Ms Ilett: I deal with I think nearly every single one of them.

Ms PEASE: I can imagine.

Ms Ilett: Yes.

Ms PEASE: I can imagine that they are all very much under the pump.

Ms Ilett: Very much so. I try to be very succinct with what I need their help with.

Ms PEASE: I do not have any further questions, but I would like to acknowledge the great work that you do. It is really important. I have had a few people come in particularly around getting access to MASS—this was many years ago—but also because of my father, and I have friends who experience incontinence—adults who have to wear pull-ups. Thank you so much.

CHAIR: In the second paragraph on page 9 of your submission you say—

As nurses, we do not receive any funding through the Medical Benefits Schedule and are not able to access support of the Primary Health Networks.

Unpack that for me.

Ms Ilett: When I first started work as a sole provider, I did try to access some help or guidance through my local primary health network but it became fairly obvious from the lack of response that I really did not fit their model, so I stopped trying to access help. I do not have a Medicare provider number. That is the big issue. If I had a Medicare provider number, no problem.

CHAIR: I think this is really important, because the recommendations this committee will make, I am hoping, will have a positive impact on services.

Ms Ilett: I am not the only nurse working in private practice in this area. There are five of us. I am the only one who does specialist incontinence work. There is an untapped resource, because nurses are working more and more in private practice, all over Queensland and Australia. Nurses are an untapped resource who can provide much more care if needed.

Ms PEASE: If there are five nurses working in this small area, there is obviously a big need.

Ms Ilett: Yes, and that is another point I did not make in my paper. If there was no need I would be out of work, but that is far from the case.

Mr BENNETT: For the committee's benefit, I have a question regarding succession. Are there plenty of new nurses coming through to supply the community-led service?

Ms Ilett: No, there are not plenty of new nurses.

Mr BENNETT: That is what I feared.

Ms Ilett: My problem is that it costs a lot of money to get a nurse up and running in my specialty area. Like I said, I do have a curriculum written. I have presented that curriculum to my own nurses and I have a website almost ready.

Mr BENNETT: Watch this space. Thank you, Sandra.

Ms PEASE: Thank you so much. Well done.

Mr ANDREW: Most of the questions have already been asked but I wanted to say thank you. It is a vital service. I know that a lot of my family went through the same situation. I cannot thank you enough for protecting their dignity.

CHAIR: I have a few friends who are quadriplegics who receive care. I know how important it is. It is really commendable work you are doing, so thank you.

Ms Ilett: Thank you for the opportunity.

MACKIE, Ms Pamela, Practice Manager, Impact Community Health Service

O'SHEA, Ms Tanya, Managing Director, Impact Community Health Service

CHAIR: Who would like the start with an opening statement?

Ms Mackie: Good afternoon. I am Pamela Mackie. I am here today with Impact Community Health Service's managing director, Tanya O'Shea. As the practice manager of Impact Community Health Service, I live and work in Agnes Water delivering primary healthcare services to the Discovery Coast region. Unfortunately, we missed the opportunity to provide a submission as we inadvertently found out about this opportunity to present, so I hope that we can give you enough information.

CHAIR: We can always consider a late submission.

Ms Mackie: Perfect, thank you. The disparities in health care between rural communities and their urban counterparts, causing poor health outcomes, is well documented, and our region is no different. I would like to begin by talking about GPs. We have heard about that today. It is cited that in urban areas there is one GP for every 766 Queenslanders, but in rural and more remote settings it is one to 1,428. For our region to be equivalent to our urban counterparts, based on our 2016 Census data, we would need eight GPs and 4.2 GPs just to be equivalent to our rural cousins.

With the COVID migration swell in population that we have experienced, it is now estimated that we would require 13 GPs. We have 2.5 full-time-equivalent general practitioners, one with closed books and only one that does after-hours calls for his own client base. That leaves the rest of our community with a three-hour round trip to access Bundaberg or Gladstone for both regular and after-hours care. After listening to earlier speakers, I want to add that one does bulk-billing and one is full fee-paying. There is a two- to three-week wait, and we at Impact actually provide co-location for one of the GPs to keep them in town.

The provision of health services in our region is complex and complicated. The lack of health professionals; conflicting government boundaries; poor telecommunications; limited commercial premises; the geographical distance; our funding models; and the unique characteristics of our communities all impact on the delivery of primary healthcare services. The most significant is the lack of hospital and health services infrastructure and services.

We heard from Stephen Bell earlier today with regard to the Wide Bay Hospital and Health Service. It has three major hospitals and seven other facilities across the rural area of the North Burnett, which has a population density of 0.53 compared to 1.6 in our Discovery Coast. Unlike these other rural communities, we have no hospital or health service infrastructure within 125 kilometres and only limited outreach hospital services. We also recognise that, due to our locality, residents from the Discovery Coast access both the Wide Bay Hospital and Health Service and the Central Queensland Hospital and Health Service. This further complicates intake and referral processes. Often we have referrals that say, 'The client is out of our catchment,' with no-one accepting responsibility for where that client lives.

The Wide Bay Hospital and Health Service strategic plan, *Care comes first ... through patients' eyes*, identifies the need to improve access and investigate options for the growing community of Agnes Water, but there is no imminent plan to address the needs of the region. Impact Community Health Service is the main provider of primary healthcare services in the region. We provide community nursing and allied health services under Commonwealth funding, through the PHN, under the Rural Primary Health Services program. Our health precinct also provides rooms for other visiting health services under various funding models and other co-location opportunities. The funding for this program has been in our community for almost 20 years. There has been very little change to the level of service delivery. In the six years that Impact has managed the program, we have had no increases in funding.

In the past 12 months there have been changes to that funding. Now it is funnelled from a bulk funded program into a Medicare model. It is our regular experience to be unable to support our clients in end-of-life care. We have inadequate mental health referral pathways. We heard from Dr Kohn today—I fully support the statements she made—with regard to the changes in funding for the mental health program. I believe that Impact will also be providing a submission to the upcoming mental health committee inquiry.

We become frustrated by navigating the My Aged Care system, ACAT referrals in rural communities, ACAT referrals within hospitals and also the NDIS. It is our regular experience to also be unable to maintain recency of clinical practice for our staff. We have difficulty with recruitment and retention of health professionals. We become frustrated about referrals from hospital and failed discharges from hospital where there is early or inappropriate planning for discharge.

We also do not have access to community based health programs as we are outside the radius of service delivery. For example, Hospital in the Home and the midwifery program are provided within the boundaries of the Bundaberg city and not outreached into the rural communities. We also have very limited access to basic after-hours primary health care. The provision of after-hours primary health care is crucial in our region as currently residents are forced to seek alternative pathways to access care such as utilising the Queensland Ambulance Service for non-emergency care; travelling to either Bundaberg or Gladstone to attend emergency departments; simply going without or waiting it out; or, even worse, seeking advice on Facebook and borrowing medications.

The current healthcare model servicing our region is fragmented and does not address any systemic improvement. Our aim is to reduce the unwarranted demand on emergency resources, to support general practice and reduce the risk of burnout, and to provide residents with appropriate, affordable and accessible primary health care. Impact is committed to working in true partnership with our community and stakeholders to develop a model of care that addresses these disparities and inequalities that are experienced by our community. An example of working in a true partnership is our fever clinic, which is operated by the HHS but is co-staffed with Impact nurses to reduce travel costs and to address staffing shortages along with ensuring that that service was actually available in our community. After two rounds of unsuccessful PRIMM funding—and PRIMM is the Primary Care Rural Innovative Multidisciplinary Models funding—Impact is now investing its own funds into developing a feasible and appropriate model of care that is co-designed with our community and stakeholders.

I want to mention briefly the GP care plan process and changes to our recent funding where our allied health services can now only be delivered through the GP-care planning process. We previously had a dietitian who worked four days per month and serviced the region. With regard to the way the care plan operates, they are allowed five visits. They might get three podiatry, one diabetes education and one dietitian. Our dietitian is usually only getting one of those care plan visits and that severely limits her capacity to provide comprehensive care and services to people because their ability to pay for private services is limited.

Our need for improved access to health services is continuing to escalate. It is now paramount due to the COVID migration influx that our community sees. These new people in our community bring a new demographic, changing health perspectives and expectations of care, and an increased burden on already stretched resources. I thank you for this opportunity to present today.

CHAIR: That was an insightful opening statement. You could pick up Agnes Water and put it in the Tablelands; that is exactly what we heard: people driving hours-long round trips to access GPs and services. How long has Impact been around? How big is it? How many people do you look after?

Ms O'Shea: Impact has been around since 1978. We have 180 people in the community working in regions and also outside of Bundaberg. About five or six years ago the Gladstone Regional Council approached Impact to take over the Discovery Coast community health service, which was funded through Medicare Locals. The funding then transitioned over to the PHN. The Gladstone Regional Council said, 'This is outside our remit. It is not something we do,' and they offered for us to take it over. That is how that transition to Impact happened.

CHAIR: It is good to understand the foundations of it. On the PRIMM funding, what was that? Who did it; who gave it? You were unsuccessful after two rounds?

Ms Mackie: We were. We submitted towards the end of last year and earlier in the year before and we were unsuccessful. That funding is federal level funding to provide the feasibility to introduce a new model of care to service the community. It would allow us to undertake the feasibility and the financial viability of these programs so that we could deliver to community and be very community focused to meet community needs. Unfortunately, we have had two unsuccessful applications. We are proposing to our board next month—

Ms O'Shea: On 28 March.

Ms Mackie:—to fund us to actually undertake that work ourselves. We understand that Queensland Health is not going to be putting any facilities or infrastructure within our region in the foreseeable future. If we are another three years down the track, we are not going to be addressing the need. We are hardly addressing the need now.

Ms O'Shea: When you talk about investment, that is a minimum $130,000 to do the scoping that we need to do.

CHAIR: Was that through the PHN or through different people?

Ms Mackie: I can get back to you on that.

CHAIR: If you can take that on notice, that would be good. I am just making commentary here. A previous witness, Wayne from IWC, said that primary care is the cornerstone of health care. If we do not get that right, we end up with what we have heard time and time again: the door of last resort, back to the ED, back to the hospital. If we can get primary care right and funded right, would that assist in reducing the burden of people going to emergency departments?

Ms Mackie: Absolutely. The changes that we have seen since Impact has taken over the program—the funding has been in our community for 20 years and it was primarily put in there to address the shortfalls in services across the board. What we have seen over more recent times is a channelling of that funding to have a specific focus on people who are at risk of chronic disease. That is fantastic when we are actually delivering services to a whole community and population; we are not just dealing with one cohort.

Our funding was changed this financial year in that that old funding was split. We now have a community nursing component, where we can provide services to anyone in our community who needs nursing services. However, our allied health services are still very much driven under the GP care plan model and the Medicare model, which restricts access for a child who needs a review with a podiatrist and things like that. Unless we are able to encourage those providers to come into our community to both do our program and provide private practice, we are actually limiting how many people can see those providers.

Mr BENNETT: It was interesting to hear you talk about the COVID migration. From a statistics perspective, I was talking to Neil the other day, and he has created 250 new post office boxes in the last four months alone in 1770. It shows that the issues you are raising about those population movements are real and present. For the committee's benefit, you should also describe the facilities that you are now working out of that you inherited. I think that is an important picture that needs to be painted about the challenges of the great work you are doing. I also echo our thanks to Impact for taking on that role, because it was such a monumental issue that we could maintain some sort of service. Are there any other partnerships in particular that you are hearing might be coming? There are always rumours about potential GPs or clinics opening up. They could be networks of success. There are a couple of questions: paint a picture of where you work out of and then talk about other networks.

Ms Mackie: I think the building that we work out of was originally an art gallery. It was acquired by the then Miriam Vale shire council to conduct health services out of. There are actually two buildings on the premises. We occupy one and one has now been vacant for well over two years. We have been trying to acquire it so we can expand services, particularly with COVID and the impacts it has had on room numbers, people in rooms and all of those things. That is an ongoing thing. That building also has not had any refurbishment or anything done to it during those 20 years. We are looking a little run down.

We also have outreach clinics at Baffle Creek and at Miriam Vale. Our Baffle Creek clinic is literally a donga. It leaks, but that is okay; we can at least provide those services in that community, which is really important. One of the interesting things about our region is that each community is very different and we need to address people's needs in different ways and have respect for those communities.

Other things that are coming to Agnes Water would be the new supermarket development, which is going to have GP premises available in there, but there is no intent by the developer to actually have it staffed. That same developer is building 200-odd retirement houses, which are commencing now, for over-50s living. That will bring another new demographic and probably also an economic profile of poorer health in that age group which will also add a burden to the existing community. We have a new GP who recently started practice but has opted to cease practice for a range of matters for the moment, but they are looking to come back and purpose-build within the next six months.

Mr BENNETT: Everything is crossed for that.

Ms Mackie: That is right. On some of these things we have to temper rumour and fact and work through it. We do try to create very strong relationships with providers in our region, particularly in the aged-care space, like OzCare, integratedliving and Magenta. We find that navigating that My Aged Care system and having those services in early is one of the key things in helping to prevent unnecessary admissions to hospital. In relation to the waiting times, which you were asking about earlier, we have clients who stay on home care packages but really need a level 3 package. They are waiting six-plus months to get a level 2, so their condition continues to go down while they are waiting for those services.

Ms PEASE: Thanks so much. What great work you do. We have been blessed this afternoon; we have heard about such amazing people. Thank you very much for everything you do. I would like to try to get a better understanding of Impact Community Health Service, and I have been looking on your website. What do you deliver?

Ms Mackie: We deliver community nursing. That could be anything from taking sutures out to providing palliative care services to supporting people with navigating the referral into My Aged Care or discharge planning from hospital. An example of where we are very limited in that space—and we talked about catheters with the last speaker—would be things like vacuum dressings where our staff do not have recency of practice or clinical competency, so it is around ensuring we can have that appropriate level training for our staff so they can do those things. So community nursing would be one.

We have allied health services that are under our contract such as podiatry. We have had chiropractic, diabetes education and dietetic services. As I said, we also have a range of visiting services that we seek to come into our community. We have a female doctor and nurse team; we have the Flying Skin Cancer Doctor; we have an audiologist and an optometrist. They come in one or two days a month or whatever it may be, which then causes us to have to do the room shuffle to actually accommodate them in our premises.

Ms PEASE: We have talked about the home care packages, and I am not sure if you have touched on the NDIS packages that are available. We have heard in other areas that there is a real shortage of service providers who can actually deliver those services. Have you come across that, because you would be at the coalface? You would be seeing the clients, as community nurses, when you visit them in their home. You know exactly what they need. Are those services actually available in your community?

Ms Mackie: No, not across the board. We often will make a referral and are told that there is no capacity when we know that the client has a package of care. That capacity is around the distances that we travel. We could travel an hour and a half within our own region—to Turkey Beach, for example—to deliver services. That is a three-hour travel component as well which makes the delivery of services more difficult. We broker our nursing services to the local aged-care providers. They do not actually have nurses within our region, so we broker our nurses to the aged-care providers. You will hear from Josie a little later on. I am sure she will be able to give you an even greater insight into the aged-care services and her experience with trying to access and navigate those services.

Mr MOLHOEK: Is Impact a not-for-profit or for-profit service? It is truly community based.

Ms Mackie: Yes.

Mr MOLHOEK: As we have travelled around the state it seems that there are dozens of small communities—not just small communities but large ones too like Cairns and Townsville—where there are shortages of allied health specialists, doctors, nurses, specialist carers. In Mossman, one of the questions I asked an NDIS provider was: is it a shortage of cash or a shortage of skilled people? How do we get people to go to Agnes Water to set up a GP practice or an NDIS service?

Mr BENNETT: Send them a postcard.

Mr MOLHOEK: Why can't we get them there?

Ms Mackie: Yes, you would think that if you sent them a postcard they would come. It is beautiful. It is a lovely place. We also have other issues for professionals when it comes to if they have children or are seeking education opportunities. They want to go shopping and buy a new pair of shoes. We do not necessarily have those opportunities in Agnes Water either. Some people will make those choices.

We also have such limited commercial infrastructure available. All of the general practices that have been in Agnes Water that have since closed or are still operating are operating out of other buildings. They are not purpose-built medical practices. From a general practitioner point of view, if you were coming in and you saw this beautiful new practice and it was telling that lovely story—in our case, we are walking into a 30- or 40-year-old building that has not been renovated in 20 years where we are sticking things in rooms—

Ms O'Shea: We are making do.

Ms Mackie: Yes.

Mr MOLHOEK: Yes, but that still does not resolve the issue.

Ms Mackie: No.

Mr MOLHOEK: We heard from someone earlier today who had made a decision to move out of one area of health practice into another because of family and lifestyle and wanting to change hours.

Ms Mackie: I think there is also a real risk and fear of burnout. They are coming to look at our community, but they are already seeing that there is little support for them. If we need a minimum of four just to be equivalent to our rural people and we only have two, you know that you are going to be working probably in excess of what you want to because you have come to this beautiful place to enjoy it.

Mr MOLHOEK: It is an interesting tension though, isn't it? I get people on the Gold Coast say to me, 'I remember when it was a seaside village back in the sixties. I wish it was like that. There are all these people coming here.' But then nobody really wants to go back to that either.

Ms O'Shea: No, but you have to keep up with that though, haven't you? For Agnes at the moment it is about the infrastructure such as having a hospital there. If something happens to your child, you have to travel an hour and a half potentially to get access to the care that you need. They are making those sorts of decisions. For us, it is about what we can put in place to be able to respond to some of those issues around after-hours care and things like that.

CHAIR: On that note, some good ideas have been put to the committee. We look forward to putting our report together and making recommendations. I thank you both for the work that Impact is doing in the local community, particularly around Agnes Water. Thank you for your contribution today.

JACKSON, Dr Cynthia, Medical Educator—Wide Bay, James Cook University; Practice Principal, Childers Family Medicine

CHAIR: Welcome. You have heard a lot of contributors here today. We thank you for your submission. It is well considered. I invite you make an opening statement before we move to questions.

Dr Jackson: Similarly to other people, I would like to acknowledge the traditional owners of the lands on which we are meeting today and I pay my respects and JCU's respects to their contributions to Australian society and certainly to our university community as well. Thank you for the opportunity to speak today. I am the lead medical educator for JCU GP training in the Wide Bay region. I am also a GP practice principal and a practice owner in Childers. My practice is Childers Family Medicine. We have been open since 2011.

For those who do not know, Childers is a small town around 60 kilometres from Bundaberg. It has a population of about 2,000, but our health catchment is significantly larger than that. I have been supervising GP registrars in my practice since 2013. I visit our local residential aged-care facility in Childers. My practice provides what I would consider to be a broad scope of rural general practitioner services: medical consultations; procedural care, including advance skin procedures and women's health procedures; antenatal care; home visits; home based palliative care; and all of our own after-hours GP services for our practice patients.

I know you have heard from various witnesses through your travels regarding the crisis in the rural general practitioner workforce. This cannot be overstated. Without adequate numbers of GPs, the default provider is going to be the public health system. Without affordable access to community based allied health, community members will be referred to their local public hospital to access care that could otherwise have been provided in their community.

JCU GP has demonstrated success in the rural pipeline approach. The evidence does support that actively recruiting rural and regional students and training them in their location actually gets them to stay and serve their local communities. Anything that places medical students and junior doctors in cities in their twenties and thirties does so at the expense of the rural workforce. It is during those years that individuals buy houses, establish their domestic relationships and start their families. Once those ties are in place, it is exceptionally difficult to get people to move back to a rural area. It is vital that quality undergraduate medical education and postgraduate specialty training is available in regional Queensland—and that is the JCU vision.

I have a couple of comments with regard to GP service provision in residential aged care. GPs are leaving residential aged-care work in droves. The work is extraordinarily poorly remunerated and it is under-resourced. It is by its nature time consuming. Patients have complex multimorbidity, frequent communication difficulties, dementia—all occurring in an environment where basic clinical tools are frequently lacking. There is a lack of registered nurses in residential aged-care facilities. Clinical handover of any sort of patient concern is frequently from a non-clinically trained staff member. That makes remote assessment of the patient by the GP fraught with difficulty. However, trying to attend that person in person as a GP may take an hour or more of your time.

GPs are not specifically funded to provide after-hours or on-call services to nursing homes. There is an ever-increasing paperwork burden associated with nursing home work which is unpaid time under the current fee-for-service structure. As a result of these issues, any non-routine problem in a nursing home frequently results in the resident being transferred to the local hospital for assessment. It is distressing to the resident and it is frequently clinically unnecessary.

My final comments concern the NDIS. For many GPs the NDIS is a mystery. There appears to be no formal communication channel between the NDIS and a patient's GP. I do not receive a copy of any assessment or plan for my NDIS patients. I am not informed as to which providers are involved in their care. What I do hear repeatedly from my NDIS patients is that they cannot use their NDIS funding to access the services that they actually need. NDIS funding cannot be used for services that attract Medicare funding. However, there seems to be no requirement that those services are available in the local area. As a result, I have patients who cannot use their NDIS funding to help pay the fees of a private local specialist and rather are required to travel to Brisbane in their wheelchairs, with their carers, to consult with a specialist in a Brisbane public hospital for a 20-minute appointment. This is grossly inefficient and it is an unacceptable burden for these patients. I thank you for the opportunity to speak today and I welcome your questions.

CHAIR: Thank you very much, Doctor. Particularly that last part is a stark reality of where things are at today in lack of speciality services. We have heard time and time again already of the assessment—the cost, the burden—and reassessment just to get a package. First, I commend JCU

for the work they have done in the rural space. The medical training program in Townsville started in 2000. Many of my peers went through, completed that and have stayed working in rural locations. It is commendable work that the university is doing. I want some further commentary around page 13 of your submission, 'The current state of outer metropolitan, rural, and regional GPs and related services: the case for increased domestic medical graduates'. You say—

The fundamental issues driving this are geographic maldistribution and unbalanced speciality mix in domestic medical labour.

Could you unpack that a little bit for us?

Dr Jackson: Traditionally, rural and regional areas of Queensland have been over-represented by an international medical graduate workforce. If you look at the number of medical graduates we are producing, we have ample numbers of doctors in Australia for our population; they are just very maldistributed. Trying to get Australian graduates out of capital cities is incredibly hard work. The focus of the JCU approach was trying to get medical graduates from rural and regional backgrounds into medical school—so starting at high school level and attracting them into a regionally placed medical school program so that they could get their basic medical degree and they do their intern training and ideally go on to get their speciality training in regional hospitals.

At the moment the problem is that, even if you are in a regional hospital—say you are in Bundaberg Hospital—and you decide you want to be an oncologist, you frequently have to go to Brisbane or Sydney or Melbourne to do that training. That is at that very crucial point in your life when you are putting down your roots, you buy your house and you find your long-term partner. They just never come back. The importance of getting speciality training hubs, which are coming up in the state, to try and get that speciality training out into the regions cannot be overstated.

CHAIR: We heard from a previous witness about incentives to bring those people here. There used to be incentives for those. What were they? What does it look like? How do we fix it?

Dr Jackson: There still are rural retention payments. Depending on your level of rurality, you will get an annual payment, depending on how long you have served in that community. The problem with some of the larger regional areas is that, under the Modified Monash classification, they are level 2. Level 2 is sort of this grey zone. It sort of comes in and goes out—it depends on what is in political play at the time—as to whether level 2 areas attract any sort of rural retention payments at all. At the moment I do not believe they do. I think your rural retention payments are starting at Modified Monash 3. Certainly Modified Monash goes up to level 7 for the really remote areas of Queensland. It is very difficult to attract someone to a regional centre such as Rockhampton, Bundaberg or even Hervey Bay if they really have no prospect of any difference in income to someone who is working in the middle of Sydney or the middle of Brisbane who has an awful lot more support networks in place.

CHAIR: The level 2 does not offer any real retention in terms of incentive?

Dr Jackson: The lower levels of that rural retention payment certainly would not be a make or break sort of thing. It is not going to be a carrot that gets someone who otherwise was not going to come to an area to actually come to an area. It is not that sort of money. It really is just a nice offset for a GP who may move to an area. It offsets some of the increased costs of living, of accessing different types of education—the expenses that can come with rural life where services are not as easy to come by. I think a lot of times it is fairly cost neutral.

CHAIR: Do you know where Townsville sits, just out of interest?

Dr Jackson: I think it is a level 2.

CHAIR: Me too.

Dr Jackson: I think it is a level 2. Certainly Brisbane and Gold Coast are modified 1. The JCU GP patch, if you are training on the rural pathway, is Modified Monash 2 and above. My understanding is that, other than a couple of pockets down on the Sunshine Coast, all of the JCU GP territory is in that rural pathway demographic, so it is level 2 and above.

Mr MOLHOEK: By way of disclosure of personal interest, my son is a rural health specialist in Emerald, the acting district medical officer there in rural health. I am a huge fan of the work of JCU. I understand the argument that they are putting about the success of recruiting, training and keeping people in rural and remote Queensland. Everywhere we have gone with these hearings, we just keep hearing the same story. Then you go to South-East Queensland and they talk about doctor shortages there as well. How do we change this? It is not just a Queensland problem. It is not just a rural and remote or a James Cook problem. If you look at the 10 megatrends that are happening around the globe, there is this massive shift of people who want to be in highly urbanised communities. You cannot just keep throwing money at it either, because some of the money that some of the rural

doctors and specialists are earning is double what they can earn down on the Gold Coast as a GP but they still do not want to stay. What do we have to do to get people back to rural and remote Queensland?

Dr Jackson: I think it is so multifactorial. I know that you have asked a couple of other people here today. I really do think there is a critical mass effect. You are quite right: you just cannot keep throwing money at it, because it is not just money; it is lifestyle. There are lots of things that come with that. There is availability of decent accommodation. There is internet access, which is abysmal. I can say as a business owner that trying to run a business on the internet service we have in Childers is diabolical. It is a matter of your overtime, the hours you are working, being on call every night, everyone in the community knowing who you are, getting asked medical questions all the time down the street.

Mr MOLHOEK: None of that is a great pitch to attract people there, though, is it?

Dr Jackson: That is exactly right.

Mr MOLHOEK: It sounds like you are talking people out of coming!

Dr Jackson: I think that is the beauty of trying to get people who have experience of a rural and regional lifestyle. Even then, it is not going to win unless we fix some of the infrastructure problems. The JCU approach is a sound one but it is not a quick fix.

Mr MOLHOEK: They are not big numbers, either.

Dr Jackson: No, they are not.

Mr MOLHOEK: They are great, but they are not big numbers.

Dr Jackson: They are not going to be, certainly not in any short time frame, because there is only a certain number of rural and regional students who have an interest in doing medicine, who want to go on to doing GP, and then only a proportion of those are going to actually stay in the community. It is going to be a very long term view. It is certainly not something you are going to invest in now and in five years expect to see big numbers come out of it.

Mr MOLHOEK: You touched on the number of international recruits. One of the figures I heard earlier in this inquiry was that, even when doctors and specialists from overseas come here, they are only required to stay in these different areas for about two years. Do we need to change the migration policy and say, 'You have to stay for five or 10 years'?

Dr Jackson: Overall, I am not a fan of the stick approach. I am a big fan of a carrot rather than a stick. The problem with depending on an IMG workforce in rural areas is that you are taking people who are unfamiliar with the culture, unfamiliar with rural people, and putting them in largely less supervised situations where they really are a fish out of water and expecting them to want to stay. I do not particularly think there is a lot of virtue in trying to force longer durations of service from international medical graduates. It is by necessity a stopgap measure—one we have used to date and one we probably will need to continue to use just to fill workforce. I do not think that should be our long-term view. We have enough domestic graduates. We need to work to see where we are recruiting those students and junior doctors from so that we can retain them in areas they want to be in. We want doctors who actually come to an area, stay in a community and get that longevity and that history with the community and patients. We do not want people who come for two years or five years; we want people to live there.

Mr MOLHOEK: How do you get them to do that? We are throwing money at them. In a lot of places we actually do provide reasonable accommodation for doctors and specialist health workers. There are QantasLink flights in and out of a lot of places—maybe not in Childers. What are the incentives to get them to stay?

Dr Jackson: By its very nature, money is going to be part of it. It is not just increasing dollars; it is the whole structure of how payments are made. The whole fee-for-service structure of general practice does not suit rural general practice at all. We do home visits. I have been on a home visit this morning. It took me an hour. For that hour I might get $60 and of that I pay a facility fee and I pay my tax. I do that at a loss and I do it because I know my community. If I were in a city, I could be part of a deputising service and just do after-hours or home visits and it is quite lucrative. The whole demographic in country areas is different. We need to be looking at how we pay those practitioners to do the job they are actually doing.

I worked at our local hospital. I moved to Childers as a GP registrar. While I was a registrar and shortly after I fellowed, I was working as a medical officer at the Childers Hospital. I stopped doing that work. We have heard about burnout. It is an untenable work-life balance to be trying to

work eight or 10 hours in your private practice during the day and being on call overnight, knowing you have a full list of patients booked for eight or 10 hours the next day. If you get called into a trauma or a heart attack overnight, you might be in the hospital for three or four hours organising retrieval and you are expected to front up the next day to private practice. Those sorts of frameworks just do not work. That is not what is expected of urban GPs, so it does not make sense that we are trying to use the same system in both locations.

Mr MOLHOEK: I would contend that I am not sure it is quite so glossy in some of the urban areas.

Dr Jackson: Maybe I have a romantic view.

Mr MOLHOEK: If you talk to some of the ED specialists at Gold Coast University Hospital—they have had a 108 per cent increase in demand in the last two years. There are horrific stories in that setting about the hours they are working as well. That is by the by, but the grass is always greener, isn't it?

Dr Jackson: I think so.

CHAIR: You are taking me back to 30 years of shiftwork, being on call in the middle of the night in some rural towns. You just have to get up and keep going. There is no back-up in Hughenden, Charters Towers or Cloncurry. Anyway, we will not start on that.

Ms PEASE: I thought you were going to say something there, Chair! You disappoint me; you let me down!

CHAIR: Just an observation!

Ms PEASE: You talk about how busy you were as a registrar. You must be incredibly busy now with all the things you are doing. How do you manage your time now?

Dr Jackson: Very carefully. There is a lot of after-hours. There is after-hours in practice ownership and practice management. There is after-hours in my medical educator role. I am a mum of two school-age kids. I need to have some presence for that. I am fortunate in that my husband is a GP, too—he is also a practice principal at the practice—so a lot of our over-dinner conversation is not particularly scintillating; it is about practice management, staffing levels and clinical concerns. We have sort of gone into that knowing that is how it is going to be, but we know that a lot of rural GPs are not in that situation. They do not have a spouse or partner who understands those sorts of things.

Ms PEASE: From the stories we have heard from other GPs, whether they are an urban GP or a rural GP, it is a small business that does not run easily because you have all of the costs that are associated with it. It is not a salaried job so it is particularly hard if you are on your own. I understand that. What made you choose to become a GP specialist?

Dr Jackson: I had a fairly circuitous route into general practice. I did quite a bit of emergency medicine in rural facilities. I did a couple of years of anatomical pathology training. Then I was working in emergency on the Sunshine Coast for a couple of years and I got sick of the public health system. I did not like the administration and the bureaucracy and the lack of patient contact. I was feeling that I did not actually get to know my patients or service them the way that I should. My husband, who was a GP at the time, said the only way I was going to be free of that system was by getting my own provider number and the only way to do that is to be a GP. That is how I ended up in general practice.

Ms PEASE: Did any of your peers try to talk you into specialising in other things?

Dr Jackson: Not particularly. I have to say that when I chose GP I felt somewhat a failure. I felt like perhaps I was not being all I could be in the medical sphere. I think GP is not a particularly respected position within medicine overall.

Ms PEASE: We have actually heard that unfortunately within the other medical fellowships or organisations it is not considered a priority whereas really the primary care of a patient is, to me, the No. 1 priority because you get to see everything and you have to be a specialist in everything and know what to do. Congratulations on picking it.

CHAIR: You have gone from an ED on the Sunny Coast to GP, which are two very different models of care.

Ms PEASE: Are you from this way?

Dr Jackson: No, I am from the Darling Downs. I grew up in a little town called Mount Tyson, west of Toowoomba.

Ms PEASE: Is your husband from up this way?

Dr Jackson: No, not at all. He was from Adelaide originally. I came up here as a registrar on the rural pathway and I loved it. I had the rural background again, which I think is so important. I loved it and I said, 'You should move up here. There are fantastic opportunities up here for us.' He said, 'Okay.'

Ms PEASE: Are you aware that the college is taking back the training of GPs and do you have a comment on that, given that it will impact on JCU involvement?

Dr Jackson: I think the problem at the moment is that there is so much uncertainty as to what that actually means. There is always a concern from a JCU GP-training point of view that either—not so much ACRRM because ACCRM's primary reason for being is rural and remote medicine. Certainly with the RACGP, the concern is that it is going to become very urban centric. As we have heard from other people today, decisions are going to be made in city centres that really have no understanding of what a rural demographic and community looks like and what they actually need.

Ms PEASE: Do you know why this has come about?

Dr Jackson: Why it has gone back to the colleges? I think a long time ago, probably 20 to 25 years ago, it was done through the colleges. My understanding is that there was concern by government that there was a lot of financial wastage in that and there was not an awful lot of oversight of how funding was being spent. Now I think it has gone back the other way. I am not entirely sure why they have decided now is a good time, though.

Ms PEASE: By 'government' you mean the federal government?

Dr Jackson: Yes, I mean the federal government.

Ms PEASE: Thank you so much for your great work and thank you to your family.

CHAIR: I am sorry to the members who did not get to ask a question.

Mr ANDREW: We know where the doctor lives.

CHAIR: I was going to say, you can see her at the local IGA.

Ms PEASE: Childers is lucky to have you.

Dr Jackson: Thank you.

CHAIR: Thank you so much, Doctor, for your insightful contribution and for the work that you do in your community. I have a very good relationship with my own GP so I know it is important work. We cannot do without you. We will move on to our registered speakers, of whom we have four. I call forward Ms Josie Meng.

MENG, Ms Josie, Private capacity

CHAIR: Josie, thank you very much for being here. You have heard a few of the submitters today as people have come up to talk to us about their experiences and issues. We welcome you. Would you like to go ahead with an opening statement?

Ms Meng: My name is Josie Meng and I live at Agnes Water. I have been a resident there for the past 30 years permanently. As Pam and a few others have said here today, our community has seen a large increase in population. Twenty-odd years ago we started the Discovery Coast Health Service, which was run by a community group and now Impact has taken it over. It is great to see that it is still going, but unfortunately we have lost a few of the services down the track. We have had a massive increase in population. COVID has helped some of that at the moment, but at holiday time—we were lucky with the small town events to get 5,000 people—we would well and truly smash that now.

Our emergency services, being our ambulance and our doctors and the likes of Impact, are stretched to the limit. Our community is stretched. As you heard, we drive an hour and a half each way to get services. Bundy is the primary health service centre for a lot of us. We gravitate to Bundy because of the services they have, and we have Gladstone as well. Services go out of our community. For example, our local ambulance could be out of town for up to five hours, depending. There is no ramping included in that. It can take that time depending on what they are doing. It is a big strain on our officers. I have been heavily involved in getting a lot of the services into our community over the years, which I am very proud of and I am fighting hard to make sure that we keep them.

We have two local doctors now, as you are probably aware. They are stretched to the limit and fatigue is certainly a big issue. They cannot get locums; they cannot afford it now because of the cost of everything, which is going to have an impact on the community. I think as you also heard here today, the shift from bulk-billing to private practice in some cases is having a big impact on our small community, which relies heavily on the government system.

Our biggest concern is that it is 22 years since the Queensland Ambulance Service built in our community. During that time, and I have been involved, we had Queensland Health telling us that they are going to have a presence. We still do not have that presence today. We may have some services here and there, but we still do not have a Queensland Health community presence. It is very hard on everybody involved and at no point do we seem to get any further. We are in a plan, but then it gets shoved out. I know that could be for a lot of the other smaller communities around us as well. We live where we live and we chose where we live and we know that now, but we are getting a lot of people coming into our community who have not done their homework and expect X, Y and Z. It makes it very difficult for everybody at this point.

Also with access to our aged-care facilities, it is very difficult for people to navigate. I have had personal experience in this between home care and the possibility of aged care. It was not a very easy path at all. I helped nurse my husband for 2½ years, with limited services, to a degree, but that is right across the board. We do not have enough workers in those areas. I think you cannot just blame COVID for all these things. You cannot. It is being used for every single thing. People make a choice whether or not they want to be vaccinated right across the sphere, but we cannot keep blaming COVID for shortages in every sphere of medicine across our communities.

Moving on from recent events, my husband was in hospital in Bundy and over quite a few years, but in the past eight or six months in particular, it has been very difficult. The services not being provided for patients, family and friends are getting worse by the day. We do not have access to the support services that we need. I thought I was pretty good at this, but I can tell you what: I have learnt a lot in the past six months. I am just hoping that we can get better outcomes in the private, public and respite sectors so people do not have to go through what I have been through in the past six months. I would not wish it on my worst enemy.

At the moment I have a very dear friend in hospital and they are going through probably worse than what I went through. It is not fair. It is not fair to the family and friends. In some cases the nursing staff are really good. They are actually carrying the weight of a lot of the staff who are not doing their job, for want of better words. That makes it very difficult for everybody.

I think there is a total lack of support across the board for everybody in allied health and I do not know where and how you are going to fix it. I honestly do not know how you are going to fix it. You cannot keep throwing money at it. By the same token, there has to be better screening of people in some of the aged-care facilities and respite facilities. As one of the doctors might have said here earlier, they are not trained in what they are doing and that is a big downfall and leads to bigger problems that somebody else has to fix. Sometimes they are not fixable.

From our point of view at Agnes Water and the Discovery Coast, we are fortunate in one way: we may have to travel a bit but we know that choice. However, we still need the services there to try to help our local doctors and staff who are fighting hard to keep services in our community and to make sure that we have the lifestyle that we went there for. We still have it to a degree, but the challenge of medical services in our areas is getting harder for the older population and even some of the young ones. The NDIS and all the rest of it is just a nightmare. Unless something can be done to help that, we are never going to have a proper chance.

CHAIR: Thank you very much, Josie. It is very brave of you to come up. I want to make some observations. Your staunch advocacy for better services and the work that you are doing in your community is very commendable. I am sure that you are engaging with your local member on that. Also, thank you for sharing your own deeply personal story. You have identified a few things that have become a theme today around allied health and getting the right model of care. I am not sure if you have gone through the home care package.

Ms Meng: Yes, I have.

CHAIR: How did you find that?

Ms Meng: Very daunting and very hard to navigate. We ended up with AusCare, which is the main provider for our community. We do get limited services here from Bundy through integratedliving as well. We have a couple of girls who work for those services at home, which makes it a bit easier. It is the lack of staff and the cost involved. There is a cost to everything, but somewhere along the line those costs seem to have become very exorbitant.

We rely heavily on Impact for a lot of those other outsourced areas with, as Pam said earlier, the nurse practitioners and all of that. Our local doctors have not got time to do it. We are very lucky that we have one doctor who does after-hours services, home visits, palliative care et cetera. We are very lucky for that. They run the risk of burnout because they cannot afford to have a locum—it is too expensive—or they cannot get one to come. I think our doctor has had one holiday in the past probably 12 months and part of that was to go down to Brisbane for a conference that he needed to go to.

With the aged-care package or any of that type of thing—I have been helping a dear friend at the moment who is trying to navigate the NDIS. We thought we had it sorted. Unfortunately, he may not be here to even see it. He is 42. It is unbelievable. We cannot get answers out of people or you have to resubmit it or you have to do this or you have to do that. It is just wrong.

CHAIR: There is a level of bureaucracy involved in it.

Ms Meng: Very much so. Also, as has been said here today, even professionals who are working in the industry have trouble trying to follow it so for a person with only a high school background it is very difficult. In our communities we have a very low socio-economic background right through the Discovery Coast and other areas so it is a big struggle for people. Agencies are trying to help, but they do not fully understand it or give you misinformation, probably not intentionally but because they are busy as well. You just cannot get on top of it. It is very difficult.

I know Stephen has heard all this before and Pam from her area. It does not matter what sector of emergency services you are in; we are all hearing it, and you have probably heard that up and down the coast as well. I do not know what the answer is but somewhere along the line people really have to have a good look at it.

CHAIR: We do not give up. The committee's task is to make recommendations to try to fix these things. Thank you very much for your contribution. Are there any questions from members?

Mr BENNETT: I do not think we need to repeat ourselves, but I will pay tribute to Josie for her years of service through local government, through the emergency services and VMR. Without upsetting you, to you and Doug, thank you for all the work that you have done.

Ms Meng: Thank you.

CHAIR: Thank you very much, Josie. I now call forward Mr Patrick Tomkins.

TOMKINS, Mr Patrick, Private capacity

CHAIR: Welcome. Thank you for being here. I invite you to make an opening statement.

Mr Tomkins: I, too, would like to acknowledge the traditional owners of the land on which we meet today and pay my respects to elders past, present and emerging. My name is Patrick Tomkins. I have been a paramedic in Queensland for 10 years. During my time in ambulance, I have worked in a variety of areas ranging from metropolitan Brisbane to Agnes Water. Unfortunately, I had to leave Agnes Water in September to follow my dream of becoming a critical care paramedic, so I am in the internship program for that now.

CHAIR: Good on you.

Mr Tomkins: Thank you. That is still my retirement plan further down the track. I just need to work on my wife a bit more. As well as working within the Wide Bay area for approximately six years, I am also the secretary of the Australian Paramedics Association Queensland, which advocates and supports over 1,300 paramedics, emergency and medical dispatchers, patient transport officers and ambulance managers around the state. I speak with ambulance staff around the state every day. I believe I have a fairly firm understanding of what issues our service is facing in the provision of health care and its impact on the public healthcare system. I do have a submission I wish to table. Unfortunately, I was pretty late in finding out about this inquiry. I have a number of copies here. I can submit a digital copy at some point.

What was called the winter seasonal surge in 2017 has continued into the crisis we see engulfing our healthcare system both in Queensland and nationally today. An ageing baby boomer population, stagnating population growth and complacency within government, as well as an overall increase in demand, have caused the current healthcare crisis that we see around the country. The strain on our healthcare system was apparent before this pandemic began. We, as paramedics, have a front seat view of the unfortunate outcome of a strained residential aged-care system, inadequate support for those with disabilities, as well as general oversight into the public healthcare system. Our public hospitals and emergency departments are the backstop of our healthcare system—something that we have heard quite a bit today. However, we are consistently finding that this has been the primary point of care, particularly in regional areas.

The Queensland Ambulance Service, like other state ambulance services around the country, are going through an identity crisis. One week we are a primary healthcare provider and gateway to the public system. Then, when we begin to experience a foreseeable surge in demand, we are an emergency service and should only be used for emergencies. The unfortunate reality is that our aged-care sector is grossly understaffed, lacking support and unable to keep up with the demand of an ageing population. This is something that is going to affect all of us if we are fortunate enough to get to that point. That is why I think this is incredibly important work that you are doing.

Our establishment within ambulance has remained fairly stagnant until recently. However, we are seeing an increase in casualisation within the workforce, including new graduates coming out regularly. Then we are also required to fill shifts that are vacant due to flexible work agreements and the impact they have had on our rostering capacity. While FWAs are absolutely a great thing to have, the implementation of them has been fairly lacklustre.

Our most vulnerable community members are still working through the teething problems of the NDIS rollout, and our community here in Wide Bay, like the rest of Australia, is finding it increasingly difficult to get timely access to a GP and cannot afford regular access to allied health care that is not subsidised by Medicare. The only place for them to go is the hospital. In regional areas this is significantly worse.

Residents in areas that have seen an unprecedented demand in population growth such as Agnes Water need to travel to Bundaberg or Gladstone to receive a significant portion of care. This essentially means that they need to travel upwards of 120 kilometres for their primary and emergency care. This often involves two paramedics working in the town, of which I was once one, having to travel extensive distances in any 24-hour period often several times each day. That takes about four to six hours per job. While the GPs and community care providers do an exceptional job, the town is grossly lacking in critical healthcare infrastructure.

Around the state, and indeed nationally, our Ambulance Service workforce are fatigued and exasperated. Establishment numbers require review in order to maintain the workload that we had been seeing before the pandemic and will continue to see into the future. On behalf of APA Queensland, I would like to table this report to the committee. The document provides further insight into this matter from an ambulance perspective and outlines eight recommendations.

Recommendation 1 is that we have a commitment from the state government to fully fund regional and rural staff enhancements to end single-officer stations. Recommendation 2 is that the state and federal government provide joint funding to upgrade hospitals in Central Queensland and the Wide Bay, including providing interventional cardiology services, and review areas with increased population demand and access to an emergency department or hospital such as Agnes Water.

The Queensland Cardiac Outcomes Registry 2020 annual report showed that about 25 per cent of people needing to go to the Sunshine Coast University Hospital for cath lab services are coming from this region—that is, Hervey Bay and Bundaberg. Central Queensland is not included in that obviously because of the geographical location. They are not going to fly them to the Sunshine Coast; they fly them to Brisbane. There is a big portion of clients in these areas who need either primary reperfusion or secondary reperfusion post fibrinolysis who need to be then transported significant distances down to the Sunshine Coast.

Recommendation 3 is the creation of a fully funded government-run agency to supply the air medical retrieval and rescue needs of the Queensland public. Recommendation 4 is the expansion of the clinical hub, CHub—as I believe the United Works Union and Dr Ash were talking about—and CDS positions to provide better clinical oversight into the cases coded in AMPDS and ensure those who need an ambulance the most receive it first. As I am sure some will know, sometimes there is a disparity. AMPDS is really good at getting an ambulance to someone who is in cardiac arrest very quickly, but there are a lot of other things that need to go through there. You need someone who has some clinical skill to go through those cases.

CHAIR: I did CDS training.

Mr Tomkins: Perfect. We need to expand that. Recommendation 5 is that the federal government commit to increasing funding and support for nursing homes, Indigenous health care and disability support in the disability support sector. Recommendation 6 is that the state government commit to extensively enhancing the Queensland Ambulance Service Patient Transport Service including expanding the cases that PTS can be used for and for it to operate seven days a week. Did you get to go to Hervey Bay?

CHAIR: No, but the committee has been there previously.

Mr Tomkins: It is my understanding that even acute transports from Maryborough to Hervey Bay Hospital are extensive. Unfortunately, in taking a patient from an emergency department where they then need to go to another emergency department, there are probably some issues with efficiency. Ultimately, health care and particularly hospital care does not work nine to five. We need our patient flow to occur outside of those hours. It does in some areas. Brisbane do it a bit, but we need to start seeing that in more regional areas too and having that run through the Queensland Ambulance Service.

Recommendation 7 is that we need significant federal government funding for GP increases in metropolitan regional areas—something we have heard a lot about—including the expansion of telehealth services, as well as trialling urgent care facilities and increasing alternative pathways to emergency departments in regional areas. With telehealth services, I find that even a lot of folks who are calling with what you would know are category 4s and category 5s, they do not know that they actually exist. Even when they do, they are having difficulties paying for it.

Outside of this as well, the urgent care model is a new concept here. I am not an expert in the field at all. I do come from the United States, and the last thing I want to see is the healthcare system here becoming anything like that. I do believe that a trial was held in Brisbane. It was one of those SuperGP funded models that significantly reduced ED presentations.

Mr MOLHOEK: There is one at Morayfield.

Mr Tomkins: There you go. We also need to increase the general alternative pathways to care. We have really great LARU services in metropolitan areas. They are adapting the mental health co-responder models. Those are really great things. We do not have them out here. We need buy-in from the PHN so that we can have these services out here to refer people to. Otherwise we go to the safety net, which is a good thing to have, but unfortunately they have to go to the hospital where they might not need to go if we had those services available. Recommendation 8 is for a review into the structure establishment and rostering within the Queensland Ambulance Service to determine its place within the healthcare system.

I really appreciate everyone's time. I am sorry I could not provide a submission earlier. I only heard about this not too long ago. I cannot thank you enough for the work that you are doing and for the advocacy that you are trying to do for your areas and for the greater health system. I am more than happy to take some questions.

CHAIR: Thank you, Patrick. We appreciate your contribution and the report. Procedurally we need to seek leave to accept that. There being no objection, leave is granted. You mentioned residential aged-care facilities. If the model of care—and you have probably heard that a few times today—was correct, and you are now aware of the amount of transports that are coming out of those residential aged-care facilities, would you support some kind of a different—

Mr Tomkins: Absolutely. I am more than happy to share a story that crossed my mind when while I was figuring a lot of this out. Essentially we had gone out to a residential aged-care facility in the middle of the night because a resident was having some chronic pain issues with his foot. He had generally been taking a normal amount of pain relief. Unfortunately, what had happened was, through one point or another, they did not have 'PON' written on their chart.

Essentially, the request for service was for us to take that gentleman from the aged-care facility to the hospital. All this gentleman needed was 50 milligrams of Tramadol or something like that. Because there were no other options, we transported that person to the hospital. They stayed on the stretcher. It still took a considerable amount of time but then we transported them back home.

I am not a doctor in any way, shape or form, but I would expect, particularly in some regional areas, that you could maybe look to involving the SMOs at the hospital. I know they will probably throw something at me the next time I present a patient there in ED. Ultimately, if there is some port of call for some of these decisions—they are run off their feet, I understand. It was two o'clock in the morning. All this person needed was some pain relief. They were very satisfied with just getting some pain relief and going back home.

CHAIR: A nurse practitioner could do that.

Mr Tomkins: Absolutely—100 per cent. I know Jamie Rhodes-Bates talked a bit about skill degradation and a catheter change, which is not something I am a professional on. There is a significant portion of people who studied paramedicine who work in the industry right now who are nurses as well. They will work on their days off at the hospital; they will work part-time. It is a bit difficult for them to use their nurse registration stuff within their job.

CHAIR: I did make reference to that when we were in Hervey Bay. It is probably worthwhile if the organisation reads the report we did on aged care and palliative care. There were significant recommendations in that—77 recommendations were made and 55 of those were to the federal government. The No. 1 recommendation was to put nurse practitioners in private residential aged-care facilities. That was two years ago. That was never responded to.

Mr MOLHOEK: Thank you for appearing today and for what you do. We hear examples of ambulances being called because someone needed a catheter changed or the example you just gave, but oftentimes people in aged-care facilities have significant critical complex conditions. What proportion of the calls could have been avoided and were frivolous, and what percentage do actually need an ambulance?

Mr Tomkins: I do not know if 'frivolous' is the right word. I think it is the by-product of the environment they are working in. I really tip my cap to anyone who works in aged care because they are absolutely under the pump.

Mr MOLHOEK: And it is a growing sector with an ageing population.

Mr Tomkins: It is a growing sector and it needs a lot more. It is difficult because they have a number of other residents to care for. In some facilities they have their own set guidelines on how they go through their protocols. Their protocol might be for this that they just need to get transported. They are in the process of dispensing medications and dealing with a number of things so it is really hard to say—

Mr MOLHOEK: There was a time when ambos saw that as just part of the job. At times you got called out to emergencies and other times you actually transported old people around.

Mr Tomkins: It is hard for me to work out a specific amount. I know from things that have come through in previous sittings that there were some 35,000 people for those really lower categories, but there are still a lot of people who need to go to hospital. We definitely cannot forget that these folks have a significant amount of comorbidities. Anyone who is on anticoagulant medication who falls over and hits their head absolutely needs to go to hospital. There is no doubt about that.

Mr MOLHOEK: As an association, do you have any statistics or data on the proportion of—

Mr Tomkins: Not in relation to any operational ambulance matters, no.

Mr MOLHOEK: We would probably have to get that from the Queensland Ambulance Service, wouldn't we?

CHAIR: The QAS has already provided that data.

Mr MOLHOEK: Yes. It might be in this pile of reading that I have brought with me on this trip. It just concerns me when we keep making these distinctions because you could equally argue that if someone shoots themselves up with drugs it is self-inflicted, so which is the more urgent call or who is the more entitled to the call-out? If there are elderly people in nursing homes suffering a critical moment, do you think they are entitled to have an ambulance come and collect them?

Mr Tomkins: I think everyone should be entitled to the same amount of health care regardless. There just needs to be more pathways available for them. Otherwise, like you have been hearing, our flow is just heading down the path of least resistance—the safe space of the hospital—and there is just nowhere else for these people to go for their health care. It is a regular occurrence when you go and see people that they cannot see their GP for several weeks. I am sure you have heard that a number of times.

CHAIR: We are out of time. Thank you for being here today. In 30 seconds or less, you said you did some practice in the States?

Mr Tomkins: No. I said I grew up in the United States and I do not want our healthcare system here to be anything like that. I will be the first to stand up and say that.

CHAIR: On that note, thank you very much for your contribution here today.

Mr Tomkins: Thanks for your time.

MORISON, Mr Martin, Private capacity

CHAIR: Welcome, Mr Morison. Thank you for being here today.

Mr Morison: I would like leave to table my submission.

CHAIR: The secretariat will collect that and then we will deal with that in a moment.

Mr Morison: I have a very quick summary. There are only a couple of pages in my submission, but I will run through a summary. Thank you for coming to Bundaberg. It is good. My wife, Terri, who is—

CHAIR: Just take your time.

Mr Morison: My wife, Terri, has lung cancer and brain—

Ms PEASE: Martin, have a drink of water.

CHAIR: And just take your time.

Ms PEASE: We are not in any hurry. We are all hear to listen to you.

Mr Morison: Unfortunately, her condition is terminal. She currently has or had three tumours in her right lung, one tumour in her right atrium, one tumour on her lymph node, one tumour on her left lower jaw, one tumour behind her right eye which has detached the retina and since radiation is now blind, and 11 tumours in her brain—

Ms PEASE: Do you want me to read it for you?

Mr Morison: If you would not mind.

Ms PEASE: May I read it for him, Chair?

CHAIR: Absolutely.

Ms PEASE: I will read your statement: 'Chemotherapy has been unsuccessful and radiation has now been stopped. She is a very brave and stoic lady and I speak on her behalf.' It says here to make mention of Professor Murphy.

Mr Morison: Professor Murphy is my GP.

Ms PEASE: Okay. I should point out that I am speaking on behalf of Martin Morison. Whilst this is Joan Pease speaking, I am speaking on behalf of Martin. Your statement continues: 'The Bundaberg Hospital has let us down on each and every occasion over the last year that Terri has attended there. The unprofessional and incompetent treatment by the medical staff and the systems under which they operate have caused unnecessary pain and suffering to Terri and enormous stresses on both of us. As a result of our poor treatment by the hospital, I lodged a formal complaint. However, I have subsequently found the complaint process is not transparent and is not designed to actually identify competency or systemic problems. The process has progressively watered down my complaints to minimise any adverse findings or impact on the hospital.

'Some of those complaints include misdiagnosis on several occasions. We were advised that there was no hospital beds within 250 kilometres that could provide Terri with appropriate treatment. Lack of urgency and misdiagnosis forced us to personally organise hospital treatment in Brisbane. Allowing Terri, when suffering post-operative complications—she was leaking CSF infection from her surgical wound—to walk out of the emergency department onto the street where I was waiting to advise me of her treatment and then to walk back in where she immediately collapsed. This was at the time when the hospital was under COVID lockdown. Misdiagnosed a tumour as being eye irritation, even though there was obvious evidence that indicated a tumour. The complaints process is designed to virtually exonerate the hospital from any fault unless there has been action that has caused amongst other things patient abuse. I maintain that we were subjected to emotional and psychological abuse. However, the hospital CEO has failed to adequately investigate this issue.

'Dealing with this complaints process is extremely stressful in an already highly stressful time in our lives. I am convinced that we are not the only people to have had inappropriate care. We know we will have to keep attending the hospital for emergencies in the future and as they have no hospice ward in the hospital I fear for my wife's end-of-life care. Terri and I still suffer from the trauma because of the way the hospital has treated us to date. I humbly request that you read my written submission and take the necessary action to ensure no other patients and families are subjected to this type of abysmal treatment.'

Mr Morison: Thank you.

CHAIR: Thanks, Joan. Thanks, Mr Morison. It is incredibly difficult when it comes to loved ones battling brain cancer. I lost someone to brain cancer, very similar, two years ago. We will seek leave to take your submission. Is leave granted? That is done. I am sorry you are going through what you are going through. I just hope that you and Terri get the care that she needs and that someone is looking after you in this time. Have you got family close?

Mr Morison: Not in this area. I have heard some really great stories from different organisations here this afternoon. When this first happened back in February last year, we got told to go to aged care and apply for it. We did. We got an assessor who came out and her opening statement—and I sort of switched off afterwards—was, 'We'll take your assessment but we've got no money in the system. Don't bother applying for it.'

CHAIR: This is the ACAT assessment?

Mr Morison: Yes.

CHAIR: To go into aged care?

Mr Morison: Just to get aged-care help so that—

CHAIR: Oh, a home care package?

Mr Morison: Yes, all that sort of stuff. We were told that there is no money in it so do not bother. We did not. I was living in a hotel next to the Mater Hospital for months while she was having brain surgery et cetera, so we were going backwards and forwards. One of the big problems that I have found is that there seems to be a lack of training for staff dealing with left frontal lobe brain injuries. I have had a bit of experience previously with a wife who was a 40-year-veteran nurse, neurosurgical. They just do not understand, just because she might sit there and answer all those questions on those quiz shows all day long. I had an operation this morning and she rang me and said, 'Our dog has got out and I can't find him.' She is not supposed to be out of the house but she is in the backyard looking for the dog. Our dog died about six years ago. So she is doing that sort of thing.

Because we cannot click our fingers to say, 'I need somebody to look after my wife while I come here because of the time change,' we just have to cross our fingers that everything is all right. She is on dexamethasone at the moment. In fact, she just finished it two days ago; you only stay on it for two weeks maximum. You can see that when she comes back off the dexamethasone the anger starts coming back and it is really hard—incontinence, falling over. She cannot walk by herself. There are all of those obvious difficulties and then she does not remember any of it. Then when we get her back on the dexamethasone: she was line dancing last week.

It is this up and down thing, and people do start coming out to the house and see that she is all right. They brought out a walker for us the other day. That is great, except that since February last year her right hand has been paralysed because of the tumour. She can rest her hand on it but there is brake on it and to use that would be dangerous. I have a wheelchair on loan. She does not even want to have it in the house. She just does not want to recognise that she is crook. At other times, I will sit her down in her chair to eat her meal and she will just collapse back, and she cannot understand why she cannot hold her own weight up. There are all of these in-house things that we deal with.

At times, it is even hard to get her across to the GP because she presents so well at times. Many a time she just did not want to go and see another doctor. Part of that was to do with the first three or four presentations at the base hospital. On the very first time, she had collapsed at the local hall after line dancing. They took her in by ambos and 4½ hours later we did not get to see a doctor. Her hand was paralysed. My wife was very impatient—more impatient than I had ever seen before, and I had seen a little bit of this personality change since this hand stopped working five days before. She said, 'We've got to go.' She said we had to go after half an hour, and I kept her there for 4½ hours. Eventually we left. Another day later, it just got worse.

I changed GPs to Professor Murphy's practice and straightaway an emergency brain scan was ordered and everything changed. We went back to the hospital. The radiology people said, 'Get over there now and admit yourself.' I said to the triage nurse, 'I was here two days ago for 4½ hours.' She said, 'I can tell you straight off now: we do not have a bed within 250 kilometres of Bundaberg, so find your own way.'

I stepped outside and by chance my daughter, who works in the Newcastle John Hunter Hospital, rang me just out of the blue and I told her this is what happened. Within about 10 minutes the Mater hospital had rung me. They said, 'We have a consultant surgeon in Bundaberg at the moment. We have stopped him from getting on a plane. He is reviewing your wife's scans and he has

ordered an immediate air evac.' There was not any RFDS so by six o'clock at night I had to drive her down to Brisbane myself. A couple of days later she had brain surgery—a 38-millimetre tumour taken out.

When I put the complaint in about this series of things, the hospital's response was: 'Mr and Mrs Morison presented and they were loud and angry.' I said, 'My wife was impatient, but that is all. We were scared. We did not know what was happening.' They told us that we have to change our attitude if we were to come back again. I now find out, and they did not know at the time, but people must present with different things and it changes their attitude. If a bloke walks in with a broken leg, you cannot expect him to stand up in the queue waiting to tell the triage nurse what it is. As it turns out, as I said, she is now up to 11 to 12 brain tumours and she just does not understand what is going on. The hospital does not understand it. When you present yourself, you are not that happy person that you used to be before you walked through the doors. I think it is a lack of training and a lack of empathy.

Then when you make a complaint, the ombudsman's office passes it to the hospital to investigate themselves. Out of about 20 complaints that I made—individual things—about three were investigated to the point that the doctor, the chief of emergency services, said, 'I don't understand what the complaint is from you. You'll have to ask Mr Morison what is he talking about,' because they have watered down my complaint to give him such a small avenue to look at. Did they come back to me or did they go back to the ombudsman or anything: 'Please supply more information'? No, they kept it in-house and nothing else happened. That was the report.

I have 800 FOI pages at home that show that every time we have had some sort of interface with doctors or nurses and expressed a concern, the concern does not detail what the concern is—just that we complained. An example is with oncology. We have all the scans to see how things are growing, because the chemo was not working. I have access through I-MED to get the scan up. I pass it down to Newcastle to my daughter. The neurosurgical ward doctors down there look at it, they give us some advice unofficially and we pass it back. I said, 'We really need to contact Terri's neurosurgeon, who operated on her last down at the Mater.' He kindly reviewed the scan, not the report, and messaged back to me: 'Tell Martin to get Terri to the hospital ASAP and get her flown down tonight.' We front over to the hospital. It was lucky that our daughter was here: we almost had to drag her into the car because she did not want to face this place again.

We get to the hospital and the first thing I say to the triage nurse is, 'Dr Robert Campbell, surgeon, Mater hospital, has some information for us. Would you please ring him?' 'Yeah, yeah, yeah. What are all your details?' I said, 'You got them. Please ring.' I say to the next nurse: 'Would you please ring?' 'No. We can't do it; the doctors have to do it.' I said, 'Alright, get a doctor to do it. It's really important.' I get fairly dogmatic but I am a fairly good advocate for my wife. I said, 'Look, if you can't find a doctor, I'll find a doctor.' That then prompted her to do something. She walked me down to their little area where all the doctors sit and introduced me to this guy. I said, 'This is the problem. There is a surgeon waiting for a phone call.' He said, 'You can't talk to me in my office.' It was an office like this; they call it the birdcage. So we took two steps to one side and I said, 'All I want you to do is ring this doctor down in Brisbane because he has some information for you. I don't know what it is. I know he is a brain surgeon. It is not an ingrown toenail we're talking about. Do something.' He said, 'Well, I can't.' I said, 'Why is that?' He said, 'I am not even her doctor.' So it is this go-around thing. I have learnt from a long time now dealing with this. I had my phone and I said, 'Alright, let's talk about it then.' He then got the security guards, who marched me back to my wife's bed. Eventually the senior doctor comes out and says, 'Yes, yes. I have the report from the scans. She's got a detached retina.' I said, 'What causes that?' He rattled off a couple of things. I said, 'So there's definitely no tumour involved with this thing?' He said, 'Absolutely not.'

The stress of it was just unbearable. We knew that a surgeon who already been inside my wife's head was saying, 'Get her down to Brisbane. There's something serious.' I am not saying she was going to be his patient, but he advised to get her down to Brisbane. Here we have this stonewall: 'Oh, I can't.' 'Why won't you?' 'I don't know the number for the Mater hospital.' I have all of this on tape, which is the concern, which is one of the hold-ups in the hospital. They do not want to ask any questions because they are concerned that the answers they will get from their staff will not match up to my recordings.

We end up leaving the place. We went home. We went to the private ophthalmologist in Bundaberg and he said, 'Look, I can't tell you exactly what is there. I can see a shadow. I only have this equipment from this side. You need to get to Brisbane.' We got in the car and drove down to Brisbane. The ophthalmologist at the Mater said, 'Yes, you have a tumour behind your eye.' I said, 'So you have the same equipment that they had in Bundaberg. How can you tell?' She said, 'It's in the scan report'—the one that the hospital sent down to them. It was already written there. It said

there was a small crescent shaped lesion behind her right eye. I specifically asked if there was a tumour behind her eye and they said there was not. Radiation started on that. The radiation got rid of the tumour but destroyed the retina and she is blind in that eye. That is the continuous type of complaints going in.

One time she was taken in by the hospital when she had a CSF leak coming down out of her head one morning. We did not know what it was. About five or six weeks previous she had had an operation on the brain. She was taken into the hospital by ambulance. It was in lockdown. They sent me outside. I sat on the bus seat. I had my phone ready. I said, 'You have to ring me and confirm whatever happens.' Next thing, Terri walks out onto the street next to me, next to all the other early starters on a Saturday morning. I said, 'What are you doing?' She still has this leak coming down the face. She said, 'They've told me to come out and tell you what they're going to do.' I said, 'Stay there.' I moved everybody off the bus seat and went inside and spoke to this same doctor who said there was no tumour behind her eye. I said, 'What are you doing letting her out onto the street? You are in a COVID lockdown. She is still not dressed. You have locked me out and now you're letting your patients walk out.' What I did not know was that Terri had then walked back inside and collapsed. They said, 'Oh, no, she did not collapse; she just fainted because we were going to give her an injection.' Fortunately the injection happened then and not a couple of minutes earlier, because she would have collapsed out in the street.

That is the sort of attitude they have. I said, 'How can you do that?' The doctor's response was—I got it on tape—'Well, she walked in so she can walk out.' I said, 'Well, she came in by ambulance actually.' That was the attitude. When the hospital investigated, his boss said that he had done everything right. There was nothing said about COVID but just said that she was independently mobile. It is the feeble words to cover up the whole thing. There is no investigation, because the hospital knows that they can do this internal thing. It is called an RCA—a root cause analysis—which is in the legislation. It is under the Hospitals Act, about section 100. It details that if they have a complaint that is serious enough they do this root cause analysis. The plan with a root cause analysis is not to blame anybody, not to apportion any penalty to anybody or any section, but to just work out what happened. When they do it, you do not get to know what the questions were or what the answers were. Above all, it is all voluntary. It is for whistleblower protection. I am not a whistleblower. That is all internal stuff.

The legislation is written wrong for the RCA on this type of complaint. Once they put it through the RCA, it is a little bit like papers going to cabinet: it then becomes sacrosanct and no-one gets to see it. When they wanted to do the RCA I said, 'Well, that's not right.' One of the aspects of the RCA is that if there is a blameworthy act, which is what I am suggesting, they have to stop the RCA and go to the coroner, the Commissioner of Police or the ombudsman and make a report from there. They have only had two applications involving 'blameworthy act' in Bundaberg in 20 years. I am thinking Dr Patel might have been the two of them. They do not want that to happen because that does not look good. When it goes back to the ombudsman, he cannot hide that sort of thing. He has to report it to the minister and it has to go before parliament, how that is going. The whole thing is just skewed so you guys do not get to hear about these things.

CHAIR: We appreciate you giving us the detail, Mr Morison.

Mr Morison: I realise the time.

CHAIR: No. So the complaint process is not yet finalised through the Office of the Health Ombudsman?

Mr Morison: No, because the hospital has to respond to it. It is nearly 11 months now.

CHAIR: It is ongoing. That is all we need on that for now. What I would like to say in conclusion is: you clearly need to get back to looking after Terri. It looks like you have been in the wars yourself.

Mr Morison: I was in the operating theatre this morning.

CHAIR: Right. And you have come here today?

Mr Morison: Well, because this was transferred from yesterday to today. Fortunately it is this afternoon; otherwise, I would have had to put the surgery off.

CHAIR: I do not know if we need to go into any further details. I just want to thank you very much, Mr Morison, for coming here today and unpacking what is a very difficult process for you. We appreciate your time.

Mr Morison: Thank you very much.

CHAIR: Thank you. I declare this public hearing closed.

The committee adjourned at 5.42 pm.