# *HEALTH AND ENVIRONMENT COMMITTEE*

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

**Staff present:**
Mr K Holden—Committee Secretary
Ms A Groth—Assistant Committee Secretary

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

## TRANSCRIPT OF PROCEEDINGS

**MONDAY, 21 FEBRUARY 2022**

**Brisbane**

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**The committee met at 9.02 am.**

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

With me here today are: Rob Molhoek, member for Southport—he is out of the room at the moment—the deputy chair; Ali King, member for Pumicestone; Joan Pease, member for Lytton; Stephen Andrew, member for Mirani; and Trevor Watts, member for Toowoomba North, who is substituting for Mark Robinson, member for Oodgeroo.

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## SANDLER, Ms Vivienne, Executive Director, Allied Health, Torres and Cape Hospital and Health Service (via teleconference)

**CHAIR:** Would you like to start with an opening statement before we move to questions? Thank you in advance for the submission.

**Ms Sandler:** I will start by acknowledging the traditional owners and custodians of the land where I am here in Cairns, the Gimuy Walubara Yidi people and the Yidinji people. Of course, our health service works with and represents traditional owners and custodians of the whole of Cape York and Torres Strait.

I thank the committee for the opportunity to talk to you all and for considering my submission. I will take that as read. I am happy to answer any questions or fill in any more detail that you would like to focus on from that submission. I thought that I would spend a few minutes talking about this most wonderful part of the country where we live and work, the type of health services we are able to provide and some of the challenges that I have outlined in my submission in providing those services.

For allied health we have three teams basically in three of the hubs: one in Cooktown, one in Weipa and one on Thursday Island. They will then provide outreach to our 31 community health centres that are in communities around Cape York, northern peninsula and the Torres Strait. You can imagine some of the challenges in doing that. There are many, many different peoples in that area, different customs and different situations in communities on the background of huge challenges in terms of social determinants of health in our area.

In our area about two-thirds of our population are Indigenous people. In our area 85 per cent of the population are in the lowest quintile. Unemployment is more than double the Queensland rate. Partly as a consequence and partly due to the nature, we have a huge chronic disease burden in our area. Obviously and passionately I advocate that allied health has a huge role to play in the prevention of some of this chronic burden of disease and also then in addressing the need of people who are affected by various disease burdens. That is some of what we are operating with and under.

I will also say how important—and I am sure I do not need to tell you—connection to country and to peoples is for our Indigenous people. In terms of our workforce, that means it is really important for them to have that understanding, to build that rapport and connection with people, with families and with communities. Therein lies another challenge for us in terms of, firstly, recruiting the right people to work in our region—professionally qualified but also culturally appropriate and tuned in and able to understand the requirements—and then to provide enough of that resource.

We absolutely are under-resourced in allied health across the board. Our clinicians are all rural generalists. I absolutely take my hat off to each and every one of them who provide services literally from birth through childhood, adulthood, elderly, palliative to the end of life. They need to be able to address and meet the needs of anybody and everybody who walks through the door and reach out to those who do not walk through the door. They are special people; they are highly talented people and well networked and resourced. Obviously they cannot be a specialist in absolutely everything. They do have resources and connections and ability to tap into other services and clinicians where it is necessary.

I could rabbit on all day about allied health in our region, but I will stop there. Perhaps there are specific areas that you would like to focus on and I am happy to talk to those.

**CHAIR:** Thanks very much. It has been a little while since the health committee was on Thursday Island. We look forward to getting back there at a point in time to see the services on the ground and identify those gaps. The committee keeps hearing that Queensland Health is the provider of last resort for everything. Can you talk a little bit to that about access and delays of getting people—

**Ms Sandler:** The reason that we are a provider of last resort is because of the paucity of other services available. There are other Aboriginal-led health services that do provide some allied health, mainly in Cape York—and that is Apunipima—but they do not provide the full multidisciplinary team of allied health professionals. Queensland Health is the organisation with the largest footprint in Cape and Torres and we provide the multidisciplinary team. Having said that, we do not have any psychologists or exercise physiologists. I see that as a gap. If we are talking about equity of access for our population, for instance, if you were in metropolitan Brisbane you would have access to many of those. If you did not like one, you would pick the next one several blocks down the street. Here there is potentially only one in town. As I say, there are some professions that we do not have at this point. Obviously it is then the market.

There are some private providers that come into the region but not many. I could literally count on one hand the number of private providers providing services across this whole cape and Torres region. They are mostly fly-in fly-out. It is by necessity; it is obviously very expensive to get up here and to stay up here. For us as a health service it is a major issue to provide housing for our allied health professionals. In their award they are entitled to housing. This is an ongoing issue for us as a health service. When we are looking to expand our workforce, which is much needed, then housing is a huge issue. You mentioned Thursday Island. It is chock-a-block. We are really battling with housing or accommodation for workers up there and the so-called population because obviously it drives up the demand and makes it more difficult for locals as well.

As the provider of last resort, we do provide a multidisciplinary team. We have to prioritise our patient load. For instance, we have one occupational therapist and one speech therapist in any of our hubs. We have two physios in some places but the waiting lists are longest for physiotherapy, dietetics and for podiatry. We prioritise our case load which means there are long waits to get access to some of the professions. For podiatry for instance, we will prioritise people with what we call high-risk feet. This is often somebody with diabetes who may have a wound on their foot. If that is not cared for properly, ultimately that can result in an amputation. It is a high priority for us to get to these people to diagnose them early and provide intervention and treatment immediately as a preventive measure. Behind all of that, if we could get in earlier and do some work around preventing diabetes in the first place, that is where our role could add such value in primary health care.

**CHAIR:** Well said. I will open up to questions.

**Mr MOLHOEK:** Could you tell us a little bit about the area that you service, the population and the number of people who are in your various catchments? I am not sure whether it was you or one of your colleagues I had a conversation with maybe a year ago. It was surprising to understand how isolated some of your communities are, how small some of them are and how big some of them are. Perhaps you could run through the list a bit.

**Ms Sandler:** Sure. I will start off by saying that our geographical area is eight per cent of the total geographical area of Queensland. In 2019 there were just under 28,000 people. I do not know what the population of Brisbane is, but it is a fraction of that. Of that population there are just under 20,000 identifying as First Nations people, so that was about 68.7 per cent of the population. This is 2019 data. Of those First Nations people, a third of those were aged between naught and 14 years, so that is a significant number that we need to prepare and get ready for school. If we are talking NDIS and early intervention, that is an important statistic.

**Mr MOLHOEK:** Did you say naught to 13?

**Ms Sandler:** Naught to 14, yes; 32.9 per cent. Most of the other regions are classified as very remote. Only part of Cape York is classified as remote.

**Mr MOLHOEK:** Can you list some of the towns and communities?

**Ms Sandler:** For instance, Weipa is just over 4,000. Weipa, as you know, is a mining town. Airfares are so expensive because Rio is running people up and down so we get to pay the same prices, but I will say more about that later. NPA has 3,163. Kowanyama and Pormpuraaw are two communities quite close together. There are 1,800 people in the two communities. Interestingly, in one of those communities there are two main families and the two do not mix very well together, so we need to be careful with staff working at the health centre in terms of who is sent to which household because they may or may not be welcome. We do have those levels of complexity. In Aurukun there were 1,418 people in 2019. Aurukun is—what can I say?—a troubled community. It has a high crime rate which obviously severely impacts on our ability to recruit people and retain people there, some of it due to personal safety. There is always lots going on in Aurukun. It is a socially troubled community. They have very strong spiritual beliefs compared to some of the other communities that are more Christian type of communities. The Torres Strait is largely comprised of Christian communities.

There is a large differential across the area. I just have a population of 5,000 for the whole of the Torres islands. There are many islands. I do not have the number off the top of my head, but they range in numbers. There are 76 people on Ugar, or Stephen Island, which is tiny. As a health service professional you can only get to some of these islands by helicopter. There is not even a long enough runway for a small charter flight to land—it has to be by helicopter—so, again, we deal with those costs. Obviously in terms of retrieval we are dealing with that as well. Thursday Island is our largest community. There are 2,500 people there. It ranges from 76 and then a few hundred on each island, from 100 to 300. Badu Island is our largest island; there are over 800 people there.

**Mr MOLHOEK:** I just thought it was helpful for the committee to understand the context of how vast the area is and the actual size of the populations.

**CHAIR:** On another piece of legislation the former health committee had the pleasure of getting to the NPA and then from Horn Island to Thursday Island and out to Saibai Island, which was interesting.

**Ms KING:** I would like to ask you to elaborate on some comments you made on page 3 of your submission about the NDIS. You noted that there was a significant underspend by the NDIS in the Torres Strait and the cape. I would like to hear more about that—how NDIS funding rates per capita compare to the rest of Queensland, if you have that data, and perhaps the reasons for it. If the chair is agreeable, I have some follow-on questions from that. If we could hear about that briefly, that would be wonderful.

**Ms Sandler:** I am not the best person to ask about dollars per population. I have tried to get that data and it is different every time I go and ask for it, so I am not the best person. NDIS would be best to supply that data, but I can tell you about our experience with NDIS in our region. Over the years they have changed their model considerably to try and bring in more allied health professionals to service the area. They are now paying a good hourly rate for allied health professionals. They have also enabled allied health professionals to get travel money. If they are seeing a minimum of three people, I think it is, in a community, they can take a bit of money from each of their funds to pay for travel to come up to the community. We have had some allied health professionals doing this. The problem for them is a scenario whereby you might have three people to see in a community, so you take a day off to travel up there—because that is pretty much what it will take you. You might get to a community and potentially one or two of your clients could be off community. There could be sorry business. There is a plethora of things—they may not be well that day—so you may end up seeing one person. You will sit and twiddle your thumbs for the rest of the day. You have to pay for your accommodation because the next flight home is only the next day, so you may potentially have to take three days off from your busy private practice. Everybody is flat out with NDIS clients, from what I understand, so if I were a private practitioner why would I do that for one client?

The scenario we offer is that we do outreach anyway to these communities, so if we are going into community we are there for a few days. So if someone is not well one day, hopefully we can see them the next day or the day after. Whomever we cannot see on one day, we have a whole list of other people we can see who are not NDIS related, but there are clients there—aged-care clients, back injuries, chronic disease, diabetes, whoever it is. We have a list of clients who we can keep ourselves busy with all day long as an allied health team. That is the scenario here.

We were invited to put in a submission three years ago to NDIS for early childhood early intervention. Queensland Health was asked to put in a submission to provide services in the Torres region and Apunipima would do likewise across the cape. We spent a lot of time and effort putting that together, saying that we could provide a team who would be able to work together, work with our paediatricians and provide early childhood early intervention services to kiddies in the Torres.

Frustratingly, this just went nowhere. There was prolonged contact and conversations to try and get this off the ground. Unfortunately, it did not get taken up by NDIA. I think they did fund Apunipima to do a program and I think it was around mental health—I do not have the details around that—but not around early childhood early intervention, which means that there have been another couple of cohorts of children who have gone to school with undiagnosed and untreated conditions, which means that they cannot sit still in the classroom for long enough, they cannot concentrate, they cannot hold their posture, their coordination is poor—all sorts of things that can really be significantly improved and impacted with early allied health intervention. That is really sad, because that just sets the tone for the rest of their schooling. Schooling becomes difficult for these kids, and I do not need to tell you about the ongoing lifelong implications where education becomes a horrible time for kids.

Recently—in fact, I think it was the day before the Christmas break—NDIS did meet with me again and said they were looking again at our proposal from three years ago. I have not heard anything in writing from them since then. We have had several conversations. I am hopeful that we will get funding for the Torres region to set up an early childhood early intervention program. From the NDIS's point of view, I think they are hoping that if we can do some early diagnosis and early intervention it will prevent some of these kids coming on to NDIS in the first place. For those who do have permanent disability, we will do the functional assessments and get them on the program. There are huge advantages to that because obviously our team works with the paediatrician. We keep an ongoing monitoring role. We are in communities and can work with families and whatnot. Often if there is one child with issues in a family then there are likely to be others, so you can have an impact on a whole family. I am very grateful and I am very excited about that, and I am very hopeful that it will come to fruition. The fact of the matter is that that is just in the Torres Strait. I am not aware of any similar funding for cape communities.

**CHAIR:** Vivienne, I am so sorry. We could speak on this topic forever but we have a very tight program. Very quickly, yes or no: do you work with the PHN and try and get funding out of them in terms of programs in the allied health space?

**Ms Sandler:** Not in the allied health space. We do work closely with them, but there is nothing in allied health at this point.

**CHAIR:** I am sorry, members, we have run out of time. If you are following the program, Vivienne, we have Claire Hewat from Allied Health Professions next. She is standing by. Feel free to keep watching. Thank you so much for your contribution. We look forward to hopefully seeing you face to face one day when the health committee can get up there.

## HEWAT, Ms Claire, Chief Executive Officer, Allied Health Professions Australia (via videoconference)

**Ms Hewat:** Thank you for the opportunity to present today on behalf of Allied Health Professions Queensland and Australia more broadly. COVID has thrown the long-term burdens on the public health system into sharp relief, but none of this is new. Everyone waxes lyrical about prevention, early intervention, integrated care, wellness and reablement, but the system is actually designed to prevent that. The burden on the public hospital and health system caused by preventable hospitalisations transfers from residential aged-care facilities which could be (inaudible), and the wait-until-the-horse-has-bolted mentality in terms of managing chronic disease actually prevents allied health from providing the kind of care (inaudible) evidence is strong approach. All of the research around preventable hospitalisations, around GP (inaudible) there is nothing on access to social services. Almost all of the funding is directed at treatment, not prevention. Private health insurance is a bit of a bandaid for people with enough money to afford it but provides minimal access to allied health care and there are significant gap fees.

There is no coordinated data on allied health, which is an extremely complex set of professions spread across a range of sectors. Because there is a siloed approach to looking at data and looking at the workforce, no-one has any real idea of where anybody is or what they are doing, so it actually makes it very hard to plan. For example, the introduction of the NDIS has seriously impacted the spread of the allied health professional workforce and shortages are emerging everywhere, not just in the usual suspects of the rural and remote areas but across the board. Professions like speech pathology, psychology and occupational therapy are becoming as rare as hen's teeth. That is definitely going to impact on public health services—not just employing those professions in public health but actually providing preventive care that stops people going into hospital.

The artificial divide between the NRAS registered allied health professions and the self-regulated professions adds to the confusion and poor planning. There is some data on the registered professions. There is no reliable data on the self-regulated professions, yet you are talking about professions like speech pathology, dietetics, audiology—really key professions. There is no information because no-one seems even vaguely interested in doing anything about it. Allied health in primary care, NDIS, aged care, education, justice, health and more can make a major contribution towards reducing burdens on the public health system, but that cannot—and will not—happen until their value is recognised and they are fully integrated into the system.

**CHAIR:** Thank you, Claire, for your submission. You commented on the prevention of transfers from residential aged-care facilities. Can you talk to that? In your submission you say at the bottom paragraph on page 1 'if allied health services were formally guaranteed in residential aged care'. How is that best done?

**Ms Hewat:** Everybody knows that the aged-care system has been a bit of a basket case for a while. One of the issues is that for many residents in aged care there is no, or very limited, access to allied health services who assist people with mobility to ensure reablement, to address falls prevention and pressure areas and malnutrition. All of those things lead to people winding up in hospital. If you fall in a residential aged-care facility and break your hip, you do not stay there; you end up in a hospital system.

There is an enormous amount of evidence that really good and targeted allied health intervention can improve mobility, improve nutrition and improve cognition. Hearing, eyesight and all of those things affect fall prevention. In so many cases, these things are not available in aged care. Malnutrition, depending on where you are and which study you are looking at, runs at anything from 20 per cent to 55 per cent in residential aged care. We know that malnutrition increases weakness and sarcopenia. It makes people confused, they do not engage and it reduces their quality of life. We also know that many people in aged care have swallowing difficulties. That can lead to aspiration and choking, which ends people up in hospitals. It also affects their nutrition and makes them weaker. It is all linked: 'the knee bone is connected to the thigh bone'.

Unfortunately, allied health is not routinely engaged because the funding system has never supported that. The royal commission stated in recommendation 38 that allied health should be funded as part of aged care—that it was integral to aged care and should be funded. Unfortunately, the Commonwealth government has only accepted it in principle and is looking for other ways to provide those services.

MBS items are not fit for purpose for allied health services in aged care. Allied health chronic disease items are simply not fit for purpose and will not cut it. There are only five visits for all of allied health for the whole year, and that does not work in reablement. It also is reliant on GP referrals and we all know how difficult it is to get GPs into aged care, so it is a vicious cycle. There has been some discussion—and I am not sure; I have heard nothing officially—that providing allied health services in aged care may be a state responsibility, not a Commonwealth responsibility. Allied Health Professions Australia rejects that absolutely. Allied health is part of aged care. It is not some add-on if somebody decides to get around it. That is the problem now. It is going to continue to be the problem if it is not comprehensively funded as an integral part of aged care delivery.

**CHAIR:** Thanks, Claire. In the interests of time, could you take this question on notice? You did say that there is plenty of evidence in terms of outcomes. Could you provide that information to the committee? We would certainly appreciate that.

**Ms Hewat:** Absolutely. It is all there. We can get it to you in a couple of days.

**Ms PEASE:** We have heard comments similar to yours across the board at many of the public hearings we have already had. It is devastating to hear the figures that you talk about, particularly around malnutrition. Our health committee previously visited one of the residential aged-care facilities that closed down. It was heartbreaking to hear the condition the residents were in. I know, having experienced the end of life of my own parents, how important access to allied health services is—whether it be a podiatrist, a physiotherapist, an exercise physiologist or someone to deal with the swallowing issue. Is there any interest by the federal government to reconsider the MBS program around acknowledging allied health services outside of the five visits for people with chronic diseases? We have heard that they visit a GP and they have their six minutes to speak to their GP. It is the same if you are aged or if you are somebody with a young child who might have audio processing problems and you need to see a speech pathologist. Is there any desire or interest by Medicare or PHNs to reconsider what the MBS is delivering?

**Ms Hewat:** No, not to our knowledge. We have advocated strongly. We have been told very clearly that MBS is not the right vehicle and that there will be new funding models. I have no idea what these new funding models might be or what they might entail. We have certainly had input into the 10-year primary care (inaudible). We value that input but we do not know when those plans will happen and what that will mean. At the moment, we are stuck with the five visits for chronic disease.

**Ms PEASE:** It is an interesting comment that you make with regard to the new funding models. Who is saying that? Where is it coming from? Is there any further engagement or movement in that space, and also with the 10-year health plan?

**Ms Hewat:** The 10-year health plan is due to be announced, as far as I know, at any time. In terms of what the new funding models might be, there are suggestions of blended funding and block funding. There are various suggestions but nothing in concrete. There have been a small number of pilots in terms of rural and remote, but that is another area where allied health is feeling totally frustrated because there is just all this piecemeal stuff. There is a lot of money being thrown into GPs but not the rest of the team, so the GPs are working with one hand tied behind their back and there does not seem to be any commitment. They are just talking about pilots that might be expanded one day, but there is no clarity about when that might be or what those pilots might mean.

**Ms PEASE:** We have heard that a lot of people are presenting at hospitals because they know that they can access the allied health services they need. As a consequence, that is putting a big load on the public health system. At one point traditionally, people might have been able to access a holistic health process in the community, without having to put the burden on the public health system.

**Ms Hewat:** Yes, that is true. It is no surprise that people are turning up at hospitals. If you have money you can buy whatever you like, but if you are disadvantaged you are going to need the allied health the most and be least able to afford it. There are significant gap fees. Even if you can get MBS items, the payment is so low that, in order to survive, allied health has to charge significant gap fees. It is the same with private health insurance. Despite all the rhetoric, there is not universal access to health care in this country. There is universal access to doctors, drugs and hospitals—that is it. Once you are beyond doctors, drugs and hospitals, if you can afford it you will get it and if you cannot afford it then bad luck. That is the reality; it is as bad as that. Also, it is good luck if you can find it. Once you get into rural and remote areas and even lower socio-economic areas, health is not there; they cannot survive. It is a vicious cycle.

**Ms PEASE:** Thank you for your time and your passion.

**CHAIR:** You can hear the passion in your voice.

**Ms KING:** Thank you Claire. I think you have painted a picture for all of us. It is a picture we have seen repeated across the state throughout these hearings. Can you please briefly return to the subject of aged care and paint us a picture from a resident's point of view? If you are a resident in an aged-care facility, what kind and how much allied health care might you be receiving? What are the likely consequences of the level of care that you are likely to be receiving? I recognise that this may vary, but what is the classic scenario you see and where is the trajectory as a result?

**Ms Hewat:** The average access to allied health in aged care is eight minutes per day. Eight minutes does not get you very far. There are some people who might have a lot of access and some who will have absolutely none. Quite a lot of aged-care facilities call lifestyle coordinators ‘allied health’. They do not even understand what allied health is, let alone whether they are providing it or not. There are the usual suspects. You get physio, you might get occupational therapy and the others are a lottery. There is a lack of understanding that allied health is much broader. A lot of what is done is—for example in physiotherapy, they are just doing pain management. They are not doing rehabilitation and they are not addressing the mobility issues. For people with cognitive issues it is incredibly limited. Particularly for people in dementia care, it is extremely difficult to get support. Access to dieticians is limited.

If you have a facility where you employ allied health it is a better picture, but for a lot of facilities they are just visiting professionals. They are doing episodic care and there is absolutely no funding for an integrated approach to management. In many cases in aged care, it is not about telling the resident what to do. The resident cannot do anything. The resident is dependent on what is being provided. You are telling a resident to eat in a particular way, but what are they going to do about that? It is the meals that are provided to them by the facility. A lot of work actually needs to be done with facility staff, not necessarily directly with the patient. That is absolutely not acknowledged and it is not funded, for the most part. It is designed to fail when you are doing episodic acute care with no reablement and you cannot take a systems based approach.

**Mr WATTS:** Thank you for your time today. I am trying to understand how the shift to NDIS over the last number of years has impacted allied health funding. How has that shift potentially meant more people are choosing allied health as a career? Are we getting things right in that space? The second part of my question is: how do you propose we integrate allied health in a better way?

**Ms Hewat:** In terms of training, there are a lot of allied health being trained, except in a couple of professions. Podiatry is in dire straits. People are not choosing podiatry and there are podiatry courses closing, which is a real issue. For others, there is an unprecedented number of students graduating, but the demand has just increased.

One of the reasons the NDIS has become an area of choice for people to go into is that NDIS actually pays a living wage. MBS and DVA do not. Private health insurance is a struggle. It is due to the market. People are going into NDIS because they can actually afford to feed their families by doing NDIS work, whereas the other funding systems do not necessarily do that; it is a really hard slog. They also do not have to charge gap fees in NDIS so the participants are more likely to turn up so they actually get paid. That has made a substantial difference.

Part of the problem with training is not so much that people are not interested in going into careers; the pipeline is driven by access to clinical placements, and the lion’s share of clinical placements is a burden on the public health system. We actually need more allied health to be going into primary care, to be going into aged care, where they are really needed. Almost all of the training places are in the public hospital system, which puts a huge burden on the public hospital system and it does not actually produce the training that we need to have people moving into areas like disability or aged care because it does not actually support that.

The systems are actually stacked against getting allied health placements in primary care or aged care because there is no funding for them. If you are providing services under MBS or DVA, private health funds, a student cannot do anything. Because it is a fee-for-service funding system, they have to sit there with their hands behind their backs. That is not a practical session; that is just an observation session. We actually need legislative change at a federal level so that students actually can have effective placements. They would have to be under direct supervision, but at least they could get their hands on the patient, whereas now they are not allowed to do that. I think probably the biggest issue is the pipeline.

In rural and remote areas, the biggest issue is training in place and grow your own. At the moment, everyone who wants to study allied health almost invariably decamps to the city and then they do not come back, whereas there needs to be systems for more training in place. There is really good evidence that people who come from rural backgrounds will go back to rural backgrounds if they are supported to do so.

**Mr ANDREW:** You mentioned earlier that there were other non-profit organisations or organisations called allied health. Are they taking funding that could be directed back to where it really is needed—at the coalface with allied health? Are they getting funding from the federal government that you know of?

**Ms Hewat:** I am sorry. I am not sure what you mean.

**Mr ANDREW:** You said there were other organisations with 'allied health' in their name and they do not even provide allied health. Are they taking funding or resources away from the coalface of allied health?

**Ms Hewat:** No. It is a confusion thing in terms of measuring what allied health services are available. Aged care has always had lifestyle coordinators, and so they should have, but identifying them as allied health is not helpful because the government says, 'Yes, but we've measured it and there's plenty of allied health,' but they are actually defining it incorrectly.

**Mr ANDREW:** So what you are saying is that the name is not representative of the actual service.

**Ms Hewat:** Not necessarily, no. It depends what people interpret it as.

**Mr WATTS:** Obviously your organisation is trying to coordinate these allied health services, but you said there are some that are recognised, some that are coordinated and some that are not. Should there be a register of people who qualify as allied health professionals—just the same as we have various schools and colleges for medical professionals?

**Ms Hewat:** Absolutely. I am not arguing that NRAS and registration with Ahpra are not important. Obviously doctors and nurses and some of the allied health professions are registered, but a significant number of really important allied health professions—like, as I said, speech pathology, audiology, dietetics, exercise physiology and social work—are all self-regulated. They do a really great job and their self-regulation is pretty much identical to the Ahpra registration, but there is this mentality that these self-regulated professions are not at the same standard, which is nonsense.

Possibly the worse thing is that there is no data collection. No-one knows where these people are, no-one knows what they are doing and you cannot plan for workforce. It is this two-tier system, which is absolutely ridiculous. There is potential for it to even get worse, because they are talking now about a possible registration system but only for people in Commonwealth funded positions. That is just going to fragment things even more and make it even more confusing as to where allied health is and what they are doing.

The whole registration system should have been set up the same way it was in England or New Zealand, where all of the recognised professions are part of the registration system, but that has not happened. Even though we were told there would be no unintended consequences from the NRAS registration, there have been. I can tell you that through the pandemic it has been a nightmare because the chief health officers have always defaulted to 'essential services are registered professions'. Hang on a minute. What about the speech pathologists and the dieticians? 'Oh, they're not registered. What do we do with them?' It has been an absolute nightmare and it has been different in every state. We have spent the last two years fighting desperately to get access to services for vulnerable people to self-regulated allied health. Every state and territory has resolutely refused and has had to be brought kicking and screaming to recognise that actually these are pretty important, but because they are not registered they were not recognised.

**CHAIR:** Claire, thank you so much for your passion and contribution. There is no doubt that we will feature allied health as part of our report moving forward because we know the importance of it. You have spoken so well to those points today.

**MARSHALL, Mr Nick, Queensland Branch President, Australian Physiotherapy Association (via teleconference)**

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

**Mr Marshall:** Thank you for the opportunity to address the committee. I want to acknowledge the traditional landowners of the land on which we stand and also acknowledge the elders past, present and emerging. I am the Queensland Branch President of the Australian Physiotherapy Association. I am also a private practice owner and a private practice clinician. As well as that, I work for the Queensland Academy of Sport with Swimming Australia. I do wear a number of different hats, so I guess that gives me a bit of an opportunity to not so much give it more legs but talk about this issue—that issue being accessibility to primary-care physiotherapy.

I am going to use that term 'primary care'. To make it easier for everybody, the easiest way to think about that in terms of physiotherapy is really to think of it as a private practice that is in your local community or at your shopping centre. It is the place where, if you hurt your knee, hip or back, you would call up or you would walk in and they would see you within a day or so. We know that these same private practices are the people who provide the services in the aged-care facilities as well as the NDIS actions. They are across that primary-care area, not just in the clinic but out in the community as well.

A number of the facts and statistics I will quote today are from the *Value of physiotherapy in Australia,* which is a report that was put out in October 2020 which I would love to make accessible to everybody. It is a report that not only shows the patient outcomes with good supported evidence but, more importantly for this meeting, also shows the economic value of utilising primary-care physio in the early stages. It is a comprehensive report put together by the Nous Group and I would love to share that with you at some point.

In terms of primary-care physiotherapy, we know that physios cover a range of different conditions across different sectors and different settings. We are not debating that so much as the limitation of the accessibility of that and the pressure and burden that applies onto our public health system—where essentially people are lining up and going onto extended waiting lists which then blow out costs because people are no longer seen in an acute setting. By the time they are seen in the public setting, they become somewhat more chronic.

The easiest way for me to explain this would be for me to give you an example—a run-of-the-mill standard physio example—of a 40-year-old mother of three who works part-time who is presenting with knee pain in both of her knees. The knee pain has come about basically because she has put on a bit of extra weight. It has been a spiralling thing in the sense that she has put on some extra weight, which is more weight on those knees, which is causing more pain, and the more pain is meaning she is more unable to keep physically active.

In the current system, if she was not to have private health cover, she would go to her local GP, who are the gatekeepers of what they call the MBS or the Medicare benefits scheme, where you get five free allied health appointments each year. They are across all allied health, not just physiotherapy. From there, the GP rightly so determines that this is a multidisciplinary approach. Of those five appointments, two go to a dietician, which is great, because obviously we are looking to reduce the weight and the weight on the knees, which will allow her to be more active.

Given also that the increase in weight in middle life is a large precursor to type 2 diabetes, the doctor has also prescribed one appointment with a diabetic educator. They can also look at things to do with the foot and the risk factors involved with diabetes. We then have one appointment with a podiatrist because, again, that is an area with increasing weight and increasing knee pain as well as a risk of diabetes—so foot care is a bit of a major issue.

Lastly, we have one physio appointment. In that one physio appointment that is available to the patient, we are expected to cure pain, reduce pain, get stronger, get physically active and get the patient back to work without any issues. We are pretty good but we are not that good. Invariably, this falls down and this fails. Because she cannot access any more allied health within the calendar year—she only has five available each year—she then goes onto a public waiting list to see a physio in the public system. Having worked in the public system, I can say that this patient can—and this patient in fact did—wait 12 months to be seen by a physiotherapist and get a comprehensive plan once they get there.

The issue is: when they waited that 12 months, they progressively put on more weight and that meant there was more weight on their knees. That subsequently meant they became more physically inactive, and more physically inactive meant more pain. No longer were they pre-diabetic; now they were a diabetic and they needed to be medicated because they were type 2 diabetes. They were also medicated because they had quite bad knee pain and were becoming quite disabled, I guess you would suggest. Subsequently, whence they presented there, the arthritis that was quite minimal 12 months earlier had progressed so that they were now on a waiting list for a potential knee replacement, which was another two-year waiting list.

The *Value of physiotherapy in Australia* report talks about a similar condition to this. Take the early stages of arthritis and the importance of six to 10 treatments, not just for patient care or best patient outcomes but obviously to reduce the risk of going on to an orthopaedic waiting list and the enormous cost to get a knee replacement and the enormous cost involved in medicating people with diabetes through painkillers. If you want to apply that six- to 10-treatment sessions, which is what is mentioned in the report, you are looking more at what the physio would call neuromodulate. It is about reducing the pain and then starting a progressive exercise program to reduce the weight on the knees. They would then address their overall weight loss. They would not be physically inactive so they would not develop diabetes and they would not go onto an increasing scale of pain medication. Ultimately, at 12 months, they would not need any follow-up physiotherapy and they would not be in a situation where they need a referral to an orthopaedic surgeon for a total knee replacement.

It is pretty hard not to see that that is a better model to have. I do not want this to be a federal government bash-up where I am saying how it should be, but I think we do have a model that currently is in place, albeit far from perfect. It is a model that we use in the compensable area. What I mean by that is: with Queensland workers compensation, it is of a similar nature. If a patient or a client is injured, they will present to the doctor, who is a little bit of the gatekeeper at that point. Initially they will get six treatment sessions that are discipline specific. From my perspective, it would be six physio treatments. That far more aligns with the *Value of physiotherapy in Australia* report. At that point, as in workers compensation, if the physiotherapist deems that they do need more treatment sessions to progress further then they apply to an independent body that reviews that condition and that case, case by case, and then they may be granted further treatment. I certainly think this is a far better way and better utilisation of funds for primary care and, in particular, physiotherapy.

The biggest thing that I want you to take away or think about is that in Australia at the moment we are spending $1.4 billion a year on treating chronic pain. Every chronic pain patient—and there are about two million of them in the country—started off with poorly managed and poorly funded acute pain or initial pain presentation. I think if we can do more at that initial stage—more to act on it when it initially presents—and not wait 12 months until we start to treat, we will see a reduction in that $1.4 billion of chronic pain payment. Obviously I will be biased, but I think the best way is to utilise primary-care physiotherapy much better than we are doing at the moment.

**CHAIR:** Thanks very much, Nick. That was very insightful. I do not think there would be one person at the table who has not used physio for an injury at some point in their lives, as we all get older. I would welcome that report. If we could have that by 28 February, that would be fantastic. We are really keen to look at evidence about keeping people out of hospital. The member for Pumicestone will remember that at our Bribie Island hearing we had a physiotherapist who is really worried about providing physiotherapy in residential aged-care facilities. I do not know what that looks like at a practical level, but there is no doubt that everything we are hearing in that space is that you keep people mobile and you prevent falls, and there is lots of evidence around that. Can you talk about the importance of providing physiotherapy in residential aged-care facilities? What does it look like? Does it fall into the eight minutes per day? We had someone talking about allied health in that space and saying that residents get only about eight minutes per day.

**Mr Marshall:** I think that is a very real issue. It is probably not an area that I deal directly in but it is covered in the *Value of physiotherapy in Australia* report. They use 10 examples of areas where they can make enormous economic change and have value by showing that falls prevention, in particular, can make a big difference. I think they are saying that if you can act on that in a timely fashion you can reduce the outgoings or the economic value by about $1,300 each year.

Falls prevention is one of those things where if you are not appropriately assessed and the time is not taken to give you a progressive exercise program then you are not going to see success. By spending eight minutes or 10 minutes, depending on what the funding model allows, you are certainly not going to have enough time to properly assess why they are falling and then I guess implement a program that will see some real change or patient change. Any kind of exercise program at a falls prevention level really needs to be supervised and I am not sure how much is actually achieved in eight minutes.

The funding model that I am talking about is giving you a far more comprehensive way of preventing hospital admissions through falls. Most falls at an aged-care facility are not like a fall for us, where you might dust yourself off and have a small ache or pain. They present as considerable time in hospital. The small real value of a half-hour to an hour physio appointment, whether that is once a week or once a fortnight, compared with upwards of $2,000 per day in a hospital—it is a small cost. For a fall that results in a fractured hip we are talking about operations and we are talking about a possible two-week stay in hospital which could very much have been prevented. It is mentioned in the report about how preventable they are with regular ongoing strength maintenance and physiotherapy input.

**Mr MOLHOEK:** Nick, I note the submission from the Australian Physiotherapy Association. The chair mentioned that we have all probably required the services of a physiotherapist on occasions. There is often a big gap between what you tell us we need to do and what patients actually do. With issues around mobility and staying fit and healthy, where is the line between chewing up appointments and opportunities and actually not doing the work? Is that a common issue that you find or is it just people like me who do not always do what the physio recommends?

**Mr Marshall:** No, not at all. That is a very real issue. I guess the very real issue relates to funding. I come from an elite sport perspective where there is no pay-for-service model. We do not send them away for exercises; we are with them in the clinic until they have done the exercises and we see significant change. Some of the areas where sometimes things fall apart is that the physio does not want to charge you to see you twice a week or three times a week, because that is quite expensive. Even with private health it can be expensive. Sometimes, due to inaccessibility or lack of available funding, you try to assess the patient, you try to do a little bit and then you are really pushing the patient out the door with a whole list of things to do.

With a better model where there would be more follow-up, there are also opportunities to do group classes. We would essentially bring people in who have the same injury and have a supervised group class and take a multidisciplinary approach. That would be where, as a physiotherapist, we would utilise exercise physiologists or exercise scientists to come through in a group class and then reassess. We do see that a little bit with the model that is available for veterans affairs, where a lot of the time a physiotherapist will assess the patient and prescribe an exercise program and then, in a group class setting that may be supervised by another allied health professional, they will work towards their common goals and then be reassessed with the physio.

That would be an absolute ideal model and that is certainly what we see in elite sport. That is a model at the moment that for the normal person in the street is just not accessible and there is a cost involved. Sometimes the reward is not always readily seen and, unfortunately, people walk away because they think, ‘I didn’t get better,’ but really they did not do the exercise that we needed them to do. Perhaps we need more contact time so that we can supervise them, albeit maybe in a group session or maybe one on one, and we will see those changes, like we do in other aspects of physio.

**Mr MOLHOEK:** Are you saying that that model does not exist outside of veterans affairs?

**Mr Marshall:** That model exists in elite sport and it does also exist in veterans affairs. There is a version of that model that exists currently with workers compensation, where we do have the option and ability to do supervised exercise programs in a gym setting. They are certainly available to physiotherapists to access on top of their initial six appointments that I spoke about. That is well utilised as we work towards the goal of the patient returning to work.

**Mr MOLHOEK:** Is that funded by workers comp?

**Mr Marshall:** Yes.

**Mr MOLHOEK:** And the physio would be getting paid a significant or reasonable fee for that. That would not be a Medicare bulk-bill rate, would it?

**Mr Marshall:** No, it is not the Medicare bulk-billed rate—not at all. It is more money for that hour session which more aligns with the standard physio cost. It is an amount that workers comp has deemed appropriate for that hour supervised session in an external gym. It is a model that is currently used but it is not a model that is used in the Medicare benefit scheme that we have at present.

**Mr MOLHOEK:** As a ballpark, what would be the normal hourly charge for something like that? Would it be $100 or $200?

**Mr Marshall:** I think it is double their standard 30-minute physio session. I believe their 30-minute physio session under workers comp is $78 to $80 and their hour-long supervised gym sessions are about $160. It equates to two appointments, essentially, but for an hour-long gym program. Essentially, the gym program is set within your initial six treatment sessions. In workers comp you would apply to the case manager to start a supervised gym program. Basically, from memory, it is usually between four or five sessions and then there is a reassessment physio point within those four sessions to make sure that you are heading towards the goals that you have set prior to starting that program. Those goals generally align with a return to work where the patient was injured. It is a far better model because people obviously are not left to their own devices. Like everything, we cannot control the 23½ hours that they are not with us so we are relying on the patient to do the right things when they are not in the cubicle, but it is a far better model than what we have currently in the MBS sort of set-up.

**Ms PEASE:** I was interested to hear your position. We have heard from other submitters around the inability for training physios to undertake physiotherapy work when they are in residential aged-care facilities because they cannot claim that. Do you have any comments around that?

**Mr Marshall:** Yes. This is one of those things that I could talk for hours on so I deliberately did not bring it up in the opening statement.

**Ms PEASE:** You have two minutes.

**Mr Marshall:** Brilliant. Student therapists need to do student clinical hours. Generally they spend their final year in a clinical setting. In a public health setting they will take on a patient case load. They will develop the skills needed to manage a case load and manage patients within that. Unfortunately, in the primary care setting, which involves NDIS and our normal standard patients as well as aged-care facilities, there is no scope at present for there to be any remuneration for a student to treat a client. As a result, for primary care physiotherapy there is no incentive to take students. Unfortunately, what happens is students do not get exposure to that in their years of learning and they do not get to put in place the things they have learnt recently. Either they get thrown in at the deep end, into an aged-care facility, and are told, ‘You need to treat,’ or they never get exposed to it and they never enter that area of the workforce.

Like I said, I could talk for hours. It is a very real issue at the moment with physiotherapy because there is not a student billing code. For primary care physios, it just costs you more money to take a student. Whilst there are thousands of physio practices that will take students, and certainly ours does, it is not a sustainable model. In a lot of cases, unless there is a vested interest that a particular owner has in training somebody to enter that workforce to replace them, which is quite rare, unfortunately the students do not get exposure to that because there is not that model in place. That model exists in the public health system, where students will treat daily a case load of patients depending on the ward or in an outpatient setting.

**Ms PEASE:** For clarity, when you talk about primary care, like a private physiotherapy practice, it is not billable time?

**Mr Marshall:** Absolutely. Those same private physiotherapy practices which enter the aged-care facilities in a subcontracting type of way—there is no billable way of achieving that.

**Ms PEASE:** For clarity, it is not necessarily just aged-care facilities; if you have a private practice physiotherapist that I might go and visit, is that billable time for trainees?

**Mr Marshall:** No, not at all. Outside of a hospital setting there is no capacity at all to have a billing code to treat anyone.

**CHAIR:** Thanks so much for your contribution. We have run out of time in this session. We look forward to receiving that report as well.

**Mr Marshall:** Absolutely.

## HOBSON-POWELL, Ms Anita, Chief Executive Officer, Exercise and Sport Science Australia

## WILLIAMS, Dr Camilla, Accredited Exercise Physiologist, Exercise and Sport Science Australia

**CHAIR:** Thank you both for being here and thank you for your submission and 34 recommendations. A couple grabbed my attention and I will put them on the record: Nos 3, 8, 16, 18, 28, 30 and 31. I do not even know where to start. I will go back to 16, the home care packages. Thank you so much for raising that. We keep hearing it. This is about keeping people out of hospital, which goes back to the very core of why we are here. They were all very important, but they are the ones that really caught my attention. Would you like to make an opening statement before we move to questions?

**Ms Hobson-Powell:** First I would like to acknowledge the traditional custodians of the lands, seas and waters throughout Australia, particularly the lands on which we are speaking today, the lands of the Turrbal people. I pay my respects to their elders past, present and future. I would like to acknowledge any Aboriginal and Torres Strait Islander people who may be involved in the inquiry, listening to or appearing at today’s proceedings.

I am the CEO of Exercise & Sports Science Australia. I have been at ESSA since 2016. I am also the chair of the National Alliance of Self Regulating Health Professions and also the deputy chair of Allied Health Professions Australia, which I think you have heard from this morning. I am joined by Dr Camilla Williams today, who is an accredited exercise physiologist. She has been an AEP for 18 years and has worked in corporate health and public health and run her own business. She has a range of clients including older people and people with disability, chronic disease and mental illness. ESSA is a peak body for exercise and sports science professionals with over 10,000 members including the exercise physiologist and the exercise scientist. Exercise physiologists apply their skills broadly across the aged-care, healthcare and disability sectors. Exercise physiologists are recognised as members of the allied health workforce who are university qualified, with a degree of four years.

Support for healthy ageing, the value of exercise physiology and prevention was recognised in the Royal Commission into Aged Care Quality and Safety report, with the commissioner noting that people in aged care have limited access to services from allied health professionals, including exercise physiologists, and recommended greater access to allied health services to prevent the deterioration of physical health. While exercise physiologists can prevent falls and treat chronic conditions in older people, their ability to offer services in residential aged care has been limited by the aged-care funding instrument. Once the new instrument commences in October this year there will be no adequate incentive or requirement for aged-care providers to offer allied health services. The Australian government are yet to offer an adequate solution to this issue. ESSA would like the Queensland government to advocate to the Australian government to mandate that residential aged-care facilities employ or otherwise engage suitable allied health professionals, including exercise physiologists, as recommended by the royal commission.

COVID has also had a negative impact on NDIS participants, particularly those who are unable to access NDIS services due to reduced staff availability, and accessibility is already limited due to overly prescriptive NDIS plans. ESSA has seen a growing trend by the NDIA planners of cutting participant funding for exercise physiologists and requesting exercise physiologists train unqualified support workers to deliver clinical exercise physiology interventions. ESSA has advocated for better funding arrangements, sufficient EP allocation in terms of plan funding and to enforce a requirement that planners undergo initial and ongoing training on the value of exercise physiology and other allied health therapies for people with disabilities to ensure long-term scheme sustainability and preventable hospitalisations.

One additional change to support the removal of GST would increase the value of home care packages for older Queenslanders and plans of NDIS clients not living in residential care. ESSA understands that in March last year the board of treasurers endorsed the proposal for the revised principle based approach to healthcare services and GST exemption, which would result in exercise physiology services becoming GST free. ESSA would like to acknowledge the support of the Queensland Treasurer for this proposal.

As recorded in the national diabetes scheme, there are over 200,000 registered cases of type 2 diabetes in Queensland which account for 20 per cent of type 2 diabetics in Australia. This figure is projected to double by 2026. Currently, there are over 16,000 exercise physiologists in Queensland with the capacity to support Queenslanders to live healthier lives and to prevent the onset of diabetes. However, only one is employed to work specifically in the diabetes service in the Metro North Hospital and Health Service.

ESSA has advocated for Queensland Health to employ exercise physiologists to deliver services as a member of diabetes multidisciplinary teams. Both the Statewide Diabetes Clinical Network's steering committee and the executive directors of allied health have supported the principle to include more exercise physiologists in multidisciplinary care. ESSA has requested eight AEPs, at an investment of $800,000 per annum, to provide services, saving the Queensland government between $887 million and $2.1 billion per annum in direct service care for type 2 diabetes. The next step is for the Queensland government to allocate this in their budget. I am happy to take questions from you now.

**Mr ANDREW:** That is a significant saving by providing early intervention. You have obviously made a recommendation and put in a request for funding.

**Ms Hobson-Powell:** We have. We have met with the Department of Health, with the chief allied health officers and with all the executive directors of allied health in the various hospitals throughout Queensland. We all have received support for it. We are now just waiting for that actual application—

**Mr ANDREW:** That is just one side of your outlook but there would be other savings as well because other services would not then be required.

**Ms Hobson-Powell:** Absolutely. Camilla can talk about the actual outcomes for diabetic patients. A lot of the work we do is in the prevention of them needing further treatment. You might have an example.

**Dr Williams:** When people come to see us, their insulin levels, HbA1c, reduce. Often they reduce their medication or go off medication completely. Their VO2 max improves, which is a measure of cardio respiratory fitness. VO2 max is the gold standard and the best predictor of overall mortality and morbidity. By doing that we are reducing their risk of hospitalisations from a variety of other conditions in addition to the diabetes they may have. Also through AEP programs they can reduce their waist circumference, which helps to reduce visceral fat. Reducing visceral fat is one of the ways you can manage your diabetes by improving those insulin levels, thereby also reducing chronic diseases.

**Mr ANDREW:** I am really interested because the Australian South Sea islanders suffer a lot from this and so do the First Nations people, as do many other people. It is very interesting to see that if we can get in early we could combat that to reduce the prevalence. So much suffering comes from this.

**Ms Hobson-Powell:** The problem is that with the Medicare system you have to wait until you have diabetes to access services. Before you show some insulin resistance, you cannot even access the Medicare services. The big thing is that there are the triggers, but we cannot access funding to provide services.

**CHAIR:** You probably have some population data around First Nations people who suffer from diabetes, type 1 and type 2. Do you have those figures?

**Ms Hobson-Powell:** Not here, but we can certainly provide those. There are particular item numbers that they can access to receive exercise physiology services.

**CHAIR:** Is it limited to five?

**Ms Hobson-Powell:** For the dietitians, ourselves and the diabetes educators there is a group item number whereby you can get eight sessions on top of the five sessions.

**Ms KING:** But only once you have been diagnosed with diabetes?

**Ms Hobson-Powell:** Once you have been diagnosed.

**Ms KING:** It is not in avoidance?

**Ms Hobson-Powell:** Correct.

**Ms KING:** Is it First Nations people who can access an additional or earlier—

**Ms Hobson-Powell:** They get additional items.

**Ms KING:** Do they receive 10?

**Ms Hobson-Powell:** We can get information, but we believe there are additional items they can access.

**Ms KING:** My question goes to your really illuminating comments about people on the NDIS getting plan reviews and then suddenly going from having your members deliver services directly to them to those members having to train care workers. Maybe you would like to give me some general comments, but specifically I want to ask about the capacity in terms of time and also skills of those care workers to deliver services they are not trained to provide? Could you provide comment? How effective are those services likely to be, and are they even going to be delivered given the context of understaffing in the disability sector?

**Ms Hobson-Powell:** The main problem is that a lot of these participants could have quite severe disabilities which do have clinical complications and do need to be monitored while they are doing exercise. It is not to say that a carer or a support worker cannot be trained up to provide those additional services. You may see the exercise physiologist once or twice a week, but then you have the carer supporting them doing their exercises—their homework or daily exercises, which are really important. What we are seeing is that the exercise physiologist will write the program, train someone up and then they are left to go and deliver it. They do not have the clinical skills to understand when the program needs to change or if they are having some side effects which need to be addressed, or in some cases they may need to go back and see their doctor. There might be a person with a disability who also has diabetes. Are they looking at their glucose levels while they are exercising and making sure they have eaten properly pre and post exercise? Our concern is that they are completely replacing the exercise physiologist. You might have a specific example.

**Dr Williams:** I see a participant who has multiple sclerosis. She is self-managed, so she writes a lot of the reports for funding. What I have found with participants is that when they are involved in the report writing and advocating for funding they get more services for people like exercise physiologists. However, if I was to write a program and give it to someone else to deliver to her—each time I see her we do something different because each day her symptoms vary—

**Ms KING:** Because you are a highly trained professional in your particular discipline?

**Dr Williams:** Yes. I would be reluctant to write a program for a month because, as I was saying, each day I see her is different. She has so many concerns that need to be considered when delivering exercises for her. It also comes back to the health literacy and knowledge of the person who is writing the reports and advocating for funding. Some people just do not know what they can access and why they need to.

**Mr WATTS:** Your recommendation 33 talks about trying to get rural placements. I am very interested in more than that. I am very interested in people being educated on their whole program who are not in the city. When I look at the distribution of the accredited exercise workforce, there is hardly anybody in remote areas and out in the regions. Can you tell us how you think the Queensland government might be able to help in dragging some of that workforce to where I live and west of where I live, which is Toowoomba?

**Ms Hobson-Powell:** Yes, most of the universities in Queensland are down here in South-East Queensland. James Cook University delivers a program and the University of Southern Queensland at Toowoomba also does a program. Our students have to do 500 hours. Often there are no incentives to help them go back to their communities to do their hours or there is no funding to have them there. There is not the funding with practitioners. Most of our people are in private practice. We did hear a bit about physios before. Ours is slightly different to their model. Most of our people do their training in private practice. There is no funding to support small businesses taking on students, particularly in the rural and remote areas where they often have to travel to see people. There is also not the funding around the suitability of having the technology to pair them up locally as well to have a supervisor. They could go out west and they could be working under the supervision of a nurse practitioner, a GP or a physio. There needs to be a Brisbane based person sometimes to supervise them. We have to rely on small businesses for the funding to allow that to happen to try and access that service to help them.

**Mr ANDREW:** The Physiotherapy Association talked about group sessions. You currently provide that in the city, but can you also provide that in rural areas?

**Ms Hobson-Powell:** Absolutely. Under the funded system under Medicare there are group items for diabetes sessions. Under DVA there is funding for group sessions. In private health there is funding for group sessions, disability—

**Dr Williams:** I would be reluctant to do that from a disability perspective because everyone is unique.

**Ms Hobson-Powell:** In aged care there have been some temporary item numbers for group based sessions. What we do see is that people come along to do one-on-one sessions first just to work out where they are at and what they are capable of doing. Once they are capable, then they will move into group sessions and then often they should be able to exercise on their own.

**Ms PEASE:** Thank you very much for coming in today and for the great work that you do. I know how important it is to our community. You spoke at the beginning about the new aged-care model. Can you perhaps give us a bit of an overview of what that is, how it came about and when it will start?

**Ms Hobson-Powell:** I am not the expert on it. The current ACFI model lists very specifically who can provide services and what they can provide. Exercise physiology was not listed as a service. There are other ways that services can be provided, but it is much easier for aged-care facilities to look at the service listed and who can provide them and just go off that list.

**Ms PEASE:** When you say that your service is not listed for residential aged-care facilities, it is not listed there for MBS claimable items or—

**Ms Hobson-Powell:** No. Under the ACFI model they actually have a particular list of items that can be provided. We are not listed.

**Ms PEASE:** Were you ever?

**Ms Hobson-Powell:** No. For example, I am going to talk on behalf of the physio. They were listed to do pain management and that was it, so it was very restrictive on what the services could be.

**Ms PEASE:** We have heard of the sorts of things that you and physios and other allied health services can do around the prevention of serious injury associated with falls, chronic airways diseases and all of those sorts of things. Has there been any engagement or activity from you to try to get your services put back on that list and also for physios to have what they can provide altered or broadened?

**Ms Hobson-Powell:** The new model comes in in October, which means that a person will be assessed and then it will be determined what services are required. It will come down to who does the assessment. There are only three professions that have been authorised to do the assessments, so again it will come down to whether they know the scope of works of what else is required.

**Ms PEASE:** Can I ask you what those three professions are?

**Ms Hobson-Powell:** OTs, physios and nurses. Through the commission we also lobbied for looking at alternative funding. Last year we advocated strongly around the need for physical therapies, particularly in aged care with all the lockdowns happening during COVID, so some temporary item numbers were put in place for ourselves, the physios and OTs to do group based sessions and then there were some additional items for individual sessions. There are two there, sorry: the original temporary Medicare items were in place for 18 months and they were for the wider allied health; then there were specific ones just for the physios, OTs and exercise physiologists in specific COVID affected aged-care facilities, none of which were in Queensland.

**Ms PEASE:** Would you happen to have any data on how successful those temporary item numbers were in working with the residents? I know they are not in Queensland, but it would be interesting to see if we have any data on how successful they have been. May I just confirm that they were temporary and so they are no longer going to be—

**Ms Hobson-Powell:** The wider Medicare items for aged care were for 18 months, so it will be sometime this year that they are up. We are advocating through wider allied health that they be maintained. The uptake has been very low. We have spoken to the department about the poor uptake. There have been concerns about GPs not actually understanding or getting enough education about these new item numbers and what they mean on top of the other items. There has not been enough education of the people who can refer into the programs.

**Ms PEASE:** Who would have been responsible for that education? Would that be the local PHNs?

**Ms Hobson-Powell:** Yes. My understanding was that the Commonwealth Department of Health was going to fund the PHNs to educate the doctors on that, correct.

**CHAIR:** That is a perfect segue into my last question. We are just about out of time but I do not want to stop you.

**Ms Hobson-Powell:** I was going to answer the second part of the question, which was that the specific group items for the physios, OTs and exercise physiologists to deliver was also for 18 months. There is no data that has come out yet, but the government has recruited a consultant to do a review of the process. Our biggest concern is that it was a prescribed program that our people had to deliver. It did not matter what your health condition was; we had to deliver a specific program and everyone is different, so that was our biggest problem with the program.

**CHAIR:** Thank you for your well-considered submission. All of those recommendations are very important. The reason I rattled those few off is that there seems to be some themes in the other 70 submissions in the public hearings we have had. I want to take you to recommendation No. 28 which, for the benefit of members, states—

> That the Queensland Government via the Health Council advocates to the Australian Government that it fast track additional Medicare Benefits Schedule allied health sessions and/or provide funding for additional allied health services to be commissioned via Primary Health Networks.

Can you just speak to that particular recommendation for a couple of minutes?

**Ms Hobson-Powell:** I guess there are two main items here. Five sessions is not enough to treat someone with a chronic condition, particularly when it has to be delivered as a multidisciplinary item. We talked at length about diabetic patients here this morning. They cannot see the dietician, the exercise physiologist and the podiatrist in five sessions, so it needs to be realistic. The government cannot determine that these items are having great outcomes because you are not going to get an outcome. We might see a person once. You are not going to get any outcomes, let's be honest. We have asked that they be increased to 10 or 12 sessions to actually have any meaningful outcome. We have also been advocating for expansion. For example, there is a lot of evidence around exercise and mental health, yet we cannot access services for those people. The process to go through is ridiculously long, yet the evidence is there.

There is also the next issue. We talked about diabetes group item numbers. There are lots of other conditions that would benefit from this as well, so it is just not related to diabetes. Also, you should not have to wait until you are a diabetic to access it. If you have the family history and you have insulin resistance starting, why can you not access it? That is what we are looking for.

**CHAIR:** If you can provide any of that evidence on notice, we would love to get it.

**Ms Hobson-Powell:** Absolutely. We will send that through to you.

**CHAIR:** Thank you so much for being here today. We really do appreciate your contribution.

**Proceedings suspended from 10.42 am to 10.56 am.**

## MARSH, Ms Ruth, Private capacity (via videoconference)

**CHAIR:** With us from Townsville we have Ruth Marsh. Ruth, would you like to make an opening statement before we go to questions?

**Ms Marsh:** Yes. I have a few things to say but I will try to keep it short. I have been an NDIS participant since 2017 and my son since 2018. I want to bring up a few things that I have noticed over that time, but particularly during COVID some of the issues with the NDIS and the health system have been more noticeable. The first thing I noticed was scheme access. Timely access is super important. It actually took me three applications, 18 months and my local member of parliament had to step in. That was incredibly difficult. Obviously it puts pressure back onto the health system because I was receiving assistance through HCC—I have forgotten what it is called because it has been a while, but the Queensland government assistance for younger people with disability.

In terms of the cost of access and access to OTs, with only five allied health appointments that we can access with a gap, it makes getting a functional assessment for access to the NDIS almost impossible. Often they are not allowed to do a functional assessment with those five allied health treatments. The cost for me to get a functional assessment was extremely prohibitive. It was over $800 and it had to be paid off before I could access the report and before I could try to apply for the NDIS. That is something that participants often have to come up with, particularly when they have something that is a little bit different. I have rheumatoid arthritis. I also have a connective tissue disorder. The NDIS need to see the function to decide whether you are severely impacted. That is why you require an OT functional assessment for a lot of things.

In terms of the availability of GPs is Townsville, particularly ones who are willing and able to fill in NDIS paperwork, it takes many months and it certainly took me quite a few appointments to go through what needed to be put in the report. There were many turn-downs and we had to go back to the GP many times to get things reworded into the correct bureaucratic wording for the NDIS to get access. I do not know how much training they have had between now and when I was having trouble accessing, but it was certainly very difficult back then.

The lack of specialists in regional Queensland has impacts on our health while we are waiting for access to the NDIS. Then, of course, access to specialists as a disabled person is always more difficult. We often need support people, especially when we have to travel. I travel to Brisbane and my son travels to Sydney to see some of his specialists. With the difficulty accessing specialists, another thing is that we have to get reports and paperwork from them as well, which is another costly thing.

In-hospital care for me was under the private health system. I definitely had great difficulties accessing a shower daily. I did not shower daily. Nurses were not available and the NDIS will not release support workers because that is supposed to be the hospital's duty and obviously there is a crossover with insurances and things. Because the nurses do not always have time to help us with feeding and nursing and showering, it can actually make it very difficult for people with complex disabilities.

The second thing is access to the vaccination centres. Outside Brisbane and the south-east there are no specialty vaccination centre for those with a disability. Things such as full wheelchair access, low-sensory or private spaces, longer appointments, fast-tracking, Auslan interpreters—none of those things, as far as I am aware, are available particularly up north. I also noticed that our car park was noncompliant with the disabled car park AS2890.6. It does not have a yellow crosshatch space for unloading wheelchairs and the ramp is in a really awkward spot, meaning that people are going out into traffic. There are a few issues. My son is autistic and to try to get him vaccinated we had to find a small GP who was willing to help with that—to give us more time and a private room, which the vaccination centres do not have.

Testing was something that I spoke to Mr Harper about. It can be very difficult to access the testing centres, particularly if we require specialised wheelchair transport. We are not supposed to use taxis if we think we may have COVID, so access means we are relying on support workers or family. We also cannot line up for long periods for lots of different reasons, from physical disabilities to people with intellectual disabilities and autism. I cannot imagine my 13-year-old son sitting still for four hours waiting for a PCR test.

The other issue is access to the vaccines. I have a very close friend who has a 13-year-old with severe autism and an intellectual disability. He was taken to the GP to attempt to get him vaccinated. That resulted in a violent outburst because he was very frightened and obviously it was a sensory overload. The GP then proceeded to tell the mother that she just needed to contact the Townsville University Hospital and they would organise it. The mother asked if a letter was required and she was told no, not required. Of course, she contacted the Townsville hospital and the hospital said, ‘Yes, we can do that but you need a referral.’ She now has to go back to the GP, after waiting to get in, to get the letter of referral. Obviously she wants to get him vaccinated. There needs to be a little bit more communication from the hospital system to the GPs about how they can manage people who need to access slight sedation to access the COVID vaccine.

The other thing I have noticed is the access to supports. This is something that starts off as an NDIS matter and then can turn into a Queensland Health issue. If I have a support person who is unwilling to come and assist me when I am COVID-positive then they will not be able to provide the services like showering, dressing, cooking—all of my basic needs. I would need to be admitted to the hospital or somewhere else where I can receive that sort of care. As I said before, sometimes the nurses are also unable to provide that because of time constraints. That actually has a massive impact on the Queensland health system. It has an impact on me and my children. Obviously it is not something that you want to do if you have a mild case of COVID, being stuck in hospital simply because you cannot access support workers.

That actually occurred to me during the Townsville floods. I had to rely on my eight-year-old son to assist with personal care. I had no supports for 10 days during that time. That obviously had a massive impact on my ability to feed myself, my older son, my younger son and obviously with personal care. Up here it is hot. We would appreciate having a shower most days.

I want to say that the systemic issues within the NDIS cause issues with the Queensland health system having to pick up the slack. The issues with communication between the systems can cause issues for all of us but particularly those of us living with disabilities who are already—I would not say that I am vulnerable, but inherently we need more assistance than other people. Queensland Health could assist with some aspects for people with disability, especially to do with COVID and the COVID response. Disaster planning that includes cyclones, floods and COVID should also be completed in all aspects, including through the NDIS but also through Queensland Health, to lessen the impact on those of us with disability and obviously to lessen the impact on the Queensland health system.

**CHAIR:** Ruth, thank you very much. We have a tight program and there are only a few moments left.

**Ms Marsh:** Yes, I was trying to talk quickly.

**CHAIR:** We have certainly heard about the impact of assessment, the costs, the financial burden and the complexity. That has become a theme throughout these hearings.

**Ms KING:** I want to thank you for your really articulate advocacy on these issues. Earlier you mentioned that you paid $800 for a functional assessment, which was paid to an occupational therapist.

**Ms Marsh:** Yes. They charge the NDIS rate in general, even for most general clients, which was $193.99 an hour. That obviously was quite a small amount she was actually charging because I have certainly been charged a lot more through my NDIS plan for further functional assessments as time has gone on.

**Ms KING:** But this one was not paid for by your NDIS plan, because it was part of a plan review?

**Ms Marsh:** No, it was because it was part of an access request. I had not actually got onto the scheme.

**Ms KING:** Could you outline for the committee and for the record what were the impacts on you and your household budget of having to find that $800? What have other people living with disability told you about the impacts on them?

**Ms Marsh:** I work part-time and I do so to pay for a lot of the extra added expenses that we have. $800 is well more than a week’s worth of work for me. We live in our own home. We are attempting to not get any government assistance, so that amount of money is significant for us. My kids go to private schools. That could be a third of their school fees for a year in primary school. It is an awful lot of money for us. That could be our groceries for four weeks almost. It is significant.

**Ms KING:** Are you aware of anybody who might be living on a disability payment while trying to access the NDIS and who has been hit with those gateway expenses?

**Ms Marsh:** Yes. There are some OTs who do their very best to offer the services at a reduced rate. Obviously some of them slide under the radar and use the five allied health appointments, even though that is obviously supposed to be for treatment, just as a way around it. I am not sure whether other states have things that people can use. I know people have tried to use the public health system but they are not able to write full functional assessments. Often people do what I did: you attend and you just pay it off over time until you can actually access your report so then you can put in your request.

**CHAIR:** Ruth, I am so sorry that we are out of time. We have a pretty tight program this morning.

**Ms Marsh:** That is alright. I totally understand.

**CHAIR:** Thank you so much for your contribution. I am glad we could make it work via teleconference. It is probably the best connection we have had to date. It was nice and clear.

**Ms Marsh:** And I do not have very good internet, so who knows?

### GOMES, Ms Amy, State Council Delegate, United Workers Union

### LENTAKIS, Mr Nicholas, State Council Delegate, United Workers Union

### RHODES-BATES, Mr Jamie, State Council Delegate, United Workers Union

### SCALON, Ms Fiona, Ambulance Co-ordinator, United Workers Union

**CHAIR:** Thank you for your very considered submission. You are regular contributors to the Health and Environment Committee. Certainly a couple of people helped us out with a very large piece of work for Queenslanders last year so thank you very much. I invite you to make an opening statement before we go to questions.

**Ms Scalon:** A lot of what we have to say is covered in our written submissions. Today we have Nick Lentakis, who is a senior clinical educator for the metropolitan south region. Amy Gomes is a CCP, working in Metro North. Jamie Rhodes-Bates is also a CCP. They all have significant experience working in our community and interfacing with the different systems that the community has to deal with. Amy, did you want to kick off?

**Ms Gomes:** We are paramedics and workplace representatives for the United Workers Union. We appear here today in that capacity. We are all too familiar with the consequences of a health system under stress. This is not a new phenomenon. Prior to COVID in the community, we were feeling the strain of working at the pointy end of Queensland's health system. We understand there is a combination of funding that goes to supporting the health system in place for Queenslanders. We have been and continue to advocate, through our union, for the Queensland government to expedite decisions around funding frontline staff and resources and for the state to hold their federal counterparts to account to ensure Queensland gets its fair share of federal health funding.

As outlined in the United Workers Union submission to this committee, the matters under consideration that require urgent attention are: poor healthcare provisions for senior citizens in the aged-care system, particularly residential aged care, placing pressure on hospitals and the Ambulance Service; undervaluing and underpayment of aged and disability care workers, hindering the retention of the skilled and dedicated workforce in those sectors; failure to fund hospitals and the Ambulance Service in line with population and demand growth; and a lack of access to bulk-billing GPs, placing pressure on hospitals and the Ambulance Service.

**Mr Lentakis:** I want to quote a colleague in the emergency medicine field, Dr Simon Judkins. Mental health presentations in ED have increased—and have increased from our personal experience—exponentially, particularly in the adolescent and the young adult cohort. The inpatient areas are full. When we bring those patients to the emergency departments, there is nowhere for them to go. The emergency departments cannot process them and triage them through the appropriate areas. Paediatric presentations, according to the doctor, have rebounded and are higher than ever.

Accessing GPs is difficult. Even for people who have long-term GPs, trying to get a GP appointment, whether they bulk-bill or not—it does not matter if you are willing to pay—is becoming almost impossible. We are talking weeks in advance now. Unfortunately, we do not get sick that early and if we are really sick and we need a doctor we are going to end up in the hospital. Basically, that is what the public decisions have meant. EDs are the destination for many concerned parents.

The doctor has observe aged-care presentations rising. I believe that is because of the very limited places in aged-care facilities. Medical aged-care wards are full so the elderly and frail lie in ED corridors waiting. If you go to any of the tertiary level hospitals, you will see they all have satellite wards and extensions of the ED, which are usually full. Patients can stay there for two or three days, irrespective of what they are suffering from. If they need to be admitted they could end up in a satellite ward for days or in a corridor for up to 24 hours. I wanted to reiterate what the good doctor has said as being fairly relevant.

**CHAIR:** Can I just start by thanking you and your colleagues, the thousands of paramedics out there who are providing care in very, very challenging times, particularly over the last couple of years. Your dedication and professionalism are well and truly noted by this health committee and we thank you very much.

I would like to speak about the impacts you are seeing on the front line in the aged-care space. There have been a lot of submissions; to date there have been some themes there. We heard from the medical director of QAS that there were some 35,000 transports, I think, from RACFs in the last year. I wonder if you can practically speak to this, particularly category 4 and 5 presentations. If there are enough long bone fractures or a fall, they are going to have to go to hospital. Would any of you be able to practically talk to some of the low-acuity things you might see in a residential aged-care facility that could be avoided in terms of another ambulance transport going to a public hospital? What are some practical examples of that?

**Mr Rhodes-Bates:** One of the big ones that we see, which we have outlined in the submission as well, is just a simple catheter change. It is a pretty simple procedure. During their training all nurses will have learned how to do it. Simply due to probably some skill degradation and policies in particular facilities, they have said they cannot do that procedure and the patient must be taken to hospital. Or they just simply do not have enough time. It might be an urgent catheter change if they have some urinary retention or a catheter is blocked. The longer it is blocked and the more the retention is there, the greater the risk of infection. They will sit and wait for an ambulance to get there. Obviously it is a lower priority call in the initial instance, and given our current demand they might wait some time for that.

That patient could have had that problem resolved there in the nursing home, but they end up going to hospital and sitting on a stretcher for a couple of hours when the hospital system is under strain. It is not really good, particularly for our older population, to be sitting on a stretcher for an extended period of time waiting for a bed for someone to change that catheter, in some instances have the catheter changed on the ambulance stretcher, and then go back home or wait for an ambulance to become available to take that patient back. With the health system and the strain that is experienced, often if those patients are sitting in hospital into the evening they might wait until three or four in the morning, and then they are sadly woken up to go back to a residential aged-care facility. I think that also has some clinical aspects, particularly with neurocognitive decline and those sorts of things, disturbing patients in the middle of the night and disrupting them and taking them back to their home.

**CHAIR:** There are 459 private residential aged-care facilities in Queensland. We heard in a previous inquiry into aged care that there might be one nurse, if that, to 120 or 70 patients, depending on where we went around the state, so it is impractical. Would your assessment be that we should fix the model of care, maybe with nurse practitioners or appropriate nurse-to-patient ratios where it would not impact on the QAS? Would that have some effect on those big transports you are seeing?

**Mr Rhodes-Bates:** Yes, definitely. Some of it might be workload. The number of nurses—even during the day—in most residential aged-care facilities is pretty low. There are lots of personal care assistants during the day attending to the daily living activities of the residents who live there, but in terms of actual clinical care, from my own personal experience, most of the time when you arrive at the facility there is a personal care assistant with some clinical notes from a nurse. The nurse is busy attending to other things like dispensing scheduled medications to patients or looking after another patient whom they have called an ambulance for because they have had a fall or something like that. They are stretched at best. I do not think there have been many cases where I have been met by a registered nurse unless the patient is particularly unwell. The nurses are so stretched that they are off doing other things instead of being able to provide clinical care to patients who really need it.

**Mr MOLHOEK:** I would just add my thanks to those of the chair for the incredible work you and your colleagues do to look after Queenslanders. I cannot begin to imagine how difficult it has been this past couple of years with the added complications of PPE and just managing COVID as a broader issue, let alone all of the other issues within the healthcare system, so I would just add my thanks to those of the chair.

I wanted to ask you a little bit about one of the points you made on page 2. I know that you made some points around Medicare funding and GPs and allied health, but you also commented about the failure to fund hospitals and the Ambulance Service in line with population growth. I note that in your recommendations on page 11 you talk about the need to restore the number of hospital beds per Queenslander. I am interested in having some general comment around that. It would seem you concur with the Queensland Audit Office around the lack of strategic planning.

**Ms Scalon:** We have been in conversations around funding for Ambulance and Health for a significant period of time. I sit on the Patient Access Advisory Committee that the government has around this hospital access space. All of the professionals who are working on that talk about the strain on the system. We think the number of beds required needs to be increased in order to feel some kind of difference, and some of that has been announced and is coming. In terms of ambulance services, we believe from data we have seen that over the last 10 years there has been a 38 per cent increase in demand for ambulance services from the community and there has been a 28 per cent increase in resources, so that is a number that is pretty live for us. Most recently there have been some decent increases to the number of paramedics who are on the ground to deal with what was expected as a COVID surge, and that was really welcomed by our members. We would like to see that continue and for those positions to be permanent full-time jobs for people in the community to service Queensland. That is always going to be our position on that kind of thing.

I think the doctors and nurses you will probably be speaking to will talk about the strain on the system in terms of just the physical place to put people. You cannot build a hospital tomorrow, and I understand there are a number of things in place to try to address that as quickly as possible, but tomorrow is not soon enough.

**Mr MOLHOEK:** In terms of that increased demand, not all of that would be population growth though, would it? Some of it would be ageing?

**Ms Scalon:** Yes.

**Mr MOLHOEK:** People are living longer.

**Ms Scalon:** With complex health issues.

**Mr MOLHOEK:** Expectations have changed as well; that would be fair to say?

**Ms Scalon:** Agreed. There is modelling that happens around population corridors and things like that. I think what has not been expected—and particularly this last couple of years, which have been unprecedented, obviously—is that particularly older people have avoided the healthcare setting in order to keep safe from potentially being exposed to COVID, which has resulted in some far more complex and serious conditions that people are now seeking help for.

**Mr MOLHOEK:** In terms of looking at Queensland holistically, where are the hotspots in terms of the need for more beds?

**Ms Scalon:** The south-east corner is struggling and there are pockets up and down the coastline. Rockhampton has had some periods that we have not seen before in a place like Rockhampton. They have really felt the strain. Cairns has a significant issue in terms of its capacity as well. If we could get everything functioning the way Townsville does, our members' lives would be great, because the Townsville University Hospital is very big, it is a tertiary hospital and it has the capacity to deal with peaks and troughs in the system, but even Townsville has had some problems coping in the current environment.

**Mr MOLHOEK:** And is still fairly reliant on overseas recruits to fill a lot of gaps?

**Ms Scalon:** It might be within the hospital. I can only speak to the ambulance side of that.

**Mr MOLHOEK:** We have seen a lot of media announcements recently for the new satellite hospitals. I am just interested to know your view on whether they will help meet needs or—

**Ms Scalon:** I might get Amy to speak to that. You have an example in the Morayfield space that works in well.

**Ms Gomes:** This is probably just from experience out on the road. We have experience funnelling all of the patients down to our major hospitals. It not only takes time to transport them to those locations but also removes them away from their family and further access to care. The rapid care clinics, the Morayfield hub and places like that are extremely helpful for us because it gives us a location away and sort of spreads the load. Satellite hospitals would be another good example of a location whereby we could spread some of the patient workload to different areas.

**Mr MOLHOEK:** They would cater, I guess, for the sort of catheter issue that Jamie raised earlier or less chronic—

**Ms Gomes:** Yes, lower category cases.

**Mr MOLHOEK:** Is that what they will be catering for? I have not heard a lot about them in terms of—

**Ms Gomes:** I cannot comment on the specifics of what each satellite hospital would have, sorry.

**Ms KING:** I want to acknowledge the strains on each of you and also on the union's other members, in particular aged-care workers. I know that everybody on the committee would join me in expressing our appreciation to them. I did want to focus a little bit on staff morale and retention. The paramedics here today perhaps could provide some comment, but I might also go to Fiona to hear a little bit about the impacts on staff of working in this overall system, particularly in the aged-care space. If you are going to aged-care facilities to collect patients for these purposes—like a catheter change—or you are seeing people present who could have been helped at an earlier stage in the prevention space, how is that for you as professionals? How do you find that experience to be?

**Mr Lentakis:** Part of my role as senior clinical educator is to investigate complaints from patients, families, hospitals and nurses. A very common complaint in that aged-care space tends to be aimed towards our staff, but our staff are the end result of a long process that has occurred prior to us arriving. We will turn up and find patients who have been on the floor for hours, literally, who are now suffering a lot more than they should have had we been there earlier, particularly if you are talking about a fractured hip or neck of femur, as we call it. Anyone who has any clinical background knows that the longer they remain on the ground, the higher their mortality rate.

Having adequate staffing and access to doctors is the other thing. A lot of the time they wait for the GP to turn up to decide what is going is to happen with that patient, and in the meantime that patient has deteriorated to the point where the nurses cannot wait. They call us, we turn up and we transport them. Had access to medical staff been available earlier, it would have been a different story. That impacts on our staff. As clinical professionals, we turn up and we know that had we been there four or five hours earlier—in some cases, 18 hours earlier—and that is not necessarily the nursing home's fault. That is also a lack of resources that play a part in that. You can see the morale of our staff every time I have to interview somebody in relation to a complaint. They all think they are going to lose their registration or their job. The first thing they say is, 'We haven't actually done anything wrong. We got the call and we were gone within 10 minutes.' But they are not aware that call has been waiting for 18 hours.

There are a number of reasons behind that. Ramping is part of it. QAS itself has some questions to answer in that space as well in relation to adequate resourcing. Flexible work arrangements came in and somehow they went awry, which affected our ability to resource our service to the community. There are a whole lot of factors that are impacting our members—our staff, whether they are members or not. As paramedics, when you are constantly seeing the same things day in, day out that could have been addressed by better resourcing or better funding, whatever the cause is, it is disheartening. Sometimes it gets embarrassing to wear the uniform. After being in the job 33 years that is a big call on my part, but that is what has happened. It is frustrating. Sorry, I had to say that and get it off my chest.

**Ms KING:** What do your aged-care members say?

**Ms Scalon:** They have also been speaking quite publicly about what they are facing. Our members are the personal carers who work in residential care and in-home care settings. While there might be more of them running around these facilities than there are registered and enrolled nurses, there are still not enough for them to make them feel like they are providing proper care for the people who live in those settings. The lack of clinical support that they have, when they know that people need it, is something that I am sure our colleagues from the QMNU will speak to as well. There are studies around what is safe, and half an hour of care a day for an elderly person in a care setting is not safe.

**Ms KING:** Yes. I was reflecting on the dreadful situation at the Jeta Gardens facility. I wonder what the impact of those really acute and traumatic events is on people who are doing their very best to provide care.

**Ms Scalon:** In the same way that our members in Ambulance feel helpless when they arrive 18 hours or eight hours after an initial call is made for an ambulance, our members who work in the aged-care setting are distressed when they see the type of care that should be afforded to our vulnerable, elderly members in the community. It is quite distressing for them as the people who are there to do their job and to do their best. If they are not provided with adequate co-workers and resources to do so, it is very distressing.

**Ms KING:** Did this predate COVID?

**Ms Scalon:** Yes, in both settings. It was not uncommon pre COVID for us to talk about the length of time that cases might be pending in the community for ambulances and the impact that the lost hours at a hospital has on our members. Pre COVID they were losing a significant number of hours—which is crews in the community—because they were waiting at hospitals to hand over patient care. During COVID, when we experienced periods of lockdown, it reduced a lot. No-one goes near a hospital in those periods. When this new variant hit the ground, people were scared and it resulted in a lot of people seeking medical assistance, often by calling triple-0 first. That saw a great surge in demand for our members in Ambulance.

**Mr ANDREW:** Thank you for everything that you do, straight up. My good friend Clancy Fatnowna, who we all know, often talks to me about the ambulance and the long service people have done. Could you tell me what the Patient Access Advisory Committee is?

**Ms Scalon:** It is a committee that has each of the HHS chairs, a representative from the unions that represent workers who work in the health system and the commissioner of Ambulance. It was set up as a result of MEDAI, which was the initial force set up to look at the effects of ramping in 2012 and 2013. It is about the patient flow into and through hospitals to try to get that as good as it can be. They share where things are working well, try to share best practice and talk about challenges. It is chaired usually by a deputy director-general of Health.

**Mr ANDREW:** Have we lost staff over the last six months? Would you consider that we have enough trained staff on the road at the moment?

**Ms Scalon:** In Ambulance we have not lost staff. There is less than half a per cent attrition rate in Queensland Ambulance Service. That is the lowest in the country for ambulance services. In terms of FTE, they have increased by about 250 in the last six months. That has been really pleasing to see. Some of that is next year's numbers brought forward; some of that is COVID surge measures which were put in place. They are holding ground now. With those numbers on the ground we are seeing a little bit of strain ease in the system. We think those kinds of things should be made permanent and the same kind of recruitment continuing year on year.

**Mr ANDREW:** You said earlier that you have seen some changes in the system in terms of delivery. Could you expand on that, please?

**Mr Lentakis:** There have been. It is related to COVID. It is related to flexible work arrangements, which we agree with. I am not disagreeing with flexible work arrangements. I just think the implementation and management of it left a bit to be desired as it left us a bit under-resourced.

FTEs definitely need an increase. I am an educator. We currently have 60 GPPs, or graduates, coming through our induction system but then as soon as they finish their induction they become casual paramedics. They are not ready to be casual paramedics and running on their own; they need to be inducted a bit longer. Their program needs to be a minimum of six months, which it was until recently. As educators we do not understand why this is occurring. Obviously there might be a cost factor, but we are putting graduates out there that are at risk, and then of course we have our patients. They try and avoid rostering them together, but that will happen through sheer necessity. There are issues which are a bit to do with the funding, as we spoke about, and a bit to do with FTEs in particular. That needs to be increased or, at the level we see now, maintained every year, because the workload is increasing; it is not decreasing.

Although we are not losing members, I think our ability to maintain staff could be an issue. I am not sure how long they stay nowadays. I think the world has changed in that respect. You do not see too many fossils like me out there anymore! It is great to see: the kids are great. They are so intelligent. Their training is spectacular and their knowledge base is spectacular, but we have to be careful we do not hurt them on the way, before they get to utilise their experience and their knowledge with our patients.

I would have said to you that, maybe up to 18 months ago, we probably had one of the world's best ambulance services in what we can deliver at the home. As I alluded to earlier, I am starting to doubt that as a 33-year veteran. That is atrocious for me personally. We need to get the right staffing levels. We need to get the right resources in the right places at the right time. That is where I think we have lost our way a little bit in the last 18 months. I understand that COVID has been an issue, but it cannot be the only issue and neither can ramping. It is a holistic systemic review that we need to see what is going on.

**CHAIR:** You mentioned mental health earlier. There are two parts to this question. The first part is about the co-responder model. This is about taking the burden off the hospital. I want to talk about getting the patients to the appropriate care, so out of EDs. Can you talk to that? As for the second part, we heard that there are some 550 beds being taken up—that is the size of Townsville hospital, a tertiary treatment hospital—by long-stay aged-care patients or patients waiting for an NDIS placement. If we could shift those people to appropriate care, be it residential aged care or home care—if the model of care was right for those people to go—would that then remove some of the blockages? We heard on the Gold Coast or at Logan that there were some 100 beds taken up by long stayers. If you want to avoid the blockage at the front, what is the solution to freeing up those beds?

**Ms Scalon:** We have heard the same things. The patient access group talks about that issue a lot. The EDs cannot do anything more efficiently or quicker than they currently do. Once their 16 or 30 beds have people in them, if there is nowhere to discharge them to in the hospital and they need to be admitted, they stay there. That is where our block then happens. It would make logical sense—

I am not an expert in health planning—that, if those beds were freed up in order for people to cycle through them in a hospital setting the way they are supposed to, rather than be a long-term stay, that would have a significant impact on our members' experience in terms of when they hit the system.

**CHAIR:** Some of those beds are 400 days. We heard that people are staying in those beds for 12 months.

**Mr MOLHOEK:** On a point of order, we also heard that the average is 31 days.

**CHAIR:** Yes, across the state.

**Mr MOLHOEK:** Four hundred days is an extreme example.

**CHAIR:** Anyway, I want to go to the mental health question.

**Mr Lentakis:** The mental health co-responder model has been exceptional. It is probably one of the better things we have done over the past 18 months to two years for two reasons. One, we have a mental health coordinator in the communications centre. Some patients of ours will call us 40 times a day and it is the same thing. With those that we know, they will have what we call a caution note on their address or phone number. It will simply say 'refer to the mental health coordinator'. They will have a chat with them, usually de-escalate them and calm them down and go with that. Therefore, we do not need to attend.

Then there is the co-responder model where we have a paramedic with a mental health nurse in an emergency response vehicle. That has exactly the same thing except that we attend because there is a potential fear that there might be some self-harm that could happen or that patient is really in danger. The mental health nurse, because of their advanced mental health experience and training, has the ability to de-escalate. We can either go into hospital if we need to without an emergency examination authority or de-escalate to the point of leaving them at home without having to transport them. That is the whole idea of that, as you alluded to.

**Ms Scalon:** That has resulted in a 40 to 60 per cent reduction in hospital presentations. The cases that those mental health co-responders go to with the paramedics has had enormous success in reducing hospital presentations.

**CHAIR:** I thank you all for your time and contribution today and for your submissions to this important inquiry.

**HODGMAN, Mr Sye, First Nations Strategy, Policy and Research Officer, Queensland Nurses and Midwives' Union (via videoconference)**

**MILLS, Mr Sam, First Nations Branch Member, Queensland Nurses and Midwives' Union (via videoconference)**

**MILLS, Ms Yoko, Member, Queensland Nurses and Midwives' Union (via videoconference)**

**RAYNER, Ms Kim, Member, Queensland Nurses and Midwives' Union**

**CHAIR:** We will start with opening statements before we move to questions.

**Ms Mills:** I would like to pay my respects to the traditional owners of this land we are speaking from and acknowledge and pay respect to the elders past, present and future. My name is Yoko Mills. I am currently a CNC working in men's and women's health on Thursday Island. I am also a First Nations branch member with the QNMU.

To give you a bit of background, I have been working in Queensland Health for over 30 years. I started working as an AIN. Then I did the enrolled nurse training on Thursday Island in the hospital based system back in 1982. Then I did my nursing degree in 2000. After that I undertook the Master of Nurse Practitioner studies in 2009. I am currently not working as a nurse practitioner. I graduated in 2012 but, due to a lot of barriers, I have been unable to practise as a NP here in the Torres Strait. I was born and bred here.

I would like to give you a bit of a general outline of the area we cover in regards to our service delivery. We have about 25 communities around the Torres Strait Islands and inner islands which includes five communities in the NPA. Fourteen of the outer islands are accessible by air and six are accessible by boat only.

I would like to also share one of our success stories in regards to the First Nations COVID team. Before we knew that the border was going to open, we were a little bit concerned about the uptake of vaccinations by our Indigenous people. With support from the QNMU we were able to get an audience with the director-general. That allowed us to state our claim regarding the lack of consultation that occurred with local Indigenous clinicians and nurses. After meeting with the director-general, we proposed a way forward in terms of a plan to establish an Indigenous COVID vaccination team which consisted of our Indigenous health promotion officers, health workers and admin officers. The whole team was led by our First Nations and Torres Strait Islander nurses. The rationale for putting together this team was that Indigenous staff from country would have fewer barriers and would be able to communicate effectively with our people. We have a good knowledge of the kinship and family group dynamics and also the hierarchical structure that exists within the family and clan groups.

The types of strategies that we used to increase the uptake included home visits—this was before the COVID cases came to TI. We were doing home visits, which were led by the health promotion boys. We also used incentives like vouchers that would assist the families. If they came along to have their vaccination, we would thank them with a $50 voucher to buy food and things like that. We also visited workplaces to try to focus on the staffing, bearing in mind that a lot of the staff members would not be able to come down to the vaccination site. Our accomplishment was that we had very good uptake from our people with the vaccination. Since we started in November we have averaged 30 to 50 clients each day, which was a marked increase in the vaccination uptake compared to the non-Indigenous scheme, which was seeing about zero to 15 a day.

On vaccinating each client, we undertook a survey which asked about their experience of coming to the clinic and finding Indigenous staffing members. Did they feel comfortable? Some of the feedback we received was very good. For example, one of the comments was, 'I found it was easy to understand. The health staff explained it to me in local broken English. Cannot understand when health staff use long English. Thank you, local team on TI.' The other comment was, 'It was a great and easy process, black people looking after black people. Well done to staffing Indigenous people. It makes a greater impact on access.' That was our success story with our Indigenous vaccination.

**Mr Mills:** I will introduce myself and take it a bit further forward. I am Sam Mills. I am a clinical nurse in renal, in CKD. I look after people before they get to dialysis. I feel that doing good primary healthcare work is imperative in preventing our people getting to dialysis. It costs quite a bit of money to look after them once they get to dialysis.

What could go a long way to address the issues in remote Indigenous communities like the Torres Strait? Building a nursing workforce would be a big step forward as well as building models of care that utilise appropriate nursing positions, like the nurse practitioners and diabetes educators. While I say that, I would underline the fact that it is imperative to increase the Indigenous nursing workforce. The bit we have done around COVID speaks to that. We would deliver services a lot better than the non-Indigenous ones could deliver in communities because (inaudible). It is important to establish pathways to facilitate First Nations nurses positions across all levels—at the DON, at the EDON, at the CNCs and the nurse unit managers—where we could make a difference in directing services. At the moment there are barriers for us to get there as nurses.

Recognition must be given to Indigenous nurses as professionals. Oftentimes when government departments come up to the Torres to talk to Indigenous and have Indigenous input into health matters, they go to the health worker. Historically, the health workforce has been the health workers, but now we have nurses and doctors who are sitting there and they ignore that. We need to work to build that relationship and build the workforce so that we have better outcomes for our people.

**CHAIR:** Thank you, Sam and Yoko, for the outstanding work you have been doing in your communities, particularly around managing COVID; that is outstanding. What you were saying there, Sam, about the workforce and making sure that First Nations people are prioritised is absolutely heard. One thing we learned when we were up there doing the Meriba Omasker Kaziw Kazipa traditional child-rearing bill was a big eso. Sye, do you want to say a few words?

**Mr Hodgman:** Sorry about the IT issues. I want to say thank you very much. I was going to introduce Sam and Yoko, but they did a terrific job introducing themselves. I want to say thank you to QNMU for allowing the QNMU members to present their experiences. I do want to introduce the fact that Sam and Yoko are also both founding members of the First Nations branch and have both experienced a significant number of barriers and overcome a tremendous amount of adversity in getting to their leadership positions in the community despite this.

A good example is that Yoko is actually a nurse practitioner. She is currently not working as a nurse practitioner as a result of the racism that is pervasive in Australian culture and the broader healthcare system across Australia which is stopping First Nations people from entering positions of leadership across the country. We see this time and time again where Aboriginal and Torres Strait Islander people are not actually employed to their level of qualification. Their ongoing commitment to their communities is a real testament to both Sam and Yoko.

I would like to introduce Kim Rayner, who is about to speak. She is a QNMU member and she is the clinical lead and nurse practitioner with Micah Projects, which is a community non-government organisation that works to break down barriers that exclude people from housing, health care and employment. Kim has 28 years experience as a nursing leader and senior healthcare manager within both the healthcare and the social service settings across Australia.

Kim is going to highlight her extensive experience with nurse-led models of care as well as the benefits and outcomes including the positive return on investment. She will also identify current challenges and the benefits of these kinds of innovative care models. I will hand over to the Kim and say very sincere apologies for those IT issues, which I thought I sorted out earlier in the week when I did my test.

**CHAIR:** Thank you very much. Yoko and Sam did a very good job in speaking to issues in their local communities.

**Ms Rayner:** Before I start, I have been asked to table Michelle O'Connor's statement as well. She is a QNMU midwife.

**CHAIR:** We can do that. Is leave granted? Yes.

**Ms Rayner:** Sye has introduced me so I will not go over that in terms of time. I will focus on Micah Projects' work here in Brisbane responding to individuals experiencing homelessness who are vulnerably housed. The majority of the individuals we have supported, and Micah continues to support, are those who experience significant disadvantage, poverty, high rates of chronic physical health conditions, high rates of mental illness upwards of 80 per cent, and high rates of substance use disorders—again, between 70 and 80 per cent. Many have disabilities. Again, the majority of people we have supported over the years have limited or no personal supports to address their healthcare, housing and social support needs.

We started to set up these nurse-led models of care at Micah when I started 10 years ago, after doing this work in Victoria, to address the over-reliance on the emergency department at Micah. Support workers really had no other option but to take people to the emergency department when they were working with them on the street or in the parks. We knew there was a high rate of mortality.

We looked at the number of people who died at that time—this was over 10 years ago. We knew from our vulnerability index data that there was a high proportion of chronic illness which was not being managed on top of their homelessness situation. That is the context of where we started to say, 'What can we do here and how do we start to drive a response to the healthcare needs or the unmet needs of individuals and the impost on the public health system?'

In the past 10 years Micah Projects has established and evaluated the delivery of nurse-led models of health care that have been integrated with community based social services, GPs and hospitals across Brisbane. That has been a consistent theme to make sure it is integrated, that there is someone leading and moving forward and responding. These nurse-led models of care have been tasked with addressing hospital avoidance and improving quality-of-life outcomes for vulnerable populations through targeted, accessible and flexible outreach services. I am stressing those three words because they really need to drive these models of care rather than excluding people's access to care.

Given the multiple and complex health and social support needs of the target group, these successful nursing-led models of care have been directly integrated with the social support services, and they operate within not only a nursing model of health care but the social determinants of health care. We are looking at the whole person, which is how nurses are trained. There have been a number of examples of these nurse-led models of care and they are not all funded. The funding has not continued, even when we have demonstrated significant economic return.

The first of those is the Homeless to Home after-hours health service—that started over 10 years ago—and the daytime complex care clinical nursing response, which was probably funded about five years ago. We were not delivering daytime clinical nursing care at night, which was all we had as an option on the street. There was also the Brisbane Common Ground integrated nursing service and the Pathways Hospital Admissions and Discharge Service for people with multiple and complex needs. That was a partnership between the Royal Brisbane hospital, the PA Hospital and St Vincent's Hospital, and the Mater was linked into that as well.

Then there was the Micah Projects ED Frequent Presenter community response team; we were part of a larger partnership with the Royal Brisbane. Again, it is about trying to respond to people frequently presenting to ED whom we all knew, and probably the ambulance team that were here would know many of those people. We knew who these people were. How do we respond differently so that they do not just keep coming to the ED? How do we invest in the community to respond?

We also set up the 2020 COVID flu vaccination nurse-led outreach program to homeless and vulnerable housed individuals across Brisbane who are often excluded. They could not afford a private vaccination. It was 2020. We did not have the COVID vaccination. We knew that influenza was a potential risk. We knew the chronic disease profile of many of these individuals who were now in hotels and also on the streets. We tried to mobilise quickly—and we did—through a nurse-led model there.

In terms of the COVID-19 vaccination model, our mobile health clinics are now operating across Brisbane into rooming houses, boarding houses, hotels and motels trying to vaccinate, again, a very isolated and at-risk group. We have the nurse practitioner-led hepatitis C program to homeless and at-risk population groups—the program I am leading at the moment—trying to respond. Amongst the homeless population, 20 per cent have hepatitis C and it often has not been treated. This is significantly higher than the general population.

We also set up a nurse-led outreach wound care service. It was a short-term response, again during the COVID lockdowns, to many people who could not get any wound care response because of COVID and services ceasing. Again, another nurse-led model was operational fairly quickly. We also have the domestic violence clinical nurse partnerships program to women and families and we have a Homefront service responding to the Princess Alexandra Hospital. We have developed quite a few models to respond to these needs, often put together with various forms of funding.

What have been the benefits and outcomes? They have been pretty consistent across these models, and we have evaluated them. For participants of these nursing outreach programs, often it has led to the resolution of their homelessness because we understand what is going on for them. It has led to the resolution of the crisis they are in—this revolving door into the emergency department. It has improved a person's health and ability to self-manage their healthcare needs; significantly reduced hospital ED presentations, hospital admissions and ambulance usage; increased GP engagement; increased access to needed support programs, the NDIS and aged care, which is a real difficulty for people to access; and improved overall patient outcomes and satisfaction.

For the service system, what have these nurse-led models of care delivered? They have delivered targeted and effective models of care, person centred. They have addressed service gaps and barriers to healthcare access. They provide a strong return on investment. They reduce ED presentations and hospital admission rates and successfully integrate health care, housing and social support services to prevent a siloed response to the individual's complex needs rather than just looking at the disease or at one issue. They need to be looked at together.

What is the return on investment? What are we really seeing? There is this shifting of funding all over the place. We took a while to get some money together and spent $120,000 that we had to secure to do a health economic evaluation of the Homeless to Home Healthcare After-Hours Service to sustain its funding. That was undertaken by Professor Luke Connelly, a health economist at UQ. He identified in 2013 on every measure that this nurse-led service was a success. An investment of just over half a million dollars per annum to provide the outreach nursing service saved the Queensland public health system $6.5 million to $6.9 million per annum while improving quality-of-life outcomes for vulnerable people in Brisbane. Similarly, we asked Luke to do some more health economic evaluation on our Pathways Hospitals Admissions and Discharge Program. This demonstrated a $3.6 million net cost benefit—we were funded for about $340,000 per annum for that service over two years—or a return of $7.25 per $1 spent. In summary, these models are cost effective and are highly effective.

What are the current challenges? There are quite a few. In summary, there is increasing demand for these integrated health and social support services. We are always being asked to respond, to pick up people who may not fit into different models of care who are presenting multiple times to the ED, who are in crisis, who other services will not pick up. We are relied upon as a key contact point for hospitals, GPs, police, the ambulance and other social services to provide crisis support, housing, access and health care to people with multiple and complex needs. Often, though, the greatest challenge is that we have inadequate or sustainable state funding, and federal funding is an ongoing challenge to keep these models going. You get lots of turnover of staff because there is no sustainability to the models, even though they are effective.

What are the other challenges? Federal government versus state government healthcare funding divisions and policy instruments stop local responses scaling up or being introduced as there are limited primary healthcare funding options available to set these models up or continue them, even when you demonstrate the benefits. There are lots of pilots getting tested, but there is nowhere to go when there is no funding pool.

MBS billing restrictions in primary health care for nurse practitioners have stopped the establishment of NP models of care within rural and aged care and to at-risk population groups such as those experiencing homelessness, mental illness or drug addiction or those living with a disability. Unless they are funded through the public hospital or from another state grant, there is no funding sustainability for these models. Current MBS items do not cover the wage of an NP, let alone running costs. Block grants or donations are required, which is often what we have relied on to do our models. Again, there is no sustainability.

In summary, the nurse/nurse practitioner-led primary healthcare models of care increase patient access to high-quality, cost-effective, person centred care in a timely manner. They reduce unnecessarily and costly hospital representations or presentations and inpatient stays, freeing up the public health system's capacity. They provide timely assessment, diagnosis and improved management and monitoring of chronic and complex health conditions in the community, preventing those hospital presentations. They allow for enhanced access to health care and social support services. Early intervention can respond to complex community and individual healthcare needs and meet service system gaps effectively and efficiently. Given the nursing skill set and high level of training in collaborative skills, nurse-led models can provide direct clinical care while also providing effective, outcomes focused care coordination across many domains in a person's life. One of our greatest strengths is to pull things together to resolve the fragmentation that is occurring.

We partner effectively with the person, the GP, medical staff and other community and allied health services to achieve these outcomes. Nurse/nurse practitioner-led models address many barriers to health care for communities and population groups while delivering accessible, high-quality health care. Funding and policy gaps along with MBS restrictions continue to restrict these models from being established in areas of need, or sustained, even when the evidence in the evaluation findings strongly support their continuation. Such models are also able to address professional healthcare staff shortages across primary health care, acute care and rural and remote settings. Thank you.

**CHAIR:** Thank you very much, Kim. That was a lot in a few minutes. We only have a couple of minutes left.

**Mr MOLHOEK:** Can I just declare an interest? As of Friday, I am actually the inaugural chair of Common Ground Gold Coast. We have just set up the company and we are just working through a range of issues with Common Ground Queensland to establish that. It is great to hear of some of those figures. We were talking about what are some of the cost benefits, and we could not find some of that data.

**Ms Rayner:** There is plenty there.

**Mr MOLHOEK:** We will be really keen to chase some of that up with you. Thank you, Kim.

**Ms KING:** My question is to Sam and Yoko. You both talked about the challenges that you have experienced as healthcare professionals working in community. What needs to be different to help people in community be able to pursue training and a profession in primary health care as you have? What are the challenges? What needs to be better and different?

**Mr Mills:** It is across a whole range of issues. Even with what we did as a COVID team, going into houses as Indigenous nurses—professionals—and explaining what we do, when we were in the house we were talking to the young ones about what they are interested in doing after school. It is about setting up an organisation like we have, because of where our passion lies, and increasing the stature of our nation. We have set up a corporation of Indigenous nurses, the Torres Strait Indigenous Nurses Corporation, which goes to the careers market and talks to schools and delivers the career chat to kids in the classroom as part of the primary healthcare work that we do in each community. In all of those 14 communities that we spoke to previously, we do not just do business as a renal nurse or as a women's health nurse; part of what we do is talk to our kids and families about what we are doing, to increase the stature of our nation. It comes naturally; it is not something that is in your role description.

**Mr ANDREW:** You told us that you had a reduced number of nurses and you went home to home. Did anyone help you guys deliver the home-to-home care or did you do it on your own?

**Ms Mills:** When we first started putting together the First Nations COVID team, we drew some of our colleagues, brothers and sisters who are nursing professionals, from the mainland, from Cairns. We got them to come on board with us and we went out into the communities, to the homes.

**CHAIR:** Thank you very much. Thank you for joining us all the way from the Torres Strait. We really appreciate your contribution before the committee. Kim, thank you. I know that was a lot. There is no doubt that the committee is looking at some of this information about nurse-led work, clinics and the models of care that you have articulated.

**Ms Rayner:** I am happy to share any of those publications, too.

**CHAIR:** If you have anything, please share it with the committee. That would be fantastic. I now declare the public hearing closed.

**The committee adjourned at 12.11 pm.**