HEALTH AND ENVIRONMENT COMMITTEE

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

Staff present:
Mr K Holden—Committee Secretary

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

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 3 MARCH 2022

Rockhampton

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The committee met at 10.05 am.

CHAIR: I declare open this public hearing for the committee's inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system. My name is Aaron Harper. I am the member for Thuringowa and chair of the committee. I would like to start by respectfully acknowledging the traditional custodians of the land on which we meet today and pay our respects to elders past and present. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander people whose lands, winds and waters we all now share. With me today are: Mr Rob Molhoek, member for Southport and deputy chair; Ali King, member for Pumicestone; Joan Pease, member for Lytton; Lachlan Millar, member for Gregory; and joining us via videoconference is Stephen Andrew, member for Mirani. I make special note of the member for Rockhampton who has joined us here today, Barry O'Rourke. He advocated for the committee to be up here. Thank you, Barry, for being here this morning.

This hearing is a proceeding of the Queensland parliament and it is subject to parliament's standing rules and orders. I remind members of the public that they may be excluded from the hearing at the discretion of the committee. Proceedings are being recorded, media may be present and are subject to the committee's media rules. Please turn off any mobile phones or put them on to silent mode. If anyone has any documents to provide, the committee will table them during the public hearing.

FRAKES, Ms Kerrie-Anne, Executive Director, Rockhampton Business Unit, Central Queensland Hospital and Health Service

CHAIR: Good morning and thank you for being here. What we have been doing is going to an opening statement and then moving to questions. So, over to you, Kerrie-Anne.

Ms Frakes: I would like to start by respectfully acknowledging the collective cultures and traditions of the recognised Aboriginal traditional custodians and the Torres Strait Islanders living here in Central Queensland that are represented across our land, our sea and our river systems and these are the systems that connect and link our health services. I acknowledge the elders, our communities and the health workforce past and present who continue in sharing their cultural knowledge and dedication that supports the healing across our communities and within the provision of health services and also acknowledge and pay my respects to any Aboriginal and Torres Strait Islander persons in the room today.

My name is Kerrie-Anne Frakes. I am the executive director of the Rockhampton Business Unit which encompasses about 70 per cent of the Central Queensland community. It includes Rockhampton Hospital, our community health services, Capricorn Coast Hospital and Health Service down at Yeppoon, Mount Morgan Multipurpose Health Service, Central Queensland Mental Health, Alcohol and Other Drug Services, oral health services, allied health services, offender health services—I am pretty sure that is about it. My directorate forms part of the Central Queensland Hospital and Health Service which delivers care every day to 250,000 people across 100,000 square kilometres from Marlborough in the north, Gladstone in the south and the Central Highlands in the west. Similar to other hospital and health services across Queensland, Central Queensland Hospital and Health Service has experienced significant growth in demand, with a year-on-year growth in both our elective and emergency presentations. We have felt acutely every up and down of the past two years through our emergency departments, particularly here in Rockhampton, including media attention of the growth in ambulance ramping, the uncertainty with COVID and unprecedented surges in demand, particularly out of hours where there are no alternative primary healthcare options. As we move through 2022 and into the future, we will no doubt see further increase in demand on an already significantly stretched system.

When I left Rockhampton Hospital this morning at 9.30 we had already had 41 presentations to our emergency department from midnight. Over half of those were brought in by ambulance. To put that in perspective, that is twice as many as we would normally expect for this time of year. Eleven out of the 21 available cubicles in my emergency department were filled with patients waiting for a

hospital or acute bed. Twelve months ago ambulance ramping and code yellows were a daily challenge here in Rockhampton and today marks our 99th day without a code yellow. I so hope we can make it to tomorrow, but it is going to be touch and go. It is a day-to-day delicate balance between bed availability and our patient demand.

One of the critical challenges impacting this is the number of elderly patients waiting in our most acute beds awaiting aged-care or disability placement. Today there are 42 people across Central Queensland hospitals, but primarily here in Rockhampton, waiting for a residential aged-care facility bed and four people in acute beds here in Rockhampton Hospital awaiting the finalisation of their NDIS package. They are not medically or acutely unwell, they simply do not have anywhere else to go. The longer these people stay in hospital, the more likely it is that, despite the very best of care, they will fall, they will develop a pressure injury or they will simply pick up a nosocomial infection that can deteriorate both their cognitive and functional capability. For some people the lack of aged-care beds here in Central Queensland results in them living in Rockhampton Hospital for months. Two years ago I led a review on the growth requirements for aged-care beds in Central Queensland. The available evidence at the time described an immediate shortage of around 190 aged-care residential beds across Central Queensland and that will escalate if we do nothing to 2,000 beds short by 2036. Without any future investment it looks quite bleak.

From that study this challenge is not going away. Central Queensland Hospital and Health Service maintains two nursing homes here in Rockhampton of around 200 beds, as well as aged-care beds in our rural multipurpose health centres. We account for about 13 per cent of the total residential aged-care beds in Central Queensland. It is critical that a collaborative approach to aged-care planning for our elderly population is taken and this must include infrastructure growth and integrated financial modelling across both state and Commonwealth funding which is underpinned by a strong primary care model that ensures the appropriate care is delivered in the right place at the right time.

My clinical background is as an allied health professional. I spent the most part of the last 20 years developing interdisciplinary models of care for communities for people with complex and chronic disease. The evidence is well documented that the benefit of good primary and allied health care in the management of chronic disease in the community can reduce the frequency and the length of hospitalisations. Through my own research we were able to demonstrate that a coordinated interdisciplinary patient care model of care significantly reduced hospitalisations, improved patient health outcomes and in one year our patients were collectively able to lose four tonne of weight. But the funding models that underpin public health care count widgets, not health outcomes, and so often the interdisciplinary community based services are hamstrung and disincentivised through activity based targets and not able to survive on Medicare rebates. We know that often our elective and emergency services are overwhelmed with demand that could have been prevented and better managed in the community or other sectors. Indeed, service gaps in our community based and primary care services impact our public health and hospital system and we see it every day on the floor.

The current community demand far outstrips the availability of primary and private allied healthcare resources in this area which means that the acute public health sector and community sector are seeing and treating the outcomes of this lack of early and consistent primary and allied health care. The introduction of the NDIS has further amplified this impact. Even with the introduction of a local suite of allied health and nursing undergraduate programs delivered through the local university, there are still significant workforce shortages.

In Central Queensland we have a significant lack of general practitioners, and particularly bulk-billing GPs, which in turn places greater pressure on our emergency departments. Over the past 10 years the private health insurance coverage across Central Queensland has decreased well below state and national coverage levels and sits below 38 per cent. Also with that, the available private practitioners have dwindled. The result is frequent and potentially preventable attendances at emergency departments, increased outpatient appointments and the increased number of admissions and longer lengths of stay. From a patient’s perspective this is a very difficult and at times uncomfortable journey. In the best instance is a four-hour wait in a noisy emergency department, at worst it is sitting in a hospital corridor whilst ambulance trolleys are pushed past and staff in full PPE shuffle by.

Medical workforce shortages represent a significant safety risk for us as a hospital and health service. With the disruptive workforce supply experienced with border closures, we have acutely experienced the fragility of our specialist services. With roster gaps in obstetrics and gynaecology, general medicine and our emergency department physicians, on top of a surge in demand and a 15 per cent growth in births in the last 12 months, this has put significant phenomenal pressure on

our junior medical workforce. This workforce challenge is not a financial challenge; rather, it is a workforce availability challenge. Whilst I know that we are not alone in this challenge, we are fighting our other HHS colleagues to the north, south and west in finding the appropriate clinicians with the appropriate qualifications.

But the clinical challenge that keeps me up at night is the considerable underinvestment in public, private and primary mental health services, particularly for our youth. I have spent time with parents at their wits end trying to access care that they need to support their child. As a mother, I have cried with them feeling the frustration in navigating a confusing system and seeing the anguish on clinicians' faces as they identify that the child is not acute enough to warrant an admission—not that we would have any child or adolescent mental health beds available in Central Queensland. For the parents, the only door available for them is the emergency department.

There is an ever-growing issue for all aspects of our community. We have seen an exponential growth in young people presenting to emergency departments with suicide ideations. The seeking of acute public mental health should be the very last resort for these consumers, but rather it is the first port of call because there are very few services and significant waiting times in the private and public sector, and when they can access services there is considerable out-of-pocket expense due to the gaps in the Medicare benefits scheme.

Our public health services are being stretched, the demand is increasing and the pressure is unrelenting, and I see no reprieve in the immediate future. What I see is that, without a paradigm shift or a pivot in our focus, the pressures will be further exacerbated by the need to treat patients whose conditions could have been prevented and better managed in the community or other sectors. As you know, health care is a complex and adaptive system that requires the ecosystem of healthcare providers to meet the demands and needs of our community. Without reform, I fear that this demand will fall 100 per cent to the public health system to address. However, as it currently stands, my service is incredibly reliant and incredibly resilient on a broad range of factors and interdependencies with our local care providers. We just need the support to support them.

I will finish by acknowledging the staff of the Central Queensland Hospital and Health Service. My team deliver care to Central Queenslanders when they need it the most. We are there with our community on their very best day and on their very worst. For the past few months, they have done an amazing job—the past few years, to be honest—and they have done this in full PPE, wrapped in plastic. They deliver this care with care, integrity, respect and commitment, living the values of the Central Queensland Hospital and Health Service and I am very proud of them and very proud of our role in the community. Thank you for the opportunity to present and I would be very happy to answer any questions.

CHAIR: Thank you. It would be remiss of us not to also recognise the significant work and the challenges with COVID in the last couple of years that everyone in the public health system has endured—providing that dedication and professionalism 24 hours a day, 365 days a year. Please pass on my thanks on behalf of the committee. I have a couple of quick things. You mentioned a study. Could you get that table to us? I think it was around the ageing population.

Ms Frakes: Yes.

CHAIR: There was something about 2,000 beds by 2036.

Ms Frakes: We commissioned a study in 2019 to look at the growth required in aged-care beds across Central Queensland. We looked at the distribution of how that growth would be. It is around 2,000 beds short by 2036 if we do nothing.

CHAIR: Can I just confirm the numbers. You said 42 beds for long stay waiting for residential aged care. I did not pick up the number you said for NDIS.

Ms Frakes: There are only four today.

CHAIR: We will go to questions.

Mr MOLHOEK: I should declare an interest. My son is the acting district medical officer at Emerald which comes under the Central Queensland Hospital and Health Service.

Mr MILLAR: He does a good job, too.

Mr MOLHOEK: Thanks, Lachlan. You mentioned the number of aged-care beds in Central Queensland and I think you said there was a shortage of 197.

Ms Frakes: About 189 or 190 at the end of 2019.

Mr MOLHOEK: What is the total number of beds?

Ms Frakes: I would have to come back with that number. From memory, the Central Queensland Hospital and Health Service has 200 here in Rockhampton, plus the multipurpose health beds, which is around 40 beds. We represent 30 per cent of the total beds available. I will have to take that on notice and tell you exactly how many beds we would have at the time. There has been a reduction though I believe.

Mr MOLHOEK: So there would be around 600 or 700.

Ms Frakes: Yes.

Mr MOLHOEK: I should add to the comments of the chair my appreciation for the work that your staff do as well. We go through this at every single hearing, but I cannot imagine being in PPE plastic today in this heat. The hospital is air-conditioned but I am not sure that it always covers it.

Ms Frakes: It is the outside fever clinics, where you have got people testing for COVID in full PPE in 39 or 40 degree heat. It is a big day.

Mr MOLHOEK: Yes, they are big days. You made quite a few comments around the need for good allied and primary health care. It would seem that this is a trend right across the state; in fact I suspect it is a trend right across Australia. How do we get more allied health workers, professional doctors and nurses and carers into the system? There have been many attempts in the past. There has been a lifting of caps in the past by previous federal governments from both sides of politics. Getting people to come to Rockhampton, Emerald or other parts of the state is not easy.

Ms Frakes: In 2010 I started a student clinic here for allied health professions that brought allied health students from across Australia and coordinated an outpatient service for complex and chronic disease. We recruited in the Central Queensland Hospital and Health Service our first student, which is fantastic—an occupational therapist who is now a leader in mental health services. At the time we could not get recruitment pools for allied health and we worked locally with the university around the creation of the university programs for those allied health professions. We have certainly seen locally an increase in our recruitment pool since that occurred. There was a significant growth in that, so certainly training locally is a big deal.

In 2019 I believe we signed the program with the CQUniversity and the University of Queensland to start medical training here in Central Queensland. Whilst this year is the first year of the undergraduate and we have a few more years until we start to see the graduates coming out, I do believe in 10 years time that will make a material difference—to train and grow locally, to be able to settle roots down in a community where it is a great place to live and to be able to have a career in Central Queensland. I think there are enormous opportunities, and we need to then as an organisation support and create those opportunities for our health workforce to be able to do their end-to-end training program locally, regardless of their profession, but with world-class facilities and world-class access to the right level of teaching.

I was a rural bonded student back in the day. As a podiatrist it was, ‘You will go to Rockhampton as a new graduate,’ and I married a fourth-generation Rockhampton boy and I am still here. I think those days are kind of a little bit further ahead, with very few rural bonded students who did stay in the communities, but I do think we could have training and developing opportunities locally. With that has to come advanced teaching and advanced research to support the progression of clinicians so there is not the draw back to the big city, if you like.

Mr MOLHOEK: Maybe we should be sponsoring eHarmony for medical—

Ms Frakes: We did start ‘Grazier wants a Wife’ during Beef Week.

Ms KING: Thank you for the very clear picture that you have painted of the challenges and also the resilience of your health workforce here. I have so many questions. Could you please paint us a picture about where the gaps are for that end-to-end training to exist here? What do you have in terms of the training journey for doctors, allied health or nursing students and what do you need?

Ms Frakes: I will start with allied health and nursing because I am probably a bit more familiar with that. Now that we have the majority of undergraduate professional training, we have had nursing here in Central Queensland for quite some time, and CQUniversity graduates a phenomenal number of nurses every year, but that is only the start of the learning journey. The first stage is the undergraduate and the prelicensed training, and I think we will get there with medicine. There needs to come the postgraduate training, which becomes more or less understanding rural generalists as a specialist area and having the training programs, which Emerald does fantastically well. It is being able to have that sort of model with the opportunity for research and dedicated time so you are not being pulled onto the floor. It is important you can actually dedicate your own work time to being able to progress your understanding, learning and training.

I think also with that comes the opportunity to have world-class teachers embedded as part of our hospital and health service. One of the challenges we have had, particularly in medicine, is an ongoing reliance on international medical graduates. Therefore, we have people who are often tied to a visa and, as soon as that changes, there is a movement on. We need to be able to support our clinicians to be able to drive their own personal studies, their own personal research. That in turn will feed onto the next generation and start to produce really good outcomes for patients and really good outcomes for students as they learn off the best. I think that investment in research, teaching and training of the postgraduate is probably the area where we are not quite there yet. Having that quarantine time built into workforce and quarantine time built into the way that we structure our services is the gap at the moment.

Ms KING: Are there enough training places in your view at this time? I understand that your medical training is emerging.

Ms Frakes: I think that is a hard question because I am not sure if it is a lack of graduates or a lack of skilled clinicians with five to eight years experience. In allied health in particular, we do tend to lose a number of staff after a period of time for whatever reason, and perhaps that is the ability to grow your career and grow your profession. I cannot say for sure if I think it is that we do not have enough graduates. I wonder if we do not have enough skill mix in our more senior clinicians and maybe having that opportunity to invest and grow in that space.

Mr MILLAR: Congratulations. I have seen firsthand how the Central Queensland Hospital and Health Service has done an amazing job when it comes to COVID, and it is difficult right now. I want to pick up something in your statement which worries me too—it keeps me awake at night—and it is about mental health, especially for our youth. If someone is diagnosed with a severe mental health problem in Emerald, where do they go?

Ms Frakes: As it stands right now, if they require acute admission, they are brought into Rockhampton, but we do not have a child and youth bed so often they are in emergency departments for three or four days waiting for an ability to get down to the south-east corner. In our high-dependency unit, not in our child and youth but in our adult population, which is our most acute area, we currently have three beds. All three are filled. One individual has been there 120 days, one individual has been there 50 days, and the other has been there 33 days. That actually closes those beds to every other person who requires it with the turnaround time for those beds, but there are three. That puts additional pressure on our emergency departments and we are starting to feel that acutely. Trying to get those specialist level beds is a challenge.

Mr MILLAR: So we have a severe lack of acute services for mental health, especially for our youth. If I am from Emerald, the only option is Rockhampton and then they are away from family and friends.

Ms Frakes: Yes, I completely agree.

Mr MOLHOEK: Just to clarify, did you say there are only three acute mental health beds?

Ms Frakes: In our high-dependency unit. We have a low-dependency unit, which is, I guess I would say, a normal mental health inpatient unit. There are 20 beds in that. We have three beds in our high-dependency unit and we have eight beds in our older persons mental health inpatient unit. When we do have youth, depending on who else we have on the wards, it may be that we outlie adolescents in the older persons mental health inpatient unit. It would be the safest option out of those three. It may be that we outlie them on the paediatric ward, but that is incredibly disruptive to the other children that are on that ward.

Mr MOLHOEK: How old is the mental health unit?

Ms Frakes: It is very old. It is at end of life. We were fortunate enough to get some funding through the last election, and I acknowledge the support of the local candidates for that. We have to remove the roof is probably the easiest way to describe it because the air conditioning and ducting is at end of life and so to do that we have a significant decant and challenge to be able to balance those inpatient beds in alternative locations for a period of time. Our new chief executive who is an interim, John Burns, has said he has supported 13 mental health inpatient units as part of his role as a CEO over the years and this potentially is the worst mental health inpatient unit that he has seen from an infrastructure perspective. It is old.

CHAIR: I need to move to the member for Mirani who has a question.

Mr ANDREW: Thank you, Kerrie-Anne, for coming in. Mount Morgan is a satellite community that is close by. I wanted to ask, because they have not had a doctor for over 10 years, how you support the ageing population of Mount Morgan? Have you got any plans to bolster the system so Mount Morgan has more continuity as far as doctors are concerned?

Ms Frakes: Thank you for that question. I am really pleased to inform you that we were able to permanently recruit a husband and wife doctor last year who have moved permanently now to the community. We have permanently employed another medical officer who is on a fly-in fly-out arrangement six days a fortnight. We have increased another three days a week for that community to bring on a junior doctor so that we can now have 2.6 full-time medical officers that also undertake a GP practice but also a training program so that we can start to support rural generalist training through Mount Morgan.

Mr ANDREW: Does that translate to the aged-care facility beside that?

Ms Frakes: Yes, that is for that entire facility. The two senior doctors have their clinic to the, as you look at it, right-hand side of the entrance of Mount Morgan Hospital and they do provide then that care for those 10 multipurpose aged-care beds on Mount Morgan and they also provide then the support for the acute beds. We certainly as Rockhampton Hospital rely on Mount Morgan to support us. We do have a number of inpatients who do require step-down care to Mount Morgan because they come from that community or around that community and they deliver fantastic care there. It has been quite critical over the past number of years, as you described. We have had times where we have not had medical staff in that facility and we have been supporting that through Rockhampton and Emerald through a telehealth model of care and nurses onsite in the facility, but now we are looking at that sustainable medical model to be able to support that community.

CHAIR: Do you know how many GP vacancies exist at the moment in your area? You can take that on notice.

Ms Frakes: I will have to take that on notice.

CHAIR: We had something like 97 in Far North Queensland. It was significant people-travelling hours.

Ms Frakes: The last time we had a look, if the average GP to population is one to 1,000, which is what we should be looking at from a planning perspective, I think we were one to 1,400. We have had quite a number of our local GPs retire and that was a very sad day for us. The other challenge with that is we are seeing a move away from bulk-billing practices. One of the clinics that was 100 per cent bulk-billing and was seeing something like 600 patients a day has moved away from bulk-billing this year which is further impacting our emergency department.

CHAIR: They just go back to the emergency department?

Ms Frakes: Yes.

Ms PEASE: That was going to be my question. You have talked about from midnight last night to 9.30 there were 41 presentations. Of those, is there evidence that you can say or support around those category 4 and 5 patients who could have been attended to by visiting their GP and cannot get in?

Ms Frakes: I think there are two parts to that. Because GPs do not go to the aged-care facilities, those individuals come in. Whilst we have programs such as GEDI, which is the geriatric emergency department intervention model, we still have people come through and if they come through at five o'clock in the afternoon then we know we have them for the night because we are not going to get them home after that time. We have seen a growth in category 4. About 25 per cent of our presentations are category 4s and 5s so it is actually a reasonably low number, but it is increasing. Over the last two years in the COVID period we have actually seen a swelling in category 3s. We are seeing more acute and chronic presentations because people have not accessed primary care in the last two years and so therefore we are seeing complications coming in a lot later than they would have been picked up in a primary level of care. In saying that, I think there is potentially the opportunity for 15 per cent of our presentations to be managed through alternative models.

CHAIR: Thank you so much for your contribution here today. It has been very insightful and informative.

CORFIELD, Ms Sandra, Chief Executive Officer, Rural Health Management Services, Central Queensland Rural Division of General Practice

CHAIR: We will let you get settled. That is a very long title.

Ms Corfield: It is an historic title. The organisation that I work for started its life as a division of general practice in the early 1990s and that was the federal government of the time's initiative towards improving primary care and capacity of general practice to provide services and they evolved then through the divisions period to the Medicare local period to the primary health networks period. As an organisation we were effectively GP led and we were Central Queensland Rural so did not include Rockhampton and Gladstone and recognised that there needed to be more innovation and investment around primary care services so we did some things that were in addition to our funded Commonwealth services. We got involved in developing infrastructure and we got involved in managing general practices. I do have some information sheets if you would like. We did not put in a submission but I was asked to come and speak from the community of Emerald. This is off-the-cuff and unprepared and I have never spoken to an inquiry before.

CHAIR: Take your time. Thank you for coming in. We are grateful.

Ms Corfield: I just really wanted to speak very openly with you about the need to change how we think about planning and delivering health services across the spectrum. As Kerrie-Anne put forward, if the primary care sector does not work then all the impact falls back onto the tertiary sector. In Australia we have a Commonwealth government that funds primary care, a state government that funds secondary care, albeit with money that comes down from the federal government, but there is still that governance that separates health into two parties, and then local governments feel the impact of failures in both of those sectors and try and invest and advocate more for health services.

It is particularly evident in the smaller rural communities where people know each other and they talk to each other and they want to work better in how they do things. Essentially all of the health services are in part funded and supported by taxpayer dollars. It does not really matter where that taxpayer dollar goes, whether it comes from the federal government down to the state government to provide health services or whether it comes from the state government investment in providing health services or it is a performance payment system like Medicare or NDIS or those insurance based schemes. I think what I have seen in the 20 years is that each of the government areas tend to measure what they measure about their area of responsibility and we need to start measuring impacts on communities and impacts on patients collectively—not just how much money does the state invest in Central Queensland, but how much money does the federal government invest and where are the shortfalls and how can we compensate that.

One of the examples is around aged-care funding. Currently the nursing homes are prioritising patients that are at home and have their own GP for admission because they know that they can manage them well. The patients that do not have a GP end up as a long-stay patient in a hospital bed at $800 or $900 a day versus what it would cost for them to be supported under the aged-care funding systems.

CHAIR: If they could get it.

Ms Corfield: Yes. We then need to look at how we solve that locally and collaboratively—what is missing in the nursing home side of the workforce that the hospital could help with and save money with? Some of that is about nursing skills and leadership and having that capacity to fund some of those services. GPs under pressure tend to stop doing things where they know the patients are safe and so if they are in a residential aged-care facility there are nursing staff that are looking after them. If they have queues of patients waiting at the door who are sick then they will prioritise that first so the nursing home tends to get done afterwards. We need to have a local plan about developing the workforce, about mentorship from gerontology, mentorship from senior nurses, developing capacity in the nursing homes. That planning process is about the local relationships. I think what the leadership from government can do is encourage that collaboration and planning so that it is not a state issue that there are too many patients in EDs and the Commonwealth government should fix primary care, and it is not an issue from the Commonwealth government that hospitals are taking up all the medical workforce and nobody is going to general practice because hospital doctors get paid a lot more and do not have to do as much work. Somehow we need to work on that pipeline locally about how the two systems work together instead of in opposition.

Years and years ago GPs used to be often part of the hospital workforce as visiting medical officers or doing some ED shifts and doctors from the hospital would work in ED. We have had a number of areas where specialists from within the hospital system will also work in general practice and provide clinics to patients in general practice. It is that mentorship and support and collegiate

approach that we have to bring back. People come to work where they are respected and where they are valued and where there is an integrated system. At the moment the hospital does one thing and primary care does another thing. If primary care fails, which it is, then the impact is all on the hospital system because patients cannot get seen so they either get well without intervention or they end up very, very sick.

What is happening now is that the workload and the burden of disease is much higher because our primary care sector is failing and failing extensively. It has to be a responsibility of every level of government to work together to work out how to plan to make that service work. I was involved in developing a document in 2013. It was developed by the Statewide Rural and Remote Clinical Network. It is a health planning process. It is meant for small rural and remote communities. We have been funded by the PHN to do a planning process in Gladstone. We are working very closely with Dr Basham and Sandy Munro from Gladstone, as well as the local council, the NGOs, the PHN and community advocacy organisations, to try to look at how we can integrate and improve those services. It is about bringing back that collegiate planning process so that there is genuine respect for all levels of the services from GP to the hospital base and from the hospital base back to general practice.

Over the years the tertiary hospital systems have changed to a specialist model rather than a generalist model. You see an ophthalmologist who does one bit of your eye and a different ophthalmologist who does a different bit of your eye and a neurologist who does one thing. It then becomes very hard for the patient to navigate those systems but also for the clinicians working in those systems. Without a GP or your nurse navigator or support, people who are very well educated and work in the system cannot navigate the system, let alone the patients who do not have that capacity. We need to bring those providers back together so that there is a genuine 'no wrong door' entry into that process.

The pressure on EDs now is phenomenal. A GP cannot ring a surgeon and organise a review or contact a psychiatrist and organise for a patient to be admitted. Every single patient has to go through ED and be assessed before they can be admitted. That is managing patient flow and managing control. It also means that, for example, if a senior registrar in Emerald refers a patient to Rockhampton, they get reviewed in ED again.

There are a number of stories of mental health patients who are in crisis when they are in Emerald but they are supported by the clinicians there, they have a lovely ride in an ambulance with a very nice ambulance officer and they are actually much better by the time they hit Rocky, so they are not admitted and they are discharged and they have no way home. It is still happening and it has been happening for years. We need to think about why does that happen and where should the services be provided and how can that assessment be made while that patient is still in Emerald.

It is about changing it so that there is genuine respect and collaboration between providers. If there is a senior clinician in Emerald or a GP who is very experienced and does the patient assessments, why do they have to be assessed again? We need to build that collaborative modelling so that there is a genuine warm referral or good clinical handover. Working in general practice now is seen as the bottom end of the spectrum for nurses, for doctors, for allied health. The pay is less. The professional respect is less. The reality is that if the primary care system does not work people get really sick. We need to change that perspective.

Historically, a lot of people who were working in primary care also did some acute work and they stayed in touch with the system. It is now very difficult for GPs to work within a hospital setting or to have interaction at a higher level with the acute care services. It is very rare that allied health professionals also work in a sessional way or have a part-time appointment within the hospital setting. Those positions are very doable but they are very rare. They usually arise because of a relationship between the two people at the time, not because it is a policy change about encouraging that. There are some workforce issues and some legalities that I am sure could be easily worked out to allow that to happen if that leadership came from a government level down. We want to see more planning. We want to see a plan for Rockhampton health services. We want to see a plan for Rockhampton aged-care services. We want to see integration, collaboration and innovation at a local level.

The allied health clinic that Kerrie-Anne talked about was innovation 10 years ago and is still delivering benefits. From a policy leader perspective, it would be brilliant if we could start having those policies that encourage the mixing of the workforce and the allowance of innovation and not having to have people assessed four times for the same thing because it makes no sense.

CHAIR: We need local solutions for local problems.

Ms Corfield: Absolutely. We did a Magnetic Island plan that was funded by the PHN and the HHS up there—no more investment needed; just some commonsense local solutions. We cannot get that signed off because the PHN is Commonwealth funded and will not commit for more than

two years, and the HHS cannot commit because it is not part of their normal planning process. It is kind of happening because everybody has read the plan and they are doing their little bit, but the policy does not exist to say, 'You need to have these conversations. As a government we want to see evidence of these conversations happening. We want to see funding dedicated to make sure it happens and that that planning is implemented.'

CHAIR: We are picking up some themes throughout these public hearings, particularly around the short-term funding for the PHN—two and three years. You just start a service and then the funding stops. We were told that they are looking to go to five years. I hear what you are saying. We need to get the model of care right. I wanted to ask you a very quick question.

Ms Corfield: I am just continuing to speak.

CHAIR: I think you bring years of experience. What you are saying is absolutely correct. I wanted to talk about model of care for a moment. We have some data from QAS that there were 35,000 transports out of residential aged-care facilities throughout Queensland last year. A lot of those were category 4 and category 5—low acuity. You mentioned nurse practitioners. You mentioned nurse navigators. If you have the model of care right in, say, a residential aged-care facility, you could get care there for a simple catheter change and you would avoid an ambulance transport back to the ED and an overnight stay for quite a low acuity. Would you support something like that?

Ms Corfield: Absolutely. It is about a partnership to set up that model of care and working out where the taxpayer dollar is best spent. You need oversight from general practitioners. The work that we are doing with the aged-care facilities and the GPs here is that they are happy to provide aged-care services but it needs to be organised so that the billing is done correctly. There needs to be support and a collegiate approach to after-hours care. The skills base needs to be there. Currently, most of your nursing workforce in aged care is not highly skilled. In some places you are lucky that it is. There are skilled pockets within primary care. There will be some very senior nurses working in general practice who have wound care experience and acute care experience and palliative care experience but Medicare cannot fund them.

CHAIR: Yes, we keep hearing that.

Ms Corfield: Then you have nurses who are sitting in the hospital system and a hospital-in-the-home process that takes a nurse and doctor out of the hospital system. If you partnered with the GPs, you can have some fee for service from the hospital to a general practice to manage that.

CHAIR: That Medicare provider number is so important in setting up a service.

Ms Corfield: There are things that Medicare do not fund. There is a little bit of innovation from the HHSs in thinking about what are the health economics behind this. If this patient stays here, it is going to cost us—I do not know; whatever a daily fee is—$800 a day or more.

CHAIR: We have heard figures of $900 to $2,000. It depends on the bed you are in.

Ms Corfield: It is going to cost at least $900 a day. If you were to stop that patient even arriving in ED, how much would that save you? Collectively, if you looked at the number of ED presentations and the number of beds being held up, wouldn't it be better to fund a nurse practitioner to work in the nursing homes, skill the nurses who are there, work with the GPs who are providing those services and ensure that those patients do not end up in ED in the first place?

CHAIR: It was our No. 1 recommendation in a previous report to the Commonwealth government two years ago.

Ms PEASE: In my electorate we have a facility that is run by Metro South HHS. It is called Camellia Lodge. It is a palliative care ward. It is associated with Blue Care nursing home, a residential aged-care facility. Metro South HHS are taking the staff who work at the residential aged-care facility through there so their nurse practitioners are getting trained to be better at dealing with people at end of life and being cared for in their own homes. That model of care is working.

CHAIR: Absolutely.

Ms PEASE: That is that relationship and partnership between innovative work.

Ms Corfield: Yes. You need to stop fighting about the money. It is not always about a Medicare item number. If the hospital has ED and bed numbers tied up and it is costing thousands of dollars for those patients to present through, look at it as a cost saving and invest some money back from the state into primary care. Everything is blocked because the state does not want to spend the money and the Commonwealth does not want to spend the money and the politicians keep arguing with each other. You just have to stop.

CHAIR: Meanwhile there are people in the middle.

Ms Corfield: Who are dying!

CHAIR: I know. We had someone in Hervey Bay who said, 'Here is my husband's level 4 home care package.' He died two years before he got it.

Ms Corfield: Yes.

CHAIR: Yesterday in Bundaberg we heard someone died six months before getting theirs.

Ms Corfield: Please, shake hands and play nicely.

CHAIR: Well said.

Mr MOLHOEK: Sandra, thank you for what you do in rural health. I know it is a challenging space. As I indicated earlier, my son is a rural health specialist in Central Queensland and his wife is in paediatrics and does community nursing. I know only too well some of the challenges that they face. I just wanted to ask some broader questions around the health system.

Every year it is record spending and record budgets. It does not matter whether it is federal or state money. It just always goes up. The distribution of it is interesting. What do you see as the opportunities to attract more people into the health services sector, particularly around NDIS care and aged care? The theme that we keep hearing through these hearings is that they are all struggling to find people. There has never been so much money available to provide services but no-one can get the services.

Ms Corfield: There are two parts to that. The money goes up and up because the cost to treat somebody becomes higher and higher because they are not treated early enough.

Mr MOLHOEK: And people are living longer too—

Ms Corfield: They are.

Mr MOLHOEK:—and developing more chronic conditions.

Ms Corfield: If the investment model was changed to look at doing something early—and it does not matter whether it is the state or the federal government that does it—then you have a chance of capping your health budget. The spend on a GP is far less than the spend on an EDMS in Emerald. The number of patients that are seen on a fee-for-service productivity based model is higher. It is about bringing back that respect and support for general practice so that we get good GPs, good practice nurses and good allied health working in private practice. We have to fund them and give them opportunities. Part of that is about opportunities to work in the acute care setting as well, opportunities to have a career path. We need to have integrated training pathways so that there are local pathways there for all of the disciplines to work together. The rural training hubs do a great job in this, but we need to have that collective supervision model and we need to have students, interns and registrars in place long enough.

Mr MOLHOEK: We are hearing that those opportunities are there, but 40 per cent of our workforce now comes from overseas. Put simply, why do Aussies not want to work in the health system and take up those opportunities? We heard yesterday it is not about the money; there is plenty of money on offer.

Ms Corfield: I swore we would never import doctors, and we run general practices. We run 18 general practices all over Queensland. We recruit and employ doctors. I have done it this year and we will import our first two doctors to work in Moura in the GP practice and to cover the hospital. They are a lovely couple and they will stay. Part of it is how for leaders and clinicians general practice and primary care is viewed as the secondary place that you work.

Mr MOLHOEK: We heard in Cairns that a lot of GPs are actually leaving private practice and going into Queensland Health because the working conditions and the salary conditions are much better and more attractive.

Ms Corfield: The solution to that is about how we put the funding in the right place so that there is opportunity for the state to invest in primary care, invest in partnership with general practice so that there is some opportunity for the GPs that are working there to do that. If you set up a competition based process where there are section 19(2) exemptions or RRMBS exemptions and the state has this wonderful own-source revenue, it is just destroying the system because the state government HHSs have a bucket of infrastructure and staffing so they do not have to have the same value for service or the same quality standards that general practice would have. The accounting systems within Queensland mean that that own-source revenue goes into a separate bucket. The expenses are paid out of the state bucket and the own-source revenue goes in separately, but it is not necessarily reinvested in that community and not transparently.

You have the likes of Torres and Cape, that are doing a lot of RRMBS billing, but it is not efficient and they are not billing anywhere near the amount of Medicare money that should be invested in those communities. There should be a whole lot more money going into those communities than there is. We need to look at the total health spend in a community and work out where the deficit is and how to make that better.

Ms KING: I want to seek your reflections on what has changed over the previous generation. I have friends and family who were rural GPs and worked shifts in the hospital or GP anaesthetists, which seems to have become a lot less common. What has changed that has made it difficult for GPs to have an integrated practice where they also practise in the local hospitals?

Ms Corfield: The acute system does not want them anymore. GP anaesthetists are seen as not good enough. GPs generally are seen by the hospital system as not being good enough clinicians—

Ms KING: Can I have your comments on whether—

Ms Corfield:—and it is not true.

Ms KING: I assumed that you would have that view. Can I have your comments on how the freeze on the Medicare rebate and the low level of remuneration for GPs has contributed to this perception that this is a second-rate health workforce?

Ms Corfield: Do you know when something happens that you do not necessarily agree with and then it is fixed, but the old niggle keeps raising its head? It is the same with the Medicare rebates. It is more broadly about how GPs used to earn their income; they would have some fee-for-service patients. It has never been high. In most practices, if you have a palliative patient you cannot charge them; the doctors just will not do it. Even if the practice managers tell them to do it, they will not do it. There has always been that, but they have had the opportunity to work in the hospital to do GP anaesthetics, to do some ED shifts, to have that ability to work across both sectors. It is the same for the hospital doctors coming out and being able to cut down to 0.8 or 0.6 and do productive work in general practice. It is much harder to have a part-time appointment now than it ever used to be. Having a GP obstetrician who is available to work two days a week—due to the process, the credentialing, the lack of respect for when they get there, it is just easier to not do it. We need to go back to having the whole workforce respected and being able to work together, and you as political leaders can set that. You can start having those conversations.

Mr MOLHOEK: Is there too much red tape?

Ms Corfield: Absolutely.

Mr MOLHOEK: Is the system too risk averse?

Ms Corfield: Absolutely.

Mr MOLHOEK: Is it that the public health system does not want private practitioners because they have different rules and frameworks?

Ms Corfield: That is why patients have to go through EDs, so they can get a few forms filled out. If they are not treated properly, the hospital has covered its backside.

CHAIR: We are well over time. We need 100 of you spread throughout the state. I was going to ask cheekily whether you have a masters in health economics? If not, you would breeze the course.

Ms Corfield: No.

Mr MILLAR: Sandra is a very well-known and very respected person in our area. I am absolutely in admiration of what you have been able to do and tell us. Thank you.

CHAIR: Well said. Thank you so much. We are out of time. We will move to the next speaker on the program.

KNIGHT, Professor Sabina AM, Director, Murtupuni, Centre for Rural and Remote Health (Mount Isa); and Director, Central Queensland Centre for Rural and Remote Health, James Cook University

CHAIR: Welcome.

Prof. Knight: That is slightly out of date because as of this week I am no longer the director of the Murtupuni Centre for Rural and Remote Health. I have been seconded to establish the new JCU Centre for Rural and Remote Health in Emerald.

CHAIR: I look forward to hearing from you. Welcome. Would you like to make an opening statement?

Prof. Knight: Thank you very much and thank you for the invitation to meet with you today. I would like to start by acknowledging the Darumbal people, the traditional owners past, present and emerging. I would like to acknowledge the Aboriginal and Torres Strait Islander people and the lands where I work and the people I have the privilege to work with. I also acknowledge those Aboriginal and Torres Strait Islander people here today and participating in this hearing. This is important work across Queensland.

I am proud to have been newly appointed the director of the Central Queensland Centre for Rural and Remote Health with James Cook University to be established in Emerald. I have come to this role after 11 years as director of the Mount Isa centre and, prior to that, 30 years in remote health, rural and remote health workforce, research and education in Central Australia.

I acknowledge that you have received opening statements from my JCU colleagues, so you will be thrilled to know I am not going to repeat that. I bring perspectives now to add value to that on some of the effort required, insights and impact of training in and for rural and remote areas of Queensland, impacts for the health service and the communities and, ultimately, for the state, the economy and the vibrancy of our communities.

It is no news to you that Queensland is a big state with vast distances and highly dispersed populations. In fact, our people count is less than our beef head count. We have wide differences in health need and health outcomes across our rural and remote areas that pose enormous challenges. We are very reliant on a generalist workforce in an era of even more focus on specialisation. So we are indeed swimming against the tide, of course, in an environment where we have heard quite a bit this morning where the boundaries of Commonwealth and state most blur: in those smaller rural and remote areas. I want to acknowledge that a lot has changed and we are, I believe, on the upward trajectory. I am an optimist, but I have seen a lot change, particularly in remote health in my career.

Whilst the tertiary hospitals automatically see themselves as teaching hospitals and are resourced appropriately, this does not flow effectively to smaller hospitals, regional hospitals, rural and remote, and we have heard that this morning. It is not because the practices and the hospitals are not actively engaged in teaching and research; they are just not sufficiently resourced to be able to do so. They are a much smaller scale. If they were sufficiently resourced, then they would be much more actively involved in teaching and research. I also want to acknowledge that given the current level of resourcing, all of these small services are punching well and truly above their weight compared to their metropolitan colleagues.

Some years ago it was recognised by the Commonwealth that to change the outcomes we needed not only additional resources but significantly different thinking, so the university department of rural health program was born closely followed by the rural clinical schools. This year the RH program has facilitated the development of academic units in remote regional centres across Australia that have developed research capacity, resources to support student placements, clinical training and, most importantly, fosters an appetite for innovation—risk taking. Those of us in the bush are very comfortable on the fringes of doing things. Tell us it cannot be done and we will have a go.

These UDRHs around the country have absolutely evolved in close partnership with their health service providers, as has happened here in Queensland. This has allowed, for example, the delivery of, in my experience, a very modest nursing program out of Mount Isa and Cloncurry that has delivered more than 90 graduates since 2004, most of which—69 per cent—remain in that area with the remainder in the Far North Queensland hospitals and only four practising in metropolitan areas across the country. That is an extraordinary success.

It is important to understand what is different about this program and what have we learnt from this. First of all, it is possible to deliver end-to-end training to a small group of people in a very remote area. It is a really important lesson to have learnt and we need to apply that more broadly. Also these graduates have very different characteristics to those who traditionally go off to university. They do want professional careers. Many of them have given up highly paid jobs, particularly underground

jobs in mining, to work in lower paid areas but want professional roles. They want to have that respect of working in professions, but they want to work in healthy professions. They have carer responsibilities and therefore have not been able to leave town. If you bring the training to them with the support, they will do it and they will stay.

Therefore, the metrics of that training, the metrics of success, is very different to how a university would traditionally view what is a sustainable program and what is sustainable for the health service, and the health service would view what is sustainable for them. They look over a period of time at the money saved by having people who are of the community, who know the community and the region, who live there so housing does not have to be paid for and who they do not have the associated recruitment costs and the recurring recruitment costs. That is critically important and it is a very important lesson for us to learn and I would like to discuss that further with you.

Another innovation we have been able to evolve is what we call service learning. We heard a bit about that this morning with the student-led clinic which was established here in Rockhampton. This is where, as a university department of rural health, we provide health services with our students. We look for an area where there is a gap, where there is a need, where an intermittent service can provide value to the community, where we are able to employ the supervisors and provide that service with the students, where there is a great benefit not only to the students but also to the community. We have been able to do that with our Commonwealth funds. By demonstrating the value, we have been able to do that with funds commissioned by the hospital and health service, for community rehab in Mount Isa, for example, and with funds commissioned by the PHN for community rehab up in the western cape.

This develops that all-important care while providing the students with high-quality placements. They get that real world experience in rural and remote areas—where they are carrying a case load, where they are absolutely stretched but supported so that they are much closer to being work ready on graduation in that rural and remote context. In that way, they are more likely to take up in those areas. We have story after story of successes where students had never considered working out west but who are currently employed out there, and where collaborating partners for local health services are directly employing from our student body. We are now delivering health professions, particularly allied health professions and nursing, but also a medical workforce into the system through our student program.

It is important that we consider the opportunities that technology has offered us to enhance the delivery of end-to-end programs but also to extend the way that we undertake clinical placements so students can undertake placements in very remote areas successfully and be well supported. Those students are also associating with their new peers in the community. Just by doing so, they are raising aspirations—if you have not met one, you cannot aspire to be one. Local young people in the communities are meeting professions they might not have ever encountered, so we are building their opportunities and the potential future workforce through that area of activity that we are doing.

I would like to recognise the importance of local government as well as the health services in enabling our work. We could not have successfully established our student placement program in towns such as Boulia, Cloncurry, Normanton, Burketown, Blackall, Barcaldine, Weipa, Longreach or Emerald, for example, without the practical support of the councils, the local organisations or the health services. Whilst it is true our Commonwealth dollars purchase, construct or lease accommodation, it is through the local governments and the hospitals that we are able to put the accommodation on land. In most of those places I have referred to, there are not places where we could put students. The current operations of Queensland Health do not build in the construction of student accommodation as part of its core business wherever it operates, and it needs to in order to be able to build a health workforce.

Not only do these local organisations provide this extraordinary local support, but they bring the community along to support our students as well. The focus on building a health workforce in and for the region is something that I would like to draw your attention to. I know you have heard this from us before at JCU, but I am now talking on the metrics of small places in and for the region. The strategies that we need to undertake to be able to do that require very modest but important investment to make that happen. The health services need to be resourced to be able to undertake teaching and research. In partnership with the universities, we need to have the student accommodation and the teaching facilities. If there are funds pooled by state, Commonwealth and community organisations, this is entirely possible—not only possible, but desirable.

I heard you ask the question today about whether we need more training places, and the answer is yes. We know that, if we are able to take on more in the north and in the west, we can deliver a workforce. For those health professional courses that are capped, we absolutely need more training places.

It is a long pipeline so we must be patient in delivering it, but we cannot take our eye off the strategies that are required to deliver on keeping the pipeline primed so it does deliver a health workforce from the other end. Yes, we need to be able to recruit rural students into programs, we need to send them to regional universities, we need to ensure their clinical placements are undertaken in high-quality areas in rural, remote and regional areas, and we need to ensure that graduate jobs are available for them in rural, remote and regional areas and that they have ongoing support into their generalist or even specialist areas that we require. That is all possible. We have wonderful pockets and large areas of demonstration where this has occurred, but we need to make sure this is now not a niche area or an experiment. This needs to be systemised across the state. I will finish there.

CHAIR: Thank you. We have said in previous public hearings where JCU has presented that it is commendable work. I have seen it firsthand in clinical practice out west of having those nursing places and they stay there in Hughenden, Julia Creek and Mount Isa. It really is a commendable program that has been around since 2004. I have a relative who is doing nursing now and is back out at Hughenden doing placement so it is quite incredible. It is very clear through your statement that the health infrastructure around the training places is paramount, to put it that way.

Prof. Knight: That is correct. The two rate limiters, to be so bold, are supervision, which is the capacity to supervise students, and accommodation. There are other things but if you solve those two you could fix the rest.

Ms PEASE: Can I ask a question on that. It is lovely to meet you and thank you for all of your hard work. I see you have an AM, congratulations. It was no doubt very well earned.

Prof. Knight: Thank you very much. Nobody was more surprised than me.

Ms PEASE: That is even better that you are humble. Just on the accommodation and supervision, I am assuming that you would support that not just for junior doctors and doctors in placement but also for nurses and allied health workers?

Prof. Knight: Absolutely. The university department of rural health program is for all disciplines. In fact the new one that has been established in Emerald is for nursing and allied health, but because we are already there and we already support medical placements they will continue. It is important that our future workforce in training at the undergraduate level is exposed to and learns about the other disciplines. When you go to uni, you are in your own tribal groups. You may not meet the other disciplines but on placement we ensure they do. We have strategies where we deliberately mix them up in the accommodation, for example. They do not get to be with their buddy in their house. They might be next door, but the medical student will be with the pharmacy, the dental, the nurse, the midwife, the occupational therapist, the exercise physiologist, whatever. They go home from work, they prepare meals together, they chat. We have them in a structured way engaged in the community, giving back. Even our students who get to university from a low socioeconomic group are still better off than many of our others so they need to volunteer back into the community. They volunteer at PCYC, at Chillin in the Park, at the races or at the show, whatever. Those things are very important. Yes, it is all disciplines.

Ms PEASE: Can I comment, and excuse my naivety on this. As a university, you provide a range of courses not just in health. If you were doing a bachelor of business, for example, you would turn up and do it and qualify and go out, yet in your medical stream it is a completely different picture. You are supporting those people through and actually working with hospitals and communities. That must be at a big cost to the university and I just find that overwhelming, the amount of involvement you have—with what you have just said that you engage with your students to participate in the local community.

Prof. Knight: We would not be able to do this without our federal funding. We are 100 per cent federal funded. It is not a big bucket of money but we spread it wide. It demonstrates that with modest investment you can make a very big difference.

Ms PEASE: Is that just for Commonwealth supported places? Do you do overseas training for students who come from overseas? Is that fee for service?

Prof. Knight: We are all for undergraduates, so entry to practise, medical and health professions, and we are funded only to support Commonwealth supported places. Occasionally, we do support internationals but we set that to the side. We are only funded to support Commonwealth supported places, and rural origin students more specifically. In our last contract, the Commonwealth wants us to negotiate with universities and health programs, so if I am talking to the dean of health sciences here to say, 'Can you please ensure that the students you send on placement with us in the

towns where we are operating are rural origin or rural intended students'—that we will prioritise those students. If we are looking to students from QUT or the University of Queensland, we will say the same thing.

Ms PEASE: Further to that, with regards to your GP programs that you run, I understand that the college is about to take back that training.

Prof. Knight: That is correct.

Ms PEASE: How will that impact on your whole package and how you deliver and are able to create a rural GP?

Prof. Knight: At the moment, as you would have heard, James Cook University is able to offer something completely unique in Australia—and it is complete end-to-end general practice training from aspiration raising through to undergraduate, postgraduate training, support through to completion in registration and support during that process. In its commitment to do so, it has a very strong presence in the small rural areas where we have those registrars placed. With the college taking that back, I understand that they are not going to invest in having educators placed in the small rural areas. Certainly, I have not heard any communication to say they will retain the JCU staff who are undertaking that support.

The other thing we are able to do is that, because we already have a presence in many areas through our rural clinical school and our university department of rural health program activity, we are able to integrate this and build on it. That person who is working in the GP training area is nested within the broader academic and rural support units that we have. I am very concerned as to what will happen with this. JCU has only had GP training for a short period of time and we know it takes a long time to establish and an even longer time to churn out graduates at the other end. The trajectory is very positive. Our undergraduate students on placement with supervisors—say, in Emerald in general practice or in the hospital—are meeting the very people they may work with in their postgraduate training and are much more likely to apply to undertake rural generalist or general practice training knowing what they could go to. If that is disconnected, then we fracture that potential pipeline and I am very concerned about what will occur. I am not alone; we are genuinely very concerned as to what will occur.

Ms PEASE: Thank you. I have a million more questions but I cannot ask them.

Mr MOLHOEK: I am absolutely a fan of what JCU are doing. There should be more of it. It concerns me to think that JCU may be disadvantaged under the change of college system. I guess that is something we can look at in our recommendations. I have two questions. We heard from Sandra Corfield earlier, and I do not want to put words in her mouth but she gave us the sense that the public system does not necessarily value GPs in the acute system because they have concerns about their ability.

In respect to rural generalists, what I have heard is that a lot of people do not want to do rural health because it is very difficult for them, after they have done time in rural Queensland, to go back into South-East Queensland and into the public health system or any significant health system apart from getting a GP job. You opened the batting in your commentary earlier by talking about the very hands-on and real-life experiences that trainees get in rural and remote Queensland. My son was stitching up people and delivering babies when his mates were still practising on pigs ears down the Gold Coast. The director-general himself is a rural health specialist and yet he probably would not be able to work in his own hospitals, he would have to go and get a GP job, because of the way people view rural health specialists. How do we change that? Is that an issue?

Prof. Knight: I think it is an issue of several parts. We will always look to recruit people from metropolitan areas to country areas for different reasons and people in country areas for one reason or another will always look to relocate into the city, but I would view that the number of those should be in the minority. If we are looking to recruit our future workforce for rural areas it should be from rural areas because they will stay in rural areas. Our evidence at JCU is overwhelmingly that that is the case. I think that is where the effort needs to continue and the increase in training places for medicine, for other allied health courses, for nursing, for dental, for pharmacy, the whole lot, needs to be so that we can continue to recruit more people into courses who will then go to those regional universities and be attracted because they already have their own networks. The entrepreneurs of the future of Northern Australia are from Northern Australia. They know how to live there, they know how to work there, they just need the skills to be able to take the next step. If we make that possible, so that, for example, we are raising aspirations for young people to go to university who have never had anyone from their family go to university, who are from a family that does not have a lot of disposable income, unless they have access to scholarships to help pay for their accommodation

they are not going to go. There are some very practical things that can be overcome for rural students. We need to continue with the pressure on universities to select rural origin students, a proportion of rural origin students into their programs and for the other wraparound programs to continue to be wrapped around them to graduate and continue.

Mr MOLHOEK: I think my concern though is that there is a reluctance to go into rural health because there is a perception that the pathway beyond that back into non-rural health is very difficult.

Prof. Knight: It depends if you see your future in rural health. If your future is in rural health then you will take it. If you see it as a stepping stone to somewhere else then you may not. I do not see it as a stepping stone to somewhere else. I think if you are good enough to work in rural health you are good enough to work anywhere in the world and we will provide you with the training to do it. The graduates are highly sought after to work anywhere in the world. I think we hold our head up high. I think we can absolutely do that. Certainly I experienced this as a young nurse. I worked in the Pitjantjatjara lands with almost no resources for some years and it required extraordinary skills to do so. I wanted to do midwifery and I was told by the director of nursing in Cairns that I needed to go and work in the hospital for a year to be a proper nurse again before I could apply. It was a very long time ago. Needless to say I did not do that. That attitude has changed.

Mr MOLHOEK: Which sort of indicates that the system is a bit risk-averse.

Prof. Knight: The system is risk-averse.

Mr MOLHOEK: There are a whole lot of people in the bush who are doing things that perhaps they would not do in the city because we are obsessed with specialisation.

CHAIR: You did it because you had to find a way.

Prof. Knight: You do it; you have to find a way.

Mr MOLHOEK: Does the system need to change?

Prof. Knight: The system is not a single system. We are made up of many systems. What you need in the city is different to what you need in a regional city, which is what you need in small rural areas and the way you operate those is slightly different, but it is possible to navigate and move between. I certainly have colleagues who do it regularly. I am optimistic, not so negative about that. I think it is indeed possible. If you are wanting to carve out a career in a subspecialisation area then doing some time in rural may well buy you brownie points into a training program if that specialty values that experience, but if that is where you are going you need to chart your course to do so. If you want rural health then we need to make that possible all in rural and that is the area where I think we can.

Ms KING: Every time we have heard from JCU I have felt so energised by the contributions that the university makes to building our rural health workforce. Thank you so much. I do want to turn back to some comments you made. You described it as service learning and talked about the provision of health services by students setting up clinics that are fully supervised where students are providing healthcare value to the communities where they are located. In previous hearings we have heard at some length about the challenges particularly for I think nursing and allied health students who do not routinely get accommodation and they are not paid for long periods of placement. I just wanted to get some feedback from you. In those student staffed supervised clinics, you mentioned the students being recruited. Are they recruited to a paid position for the purposes of their placement?

Prof. Knight: No, students are not paid, but we subsidise their placement in that all students who do placement with us out west do not pay for accommodation. We have evened it up. Traditionally for a long time medical students and pharmacy students have had a subsidy paid by the Commonwealth through the universities to be able to undertake placements. They often come from a background where they are more likely to have additional resources to assist them anyway. However, we have levelled the playing field out west and no student, whether they be in Longreach, Barcaldine, Emerald, Blackall, Mount Isa, Normanton, Cloncurry, Weipa, wherever, pays. At this point in time we use our Commonwealth grant to provide them accommodation. We have hit our straps, but I am holding onto that because it makes a big difference. They still have to get to us, they have to get to us in Mount Isa or get to us in Weipa or get to us in Longreach or get to us in Emerald, but if they are going on from there to a more remote site we get them there. We will fly them there or drive them there.

Ms KING: What interests me about that though is that that is a measure that the university has determined to adopt to provide equity for students and incentivise those who wish to do their placements and their learning in a rural and remote location. What would the impact be if—I will not

say who, but if somebody, if government, funded that placement accommodation cost for allied health and nursing students in the same way that many medical students are funded for that accommodation?

Prof. Knight: The medical students and the pharmacy students are funded to do rural placements so they will not get funded to do them in regional cities. I think that would make a large difference in Queensland because we only operate in so many places and we use our Commonwealth grant to do that. As director I have a fair bit of autonomy over my budget. There might be some differences of opinion internally but this is what we have decided to do with it and we will get the best returns and using the evidence as we understand it currently. It is really important. As I said before, if Queensland Health invested in the teaching and research part of its health services in the smaller areas as it does and would assume always does in the city then it would consider always building in student accommodation, additional teaching capacity, educator capacity in their whole services and some release time for staff to do research which means that you can keep people for a long time who build their careers. When I look around the health leaders, particularly the public health leaders in Australia today and over the last 10 years, they have all cut their teeth in remote regional areas. I have worked with many of them myself proudly. There is an absolute career pathway there if we create it and make it possible.

I would just like to add one more thing that I think is critically important: the rural integrity of the health dollar and the education dollar is very important. If we are paying a health workforce to fly in and fly out not a single dollar retains in that town other than $50 for groceries, perhaps. Nor does any of the intellectual capital stay either. The children do not go to school, they are not part of the P&C, they are not part of the local clubs, they are not part of teaching and they are not part of research at work. They arrive, they do their job and they go again. This is an important thing to pay attention to as to how health services are funded, as to how they employ their workforce. It is critically important they live and work in the areas. It is critically important that we hold the line of sight, that we do want Australian graduates or graduates who have trained in Australia over time to be employed in the services. If we continue to take on international graduates we know from the evidence that the greater majority of those only stay until they get their qualification and then they leave. The bush is subsidising overservicing in the city and this is just not right. We need to be able to address that. It is not an easy space in the middle period, but we really have to collectively work together to overcome that.

CHAIR: I like that: cutting your teeth out west. I did a lot of work out west. I was shoved out there in the nineties for a reason.

Mr MILLAR: This is just a statement: you have done a fantastic job in what you are doing and how you have given it to regional Queensland. Just to give an example, Sally Magoffin—Dr Sally Magoffin now—is a graduate of James Cook University. It was only two weeks ago she did her first caesarean and is practising in Mount Isa. We need to get that James Cook University model that you have got going for Western Queensland and for regional Queensland across all of Queensland. Anything I can do to help let me know.

Prof. Knight: I think it is the belief that we can and the belief that the quality of training in rural is as good as, and I would say sometimes better than, what you can get in metropolitan areas and we continue to practise what we believe and to grow that belief and it is important that we continue to evaluate what we do and produce the evidence, that we are honest with that, and be able to share the lessons but also own things that do not work and learn from things that do not work. That is important as well.

Mr MILLAR: Congratulations. Mr Chair, you might have to excuse me. I have to go and get a future health worker, my daughter, who is studying nursing at CQU, and give her a free lunch.

CHAIR: Well done!

Mr MOLHOEK: I am wondering if you could comment a little bit further on FIFO health. That is an emerging trend.

Prof. Knight: It is more than emerging. It is an easier strategy to be able to keep a service going, and a busy health service that is under the pump. It is something that people will reach to as a way to keep going, but unless you put the intellectual and the economic investment in to not only deliver today's service, but contribute to delivering tomorrow's we are never going to be anywhere different to where we are now. We have to be committed to changing that. The most highly paid health professionals in town, if they are not spending their money in town and their kids are not going to school in town we are absolutely diminishing that community.

CHAIR: Member for Mirani, do you have a question?

Mr ANDREW: Yes, I do, Chair. Thank you, Professor, for coming in. I was listening to Sandy before and she commented on the divide between the state and federal governments and policies that could be put in place for the monies coming through the system to be able to hit their mark. Would you agree with that? Have you seen from your side of things that policy could be improved to make sure that money is utilised in the best way for all these services?

Prof. Knight: I think the best example is the multipurpose service program. The multiservice program pools Commonwealth and state funds to be able to provide aged-care, acute-care and general practice services in the area. That program was capped. I was part of the National Health and Hospitals Reform Commission way back when and we recommended that the population size was increased to be able to roll that program out to larger rural populations across Australia. I think it is important to revisit that. The framework for that program is incredibly successful. It is not the only success; there are other things. We need to have the workforce to prop it up, to support it, but it provides a fund-pooling mechanism where Commonwealth and state aged-care funds all come together to provide a service. I think that is really important.

You asked Sandra and my previous colleagues questions around aged care. Certainly our aged-care workforce needs to be better paid, particularly the nursing workforce, in order to attract people into it. We also need to create a career pipeline. If we renumerated nurse practitioners in aged care sufficiently, there would be an aged-care nursing workforce pipeline because you cannot be a nurse practitioner unless you are an experienced aged-care nurse. That would drive a profession development pipeline into the future. I think that is one that should absolutely be explored. That could be supported by both the state and the Commonwealth.

CHAIR: We have gone over time. I appreciate the patience from people who are yet to come to the table. Professor, thank you so much for your excellent contribution. It is greatly appreciated by the committee.

Prof. Knight: Thank you very much and thank you for the invitation to speak with you. I wish you well in your deliberations. We welcome the next registered speaker.

KIRBY, Ms Linda, Private capacity

CHAIR: We need to deal with some papers that have been tabled. Is leave granted? They are so tabled. Welcome and thank you for coming before the committee today. Would you like to make an opening statement before we move to questions?

Ms Kirby: Thanks so much for having me. I do have some documents I want to table. I will leave them with you.

CHAIR: Is leave granted? They are tabled.

Ms Kirby: Before I begin I would like to acknowledge the traditional owners of this land, the Darumbal people, on which we meet today. I would like to pay my respects to elders past, present and emerging and extend my respects to any Aboriginal or Torres Strait Islander people here today.

I am a nurse practitioner and I have worked both locally in Central Queensland and throughout Australia. Over the past 16 years in my nursing career I have been to remote parts of Australia to care for First Nations people, including all the way to Christmas Island to look after asylum seekers and refugees. I have worked in prisons and also in rural and metropolitan emergency departments. I have now established myself back in Rockhampton to work with the sole specialty focus of women's health.

Today I would really like to talk to the point about the barriers which I face daily in my clinical practice. I am in the private sector which directly affects and impacts my patients in accessing timely and equitable health care and the significant impact that has on the Queensland public health system. I would like to pay particular focus to the Medicare Benefits Scheme, the MBS, and the Pharmaceutical Benefits Scheme, the PBS. My intention is to hopefully offer some research supported remedies to these issues.

What is women's health? Patients will come and see me as a nurse practitioner for the diagnosis, treatment, referral and ongoing care of some different things but definitely not limited to things such as: heavy menstrual bleeding, cervical screening, endometriosis, polycystic ovary syndrome, terminations of pregnancy, I see survivors of domestic violence and people who currently experience domestic violence, pregnancy, menopause and contraception—which could be inserting Mirenas, Implanons, prescribing oral contraceptive pills and giving Depos—and then there is general education about sexual education and reproductive health. At the moment the hot topics are things like consent, information technology sharing, the current laws and how that is changing, particularly with young children as well—educating in that space.

My clients identify from all different walks of life. I see a lot of department of child services clients—they are our most vulnerable young children and young adolescents—NDIS clients, people who live in rural and remote areas who drive a very long way to see me, Aboriginal and Torres Strait Islander people, LGBTIQ community as well as culturally and linguistically diverse groups. They are some of the very many minority groups I see, and I see people across the whole entire life span. The restrictions I face as a nurse practitioner with MBS funding and PBS prescribing provide an absolute hotbed for the breakdown in continuity of care and directly entrench the barriers to health care for my clients. To exemplify these restrictions I would like to use one clinical scenario with you. At this point, I would like to add a trigger warning that I will be discussing terminations of pregnancy.

Whilst I could talk about one patient journey with you, sadly, these presentations are not individual for someone who is requiring a termination of pregnancy. They are very similar and they are filled with disjointed care, requirements of high health literacy and communication, tight time lines and trying to find availability to access things such as pelvic ultrasounds in already heavily booked radiology services throughout Central Queensland. Instead, I will share a general journey of a female trying to access a medical termination in Central Queensland and the barriers that both the patient and I as the clinician face.

First a little background: currently in Rockhampton the public hospital does not offer medical or surgical terminations. There have been small inroads to help this but with some exceptions for access, however it remains mostly inaccessible. This has been the case for over a decade with increased pushback from medical professionals and support from executives in refusing to perform terminations. That has led to terminations of pregnancy being outsourced to Marie Stopes through a telehealth service in Brisbane. Marie Stopes did stop their face-to-face services last year in Rockhampton.

For Queensland Health to subsidise a termination, the woman must meet a really strict criteria, otherwise she will be required to pay for this private service. A little bit of history about the criteria: the medical termination of pregnancy—and MTOP is the acronym we use—is where tablet medication

is used to stop the pregnancy. It can be performed up to about nine weeks gestation. Surgical terminations of pregnancy—and STOP is the acronym—can be performed up to about 22 weeks without a medical reason.

There is a series of three appointments. The first appointment for a woman requesting a medical termination is where we ascertain particular information before any procedures, prescribing or administering of medication can occur. We need to know how far along pregnancy is; what the gestation is. That would involve a pathology request form and a pelvic ultrasound to ensure that the pregnancy is in utero and potentially even getting a dating scan, which is an ultrasound request. Noting the gestation at this consultation would be paramount because we would need to know if they need an MTOP or a STOP. Obviously when they are closer to nine weeks, that really starts to increase the pressure to get the blood work completed and the pelvic ultrasound booked; getting that in is paramount. We know that in communities our general practitioners are absolutely overwhelmed already with clients requiring care. This sort of situation highlights the underused resource of nurse practitioners in our scope of practice.

This first appointment could be conducted with the nurse practitioner and we could order both the blood tests and the pelvic ultrasound. However, if I was to order the pelvic ultrasound, the patient would be charged an out-of-pocket fee. Under the recently revised MBS scheme, the nurse practitioner does not have the ability to completely bulk-bill an ultrasound. This is a financial barrier to patients. They may have to make an appointment with the GP to get the GP to request the pelvic ultrasound. This MBS revision to pelvic ultrasound pertaining to nurse practitioners is not only a professional insult, but it halts the most important diagnostic tool that we have as women's health nurse practitioners. It is paramount in diagnosing and treating some of the health presentations that I mentioned before. Currently under the PBS the medication MS-2 Step, which is the tablet component of the medical termination, is only permitted to be prescribed by a medical practitioner.

More recently across Australia key stakeholders have been researching the crippling burden that these restrictions are placing on the public healthcare system due to the PBS and MBS policies. The documents I wanted to have tabled contain supporting evidence of what is happening at the moment. One is a situational analysis written by Mainey and others in 2021, which is entitled *Unfit for purpose: a situational analysis of abortion care and gender based violence*. It discusses the fact that we need to be using nurses and midwives to our full scope of practice to help provide timely access and provide safety and wellbeing for parties, patients and staff. Another document also written by Mainey and others in 2019 is entitled *The role of nurses and midwives in the provision of abortion care: a scoping review.* It highlights the changes to the PBS policy and looks at not just a medical practitioner providing the MS-2 Step component but a nurse and a midwife being able to provide that service.

Hopefully this clinical example has helped to highlight the barriers that I face as a clinician with MBS funding in relation to pelvic ultrasound and also the PBS scripting. If these items and the PBS changes could occur, it would be a massive reduction in the pressure on the public health system and on access to GPs. It would really demonstrate that nurse practitioners are willing, able, competent and skilled to give timely, holistic, non-fragmented care to their patients. If legislation and policy can keep up with the demands of the community it would, therefore, allow the Queensland public health system to deliver and empower skilled labour with tools such as appropriate MBS and PBS, particularly something as simple as being able to prescribe MS-2 Step.

Whilst I was writing this, I thought it was noteworthy that there was an MBS change recently in relation to the funding for IUD insertions for GPs. As a nurse practitioner, I do exactly the same training that GPs do to insert Mirenas and IUDs. I do the same training to put in Implanons and in script writing—the exact same training—however I have no MBS billing number. I have one billing code that I can use, and that is just a consultation. Whilst there have been many studies—and I am sure my colleagues before me have discussed that—and multiple papers written about the holistic nature and the care that nurse practitioners can give, those changes would mean that I could see someone, give them some contraception and they could come back and see me at any stage. It is fantastic. It is good to see that the MBS is trying to catch up and trying to get GPs on board with allowing us to insert them, but I think we have about a six per cent rate of using long-acting contraception and it is a barrier. Nurse practitioners can do these things.

These limitations related to the MBS and the PBS really demonstrate that the laws and the regulations are not in step with industry and patient needs. The industry is tying itself up with red tape instead of utilising an already willing, capable and highly skilled workforce to the best of its ability to provide equitable, accessible and holistic health care. That simple correction of the PBS and MBS

would benchmark the safety and success of the provision of care by nurse practitioners, offer continuity of care for patients and ease the burden on a very much already drowning public healthcare system.

CHAIR: Thank you very much, Linda, for the important work that you are doing in this space. It is commendable work. They did not just stop in this area; they also stopped in my home town of Townsville. The HHSs picked up that work. I understand a service will be established in Gladstone. I am not sure what that looks like.

Ms Kirby: It is very limited and at this stage they are only accepting Gladstone patients.

CHAIR: Thank you for highlighting that for us.

Ms KING: Linda, I am a huge supporter of the services that you are providing. I find it quite tragic that, after an 111-year fight to get women access to legal abortion care, services are falling over in regional areas. I know that that view is shared by many of my colleagues. I want to ask some questions about your comments around the use of long-acting contraception. How do our rates in Australia—you mentioned six per cent—compare to those internationally and what are the differences in models of care, if you know, that might contribute to higher rates in other areas?

Ms Kirby: I do not know too much to really talk to that point specifically, but I know that in Australia the key focus is education. I do know that MBS billing is a barrier, but also that heavy burden for GPs in particular. Having to get through a heavy workload of patients and the time taken to insert LARCs particularly is a massive barrier. Particularly where I work, we know that we can put patients with nurse practitioners and we can spend that little bit of extra time with them and get them in. I am not too sure what the models of care are overseas, but I think that having the MBS come to the party a little bit for general practitioners is good; however, the time taken for these procedures is definitely still a barrier. There is a ready and willing workforce of nurse practitioners that can do these things, but we simply do not have any billing to do it and I guess we are not recognised in that space.

Ms KING: Especially for Mirenas, I know that often the care at one time will be provided by several people, one person holding each hand or whatever is required.

Ms Kirby: Yes, absolutely.

Ms KING: That is a high-density workforce to maintain, with only 1½ cost centres to bill to, I suppose.

Ms Kirby: Yes. I think in a patient's journey when they first come to see us to maybe talk about contraception, if they are seeing that face you are breaking down some barriers as well. I do see a lot of patients who have had previous sexual trauma and they know they might be almost in another DV situation where there is reproductive coercion, so it is really important that they have some LARC with them. If you can have a really good therapeutic relationship in that time and then be the person to insert the device, we know that they will come back. But if they know they have to come and see another clinician—there might be previous trauma there when coming into a medical establishment—that is such a barrier as well. I think that is where that holistic approach, from the first meeting all the way through, is good.

Mr MOLHOEK: I could probably spend an hour asking questions. Obviously you rely on co-payments or people paying outright for services.

Ms Kirby: Yes, we have mixed billing where I work. We are very proactive in advocating for our patients. We have to rely heavily on NGO companies, such as Children by Choice, to see if they can help fund if there is a component that we cannot pick up or try to bulk-bill as such, but it is so limited. I guess the pressures that I see women face daily—gosh, even today, for instance. A young girl came in and said, 'I can't go to Brisbane—I have so much—I can't. I've never been on a plane before. I've never been into the city. I need a surgical termination. I'm really close to nine weeks. I don't want to have a medical termination. I know that my mental health would not be able to withstand the process, the bleeding. Help!' The absolute desperation that you see in people and you think, 'What can I do for you?', and then having to lobby a hospital service to see if they would provide it. It is pretty much a tough day in the office regularly.

Mr MOLHOEK: Do you operate out of a medical centre?

Ms Kirby: Yes.

Mr MOLHOEK: There are GPs there as well?

Ms Kirby: There are GPs. Currently, in CQHHS, in particular, we are inundated with performing medical terminations of pregnancy. With women's health particularly, there are so many other things that we already have as our 'business as usual', but now we have also an increase in

medical terminations. If I am seeing someone, I have to quickly knock on the door in between patients and say, 'Can you quickly write me a pelvic ultrasound, please?' It is so fragmented. Or I will say, 'Can you come back tomorrow and then we can get a pelvic ultrasound written for you?' It is the stress and the pressure that those young women are under—and it is not even just the young women; it is women in general. They have to wait, they have to see a few different people and then they have to try to get into an ultrasound appointment. It is really hard.

Mr MOLHOEK: If they do require a surgical removal, do they all have to go to Brisbane?

Ms Kirby: At this stage, as I mentioned, there are some insteps to try to get surgical terminations back here in Rockhampton. As you alluded to before, Gladstone is trying to set up their hub. However, at this stage, on a case-by-case basis, the hospital will look at the surgical terminations. Now it is through Marie Stopes. As I mentioned before, when women ring Marie Stopes for a surgical termination they have to meet a very strict criteria for the hospital to pay for that otherwise they will be out of pocket.

Mr MOLHOEK: Is getting access to that through Queensland Health or the local hospital made harder because there is a shortage of health professionals who are prepared to participate in the procedure or is it that they have pressures with their elective surgery and other surgical waitlists?

Ms Kirby: Choice. A significant number of clinicians—

Mr MOLHOEK: So there are just not enough practitioners who are willing to participate?

Ms Kirby: Yes.

Ms PEASE: Linda, thank you for your great work. Like my colleague, I acknowledge that it has been a long time coming that women's health is being cared for appropriately. You made a comment around nurse practitioners and the changes to the MBS. Was there a change to the MBS that stopped you? What was that change?

Ms Kirby: I am not fully aware of the review that happened. I do know that the Australian College of Nurse Practitioners has been lobbying with the MBS for a review. In 2019 all of our requests to get things put back on there were declined. I am not 100 per cent of whether it was purely a policy change. I am not sure. We did have funded public ultrasounds.

Ms PEASE: Under the MBS and then it was removed in 2019?

Ms Kirby: Yes.

Ms PEASE: Are you able to find out what that was?

Ms Kirby: Yes. I have been liaising with the federal and state government. I do have an email trail back about it that I can give you, to table.

Ms PEASE: Would that be alright, Chair? I think that would be interesting.

CHAIR: We will put that on notice. If we can have that back by 10 March that would be fantastic.

Ms Kirby: Yes, that is no problem.

Ms PEASE: To clarify, whilst you might see patients and have consultations, you cannot write prescriptions or referrals so they can have an ultrasound or blood work?

Ms Kirby: I can have it bulk-billed. I have MBS fully covered pathology so I can do that. I can write scripts. Scripts can be covered. However, if I write a pelvic ultrasound the patient is not fully covered and they will have an out-of-pocket expense.

Ms PEASE: So it is just the ultrasound, which is why you go to the doctor?

Ms Kirby: Yes. My colleagues in other specialist areas probably have other issues where they do not have fully funded things. I can only really talk to the point about the things that affect me in women's health and it is those pelvic ultrasounds.

CHAIR: Member for Mirani, do you have a question?

Mr ANDREW: I do not have any questions at this stage but, Linda, thank you for your information today.

CHAIR: Thank you, Linda. It has been very helpful for us to hear you. Thank you for the work that you are doing in this space. It is very important.

Ms Kirby: Thank you so much for coming. It is very much appreciated.

CHAIR: I call forward our final speaker.

HAY, Ms Dawn, President, Central Queensland Multicultural Association

CHAIR: Dawn, I met you briefly at the door. I think it would be very helpful to the committee if you gave a little bit of the background that you gave to me. I think the work you have been doing is very important.

Ms Hay: I will try to pull it all together but you have to appreciate that I am doing this from memory. My name is Dawn Hay. I am the current President of the Central Queensland Multicultural Association and I am also their volunteer manager. I will start by recognising the traditional owners of the land on which we are standing today, past, present and emerging.

I would like to congratulate the Queensland government for activating two courses, the Community Action for a Multicultural Society and Skilling Queenslanders for Work. Out of both of those courses, amazing things have happened in the community. A lot of people have gained self-confidence, settled in the community, stayed in the community, have been able to learn to drive within their own country and have gained employment. That speaks for itself. We have won two training awards under the Skilling Queenslanders for Work program. I need to acknowledge that right up-front, but we do have challenges.

I want to give you a little bit of background of where I am coming from and my passion which is why I am still here as a volunteer. I am a registered nurse, I am a registered midwife and I also have degrees in health administration and management. I have been fortunate enough to have worked across cultures for the past 52 years. I have worked with the United Nations. I went out of the country for 10 years, came back in and worked with the university as a senior lecturer. When I retired I thought I would just sit on the beach but someone grabbed me and said, 'No, you can't!' I have never had to apply for a job because of my knowledge across all cultures, it does not matter where they are in the world.

What we are facing at the present moment—and it has been interesting to hear the other speakers in relation to this—has all the similarities of what we seem to have been facing for about 30 years. When I was at the Central Queensland University, we were facing work shortages, models of care that should be different and so on. But we are in a new world and we do have a very strong cross-cultural healthcare workforce, as well as in hospitality, trades and so on. Just taking health for a minute, there is a breakdown. I sit on the Central Queensland Consumer and Community Advisory Committee for the CQHHS and I was chosen to go there because of my cultural background.

Historically, the GPs who were paid at the federal level under the Medicare scheme had time to sit and talk with their clients. Clients now feel that after they are there for three minutes they are shunted out, so the GP is not hearing the story. The GP obviously does not have time. I am not going to go into those areas. There is a breakdown there.

Whether clients are from a cross-cultural background or not—it could be any one of us—if you are not heard, you cannot tell the story. If you cannot tell the story then you are going to go to another place to get it, and that is accident and emergency at the hospital. That is where the overload and the breakdown is occurring. We have a motto: 'stop it before it happens'. Health prevention activities are not occurring enough within the community. That is then fed through to GPs and then through to accident and emergency.

Two years ago we were funded to do a research project—it was about breaking the barriers of health communication. We went into this research not knowing what we would come out with. We found that there was a breakdown in GP communication to healthcare services and to other private health sectors as well. There was a recognition that the consumer could not communicate well and could not navigate the healthcare system very well. We then had our medical doctors in the healthcare system saying, 'We are not communicating well with the consumer. There is a breakdown there.'

With that, we are now working with the local health service district. We are looking at doing a community care connector program. We are really keen to push this forward. We are doing it voluntarily at the moment. I will give you an example of it. We do it in disaster management under VOAD, supported by the Queensland government, Red Cross and so on. We are now recognised across cultures as the community care connector organisation within the community, but it is not funded. We are doing it as we feel there is a need following on from this research.

For example, I get a call from the hospital: 'Dawn, can you help? We haven't got anyone to speak in this language and we have an emergency on our hands.' It was a mental health person. We followed that mental health consumer right through to Gladstone and back up to Rockhampton. We are still supporting that person, alongside their caseworkers and alongside their healthcare professionals.

Another very good example is how miscommunication occurs. I get an emergency call from the maternity section of the hospital: 'Can you help, Dawn? We have a lady who has had a preterm baby. She has the ability to breastfeed but nothing is happening.' Talking to her and because of my knowledge across cultures, I said, 'Give me an hour and we will resolve it.' That lady was breastfeeding within 72 hours. The reason for that is that no-one had recognised or asked, 'Why aren't you breastfeeding? I do not understand. Can you tell me a bit of your story?' Because the workforce is so overloaded, they do not have time to listen to the story. It was a matter of me getting someone in the community I knew, because we are right across all cultures within the community. It was about food. As soon as she was given that food and she had been given the right to eat that food, the problem was solved and it saved the healthcare workers.

We are saving healthcare workers with community support. That is the strongest message I can give. We are really keen to be recognised by the government for the work we do in that healthcare sector. It runs right across everything we do. The lady from Mount Isa was speaking about the different training. If they have social support within the community while they are training, whether that be finding them reasonable accommodation or finding them a network that they can talk to within the community, and they feel self-confident within that community sector, they do extremely well and they stay within the community. It does not matter whether they go to Biloela, Moura or Emerald. If they are connected with a community care connector—it does not matter if it is health or whatever it is—they will stay within the community.

I have been invited by the University of Queensland to be on their advisory committee. This is one thing that I am really keen for them to follow through. I said, 'You get people from all different urban areas. Why don't they stay here?' It is because they are not socially connected. They do not feel socially supported. If you come into a community and the community gets behind you and embraces you—on a daily basis I get asked, 'Dawn, what can we do? We are new to the community. Can you please tell us what schools are here? What do we do to get a tenancy agreement?' If they feel safe within the community they will stay in their own communities. It does not matter where they are. That is my message for you.

This came out of breaking the barriers of health communication. It also came out of another research project about core women being unutilised when they come into this country. I have doctors who are trained back home in their home country and have to pay another $30,000 to be recognised in Australia. They have as much knowledge as we have, or probably more knowledge than we have. That is a little bit about what we do.

I have a deep concern about the fact that we have training organisations across Queensland but we cannot get trainers. We may have an RTO, a registered training organisation, but the university cannot get trainers and other organisations cannot get trainers, particularly in aged care. We run two courses—one in Rockhampton and one in Biloela. We need trainers to be able to train them. That is another challenge that we have at present.

The other issue is that we need personal carers in the aged-care sector. It is an emergency. We started in Rockhampton last week. It has been well received here. It is the same in Biloela but they cannot get personal carers. They have been given communication from the Commonwealth that personal carer training will be recognised but it is not coming fast enough. If it is not recognised then you have someone walking in off the street saying, 'I'll be a personal carer.' There is no recognition for a personal carer, which is a Certificate III in Individual Support. It is an emergency now. If we do not get that recognition, people do not think it is really worth it.

With the certificate III, our graduates go on to get jobs in the local healthcare industry as well as in the private sector. Also, they have gone on to be nurses. They are graduating as nurses. They are graduating in allied health. They are graduating in other areas like podiatry. This certificate III has opened a gateway in health in a big way.

We look at ways to be part of health prevention in the community. About 10 years ago the Central Queensland University had people graduate with a Bachelor of Health Promotion, and it has never been utilised in any way, shape or form. It would help the healthcare industry in a big way if we could look at that.

The other point is about aged care. I support the other speaker when they talked about a new facility being needed in Rockhampton. Like I said, we are in dire straits for personal carers. There is a shortage. I have two trained staff who have gone through their traineeship to be a trainer but, because they are not seen as being in that particular industry, they cannot teach in it, whereas if they had a little bit of support they could go and do the 12 weeks and then they would be fully qualified.

I am a registered nurse. I have been teaching across cultures for more than 50 years, but they will not let me be a trainer. Why is that? We have healthcare workers in rural areas who are highly qualified in midwifery, nursing and all sorts of industries and they are not recognised. Yet they are training these people in their own towns and cities. Is there any way that the government can convince whoever to look at the status of that? It just seems crazy really. How is it that you can train at the university level and then you drop down into a community organisation and suddenly you are worthless? It seems really quite strange.

There is a workforce shortage here. We are all working together. I give my compliments to the CQHHS during COVID who were given permission to bring Jeannette Young's communique into the community because it was not being heard until our CEO spoke. That was a great move and I hope it continues.

The other thing is that people have talked about a model of health care. I have just touched on it in relation to the barriers in health communication. I do not know where we start to get a GP visit not only to be accessible but so that the GP has the ability to listen to the client to be able to then move them where they need to.

From a CQMA point of view, we are in the community to serve the community. We do it more than 50 per cent—probably 100 per cent—on volunteerism. The only time we have money is when the government kindly supports us and that was Community Action for a Multicultural Society, which is right across Queensland. It is very successful.

I noted, Aaron, that this is the Health and Environment Committee. I now need to bring up the environment. In the Community Action for a Multicultural Society we have looked at that. We are now working with the Rockhampton Regional Council on a plan to promote recycling in a big way. We are looking at how we can do that and build the partnerships that are needed.

I am getting overloaded with requests from the cross-cultural community—Barry O'Rourke supported us and he will support us again—for a sporting ground for the multicultural society here in Rockhampton. We know there is a shortage of land, but we have to find a way to recognise them as a multicultural sporting association. We have been working on it for a couple of years, but we really need some more support in this area to be able to pull it off.

CHAIR: Thank you very much, Dawn. Keep working with your local member.

Ms Hay: I have two more points.

CHAIR: For someone who walked in and was not prepared, you have done very well.

Ms Hay: The other thing is that we want to grow Rockhampton, Gladstone, Biloela and all of these areas. We are very passionate about it. We are linked to Emerald as well and we work in that area. We are across cultures. There are probably about 48 or 50 cultures that we work with on a daily basis. The important thing is that—we were not allowed to use the word before but we can now—they need to be supported to integrate into the community in a really big way.

Is there an opportunity—I know it is probably more federal than state; I do not understand the politics, so I am not going there—for us to resettle Afghanistan refugees? It looks like now there will be Ukrainian refugees. Why don't we take the opportunity to see how we can work to provide those services? We have a program sitting and waiting that we would like to present to whomever necessary.

That is just a little bit about CQMA. It has been in the community for more than 30 years. It ran basically on volunteerism until about 2016 when the government tapped us on the shoulder and we have been running ever since. We have gone from a volunteer organisation to a business model. That is a challenge in itself. As I said, we have been very successful with two major programs.

Our whole idea is: if we can prevent something before it happens, let's try to do it. We have now put in and been successful to look at prevention of domestic violence. This is a model that came from our Indigenous people about 10 years ago and no-one was listening. We decided to use a multicultural angle to see how we can prevent it in the community itself. I think that is about it, but I could go on forever, as you can imagine.

CHAIR: Dawn, you are an absolute wealth of knowledge. We are out of time. I will ask if anyone has any questions. Those 52 years of nursing have not been wasted because you are firmly embedded in the community. It is commendable that you are on an advisory board. The work that you are doing is simply inspiring. We all need a Dawn in each of our communities.

Ms Hay: I do not think we all need a Dawn. We need to recognise the Central Queensland Multicultural Association as a community organisation. They are giving back to the community in all different ways. If there is some way that the government can give recognition not only by saying,

'You're doing a good job and you can have this next project round,' but for the work we are doing, that would be great. We are keen to push forward that we are a community connector. We are doing it for disaster management. We want to now do it in a big way for health because, if we do it and we do it well, it will save dollars at the other end.

CHAIR: We may well get you in front of us on the environment.

Ms PEASE: Thank you, Dawn. I would like to acknowledge your great work and your fierce advocacy for the multicultural community in the area. I am particularly interested in the community care connector program that you run and agree that early intervention is a great way. We only have to look at smoking and Dr Jeannette Young. By bringing the numbers down, it is less of a burden on our health system. Do you have a website or a Facebook page?

Ms Hay: Our website is down for a minute because we are trying to find the finances to get it back up.

Ms PEASE: I will speak to Barry about it. He will no doubt be able to fill me in. I have a community that I think would love to benefit from that program. I will have a chat to Barry to get more details rather than take up time here.

Ms Hay: It is fractured. We have to try to build it up again. We are on Facebook.

Ms PEASE: Congratulations. Thank you and your committee for the great work that you all do.

Ms Hay: You can never do anything alone. The work I do I cannot do alone. I have a strong multicultural team—India, Sri Lanka, Papua New Guinea, Bangladesh. When you look across the cultures and draw on that knowledge and strength, that makes your organisation a good one.

CHAIR: There being no further questions, we will close proceedings. Thank you very much. I now declare this public hearing closed.

The committee adjourned at 12.37 pm.