HEALTH AND ENVIRONMENT COMMITTEE

Members present:
Mr AD Harper MP—Chair
Mr SSJ Andrew MP (virtual)
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

FRIDAY, 4 MARCH 2022

Longreach

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The committee met at 9.28 am

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

With me today is Rob Molhoek, the member for Southport and deputy chair; Joan Pease, the member for Lytton; Lachlan Millar, the member for Gregory—and in a few moments I will hand over to Lachlan to say a few words; and joining us via teleconference at some point will be the member for Mirani, Stephen Andrew. This hearing is a proceedings of the Queensland parliament and is subject to the parliament's standing rules and orders. I ask that you turn off any phones or put them on silent. These proceedings are being recorded. The media may be present. The ABC told me they were going to come in so you may be photographed. Lachlan, we are in your patch. It is always common courtesy to ask the local member to say a few words, so over to you.

Mr MILLAR: Thank you, Mr Chair. I welcome my parliamentary colleagues to the best health service in Queensland. The Central West Hospital and Health Service has been an outstanding contributor to health in outback Queensland. I always tell my colleagues that if you want a model on how to run a health and hospital service it will be the Central West Hospital and Health Service—so much so that I am trying to get Emerald to come over into the Central West Hospital and Health Service.

David, Anthony, Karen, Louise: you all did a fantastic job when it came to COVID. In fact, when COVID first hit as an outback community we were very worried about how we would be able to handle an outbreak of COVID here. The effort that this service went to was beyond anything seen in making sure that we had vaccine and people were getting the jab. I congratulate you on that. They are all good people out here. We all get on. This health service basically covers an area the size of my electorate. Other health services are more compact and there are more opportunities to be able to use a service down here. I think we do a great job. Thank you, everybody, for coming along here today. It is good to be in my home country. Let's be honest and let's get something out there so we can improve our service.

CHAIR: Thank you, Lachlan. That is a great start.

McLELLAN, Ms Karen, Acting General Manager Acute Health Services, Central West Hospital and Health Service

POOLE, Ms Louise, Assistant Director of Nursing, Primary Healthcare Team, Central Hospital and Health Service

WALKER, Dr David, Executive Director of Medical Services, Central West Hospital and Health Service

WEST, Dr Anthony, General Manager Primary Health Services, Central West Hospital and Health Service

CHAIR: To the team in front of us, we want to hear about impacts on the public health system. Over to the health service. Thank you for being here.

Dr West: Thank you very much everyone. I might kick off. I am Anthony West. I am usually the general manager primary health services here in Central West. Currently I am the acting health service chief executive and have been for the last three months. I might just add to Lachlan's remarks about the region, just to set a little bit of context.

We hold the strange position of being both the largest and the smallest health service in Queensland. Certainly we are largest by area, at around 23 per cent of the state, but we are well and truly the smallest by population, with about 10,500 people or about the size of a small Brisbane suburb. The whole region is classified as very remote in the Monash model. Therein lies our challenge for providing services, particularly in terms of making sure that our access is timely and equitable across all our communities. Attracting and retaining workforces is one of our major challenges, and I acknowledge that the cost of service delivery here is higher because of the small population and the amount of travel we have to do. As time progresses our challenges really are increasing. The population is decreasing in the western part of our HHS. It is ageing and it is socio-economically disadvantaged as well. We have higher health risk factors here such as high levels of smoking and obesity, higher dangerous alcohol use and we also have higher hospitalisation rates than other parts of the state.

There is a very small number of other providers here as well. We are often referred to as a provider of last resort. We are the primary provider of primary services, community and hospital based care for the whole region, but we do rely strongly on partnerships where they are available and where we have other providers, NGO and private. We have strong relationships with our local government here and so we are a bit unusual in that way. I am happy to take any questions on the basis of that context.

CHAIR: Thank you very much for those opening remarks. I think it is probably good to get a bit of a snapshot in terms of bed capacity and anyone can answer this question. How many people are frequenting the emergency department and are there delays in accessing GP services here? It is a bit of a broad set of questions, but tell me about the challenges that exist. If I can provide some context, some of the information we have heard to date—and I come from regional Queensland so I can only remark as to Townsville and the surrounding district—is that some 250 people a day go through the emergency department, of which 70 per cent walk in because they cannot access a GP. I want to get a bit of a view of what is happening in Longreach and in Emerald, in this local area, in terms of similar questions. Who would like to go with that?

Dr West: I will kick off. You might have to remind us of each of those points as we go. In terms of pure bed capacity across the health service, in our five inpatient facilities we have around 50 beds. That is outside the MPHS beds. We also have aged-care beds that we oversee and have as part of our multipurpose health services. The average number of people in the facility at any one time—occupancy—is quite low, between 30 and 40 per cent, so much lower than even regional or metro areas. I might hand to Karen.

Ms McLellan: Thank you, Anthony. Just following on from Anthony's comments regarding our five acute facilities, which I am responsible for, our occupancy does range between 30 to 40 per cent depending on the time of the year, of course. In our A&E departments, patients are seen in the required times. Our times, as part of the triage timing—we do meet those. On the average throughput for Longreach Hospital, for instance, our A&E presentations range between 18 and 30 patients a day, Longreach is the largest facility in our health service. The other facilities also have A&E departments and, of course, their numbers would be lower because of lower population in those areas.

CHAIR: Are there any other comments from anyone on some of those questions? Maybe on accessing GPs?

Dr Walker: That is my bag. I have been in Longreach for a while now. My role is the professional oversight of the medical workforce, and I obviously still work as a general practitioner, here in Longreach. There are a few parts to this so please redirect me if you need to.

I guess one of the important things, just to set the context, is that there are not any private general practitioners in the Central West. There are four practices across the four hubs—Winton, Longreach, Barcaldine and Blackall—and for probably at least 10 years now there has not been a private general practitioner as such. The Central West Hospital and Health Service runs those private practices. There are a couple of different arrangements, without going too far down a rabbit hole, but certainly the Central West health service actually supplies the primary care to the general practices. Of the doctors, there are 22½ FTE senior medical officers across the Central West, and they are all general practitioners by trade—'rural generalist' I think is the catch phrase these days. Those doctors work across both the acute space in the hospital and also in general practice. The general public would probably not know the difference, that there is not a private GP. They are seeing GPs who are GPs by training and they have the usual general practice relationship that patients would have. That is, I guess, an important point of context with regards to how the general practice setting here is.

I guess we have the usual challenges of recruiting to the medical workforce. Again that probably could take up a whole inquiry by itself. At the moment we have some vacancies across the sites but also some really positive signs in some of our sites. Longreach at the moment is almost completely fully staffed, with just a recent resignation, but it sits at 10 FTE and access within Longreach is really good. I did a little bit of a month audit to see what our access was like and there are vacancies across every week in the general practice, an FTA rate of about five per cent, which is hard to get a benchmark but seemingly compares to some data I found from overseas. It was interesting looking back and seeing how that matched up.

One of the other interesting things we did was in about 2013-14 we actually started a bulk-billing practice here in town. Pre COVID the general practice set up in Longreach was a mixed billing practice, which has been in town for a long time, Longreach Family Medical Practice, and then a public access clinic, the Longreach Primary Care Clinic, which is a walk-in bulk-billing clinic. Part of the reasoning for that was to actually increase access for people who would have usually gone to the hospital. Historically Longreach Hospital, like a lot of rural hospitals, actually had booked general practice appointments and I think some hospitals in Queensland still probably do that, but we felt it was more appropriate to provide general practice in a general practice setting so had that bulk-billing access. That changed with COVID, as some things did, and it became a federally funded respiratory access clinic and is just in the process of transitioning back to Longreach Primary Care Clinic now. That is the context of general practice in Longreach, which is where I am most familiar, but we certainly have practices across all the sites and the doctors, as I said, work across both the hospital and general practice setting.

Dr West: Do you mind if I add one thing to that: the one exception to that is in our western corridor, which is what we call the Diamantina, Boulia and Barcoo shires. The five towns out there receive their medical services from the RFDS. We have nurse-led primary healthcare clinics, five of those out there, but they get either weekly or fortnightly GP type visits from the RFDS.

Dr Walker: With the other primary care clinics, because there are quite a number of those, the others get outreach from our hub sites. RFDS down the western corridor and then outreach to the smaller hubs, the smaller PHCs, from our four hubs.

CHAIR: I want to touch on the nurse-led primary clinics. There is a really good model we are looking at in the ACT, which has taken thousands of people in its 10-year existence for category 4, category 5, suturing—low acuity stuff that you do not want to be funnelling through the front door. Do you have any numbers on the nurse-led clinics, on how many people they are seeing—this can be taken on notice—over the last 12 or 24 months so that we can see any impacts of COVID and how long have they been established now?

Dr West: I cannot give you specific numbers off the top of my head so I am happy to take that on notice, but those clinics have been in place for years. They certainly precede the establishment of our hospital and health service, for example. The Diamantina Shire PHCs were run by the council until the establishment of the hospital and health service. They are certainly nurse led. They take all kinds of low acuity cases. They have small EDs and procedural rooms. They are open business hours Monday to Friday and those nurses are on call after hours and on the weekends. They are actually a terrific little service in those towns, one we are very proud of. When we get staff there who are devoted to that and love that lifestyle it is a match made in heaven. Workforce can be an issue for us and keeping those clinics staffed is our greatest difficulty.

Dr Walker: It is slightly different to what you are describing in a metro city. They are the classic bush nurse in a tiny little town that might have a population of 100. They are the primary point of contact for people for emergencies and also increasingly primary care. They help coordinate the clinics with the RFDS or the visiting doctor coming from the hubs, but they are not in a town where they would funnel presentations from a major emergency department, if that makes sense.

CHAIR: I am looking at the model. I am familiar with it. I am sure I will get the usual jibes from my colleagues when I say that I have actually worked in those areas myself in my former career and retrieved patients. They see everyone, from coughs and colds to motor vehicle accidents. I think my last memory was Blackall, and a nasty accident. We had the senior consultants in Townsville looking in at what we were doing via telehealth, which was fantastic. It is about finding the best way to give care. They do a great job and commendable work. You just find a way in Western Queensland.

Mr MILLAR: As I said before, I am very proud of this health service and I will always advocate for it because it punches well above its weight. Could you explain to the committee the isolation of our potential patients and how we try to administer a preventive program? The Central West have always looked at prevention, although they are always looking at a cure too. How do we put a system in place across the whole region on preventive health?

Dr West: I think you are aware of the health services plan that the health service developed through 2019 and 2020. That was assisted by our partner organisation at Metro North HHS, which has a lot more staff capacity than us. That process looked at research and literature in terms of the types of activities that we should be providing over our health service over the next five years, and it also consulted very strongly with every community. The feedback from that was certainly that those people wanted more preventive type work, particularly in some specific areas. One was mental health and there were other ones, particularly around child health and aged care. We have started ticking off those actions that came from that list. They are challenging for what is essentially an acute health service to deliver, but we completely acknowledge that we are the big fish in this sea and if we do not step into that space then things are unlikely to happen.

Probably the greatest challenge for us here is health literacy—that is, making sure people understand things about preventive health and how they can make themselves more healthy—and also understanding that if they have a chronic condition what that is and how they manage it. We have activities underway to try to, firstly, measure the baseline health literacy across our health service, because we do not have that, and then also take a stocktake of all the health literacy tools that are available for remote communities—what is available to us and how we can start on that journey. That is a very long-term project, but when the health literacy of the community is better the health of the community is better as well. That is a step.

In other areas we have more active programs going on right now. In our mental health space, we have a program called TRAIC, which is Tackling Regional Adversity through Integrated Care. Whilst the majority of our mental health team deals with people with severe and persistent mental illness in the community and tries to manage them and keep them out of facilities, the TRAIC program looks at the mental health of people in communities every day and how we can help to make sure that is looked after. That is through things like making sure they are engaged with their community and that they have options to engage. A lot of the projects that occur there are very typical outback type things—for example, leather workshops. Often times if you invite a bunch of people in Bedourie to come to talk about their mental health, no-one will come. However, if you invite them to a leather workshop where they might make a keyring or a belt, they will come and then we have facilitators who work around the room and check in on people. That has been really successful and we have been really pleased. That is an example.

The other area where we had a lot of feedback was on child health, particularly amongst First Nations people and particularly in the area of alcohol and drug use and sexual health. We do have programs in their infancy there that are looking at trying to assist people, particularly where we have larger Indigenous populations, which for us is mostly Barcaldine and Boulia, and trying to engage that group. That is very hard. At the moment as part of the health equity strategy, we are building our First Nations workforce. We can certainly say that we have made great leaps in that in the last couple of years and we are getting more health workers in place. We have Indigenous nurses as well who are able to really make some ground there, and we also just recently appointed an Indigenous medical officer here in Longreach.

They are the types of things we are working on. These are not easy projects, particularly when we are a health service that spends a lot of our time responding to emergency or emergent care. As I said, that is certainly the feedback we have had from our community. We have heard it loud and clear and we do have things in place to try to address that. I am not sure if anyone else wants to add to that.

Dr Walker: That is really that prevention community health kind of stuff. We are starting, unfortunately, as Anthony said in his opening remarks, with high rates of obesity, high rates of smoking and high rates of alcohol use. We know that they are all areas that we need to tackle. Once people get into the general practice space, it is good that we have that footprint. The benefit of being in the general practice space is that we can get into the secondary prevention care.

We integrate with the hospital so if a patient is discharged from hospital every doctor in town is involved. We all know who is where at any particular time. They step down from the hospital back to their general practice and we can help manage their primary care. Likewise, if our patients are admitted to hospital we know who is looking after them. We have that integration across the primary and acute-care spaces, which is really good. Like every general practice, we have chronic disease programs and chronic disease nurses. We are actually measuring our performance against chronic disease, especially in diabetes, smoking and obesity. Once we move from the population based interventions, we move into the general practice and primary care.

Ms Poole: Just to add to that, within my team, it is all the specialist nurses who link in with our GPs and services—ranging across chronic disease, child health, nurse navigators, cancer care, palliative care and aged-care services. Our teams support our patients in the community with primary

prevention. Also, from an acute point of view, if they are admitted there is the discharge process and if they are sent away to our metros for retrieval or their ongoing care with specialists in Brisbane we look at how that communication is linked back with our GPs and ongoing services. A lot of those services are by telehealth out here and we have our GPs sit in on those services with our specialist consultants.

Ms PEASE: Thanks very much for coming. Like my colleagues, I would like to thank you for the great work you all do in such a remote and challenging location. I am interested to hear that you provide the primary care and GP services. Were there ever private GPs out here?

Dr Walker: Yes.

Ms PEASE: When did they close down and why?

Dr Walker: To answer the question of when they closed down, the short answer is that it varied across towns. When I first came here in 2006, there were private general practitioners in all of the sites. Then in 2010 there was still a private general practitioner in Blackall, a private general practitioner in Winton for another year or so and a private general practitioner in Barcaldine for another year or so. It would be roughly around that mark.

I think it is complex. I certainly would not profess to know every reason why every general practitioner came. I think there have been some generational changes with doctors' choices. I was speaking to a senior doctor some years ago and I remarked that he had gone to a country town and stayed there for the rest of his career. He had a couple of years in the hospital and then moved out. There are doctors like Pat Manning in Barcaldine who was there for many years and had done pretty much the same thing. He had done some training in hospital and then moved. I think there are some generational changes with the way the rural medical workforce exists.

I think it would be fair to say—again, without being an expert—that there are probably market factors with regards to general practice and the viability of general practice and running a small business essentially. I have worked in the private practice here when it was a private practice and I have worked as an SMO here as well. I have seen a little bit of both sides. I certainly can appreciate there are some challenges but would not profess to know every reason. Market failure I guess is the general term we use.

Ms PEASE: We have heard a lot in our travels about the ability to encourage and retain GPs, nurses and allied health staff. How are you doing that? Many of you have been here for a long time and made those choices to stay. Do you have any advice about what is important in attracting and then retaining? We have heard James Cook University are training up local people, but are there other barriers and what do you suggest we could be doing?

Ms Poole: It is not just about retention; it is recruiting, retaining and how we can keep people here on a long-term basis. For my team, they are mainly specialty nurses. They have a special interest or they have had ongoing study and they bring that specialty to support our community—whether it is cancer care, palliative care, chronic diseases or child health especially. It is extremely challenging to recruit those staff to come out here, even from an agency point of view. I have tried different methods and I have had some very successful methods, working in partnership with Metro North, of people wanting to come out here for a taste and they are still here two years on with their families. They love the lifestyle and they can grow professionally out here. They may have come here as a grade 6 clinical nurse and they are going into a grade 7 job and they can embrace and share their knowledge and expertise out here. That is probably one of our greatest challenges here—that is, recruiting and retaining staff—but I think grabbing people from metros has been a good partnership.

Dr West: I could provide some broad remarks as well because we all want to talk about this. Sitting at this table, we probably spend 75 per cent of our time thinking about this and working on it. It is our great challenge. It is frustrating, but when we get it right it is great. When we get the right people into those roles, it is great for us and those people find it incredibly fulfilling and I think our communities benefit.

There are a range of initiatives underway at any one time. A couple of years ago we did a campaign called Reach for the Stars. It was a little video that we linked up to all of our ads. That got us a bit of press for a while but it waxes and wanes. We just have to keep our foot on that pedal. At the moment, we are exploring good old-fashioned clinical staff rotation models with larger HHSs. They start work for a larger HHS where they might live by the beach or something but they come out here for three, six or 12 months and then go back with some experience that benefits that health service as well. We are always coming up with a new angle, but I am sure my colleagues have some really specific examples of what they do.

Ms McLellan: I can speak about the nursing in the acute facilities. I have been here for many years in the Central West. We do pride ourselves on the appropriate staff. We really need rural generalist nurses here. When I first graduated from nursing, an old charge nurse said to me once, 'If you can scrub in an operating theatre and be a midwife, you'll always get a job.' I must say I do tell that to some of the junior girls and gentlemen coming through.

We also have nurse graduate programs with the universities. We partner with them for their placements. We have just had an increase of 16 graduates for the HHS start in February. Do not quote me on the numbers, but I think at least six or seven of those students came out here on a placement, loved it and applied. It is word of mouth, it is someone knows somebody or someone went to school with somebody and it is the lifestyle.

We are also setting up a buddy system where we can buddy these nursing graduates. You do not have to be clinical. Any one of us here could meet them, show them where the squash courts are, take them somewhere, tell them who to ring if they are sick, whatever it might be. It is just little things like that. For some of the graduates, it is the first time they have left home. As a mother, I think this could be one of my children in one of these towns who needs a bit of TLC. We are putting in this buddy system and I think it is going to be a great support for these nursing graduates.

I think the universities have really come a long way with us. It is word of mouth and our increase of numbers. Last year we had X amount of graduates and we have re-employed them permanently. There are about six of those who are now scattered through the HHS as probably second-year nurses. Again, they learn here. I say to the staff to take them under their wings and show them and teach them. These are skills they will never pick up in a big metro area.

Mr MILLAR: I actually do have a candidate for you. My daughter is just starting nursing this year at CQU and she actually does want to come and do a placement in Longreach.

CHAIR: I can top that. The last time the health committee was here, we went to the hospital to have a look through. I actually have a relative, a nurse, who works here. She went and had a baby but she is still here.

Dr Walker: It is probably good these guys went first. It gives me a chance to get my thoughts together. I could literally talk about this all day. It is a real interest of mine. It is a centre point of my role and it is also, unfortunately, the thing that keeps me up at night.

I think it would be fair to say we have had mixed success in recruiting, but what works is really hard to generalise. Over the years, as Karen said, the universities have put a lot of work in and there is a lot of research out there as to what influences people to want to work rurally—and not just as a doctor. A rural life is not for everybody and certainly as a doctor it is not for everybody. A lot of work has gone into personality traits that lend themselves to being a rural doctor—things like risk tolerance and acceptance of uncertainty. There are actually things you need to have. It is not for everybody. Identifying those people and training them properly is the first hurdle, but then it is about getting them here and supporting them. They are still junior when they come.

We have done a lot of work in wrapping our arms around people and making sure that for that first six months, 12 months, two years they are really supported and they feel like we have their backs. It is a really important part for a young doctor. They may have a whole year of anaesthetics up their belt and they will be really comfortable in emergency, but when they come here we need to make sure we support them. We have really worked on that. If you look at a town like Longreach, it has just hit that critical mass. We have 13 doctors here now by headcount. For the first time we have two doctors who were both here as medical students. One doctor was here as a fourth year and then she came back as a sixth year and now, six years postgraduate, she is back as a senior medical officer. There is another one who was here as a sixth year and is now back here as a senior medical officer doing both anaesthetics and obstetrics. It is very rewarding when you look at that.

Longer term, most of the panel have been here for more than 10 years. Anthony is a junior, but he has still been here for almost four years. What keeps people here? I always say that I came for the work but I stayed for the community. I think there is certainly space to look at how communities embrace their medical workforce, how we engage them in the community and how we engage their partners. There are issues around housing and employment and all of the other things that are really challenging, which I do not think is news to any of us. However, that said, it is not the same for everybody. We had a doctor a couple of years ago who told me that what I enjoy about living in Longreach is what he hates: being in the spotlight and everybody knowing who he is. He does not have the anonymity he would have in the city. Again, it goes back to that point that we are all different. How do we make sure we identify the people who are suited to rural practice and actually train them properly and support them?

Ms McLellan: On the back of that, apart from medical officers this also goes for nursing staff, allied health and other professionals. We do need to wrap our arms around them as such for the first six months, 12 months, two years to ensure they have the best experience and that we have their backs. If something goes pear-shaped at two o'clock in the morning, that little nurse can ring someone who will come and support them and teach them at the same time, be hands-on, support them and talk to them. If something has gone bad, you then talk through that. Again, it is a learning experience for them as well and I think that is very beneficial.

Ms PEASE: Thank you very much. That is really informative. Interestingly enough, yesterday we heard from a professor from James Cook University. She talked about the fact that most of the doctors who are leaders in this space have done work in remote and rural areas. She also talked about the social support being just as important as the technical training. Do you actually have training places? You do take nurses and you also take doctors?

Dr Walker: A key part of our workforce is training junior doctors. These days a large percentage of them are from the rural generalist training program, and I imagine you might be familiar with that from previous panellists. Rural generalists essentially come with a few years of possible experience and an advanced field in something. Traditionally, that was anaesthetics and obstetrics but more commonly these days it is emergency medicine, adult internal medicine, paediatrics or mental health.

When they come they are still not a fellow general practitioner, so we need to put in place the structures to train them. Again, adding to the complexity of the workforce, there are requirements from a training point of view—and at the moment our training partner is James Cook University general practice training. They have requirements for how junior doctors, quite understandably, are supervised and how we support them. That is hard in towns where the workforce might be unstable or there is a small establishment. We have really had to look at how we provide remote supervision models for some of our doctors who are still training and make sure they really feel they are supported. Yes, is the short answer. The longer answer is that it is a challenge to train them and supervise them.

Mr MOLHOEK: I am keen to understand how you deal with some of the allied health services. We have NDIS packages now and home care. You touched on the fact that your population has some chronic health conditions, people with higher rates of obesity and those who drink alcohol. How do you support those areas of need within the community? How do you go about finding the people to provide those services?

Dr West: Obviously the allied health team here is a fairly dynamic but reasonably young team. We have just over 20 members of the allied health professions in the HHS and that is across all of the different professions. For example, we have only one dietitian, we have two social workers and three OTs. When you stretch those across a large area it does get difficult.

In terms of our basic work for allied health in both the acute setting in hospitals and the community, we do very well. We manage those patients well. Obviously we have to factor travel into a lot of those workers' days because they are based here in Longreach but they spread themselves out. When it comes to other services that is when we get stretched. As I said earlier, we are a provider of last resort. There are other allied health providers that do function in the Central West. North and West Remote Health, which is based in Mount Isa, come and do visiting clinics here. In those major professions like physio and OT, they have exercise physiologists and those types of services.

Our team tends to be young because people will come out here, try it for a couple of years and go. That is the reality and that is almost the way we approach recruitment to our allied health professions now; we expect them to stay a couple of years and then we are ready to replace them again, and we have pretty good success. The other allied health providers struggle a bit more. I do not think their conditions are quite as good as the public system, so staff will often move in there and move through more quickly. Whilst they are a really good support when they are there, sometimes they are not there, they have trouble recruiting and we end up picking up some of that slack.

We are not an NDIS provider. Our board made a decision years ago not to register as a provider. Still, we have a commitment to our community and to our patients. We do find ourselves providing services to some NDIS or potential NDIS participants, either while they are awaiting a package or awaiting a provider. Across the team we have about 25 people in that situation at the moment who are either applying to NDIS to be an NDIS participant or who have been accepted but do not have a current provider. That is mainly in OT and for those functional assessments that are such an important part of NDIS provision. That really puts a big strain on our three OTs, particularly currently because we have two vacancies in that area. Luckily, our allied health team leader is also an OT and is able to step into that space. I know some of the NDIS providers in the HHS really do

struggle with this, particularly that OT assessment, which is really a gateway into your plan. Barcaldine Regional Council, for example, are a provider but they struggle to get that OT assessment that can then lead their consumers into a plan. Does that cover everything you asked?

Mr MOLHOEK: I think so. Part of the focus of this inquiry is to look at the impact of aged care and NDIS care on the overall public health system. I am curious as to what impact it is having on the Central West Hospital and Health Service. Looking at some of the statistics, it would appear you do not have too many issues with bed block, ED presentations and the fact that you are running a GP clinic as well to divert people away. It sounds like we should be exporting this team to some of our other health services and getting you to run the show.

Dr West: Certainly I think being in small communities does assist. We do have a very active employee of the NDIA based here in Longreach who assists people to get their plans. Because she is around the corner and we all know where she lives and we run into her in the shops, we do coordinate quite well, particularly across child health. Child health is a real specialty area of both nursing and allied health. It is difficult to recruit people into those places, so we need to make sure that particularly in that early childhood early intervention space we are coordinating well. We are doing that effectively.

We have some really good cases of kids who have lived elsewhere and have not had the supports from families who might have really low literacy in those areas and then they come here. Because we can see them more readily and easily at the kindergarten or the school or the GP, we can push people into those pathways more easily. That is the benefit of being in a small community. While that works it is not an absolute safety net and it worries me that those systems are not always robust enough to capture all those potential participants, particularly the kids. The earlier you get started, the better your outcomes are going to be.

Certainly more resources and more staff here would be great from an NDIS perspective. I think our remote area workarounds are effective and they provide services that people in regional and metro do not get.

Mr MOLHOEK: In terms of the efficiency of the hospital and health service—an average weighted activity unit—how does this service compare on the average cost per activity unit with say metropolitan and other services?

Dr West: I will start with a really broad statement and then hand to my learned colleagues. We are a block funded health service so we are not funded through the activity based funding as those larger areas are. We get a block of funding that recognises that we are less efficient because of the nature of our geography. However, we still rabbit away and collect statistics on what we are doing because we do report those back to the Department of Health and try to ensure that they understand how hard we are working. Do you have those statistics?

Ms McLellan: Not on hand, I do not.

Dr West: I am happy to take it on notice. Generally, when you compare it, we are less efficient obviously than a metro or regional service and that is just because of the travel that is involved in what we do. We need bed capacity. Whilst Longreach averages 35 per cent occupancy, sometimes it is 100 per cent and we have to have those beds available for those times. It happens when you least expect it—always on a Saturday night. We have to have that, but we do not have the economies of scale that the larger HHSs would have.

Mr MOLHOEK: I am guessing that the offset for that is that there is a little bit more goodwill in the system here in terms of the way you function as a team and how the health service functions. I am hearing about some of the larger markets. People like David would make comments and say that a lot of the goodwill is leaving the system because people are being so stretched and they have had enough so there is not that level of support.

Dr West: I think we have our moments, our ups and downs. But broadly we are part of a larger community and social services system here. We have to be. We do not stay in a silo in the same way that other HHSs do. We are forced in some ways to work more closely with partners. We had the district disaster management group in this very room yesterday at this time. There was a great feeling of collaboration in the room. Everyone knows each other. We have robust conversations—we have to with some of our stakeholders—but we stick it together. There is no-one else; there is no other option. Even if we have an argument, you walk outside, you leave it behind and you get on with it because you will run into them in the IGA tomorrow.

CHAIR: You can't have a dust-up on the main street!

Dr Walker: I was going to extend that to the patients as well. As I am sure these guys will attest: you become part of the community, you know the people you are looking after and you become very attached to your role within the community. I am not saying that people in the city do not—I am certainly not trying to suggest that—but I really love working here. I love being part of the community. For me, I would like more people to understand the joys and benefits of working and living in such a remote place.

Ms McLellan: Just to add to that, as a nurse you are very proud of your town and you are very proud of your hospitals. I have lived in Longreach for 20-odd years. Even though I am not still working up there, I was the DoN, the director of nursing, up there for about 15 years. Today I am still very proud of Longreach Hospital. Again, as we said, we go above and beyond to serve our communities here. That is evident in our patients, in the HHS and in the care we do give them.

CHAIR: That is a great way to end this session. You should be very proud of the work you do, being in such an isolated community. Having worked in Hughenden, Charters Towers, Bowen and Ayr, I know that you do become part of the community. You are diagnosing at the bakery. You do become part of the fabric of the community. I want to end this session by commending the work that you do. Keep up the fight in recruiting and retention. It is great to be back here to hear about your fantastic work and the challenges that you have. Thank you for your contributions today. We do appreciate them.

FRASER, Ms Leisa, Executive Manager Service Provider Commissioning, Western Queensland Primary Health Network

CHAIR: Welcome. You can start with an opening statement if you like, and then we will move to questions.

Ms Fraser: Our CEO, Sandy Gillies, sends her apologies today. The Western Queensland PHN covers just under one million square kilometres of Queensland, which is about 55 per cent of Queensland. We work from Mornington Island down to Dirranbandi and out to some of the most remote places. Our main office—because that is where our CEO is—is in Winton. Sandy and I have an office in Winton. We are not just working and commissioning services in this patch; we go across three HHSs—the North West, Central West and South West. We work very closely with the HHSs around trying to commission services that complement each other. There is a way to go in that in some areas. We have been able to get some really good things with that. For us, it is about that collaboration, co-design and joint planning because, at the end of the day, that is going to make a difference for the people on the ground. Some of the things that you were talking about earlier—the allied health space, the NDIS, ageing—are key items within our strategic plan that we want to address.

CHAIR: Thank you, Leisa. I chair a regional forum that was out at Mount Isa recently. I have met a lot of people through the PHNs. I have been very impressed with the Western PHN service provision and the way that you collaborate with the HHSs, particularly in the Mount Isa area. It is really remarkable. I walked into where we were staying and they were doing a booster clinic there. It is quite impressive, the way the PHN works. I want to ask about the PHN broadly. You cover such a big space. In the primary health space—and I do not know whether or not you want to take this on notice—I would like an idea of how much of your budget focuses on primary care. I asked the same question of Metro South where they allocate a certain amount to primary care in the health prevention space. I want a bit of a picture.

Ms Fraser: I will need to take that on notice, but I will definitely be able to provide that to you. We have teams that work in that primary care space, working with general practices to assist them with capacity building, implementing the Western Queensland Health Care Home, which is a set of metrics and a continuous improvement cycle that can help in addressing the chronic disease burden and putting people into that planned and structured care.

With some of the programs that we have been able to deliver, we try to promote people having that regular health assessment. We obviously have the details in relation to demographics and the burden of chronic disease in our patch, but we know that that is probably a lot less than what it really is. We know that a lot of the people who live in our communities do not go for regular health assessments. The first time they realise that they have a chronic illness is when they have got acutely unwell and have gone to the hospital. That is one of the things we are really passionate about: getting people into planned and structured care within that primary care setting and then also being able to wrap around what we call the Western Queensland Health Care Home neighbourhood, which is the allied health care services—if people need to be referred to NDIS, your children and families. That is a big project that we are working on currently in establishing that Health Care Home neighbourhood.

CHAIR: Some of the submitters have identified in their written submissions that the funding of the PHN is sometimes limited to two years. You stand up a program, you just kick it off, you start getting some metrics, you start getting some results out of it and the funding ceases. Is there room to expand the funding under the current arrangements to a longer term to give people certainty when they are doing these health prevention strategies?

Ms Fraser: That is something that we are working on with our funders, with the federal government, around extending the amount of funding over a number of years because we are experiencing exactly the same thing. With short-term funding, you are just getting the runs on the board and then there is no funding available. That is something that we have been really proactive in doing. We hope to continue that. We have also done some research in relation to some of our projects, in particular with Aboriginal and Torres Strait Islander health in that space, to try to give people three-year funding agreements rather than just 12 months. It is on our radar and we are working towards trying to get that happening.

Mr MOLHOEK: Leisa, it is good to see you again. I think we caught up about a year ago, although I am not sure whether it was here or Boulia. I want to ask some questions around mental health services in respect to counselling and support services. We hear all sorts of stories about suicide. When we were out here about a year ago—I cannot remember the group we travelled with—we went out to Boulia for a seminar on mental health and suicide prevention. Can you give us a bit of an overview of some of the services for both young people and people working in fairly isolated and remote parts of the area?

Ms Fraser: We operate a stepped care model for mental health. It starts with just counselling-type services in what we call P1, which is no referral is necessary. People can just contact the various providers. We do have a fact sheet for each different community, so you can go on there and look at who are the providers. We have P4 nurses who are assisting in the general practices with psychological services and then doing the referral pathways under a GP management plan. We also have some programs within the SEWB—social and emotional wellbeing services—for Aboriginal and Torres Strait Islander people. We commission under the Wellbeing in Schools program for children and youth in the schools. We also have headspace in Mount Isa and Roma that we currently commission as well under that model.

The idea is that we have a prime contractor, RHealth, which manages those projects for us. With all of the providers that we commission through that process, we really work with them around this, stepping people up if they need care. If people are coming in constantly for counselling services, we can look at whether we need to step them up into a more high-level service or, as people get well, move them back down into services that suit them. Our statistics are telling us that that process is working.

We have also recently commissioned the North Queensland Resilient Kids project with the North Queensland PHN. That is all about providing counselling support services to children affected by the monsoon event in 2019. That is in the process of rolling out. Outback Futures is one of the providers that has been commissioned, as well as yourtown in the north-west area.

CHAIR: In relation to the deputy chair's question on the mental health space, with that stepped process from assessment through to headspace, is there a limit on how many times a young person can be seen at, say, a headspace? Are there only so many visits?

Ms Fraser: I will have to take that on one notice. Some of them are six to eight sessions. At headspace they can come in at any time; it is a no-wrong-door policy. But I will take that on notice, if that is okay.

CHAIR: I thought there were caps on how many visits they had.

Ms Fraser: We have tightened up the number of visits across that stepped care process, just because we were concerned around people not getting the service that they really needed. They were getting either a lesser-level service or a higher-level service.

Mr MOLHOEK: How does it work, say, in Longreach? You said you have headspace in Mount Isa and Roma. They are a long way away from each other and Longreach sits somewhere in the middle. Is it all done through telehealth?

Ms Fraser: At the general practice here, we have the P4 nurses. We have the Royal Flying Doctor Service. We also commission for mental health services here in Longreach. Outback Futures does a service where they actually come in every quarter and then they also do telehealth and associated services.

Mr MOLHOEK: There would be limited face-to-face opportunities?

Ms Fraser: The RFDS is here in town. One of the issues—and I guess my colleagues from the HHS also talked about it—is around workforce. There are a number of people who do offer that fly in, fly out. It seems that we are doing a lot more work with consumers around access to telehealth. Some of the feedback that we did get around some of our programs was that people were finding that a good alternative to being able to have to go in, sit and talk to somebody. They might feel embarrassed that they are going to see them at the shop or whatever. That was some of the information that we got back. We are doing a piece of work currently with our service providers around what telehealth looks like. We also are getting consumers to be informed around how to use telehealth, do they have access and improving health literacy around telehealth.

Ms PEASE: Thank you very much for coming today and for the work that you do in the community. I understand that with the PHNs much of the works that you commission are standard across all of Queensland and probably all of Australia, headspace being one of them. What are the services that your PHN provides locally?

Ms Fraser: We currently provide primary mental health care through the P4 nurses, Outback Futures, RFDS, new access via telehealth, Lives Lived Well—which is alcohol and other drug services. There are two workers here, soon to be three, who will look after the whole of the central west and particularly out to the western corridor. We do some work in the healthy ageing space.

Ms PEASE: Do you have any figures around the amount of money that is spent on the local projects that you are working on? What is your budget compared with what is commissioned?

Ms Fraser: I can provide that for you on notice. The other big parcel of work is in allied health. We commission North and West Remote Health to do a lot of the allied health services out here.

Ms PEASE: If possible, could you give me the budget for your governance and for your infrastructure? What does it cost to run the organisation? How many staff do you have in the PHN at Winton?

Ms Fraser: In Winton we currently have two.

Ms PEASE: You talk about the locally commissioned programs. What oversight and review of those do you have? Do you actually outsource to an organisation to run those projects for you or do you manage them internally and, if so, what is the oversight in both instances? What is the evaluation process?

Ms Fraser: For our primary mental health care we commission the prime contractor, which is RefeRHEALTH and they use the RefeRHEALTH tool. They manage those for us and then provide information back to us via a rubric process, which is a way of looking at all the data and the financial information. The remainder of the providers are managed through our own internal processes. We have schedules and contracts. We also have a rubric process within the PHN and we collect financial and statistical data from our providers on a quarterly basis.

In the allied health area, in my team, the service provider commissioning team, we have six people and they are broken up so that each person has a specialty that they look after. The person who looks after our allied health collects the data monthly. It is analysed and we provide feedback to the providers where there are any issues. We also look at where there are identified needs. We have just completed our health needs assessment. It is almost ready for publication. We are just waiting for it to be approved. That is how we commission for the future: what we have identified in our health needs assessment based on what we are hearing on the ground. We are in the community so while we look at the information at the end of the day we are hearing a lot on the ground as well so you get that local knowledge.

Ms PEASE: You have a very large area to cover given the number of HHSs that you service. How many staff in total work for your PHN?

Ms Fraser: We have 33 staff. We do not have a lot of staff really for the area that we cover. We are fairly thin on the ground, but we do a good job.

Ms PEASE: Of the projects that you talked about that you are running in this region, are any of those short two-year projects that are about to cease?

Ms Fraser: All of our projects are commissioned out for one year, just because of the way the funding has rolled. We have one lot of money, which is the alcohol and other drugs national ice strategy money, and 65 per cent of that AOD budget is actually ceasing at 30 June 2022. We are currently working with the federal government to check whether there is going to be anything going forward because we have done a lot of work in that space and we do not want that to fall over.

CHAIR: It is a really important topic.

Mr MILLAR: Thank you, Leisa, for coming along. I want to make a quick statement of clarification so that my colleagues understand this: the people sitting in this room, including Leisa, have to travel hundreds and hundreds of kilometres to be able to provide a service. As a government and as parliamentarians we have to make sure that we provide them with the best resources possible to be able to get around a very large area. I do thank you for that. One area I have talked to you about previously is child health in remote areas such as Boulia. What can the PHN do to provide for child health issues such as speech pathology and those sorts of disciplines?

Ms Fraser: We have been working on a pilot project at Cunnamulla over the last 12 months that has involved commissioning BUSHkids to provide some additional supports that could not be readily provided in Cunnamulla and that has had some really good success. We are hoping to be able to replicate that. We are having conversations with BUSHkids at the moment, looking within our budget to see if we can replicate that to some other places in the Boulia area.

The other thing around it, which was a bit sidetracked by COVID last year, is working to do a bit of a launch, a soft sell, to bring community in and bring families in to talk about our Healthy Outback Kids project, to get a better picture of what is needed in those communities. We could then offer the BUSHkids passage to provide services that are not readily available and then stitch that into NDIS services, if that is a requirement as well. It is getting all of those people to the table, which is what the PHN did last year with the NDIS forums; trying to get the NDIA, NDIS and COTA to the table to identify different ways that we can service those communities. In a roundabout fashion we are hoping to do that in future out in Boulia.

CHAIR: Thank you very much, Leisa. We appreciate the work that is being done. Good luck in fighting for that funding, although you should not have to fight. An issue that we are hearing about all the time is the shortened funding. We are hoping that funding can continue from the federal government. Keep up the good fight and thank you for the contribution today.

WALKER, Dr Clare, Secretary, Rural Doctors Association of Queensland

CHAIR: Clare, thank you for being here today. We normally start with an opening statement and then move to questions.

Dr Walker: I am secretary for the Rural Doctors Association Queensland and have been a previous president. Just to declare a couple of conflicts, I am on the board of the Central West HHS and also the Western Queensland PHN. I am a clinician in town here and I work at the hospital and at the practice. I have an opening statement and a list of issues that might take slightly more than five minutes, but feel free to stop me at any point.

CHAIR: We have half an hour with you so please continue.

Dr Walker: I guess we all know that the reason we are here is because, in a perfect world, all of the health care for our patients would be seamlessly integrated from primary care, tertiary care and allied health, right across into aged care and disability services. Unfortunately, increasingly we hear things like ring fencing, cost shifting and blunt levers for funding and funding models that actually incentivise poor care for patients. I have broken that up into three different areas that we are looking at today: primary and allied health care, aged care and the NDIS process, and also the private healthcare sector.

I am a GP and obviously primary care and allied health care are part of what I do every day. We know that Medicare is supposed to be a universal funding system. It is supposed to fund all of the patients across Australia to access health care, but we know that it is not working. We know that it is all but dead in remote areas in Australia. When it comes to private general practice, the Medicare system is not fit for purpose for funding private general practice in rural Australia. Medicare rebates are not just frozen; they have never been indexed to inflation, let alone make up for increased operating costs, the increase in consumables, IT et cetera. That is a step up again in rural areas. Bulk-billing is impossible in rural areas in a private general practice. It is impossible to make that sustainable and to get GPs into a community in the long run. There is no incentive through the Medicare system. The Medicare rebates for most consultations are the same whether you are in the middle of Brisbane or the middle of Mount Isa, and we all know that the cost of living and also the cost of running a business are much greater in these areas.

We know that there is a lack of GPs. Rural patients are often more complex. You often spend longer with them because you are not just looking after them then; you do not have a hospital down the road to send them to. Medicare actually incentivises seeing more patients for less time so the longer you spend with a patient the less dollars per hour you are actually earning. We know Medicare takes item numbers away. Last year they took out the item number for GPs to read an ECG. We run the hospital here so if I have a patient with chest pain I can send them to the hospital, which is me as well, but Medicare does not fund me to read the ECG.

CHAIR: Just say that again.

Dr Walker: Medicare took away the GP Medicare rebate for reading ECGs.

CHAIR: That is ridiculous.

Dr Walker: We are allowed to take one but we are not rebated to read it.

CHAIR: This is someone who is having a heart attack.

Dr Walker: That is right. Apparently a cardiologist is supposed to read that ECG. We can all see that Medicare is designed around urban places and unfortunately a lot of the high cost of Medicare comes from urban places. If you want to look at the statistics, there was a study done in 2017-18 that actually looked at how much Medicare dollars are spent on rural, remote and urban patients. For every one dollar spent on a city person by Medicare, 56 cents is spent on a very remote Australian. That is not just a feeling; that is actually fact. We know some of that shortfall comes from the state health system and some of it does come from other federally funded bodies like RFDS, but overall that is far less. That comes from a report that I am happy to send your way. It is called *Is Medicare Fair?*

CHAIR: We will get that tabled. Is leave granted?

Ms PEASE: Aye.

CHAIR: Thank you. Continue.

Dr Walker: We know that there are some rural incentives and they are good. Personally speaking, it pays for one of my kids to go to boarding school. When you compare the cost of living in these remote places with that in urban environments it is good, but there is certainly a shortfall that still exists. We have heard about the current model here and we know that private general practice is

basically a market failure in a lot of places. In the Central West HHS the state health system has picked up the primary care responsibility and currently run an SMO model where the state employed doctors look after primary care. In general practice it is also a retrospective funding model so if a town has no GPs they cannot access Medicare dollars. There is not funding per town—it is per doctor—and the fewer doctors you have the less Medicare funding you can access. Another recent example of Medicare failing is the recently implemented removal of general practice support to specialist telehealth, which does not sound that significant but it is the entire way specialist care is delivered to some remote places.

Again as an example, in the central west our entire cardiology service from the Prince Charles Hospital is delivered by telehealth. A GP at one end is examining the patient, looking after them in between cardiology telehealth, doing their assessments and handing that information to the specialist on the other end of the computer. That Medicare rebate item has been removed now—as of 1 January, whilst no-one was noticing. We all returned to work this year and found that our cardiology service no longer operates as it should because there is a patient sitting in a room with a computer by themselves talking to a cardiologist at the Prince Charles.

CHAIR: I am speaking tongue-in-cheek here. You would not wish chest pain or a cardiac event on anyone, but if the Prime Minister were here and had chest pain I wonder if he would take notice of that because that is the most ridiculous thing I have heard. I have worked in health for 30 years and I have never heard anything so ridiculous.

Dr Walker: It is something that we are pushing up through the Rural Doctors Association. Obviously it is a federal issue, but it affects the state health system. The only way around the situation is to pull public doctors out of hospital care to try to facilitate telehealth and to keep it operating for the patients, but it is far less efficient. It only makes sense to have the patient's usual GP sitting with the patient and with the cardiologist. Pushing it off to a junior doctor in a hospital who does not know the patient is not a solution, either.

Mr MOLHOEK: Dr Walker, you mentioned that two of the rebates have been removed. What is the theory? Has there been previous advice given about it? Have people been overbilling and over claiming? Why would they remove those rebates?

Dr Walker: Both of those reasons are true. There is a Medicare advisory committee federally. It is heavily weighted with urban practitioners. When they look at case examples, they really only consider the urban situation where there is a cardiologist at the hospital down the road who can look at an ECG for a patient. They are likely to be transferred to a specialist hospital. There has not been a consideration of rural areas in a lot of these changes and there has been overbilling.

Whenever Medicare billing exists, there are places—especially corporates and especially in the city—that take advantage of it. From the rural doctors' point of view, we think that these Medicare items should be reinstated for rural and remotes—not necessarily across the board. That would solve a lot of the issues. We also think that Medicare rebates in general should be indexed to your rurality. We have got a good modified Monash model that indexes rurality and the costs go with that so why not index Medicare rebates according to that? You would suddenly get a lot more GPs in Mount Isa if they are getting increased Medicare rebates per consultation.

CHAIR: Do you want to keep going or should we ask questions? I know you have more there.

Dr Walker: I can go onto aged care and the NDIS. We have good aged care in rural places where there is critical mass. For example, in the town here there is a good private aged-care provider. Where there is not the critical mass or where there is a market failure in that space, the HHS does provide, in conjunction with federal funding, aged-care places. That is done quite well in rural places. In aged care, one of the things that could be improved, though, is again looking at rebates. The Medicare rebate for an after-hours attendance at a nursing home by a GP is insanely small. It is often easier for patients to be transferred to a hospital for assessment rather than actually being seen by their GP.

CHAIR: Which requires an ambulance and is back to the door of last resort. When you say 'insanely small', what is the rebate? You can take that question on notice, if you need to.

Dr Walker: I can send it through to you, but it is less than $100. Again, some of these rebates get overused and used in the wrong way by corporates and whatnot in urban areas so everyone gets tarred by the same brush, sometimes, when it comes to Medicare. I think there needs to be nuances for rurality.

There is opportunity in this space. Because there are blurry lines in rural places between hospital and health services and private general practice, and federal payments through the Medicare system and through aged care, could we look at opportunities? For example, is there capacity for a

hospital and health service to pay private general practitioners to keep patients out of hospital? I know that in other regional areas there has been the adoption of SWOT teams that come from a regional hospital and go to a nursing home when a patient is identified as needing to be sent to ED, to try to cut them off at the pass. But it would make much more sense to have their usual GP doing that, rather than a couple of people from a hospital who do not know the patient. There are opportunities there to look at hospital avoidance in aged care and incorporating GPs into that process.

The NDIS has had mixed success in rural areas. Unfortunately, a lot of patients who qualify for packages cannot spend any of the money in their packages. There are often no providers in some of these rural places. Once people become an NDIS client and at times have access to private providers, in some circumstances they are not able to access the state provided allied health. Sometimes the NDIS patients are in a worse place than they were without NDIS. An example of that might be clients who have disabilities where they qualify for supported accommodation, but most rural towns have no supported accommodation for them to go to. We have had situations where disabled people who are not aged are living in hospitals in rural Queensland because there is nowhere for them to go and their carer cannot care for them, which is not acceptable.

CHAIR: Do you have any examples of those long-stay aged-care people in this area?

Dr Walker: Not long-stay but we have had cases in the past of people with significant progressive disease. They are not over 65 and there is no capacity for them to go to the nursing home and the NDIS process takes too long, so we have had patients in our hospital here for a couple of months.

CHAIR: It is actually not healthy to be in a hospital.

Dr Walker: No. The other issue that I think is interesting that NDIS has is that where there are private providers it has changed the price point and the accessibility into the private system. The private speech therapy available to NDIS clients in this region is provided by a private provider at a cost of $185 an hour. Someone who would normally be able to access private therapies at that price point, it forces them back into the public system. That is an interesting unintended consequence of NDIS funding in an area where there is not a large private market and very little competition.

I have a few comments about the private health system and private health care. We commonly share both public and private procedures and admissions in rural hospitals. Obviously, there is no private hospital in most rural towns but there are reasonably high levels of private insurance in a lot of country areas so in the past private insurance was used quite widely. There are examples, unfortunately, where in the state health system the price point has changed so it is now more cost effective, seemingly, in hospitals to admit private patients publicly and get funding for the activity rather than patients accessing their private insurance and getting the private funding.

There are a lot of flow-on consequences. I can use the example of Atherton Hospital. For many years they have had access to private general surgery, private gastroenterology and also gynaecology. It was a service that was quite successful for local GPs, who provided anaesthetic service for that. It was identified by the hospital that their revenue would be higher if they changed the private system to activity and made those patients public. That meant that the private GPs in town no longer had anaesthetic lists; they no longer maintained their procedural qualifications. So then you have a whole bunch of people in town with a high degree of skill and experience no longer able to practice, reducing the experience depth in the town. Also, often they are then not able to support junior staff who are at the hospital in these rural areas.

This is not the case just in activity based hospitals. While Atherton is an activity based hospital, a lot of our rural hospitals are not. We are seeing a reduction in GPs permitted to have visitation or admitting rights in rural towns. It does not make any sense to reduce the already-small workforce in rural places and it does not make any sense to cut out the most experienced people in town, who also are the ones most known to the patients. In a perfect system, our state health system should not just allow private GPs admitting rights but should really thoroughly encourage it. That is my run-through summary; I am happy to take questions on any part of that.

CHAIR: Thank you for a very frank and open assessment on those topics.

Mr MILLAR: Clare, we definitely need to sit down and look at some advocacy programs for the Rural Doctors Association. Why is there a discrepancy between Medicare payments in rural and remote areas and those in urban areas? You mentioned a figure of 56 cents compared to whatever the urban figure was. Can you tell me why? I need to find out why.

Dr Walker: It is multifactorial.

Mr MILLAR: First, for Hansard's sake, can you repeat the figures?

Dr Walker: For every one dollar spent on a city patient during the 2017-2018 year by Medicare, only 56 cents was spent on a person in very remote Australia. Those figures go down from a dollar as you move from city, regional, rural, remote, very remote. One of the problems is that Medicare is not funded to the population, it is funded to the provider—if there is a provider—in the community. If you have no GP you cannot access Medicare at all. A whole town may go without any Medicare dollars being spent in the town. It is a retrospective funding model and it requires the people to be there in order to access the funding.

In some towns, that shortfall is made up of other federally funded organisations like RFDS. For example, some small communities, such as Birdsville, have RFDS as their general practice and they are federally funded so that does not come up as Medicare dollars. But it does come with its own issues. Because they cannot bill Medicare, they cannot trigger some of the other services that are available. For example, if a patient wants to access some of the mental health programs that are available and the psychologists that are Medicare rebated, they need to have a care plan billed, but RFDS are not able to bill a mental health care plan because they are not Medicare funded.

Mr MILLAR: That was my question, Mr Chair.

CHAIR: There is a chance, I think, that we are bipartisan and we would agree that this needs to be restored and this needs to be sorted out.

Ms PEASE: Thank you for coming in and for your great work and passion for the area. It has been amazing to hear from everyone. What I have been hearing is the dedication, professionalism and commitment you have to your communities. How long have you been here for?

Dr Walker: Twelve years, this year. We came for a year of training and have been back here for 12 years.

Ms PEASE: Obviously you have decided to stay; is that the plan?

Dr Walker: Yes, that is right. I have one child at boarding school and three to go.

Ms PEASE: Like my colleagues, I am surprised about the removal of Medicare rebates. I am interested in your suggestions about how we can resolve that issue. Are there other items that you are aware of?

Dr Walker: There are. There has previously been a 20 per cent loading for specialists doing telehealth to rural patients, which was also removed on 1 January. There are models of care that were set up based on that model. I can give you an example: in South West there was a telepsychiatry service. A private psychiatrist had a large population of rural patients and because they were loaded 20 per cent they could bulk-bill the patients. At no cost, the patients could access quality psychiatry services by telehealth. That 20 per cent loading was removed on 1 January as well.

Ms PEASE: That is terrible—terrible. The other comment that I would like to make relates to care plan packages and how difficult that is. We have heard that whilst those care plans of maybe five or 10, depending, probably needed to be extended, at least they gave people some hope and some opportunities. Not being able to access them at all is actually rather frightening. I have no further questions because your comments were so thorough. Thank you very much for coming today and sharing and for the great work that you do in the community. Keep it up.

CHAIR: Hear, hear! The deputy chair is also on the Mental Health Select Committee. I am sure what you have just said about the telehealth rebate being removed would be of great interest to that select committee.

Mr MOLHOEK: I think we are coming back with the Mental Health Select Committee sometime in the next few months so perhaps we can flesh that out more then. I am interested in your comments around the NDIS. I think you said that many people have packages but there are no providers. It sounds like the money is available for the services, but how do we cover some of the gaps with providers?

Dr Walker: It is really interesting and it is a circular problem. In some areas, a bit like aged care, the public health service is the provider of last resort.

CHAIR: We have heard that.

Dr Walker: However, there is a circular problem in that they do not have enough staff to provide the level of care that is required by a lot of patients with high needs. They definitely do not have the staff to go through the process of qualifying to be an NDIS provider, but if they were able to do that then perhaps they could fund more staff. Perhaps, at a state level, there could be a push and some funding to allow places where there is a market failure in the private space to get public services NDIS qualified, increase their FTE and their clinicians, and really allow that to not just make it the last resort but also make it quality and get more funding into the regional areas to make up the shortfall.

Mr MOLHOEK: My observation from across the state is that we have seen a massive increase in funding through the NDIS for services, so the demand has gone up exponentially, but there are not the allied health workers and support workers available to meet the demand. That is not just in Longreach. If we were sitting on the Gold Coast talking to NDIS service providers, they would be saying, 'We have plenty of packages but we have no-one to provide the service.'

Dr Walker: One hundred per cent. That is definitely true. There is also a big gap between having the funding available for people to spend their money and an allied health clinician wanting to work somewhere. We need to create the jobs for them to be able to come to. It is very challenging. We have a couple of solo independent allied health professionals who service this area. North and West Remote Health is one of the bigger ones in the western Queensland area and I know they do have trouble recruiting and retaining long-term staff. Like Medicare, I am not certain that the NDIS packages have indexed in the increased costs of delivering some of those services in rural areas.

CHAIR: We are right on time. I would like to thank you very much. I am so pleased that the committee came out here because your contribution was very much focused on exactly what we need to fix and what we will make recommendations towards fixing. Thank you for the work that you do in the community. Thank you for being the voice of common sense for rural Queensland. We really appreciate your contribution here today.

Dr Walker: Thank you very much.

CHAIR: I call forward Professor Catrina Felton-Busch.

FELTON-BUSCH, Professor Catrina, Associate Professor, Murtupuni Centre for Rural and Remote Health, James Cook University

CHAIR: Welcome, Professor Felton-Busch. Would you like to make an opening statement and then we will move to questions?

Prof. Felton-Busch: Good morning, Chair and committee members. I am Associate Professor Catrina Felton-Busch. I am currently the director of the Murtupuni Centre for Rural and Remote Health at the James Cook University. I have been seconded to this position in the last fortnight from my role as the Associate Professor of Remote Indigenous Health and Workforce. Some of my JCU colleagues have addressed this committee in earlier sessions and a JCU opening statement was made at that time. You would have heard also from my colleagues in terms of medical nursing and some allied health workforce successes, opportunities and challenges. What I would like to do is provide a statement focusing on JCU's efforts in terms of Aboriginal and Torres Strait Islander health in the context of the work we do through the Murtupuni Centre for Rural and Remote Health and reference the important work of Aboriginal health workers, Aboriginal health practitioners and allied health professionals in primary care, which also has implications for aged care.

I would like to start by acknowledging the traditional custodians of the land on which we are gathered today and pay respects to their elders. I would also like to acknowledge the people whose lands we work and live on within the footprint of the Murtupuni Centre for Rural and Remote Health and the wider JCU footprint. I am a Yangkaal and Ganglidda woman from the southern Gulf of Carpentaria and I call Mornington Island home. My aged parents still reside there.

I commenced my academic career at JCU at the Mount Isa Centre for Rural and Remote Health, which is now Murtupuni, in 2000. I currently live and work on Kalkadoon country in Mount Isa. Murtupuni is the university's department of rural health which was established in Mount Isa in 1997 for Queensland and is one of the first to be established in the country. Federally funded UDRHs are an important element of developing a rural and remote health workforce and they bring an academic presence to rural and remote areas, including resources and infrastructure that support health services, health professionals and students as well as the communities in which they are established. Murtupuni's service footprint extends from Mount Isa to the southern Gulf Carpentaria communities, the Flinders Highway, the central west and the western Queensland corridor to Boulia, with a presence to support allied health placement in Weipa on the western cape. By 'footprint' I mean we have a presence in those communities in terms of student placement accommodation as well as having technologically enabled study centres in Cloncurry, Burketown and Longreach, and placements and research staff in Weipa. JCU has recently been funded to set up another UDRH for Central Queensland, to be established at Emerald.

Integral to our work is the strong partnerships we have with Queensland Health hospital and health services and the Aboriginal community controlled health services, such as Gidgee Healing in Mount Isa and Apunipima in the cape, and other entities providing health services to our communities. None of our outcomes are possible without local government, the people and community organisations in those small towns taking a special interest in our students and supporting their placements. They see it as an investment in the future health professionals for their communities and student activity is a great way to promote a health career and inspire kids from the bush.

I would like to talk briefly about Aboriginal health in an attempt to share our learnings in relation to health workforce development. I would like to qualify my position by saying that I speak from my experience and my stand point. There is strong advocacy for the communities both from local government and health services and I do not seek to usurp them in their efforts, but rather to focus on three challenges that we face that I thought would be worth highlighting in delivering a culturally and clinically safe health workforce for those communities.

In my discussion I would like to talk specifically about Mornington Island by way of illustration. Over 25 years of our history, our centre has seen the establishment of student accommodation across our footprint with the exception of Mornington Island. Our efforts have been hampered by the availability of land, native title issues and the ageing infrastructure to support new buildings in the community. It is an island, obviously. In recent years, Gidgee Healing, the Aboriginal community controlled health service in Mount Isa, received funding to provide services to the community through what is understood as a transition to community control of primary healthcare services. In my opinion, that is an appropriate strategy if resourced well. In the past year, Gidgee Healing has also been funded to provide aged-care services in the three largest southern gulf communities of Mornington Island, Doomadgee and Normanton.

From my perspective, we have three main challenges on Mornington, which are the same challenges that face Gidgee. These relate to the lack of suitable accommodation for student placements, including for teaching; a really big one is the complexity of the entrenched social disadvantage plaguing our communities, which impacts on our kids having the skills and knowledge acquisition to participate in higher education; and the lack of an evidence base to deliver culturally appropriate models of care and a fit-for-purpose health workforce to meet the needs and priorities of the communities. I am happy to stop there and take questions.

CHAIR: Thank you, Professor Felton-Busch. I think that we need to get to Mornington Island. It is really important that at some point we go there and look at the delivery of health care. You raised issues about culturally appropriate care in Indigenous communities, which is absolutely vital. Thank you for your advocacy and for the work that you do in that space. I want to get clarification: you mentioned the Gidgee Healing model. Are you not in favour of that model of care?

Prof. Felton-Busch: No, I am absolutely in favour of the Gidgee model of care. Aboriginal community controlled health services are very appropriate; they need to be resourced well though. The challenges that we are facing on Mornington are really complex. The level of complexity is really quite daunting. We are used to facing those challenges. We have been to Mornington to try to provide student accommodation, which then enables students to come. It also provides an opportunity to provide training. However, there is that raft of issues that I just mentioned in terms of trying to do that.

We have built in Burketown so that we can service Burketown and Doomadgee and then we will get around to thinking about how we might bring some Mornington people over or things like that. There are problems that face Gidgee as well in terms of infrastructure. They have primary health care as well as aged care now, so they are funded to provide aged-care services. They have the same issues in terms of not having a lot of space for accommodation for their staff and not a lot of room for their services. Their allied health staff is FIFO from Mount Isa. They have to rely on agency or expensive locums for their doctors. There is a very complex level of issues there and obviously it requires a multifactorial approach across all areas of government to try to find a solution.

CHAIR: We heard this yesterday in Rockhampton. JCU—

Prof. Felton-Busch: Yes, it would have been Professor Sabina Knight, my colleague.

CHAIR: Yes. If they are doing that work and need to retain people in community or give them the opportunity to work and train in the community, you need infrastructure such as accommodation. Point taken. I think it is important. I am going to hand over to the member for Gregory for questions.

Mr MILLAR: First of all, congratulations on what you are doing. A lot of our remote and rural areas, certainly in the back country, are populated by Indigenous people. How do we get more Indigenous students involved in health and applying that discipline back in their own communities? What is needed out there?

Prof. Felton-Busch: I think that is quite a challenging one and one that we face. As I mentioned before, there are issues around the level of education that people have. If you look at the measure called NAPLAN, which measures students' skills and knowledge across the main areas of writing, literacy, reading and so on, Aboriginal communities compared to the rest of Australia perform really quite low. I do not have the figures here, but I am happy to provide them. That is challenging to us, because that is signalling to us that there are going to be deficits in their foundation knowledge in terms of how they are going to be successful going into high school. That translates then into how they are going to be prepared to do the subjects that are required.

For health degrees such as for medicine and pharmacy, typically you need maths B and chemistry. The opportunity to provide VET sector training in the communities is the other thing. It is really quite challenging. We are not giving up. We are trying to work across a broad range of stakeholders to think about this and to think about what research is needed to provide the evidence base for what we do. We have to have place based solutions to these issues. We have to try to meet the communities where they are at. That is always a challenge. We do not necessarily have the models, but we need to be funded to be able to do the research that will provide that evidence.

There is an opportunity now with the very welcomed legislative reforms around the health equity agenda—the work that is being done with Queensland Health and the Aboriginal community controlled health sector—to have a range of consultations and have plans for how they are going to address their health inequity. We are very keen to be a part of that in that we are obviously health workers. We actually have a nursing degree delivered in Mount Isa.

Those sorts of models are things that we want to replicate in other areas. It probably takes a lot of friendships, a lot of relationships and a lot of bringing people together. Local government have been fantastic. They have given us land. They have peppercorn leased us land to build student

accommodation in Burketown. Some of our centre in Mount Isa is on gifted land. Cloncurry has given us their old chambers to make a health precinct. The communities respond really well to support us. We could not do this work without them.

CHAIR: It is really good when all levels work together. I have met the team from Gidgee Healing in a regional forum separate to this. They do great work.

Mr MOLHOEK: I have heard on a number of occasions people talking about Gidgee Healing practices. Could you explain what some of the differences are or give us some of highlights of that as a health practice—how it differs from normal?

Prof. Felton-Busch: Gidgee Healing is what we call an Aboriginal community controlled health service. Their approach is a holistic approach. The phrase that is often used is 'enhanced primary health care'. It is a multidisciplinary model. It has similar sorts of things like a GP, so people will see a doctor. In smaller communities you might have a nurse practitioner who does that. Ideally in the bigger centres they will have wraparound services such as all your allied health services. Because it is holistic, they might have child services or social services. Aged care is coming into the mix now for Gidgee. Care will be different in that you will see Aboriginal and Torres Strait Islander health practitioners or health workers at the coalface. It will be led by health workers. It is a multidisciplinary comprehensive team that deals with that. It is different in the sense that it is more holistic, I would say—it is that patient journey right through.

Mr MOLHOEK: I have also heard people talk about it being more culturally appropriate.

Prof. Felton-Busch: Philosophically it is underpinned by Aboriginal ways of knowing, being and doing. It is built on a history of health services being not responsive to Aboriginal people because of cultural barriers and socio-economic barriers. It is a movement that developed back in the early seventies. The first one was in Redfern. The second one was in Townsville. They are made up of community boards. Aboriginal people from the community are elected to the board and they make the decisions. In Queensland there is a network of these. Their peak organisation is the Queensland Aboriginal and Islander Health Council. They provide member support for those services.

Ms PEASE: Thank you for all of your great work. Two weeks in—how does it feel?

Prof. Felton-Busch: It is a steep learning curve.

Ms PEASE: I can imagine. Congratulations and thank you for being here today. I would like to explore a little more about culturally appropriate training. It is a really important process not only for the people you are training so they are able to deliver culturally appropriate training but also for the people who are participants so they are being trained in a way that they are comfortable with because they are off country, sometimes they are a long way from home and they would need a lot of support. I know we talk about the importance of trying to do the training at home or at a centre closer to home. Often that is not feasible. What do you see as important or is it equally important—supporting the person who is doing the training with culturally appropriate training but also for those people who are coming off country to learn to become an allied health provider or doctor or a nurse?

Prof. Felton-Busch: That is a good question. In terms of our students who come on placement, they undertake cultural awareness training. That is quite comprehensive. In their curriculum they have Aboriginal and Torres Strait Islander content throughout their curriculum in all degrees. When they come out and do placement they will do cultural awareness training but orientation to the communities as well. Usually we try to cover off on things in the community where people would be mentors or support the students. That is something that we are working on at the moment.

For JCU there are particular units. There is the Indigenous Education and Research Centre. That is funded to provide support to Aboriginal and Torres Strait Islander students seeking to do health professional degrees. They get support in tutoring, support in accommodation and support with scholarships. There is a winter school that Aboriginal and Torres Strait Islander kids still in school can go to as a taster for university to see whether that is for them.

In the Murtupuni Centre for Rural and Remote Health, our head of Indigenous Health provides mentoring support for both non-Indigenous students and Indigenous students. There is a range of students who do their degrees externally—nursing or social work, in particular—so support is provided to them. We also try to travel to communities to participate in events that the communities may have such as career days or health expos and things like that. Often communities struggle to put on good things, so we would go. We make an effort to go to everything—we call it every dog and pony show—to try to offer that support and always continue doing aspirations raising.

Ms PEASE: It is really important work. I am from Brisbane. I am part of the Brisbane City Council. Cultural appropriate training for any healthcare workers is really important. My area has a very large First Nations population. We do have a fabulous Yulu-Burri-Ba health service, which is a great service. It is really important that as a patient you are treated in a manner that is appropriate to you. Thank you for your great work.

CHAIR: Thank you very much for your contribution. There being no further questions, thank you for being here today. It is an important topic.

Prof. Felton-Busch: Thank you very much. I drove seven hours from Mount Isa. We have a centre here. Our footprint comes down this way and out to Barcaldine and Blackall. We have a centre here on the hospital grounds. I came to see staff as well, so I could fit a few things in. It is all good.

Ms PEASE: Good. Thank you for the drive and drive carefully home.

Mr MOLHOEK: Did you come yesterday?

Prof. Felton-Busch: Yes.

Mr MOLHOEK: So you did not get up early this morning.

Prof. Felton-Busch: No. I came yesterday and I am heading back tomorrow. We love it. Don't worry. I am a bush girl. I grew up around Mount Isa. I am fine with the driving.

CHAIR: I hope that we get to travel to Mornington Island. I really do.

Prof. Felton-Busch: Please do. My parents live there. They are aged. They do not have the range of access to services. It is complicated in terms of how we support them as they age. My mum is 90. How do we support them in an environment where there are not services and none of their children live on Mornington? It is a real challenge. I just thought I would leave you with that one too.

CHAIR: Thank you so much for being here today. Safe travels home.

THOMASON, Ms Simone, Nurse Navigator, Central West Hospital and Health Service

CHAIR: I welcome our final speaker, Simone, who is a nurse navigator—one of my favourite topics.

Ms Thomason: Thank you for allowing me speak today. This is a little ad lib. I am employed by Queensland Health as a nurse navigator, so I work across a large span—from birth to people passing. I have been out here for about 4½ years. I have worked in lots of different areas.

I wanted to make comment regarding more systemic issues that are coming up. In rural and remote areas we see what happens systematically more because there are fewer people and we are more remote. When I was running the primary health care team about a year ago—I was temporarily managing—we had a lot of university students come out and they did not actually know what primary health was. I am thinking about more systemic issues around education.

I think we need to not fall into the trap of siloing education in the health industry into rural and remote necessarily. I think everybody who puts their hand up to be allied health, doctors or nurses should all do a component of rural and remote because that is part of our population. When I did my masters of education I did some reports and readings on how people think that if you cannot cut it you work in the bush. In fact, it is the opposite—you have to wear more hats.

We are noticing with a lot of our junior staff—and I am talking more from a nursing perspective here—that discharge planning is a really important role, having that corporate knowledge about who is in your community and who your patient has contact with. People are just not trained in it. As a nurse I did not know what Home and Community Care was. I did not know about packages. I did not know what the Commonwealth Home Support Program was.

As a junior nurse, when somebody would come in from the community who was maybe over 65 or maybe under a disability service banner, we might ask them, 'Do you have community based services?' Then we might ask them: 'What services do you have?' Again, that is a jargonised term. As an elderly person, they might say, 'I don't know what she means. I only get my car serviced. What does she mean by the word "service"?' We should ask them, 'Does somebody take you shopping? How do you get your meals?'

We are so acute focused in our medical and nursing training. It is 10 per cent of our lives if we are unlucky and probably 0.1 per cent of our lives that we are in an acute setting. The rest of the time we are in a primary setting. When the director-general came out last year we were talking about this disparity of distance and geography and saying how when our patients are flown to a tertiary centre we are now adopting armbands that are fluorescent saying, 'I need to be discharge planned,' because they will be aerial retrieved and they have no way of going back. Some of these big hospitals discharge at 1 am. A lot of people find it very difficult to brokerage for themselves. That is just one issue: we are not equipping our workforce to recognise that metro and acute are not the only way we care for people in our general population. It is really important to shift the focus.

The director-general agreed too, because he is obviously from a British background, and the NHS—whilst we do not always get it right or they do not always get it right—do have a lot more services that address lower acuity in the workplace. So you have your GP practice and you have your acute centres where people might come in with a broken wrist or something, so they are not coming into the ED and only the critical people come into the ED. Again, every person who came in was asked, 'Who is your district nurse?', which is us, our community nurses, 'Who are they? We're going to refer you back to them.' When that person gets discharged their district nurse should ring them up and say, 'I heard you were in hospital after a fall. How are you going? Are you linked in back with your services?' There is nobody meeting the needs. As a nurse navigator we are doing some of that brokeraging between GP and ED. There are 400 of us currently across the state—some are more specialists; the rest of us are generalists—and we are only barely scratching the surface.

My colleague here covers the southern area and we are abreast of the grassroots issues about access and poor staffing to get the NDIS. We almost feel guilty when people get an NDIS package out here because we know we do not have support services, and that is not a new thing. We know we have to grow our own, but what I am saying is that what we see in the west and in rural areas is happening everywhere, but we have to look at why it is happening, and I think it comes back to education. There are also incentive programs. We do not have as nurses the RANIP here, which is the Remote Area Nursing Incentive Program, which enables us to get away for professional development and education. I think we are only one of the very few HHSs that do not have that. I had to make a decision when I came back here after working for 17 years in cancer services: did I want to go to a rural area? Would I de-skill? It was a question professionally for me. I have been supported into education as well in certain things that I chose to do, which was great, and I really respect my employer for that, but I do think though that we just need to enable people to come out here.

The last comment I would like to make is that—and I think I have it right—the education department does not have a staffing problem the way health does. Traditionally—and I think it still currently happens—teachers are bonded to a western service for at least two or three years, so you have your workforce. You are not having to put up flashy 'come and live under the stars' things because they are already bonded there. They are there, they come for two years and you have this constant workforce. Some people choose to stay, which is fantastic, but you get that rural experience. Many patients come back from Brisbane hospitals, for example, or Rocky or Townsville and the doctor says, 'Here you go. Go and have an MRI,' yet there is no MRI here. They think that we live locally.

Even in terms of the director-general, going back on a very basic thing, when I was working in the Territory we had a map up in every consult room in every hospital because we would say to that patient, 'Show me where you live,' and as a Darwin person I do not know where half of those places are. You say, 'Wow. You've come that far?' So I am not going to say, 'Go and get your MRI next week.' We have to organise it. We have to think more connectedly and be more aware. A little map in a room and allowing people to engage by saying, 'This is where I live. I don't think I can do that,' enables people to speak for themselves as well. It is a bit like having Indigenous flags in hospitals. We are saying, 'You are welcome here.' It is the same in an urban area saying, 'You're welcome here. We understand where you come from. We're here to help you.' I know there is a lot of debate around who should take what responsibility for what, and we have a great arrangement with Metro North to help services and specialties here, but it is a big issue in terms of that divide and connectivity. Thank you.

CHAIR: Thank you very much. Again it is about connected communities, because once you know all of those services and the Commonwealth support services and all of those things you would be seeing that now as you navigate a patient's journey. I wanted to ask a question about your experience. Going back to the core of the inquiry—trying to keep people out of hospital—I refer to the Commonwealth home care packages. On a, say, level 4 you are really unwell. In a previous inquiry that we did people told us that they did not want to go to hospital; they wanted to stay in their community, stay at home and have that support provided. We heard some really sad cases where they could not access assessment—it took too long—and they died before they got their packages. We heard of people—it was in Bundaberg just two days ago—where someone's package has just arrived but they had died six months prior. Have you come across any of those in your experience? What does that do to the person, because there is a person at the end of this and they end up generally in the door of last resort, as we have heard, back at the hospital?

Ms Thomason: Exactly. It does happen that way and it is a default place—the hospital—when they do not have anything else. We are seeing people doing with very little. It is not a good level of living, really. They are living without people to help them open food or to get food. They might get Meals on Wheels. We have had to do a lot of work to get Meals on Wheels delivered out to properties and get them frozen and we have worked around those sorts of challenges as well. I think the problem is that packages are historically taking over 12 months. I know that what used to happen traditionally—and I am not well versed in it, but about four years ago—is this, and, for example, we have Anglicare here. They would hold two or three packages of different levels, so, yes, it probably was not the best cost-effective thing because if they were not filled they were still sitting with that agency; now they have gone on to a national queue. Everybody gets queued and they get delegated accordingly. We only have one package provider here and the rest is Commonwealth home support and I can tell you—and Louise can vouch for me as well—that the providers here that offer Commonwealth Home Support, which is less funding and less hours and less acuity for the client, do over and above because they feel like there is no other option. The person will get used to that provider and then for a package they switch over to another provider—that is, a new lot of people et cetera. It is difficult. For levels 3 and 4 I know that the people who run those agencies find it really hard to get the workers, and it is the same with the NDIS. Like I said, we have people on NDIS who do not have people who can just drive them up the street or take them things. It is an issue, and I think it is around education.

I notice that the federal government, I think it is, have put a good advertisement on TV about trying to make caring a great career and trying to entice people into it. We have had the Queenslanders with Disability Network going out to the high schools and saying to the kids, 'You may not want to go to university, but you could train up in aged and disability support and it's a great thing to do.' So we need to make those sorts of things a little bit more sexy, for want of a better word, because it has not been. In order to change public perception, we need to do a bit more marketing around that. Also, we well know that aged-care workers have a very low ceiling of career, so you work at this level and that level and that is it, and the hourly wage is appalling. There is no recognition for child-care workers or aged care and basically some of us dread getting old because who is going to

look after us? So we need to acknowledge, respect and pay people accordingly. I know locally in Longreach we have a lot of employees from Kiribati in the Pacific because we do not have Australian workers here, and that is great for them. It is a win-win each way.

Obviously housing is another issue. Our bulk-billing closing is another reduced access to equitable care and if we could have bulk-billing agencies everywhere it would be fantastic. I know as navigators we try to encourage people to get into their GP to keep their scripts regular. The cost of pharmaceuticals out here is quite extraordinary too, so that is another barrier to people's access that we find as well, unless they are on a care plan or unless they identify as Indigenous or Torres Strait Islander getting a blister pack or Webster-paks so that people can facilitate that. There are lots of little things. Some things we do well. I think the telehealth is really good. We have an extraordinary array of specialists out here but, like Claire said, not having the GP there is a real slug.

Anyway, I think lifestyle is the key here and I am just a bit concerned that the other level of difficulty for the educational service in medicine and nursing is the COVID experience and how that is going to deter people. Again, we need to jump on board with marketing to try and get people back into the industry. I really believe that rural and remote and primary health and discharge planning should be up-front in our education for nurses, doctors and allied health. It is sadly lacking and we just expect people to come out with those skills and it is not happening, so they are not well versed in it.

I have worked in a lot of metropolitan hospitals. We have discharge coordinators. The nurses do not even know what they do, so when they come out here and Mary comes in after a fall at home, who is going to discharge plan her? Or the tourist who comes through? We have had multiple tourists come through. We rely a lot on social workers, but we only have two for 12,000 people—it does not really work; it does not add up. How do we get them into motels when they were not planning to be here but they have had a motor vehicle accident?

Thank you for your time. I just wanted to bring up some grassroots issues. We have four nurse navigators in our HHS, which is fantastic. We cover a big area and sometimes it is hard to get around with cars, but home visits are the key because we are meeting people in their homes. People tell you that they are doing okay, but when you see their home that is when you bring your clinical expertise into the situation and go, 'How about we just maybe get your feet done or this done,' so we add that in a really rapport friendly way. Thank you for your time. I hope you have had a good journey around the district.

CHAIR: Before you take off, it is us who should be thanking you and Louise. I love the idea of the nurse navigators and the work that you guys do is so important. I will just ask if there are any questions before you go.

Mr MILLAR: Mr Chair, I have not so much a question but just want to backup Simone. One of the major issues that I get in my office here at Longreach is when we have a patient who has broken their leg and been taken down to Rockhampton by the Royal Flying Doctors and then they are discharged at 1 am in the morning and we cannot get them back. I know the terms of reference of this inquiry, but with your indulgence I think something needs to be put in this report about a discharge plan for rural and remote people. A lot of them are elderly and they end up being very frightened. I am not blaming the Rockhampton Hospital or the bigger hospitals—they have work to do—and I think putting an armband around someone and saying that we need a discharge plan is great, but we need to have some sort of recognition that there needs to be something for people out here.

CHAIR: Great point, Lachy.

Ms Thomason: I want to make a comment about that as well, Lachy; thank you. I think that traditionally the hospitals in remote areas and probably metropolitan areas had this, but I know that in the Territory where I used to work we would have hostels attached to the hospital. For those people from remote areas—obviously an acute bed is in high demand—they would have some surveillance in that hostel so that transitional care was a great incentive that came out of, I think it was, federal government funding. Say someone had a fall but might need allied health services before they go home. They can have six to 12 weeks, I think, of hostel accommodation with allied health input to get them back and robust and independently back home. So they are things that have gone by the wayside and we do not have those out here as well.

Ms PEASE: Thank you so much, Simone, for coming in and to your colleagues. What amazing work you do. Thank you for coming and talking to us today about that. Like Lachy, I am very interested about the transfer of remote patients to a tertiary hospital and then their discharge. Did you say that they are currently wearing armbands or it is just in some places they are doing it?

Ms Thomason: The normal hospital armband has an ID on it. That is not what I am talking about. We actually did a project here. It is a fluorescent armband, a bit like when you go to the sporting ground. It is highly reflective and obvious—not to be confused with a hospital ID armband—and it says, 'I need discharge planning.' It has a QR code.

Ms PEASE: Do you put that on before they are flown out and that stays on?

Ms Thomason: Yes.

Ms PEASE: Is that working?

Ms Thomason: I had an example this morning where I was talking to one of the staff members whose husband was flown out. He was asked to leave very early in the morning and he said, 'But I got flown out. I don't know how to get back. How will I get back?' Arguably, he played devil's advocate: he did know how to get back because he actually had some knowledge, but he also wanted to see how that system was working. So he said, 'I need discharge planning. I need a social worker to help me find somewhere,' and then that actually fell into place. However, not everybody will say that for themselves. They will not stand up for themselves because they do not feel they are able to.

Ms PEASE: Absolutely, and they do not know how to.

Mr MOLHOEK: The Chair has asked me to wrap up in a second. I am just trying to understand why people would be discharged at one o'clock in the morning.

Ms Thomason: It is interesting, isn't it. They may have finished their IV fluids by that time and there was no more intervention and no more acute care, or the bed might be required. People make an assumption that the person lives locally or has somebody who can pick them up. If my brother rang me or somebody rang me at two o'clock in the morning to go and pick them up, I would be a bit cheesed off. Getting a taxi in Rockhampton at two o'clock in the morning is quite a challenge. Then there is the problem of having the funds. You get flown out with not much. If you have fallen on the street and you do not have your wallet or any cash, how do you get a taxi out of there? There are so many layers of issues. You may not have any footwear, you may not have any decent clothing, you may be in your nightie and then you get discharged.

CHAIR: In one of those nice hospital gowns.

Mr MOLHOEK: Where would they go at two o'clock in the morning?

Ms Thomason: They sit outside the front and wait until daybreak.

Mr MOLHOEK: And then what?

Ms Thomason: And then I do not know.

Mr MILLAR: Then my office gets a phone call.

Ms Thomason: Yes. We have sadly heard it many times. They often will ring a family member but that family member may not be near where they have been flown to, but they ask, 'Can you send me some money? Can you get me somewhere?' There are multiple levels of trying to negate that as well at the discharge hospital. If we are flying them out here from Longreach, we do register them with patient travel service here to be aware but our hospitals do not ring all of the time. It is up to the admitting hospital at the other end to ring us to book them back.

Mr MOLHOEK: How do they get back from Rockhampton?

Ms Thomason: Rockhampton is a challenge. It is the bus or the train, or you fly via Brisbane or Townsville—and Townsville is only twice a week—or you drive, which is about a nine-hour drive. It is quite a challenge. If you are unsteady on your feet, I would not recommend the bus. The train takes 12 hours—

Mr MILLAR: It takes more than 12 hours.

Ms Thomason: Or 24 hours, something like that, and it is very expensive too. You only get so much on patient travel as well. You only get $60 towards accommodation at night too, so if that person was discharged and a train did not go for three days, you have to advocate as to why they should pay for those three days and it would be $60 a night. You cannot get anywhere for $60 a night. Then you have to get your food. Ground transport is another one. It is difficult. Socioeconomics plays a big part in people's health.

Mr MOLHOEK: Given the changing rate of transport, flights and communications, would it make more sense to be sending patients to, say, a larger centre like Brisbane where they only have one flight? They can fly to Brisbane and then fly back.

Ms Thomason: It is the way the government has been set up with their referring hospitals as well. You can imagine the burden on Metro North and Metro South taking all the patients. Our major referring hospital is Rockhampton. We just do not have the transport to back it up.

Mr MOLHOEK: Geographically, the link is kind of challenging, isn't it?

Ms Thomason: It is. We get flights every day to Brisbane, a 2½-hour flight. A lot of our cancer patients go to Brisbane. We have an excellent service from there but not all cancer patients can have telechemotherapy here as well. That is a new service that has happened in the last two or three years, but that is Longreach-centric. We just started sleep studies here; again, that is Longreach-centric. We are trying to get other people here. We are trying to make things more equitable and locally based. Obviously, we do not expect to have every service here. We will never have an MRI here and nor should we.

What I am saying is that it is the tyranny of distance, of trying to get people to things. Then it is the ground transport. I have come across a couple of people who have never been on a plane. They have never been to the Brisbane Airport, which can be a bit confusing at times, and there are multiple roads to cross to find a taxi and they do not know what a luggage carousel is. That was quite a challenge and an eye-opener for me. Patient travel does not cover any ground transport in Brisbane. We desperately need a rural bus service to meet transports to take to hospitals. As nurse navigators, we are detectives and we have found out a few other ways, but they still need a credit card or a decent amount of cash to actually get to where they need to go.

Mr MOLHOEK: Thank you. The chair is letting me wrap things up today. To all of you who have come along today, thank you so much. It is incredibly helpful for us as members of the committee to be able to travel and hear firsthand from people like you, Simone, in rural and remote Queensland. It is an eye-opener at times. Our sincere hope is that out of this inquiry we will be able to make recommendations that will continue to improve the healthcare system.

Ms Thomason: I sincerely thank you for coming. We have a rewarding job and we like to keep advocating for our patients. Thank you for taking our comments.

The committee adjourned at 11.50 am.