HEALTH AND ENVIRONMENT COMMITTEE

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

Staff present:
Mr R Hansen—Committee Secretary

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

TRANSCRIPT OF PROCEEDINGS

TUESDAY, 8 FEBRUARY 2022

Mossman

TUESDAY, 8 FEBRUARY 2022

The committee met at 10.08 am.

CHAIR: Good morning. I declare open this public hearing of the committee's inquiry into the provision of primary, allied and private health care, aged care and the NDIS care services and its impact on the Queensland public health system. May name is Aaron Harper, member for Thuringowa and chair of the committee. I would like to start by respectfully acknowledging the traditional custodians of the land on which we meet today and pay our respects to elders past, present and emerging.

With me today is our deputy chair who has just had to step away on a call, Rob Molhoek, member for Southport; Ali King, member for Pumicestone; Joan Pease, member for Lytton; and Trevor Watts, member for Toowoomba North who is substituting for Mark Robinson. Joining us via teleconference is Stephen Andrew, member for Mirani.

The hearing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. We will have some media present.

McNAMEE, Dr Heather, General Practitioner, Cairns Sexual Health Service

CHAIR: I welcome our first witness who is well-known to the health committee, Dr Heather McNamee, to provide some information. Would you like to start with an opening statement? Then we will go to some questions.

Dr McNamee: I would also like to acknowledge the Eastern Kuku Yalanji people, the traditional custodians of the land on which we are meeting, and I pay my respects to their elders past, present and emerging. My name is Dr Heather McNamee. I am a general practitioner who specialised in paediatrics for many years and then completed my GP training in the UK in 1996. I immigrated to Australia shortly afterwards. I have established, managed and sold two medical centres—one in Brisbane and one in Cairns. I resigned from general practice in 2020. I would argue that it is the hardest job in medicine. General practice is in crisis in Australia and many GPs feel no-one is listening and no-one cares.

The current structure of having GPs run their clinics as profitable businesses, but businesses that are subject to frequent government interference, is just not sustainable. The Medicare freeze, meaning rebates have not changed in real terms since 2014, and the fact that the current bulk-billing rates are at an all-time high of 88.8 per cent makes breaking even, let alone seeing any profit for their efforts, a struggle. No wonder interest in GP ownership is at an all-time low; so is interest in medical graduates becoming GPs. GP training places which used to be fought over remain unfilled. Only 15 per cent of medical graduates in a survey in 2019 were planning to enter general practice.

Fee-for-service is not an efficient way to run any health service, particularly one where prevention should be of major focus and in the era of COVID where telehealth has become a part of normal practice. Nurses are severely underutilised in Australian general practice, unlike in British general practice, because of the lack of proper funding for the work they do. Even back in 1996 in the UK, practice nurses ran asthma, blood pressure, diabetic, immunisation, well women and healthy kids clinics. Here, if the GP does not see the patient, no or minimal medical rebate applies. Here the government's latest idea to take some of the pressures off GPs is to fund pharmacists to diagnose and treat minor complaints. What about the long-held principle that the person profiting from the sale of the medication should have no control over the prescribing? Unlike nurses, pharmacists have no clinical training around clinical diagnosis and appropriate ordering of investigations. Does the fact that the Pharmacy Guild contributes more in political donations than the whole of the pharmaceutical industry have anything to do with the federal government's love of pharmacists?

A fee-for-service model lends itself to overservicing and is not health-outcome driven. A GP working in a 24-hour clinic offering fast, often substandard care can easily earn a lot more than a GP with a regular patient base offering holistic and preventative care. The current funding model leads itself to a two-tier primary care system where, if you want a decent GP who can afford to spend the necessary time with you, you will have to pay.

For difficult situations, such as the upcoming introduction of voluntary assisted dying in Queensland, the current answer is to fund this through GPs charging their dying patients. Again, this will lead to limited access for lower income Australians, let alone the ridiculous complexity of the Medicare Benefits Schedule, now as thick as a phone book and no longer published in paper form partly for that reason. They expect us to remember and utilise thousands of complex Medicare item numbers, but punish, fine and shame us if we make mistakes. Is it any wonder GPs feel underpaid and undervalued? Specialists are paid nearly twice as much as GPs—to be exact, 1.86 times more—and their jobs are simpler, more rewarding and most definitely better respected than that of a GP, despite both requiring approximately 10 years training.

Everyone in Australia is aware of the massive strain on emergency departments, naturally exacerbated by the COVID-19 pandemic, but obvious long before 2020. A lack of beds and ramping of ambulances for hours leads to unacceptable delays in treatment with poorer outcomes. An Australian Institute of Health and Welfare study showed that 37 per cent of presentations to EDs are considered lower urgency, that is, readily managed by a GP. The lack of access to GP appointments, especially out of hours, drives people to misuse EDs. Numerous studies here and in the UK have shown that employing GPs in emergency departments reduces rates of investigations, prescriptions and referrals leading to reduced health costs, but at the same time resulting in increased patient satisfaction. It is no wonder when you compare the clinical knowledge and experience of a junior doctor who sees the majority of ED presentations to that of a GP.

The core of the Australian health system is primary care. Everyone knows that is where you get most bang for your buck, but successive governments have failed to address the crisis in general practice leading to difficulties recruiting and retaining GPs and resulting in a reliance on overseas graduates, often from developing countries. These issues become multiplied tenfold where rural, remote or First Nations communities are concerned. We need to utilise our nursing colleagues' considerable skills more effectively and make the remuneration for primary care outcome based. This will then reward the GPs who are offering holistic and preventive care, adding to their job satisfaction and helping to improve the health of all Australians.

Healthcare homes may be the first step in the right direction, but GPs' concerns in relation to the level of funding and bureaucracy must be listened to. I have a slightly heartbreaking statement which was put up anonymously on a website from a recently qualified GP registrar who had only just finished their exams and training. I think she states very clearly what it is actually like day-to-day being a GP and why she unfortunately, having just finished her training, is leaving. She has only just qualified.

CHAIR: Would you like to read that out?

Dr McNamee: Okay. I think she did it anonymously because in medicine speaking out is not welcomed. She writes—

As a general practice registrar in Queensland about to finish I can tell you why I am leaving general practice and I can't wait to skip out the door. It is the pay—we are paid next to nothing.

That is a slight exaggeration, but compared to specialists.

It is the lack of respect, from colleagues to the general public. It is the anxiety and the time pressure. We are rushed to see cases from a variety of all specialties and history taken, provide examinations and plans all in 15 minutes before the next bulk-billing patient gets angry. It is the litigation. Over 75 per cent of cases are against GPs. We pay Ahpra each year to help vexatious, litigious patients to chase us when they are not happy. It is the isolation. We are locked in three-by-three metre rooms by ourselves all day, little sunlight or interaction with anyone other than demanding patients. It is the harassment. Practice managers, greedy owners, entitled patients who have done their research. It is the funding. We get nothing for all this risk. We have to pay for our own holidays, pay our own super, pay our college fees, sit ridiculous exams so farfetched from our actual practice. The general trend of 'I should be bulk billed by a doctor' is greedy. It encourages patients to treat us like dirt. Gone is the respect, gone is the pay. You would be crazy to start training.

That is pretty depressing from a younger doctor.

CHAIR: Thank you, Dr McNamee, and thank you for your decades of being a GP and for seeing the thousands of patients you would have seen. Quite clearly you have absolutely nailed some of the barriers around owning a practice and the burdens that come with that. I want to go to the commentary you made around nursing and the expanded scope of that role. I am aware that the ACT has some walk-in clinics where they are doing minor procedures, be it suturing or the removal of sutures. Do you think there is value in exploring other opportunities in that space?

Dr McNamee: There was an attempt by an entrepreneur to set up nurse-led general practices, but that failed. I think the issue around that was they were charging pretty much what you would charge to see a GP so people are going to go, 'Meh, I'd rather see a doctor than a nurse.' When I did my training in the UK, I did it in a rural practice and to me it seemed like that was a good way to fund general practice. Like I say, when I came to Australia—it was 1996 so a long time ago—I was horrified

by how little the practice nurse was allowed to do. I would be repeatedly sending patients off down the corridor to the practice nurse and have reception phone me to say, 'No, you have to do the pap smear.' I would be like, 'What?' They would say, 'You have to syringe the ear out' or 'You have to do the stitches'–whatever. That is entirely around funding. In the UK at the time GPs were paid a weighted amount for the complexity of the patients who were enrolled with them.

Another issue in Australia is that patients are not enrolled in practices. When I first started here people would come and see me and say, 'About that antibiotic you gave me' and I would say, 'I haven't given you any antibiotic; it wasn't me'. They would say, 'It must have been that other doctor I see when I can't see you.' They would mention an operation they just had and I would say, 'I didn't get a letter from the hospital.' They would say, 'Maybe they sent it to the 24-hour clinic.' It is completely disjointed.

As I say, I am not really across the UK situation now as it is a long time since I have lived there, but people had to register with a practice so that was your practice and that was your GP. You could see any of the GPs in the practice but you had to stick to that practice so you had real continuity. You did not have issues with polypharmacy and interactions being unknown because nobody else was prescribing; it was all in that chart. We had an elderly population so we got more money per head of patients enrolled because they would be anticipated to have more health issues. We were not paid face to face visits. People did not have to sit in front of me for me to get my wage so we consulted a few hours a day and then we did a lot by distance. This is way before telehealth, the internet, whatever. We would phone patients. We would be happy to do repeat scripts without seeing them because we did not have to see them to be paid.

The nurses were highly skilled practitioners in their own right. They would literally be running the diabetic care of most of the patients. They did all the pap smears pretty much. We had to fight in Australia for nurses to be allowed to do pap smears and then they are paid 10 bucks to do one. It is not worth the GP's time. When I was employing practice nurses it was incredibly difficult to recruit because you cannot meet the hospital pay grades so they are underpaid. You can only get them to be your assistant really. They cannot practice individually, yet they are an incredibly knowledgeable, clinically skilled group of individuals.

You do not need to make them nurse practitioners. I have worked in a practice with a nurse practitioner and I did not feel it was overly better than just having another GP, to be honest, and it might have been slightly cheaper for the health system. Nurses have the skills and they have the abilities, but in general practice in Australia you just cannot use them. Even something as silly as a childhood vaccination, which nurses do do, there is this ridiculous thing goes on where the GP has to go out and sort of wave at the baby. So you just go and say to the mum, 'You right? All good? Yep', if they do not need another check-up and they do not need anything else done. And that is for Medicare. That is to make it legal under Medicare. I feel really strongly about it.

I work in a public clinic at the moment where our nurses basically see patients independently and we are there for backup and questions and prescriptions for the more complex patients. But they are basically trained in their area, which is sexual health, and most of our patients are seen by nurses and not doctors. It is easy logistically to make it work. The issue is Medicare and the item number.

CHAIR: I will open up to questions.

Ms KING: Thank you so much, Doctor. It is good to see you again. I have a quick follow-on question about your present work in the sexual health clinic. How is it that your clinic is able to be largely nurse led? How does the funding work? Is it a Queensland Health funded clinic?

Dr McNamee: Yes, it is a Queensland Health facility. One of the nurses who works with me now, who is very experienced, actually worked for me when I set up my last private clinic. She asked for her Queensland Health wage and I gave it to her. I had to to get her to work there. There was no reason in my private clinic she could not have been doing the work she does now, which is seeing HIV patients on her own, taking their bloods, sorting out their medications, counselling women around medical abortion, treating people for syphilis. That is the job that she has under Queensland Health, but I could not have her do all those things because I could not afford to. I had to be involved in order to be able to employ Medicare. Yes, it is a Queensland Health clinic.

Ms KING: In your current clinic, how is your working life better and more satisfying because you are not on the ground for every single patient interaction as you described? Tell us about the difference.

Dr McNamee: It is a much more a team approach, unlike as a GP where it is you and the patient, you and the patient, you and the patient. Although they talk about the team work in general practice, really it is a day-to-day grind of eight to 10 hours of face to face with patients. We sort of

share the patients out amongst the staff who are on. They are triaged and we decide if they are appropriate for a nurse or a doctor. If the nurse gets into trouble they will come and grab one of us and we will either supervise or examine or take the patient over.

It is better for me specifically because I am able to subspecialise properly. I tried to do that in general practice. I tried to do women's and reproductive health. It worked when I owned the clinic because I was in complete control, but the minute I sold it kind of crumbled because they would put in general practice patients or my patients would become my general practice patients and it was impossible to maintain really. So I can specialise in an area that I love.

In our clinic our director says that we are paid to see the patients other doctors do not really want to see. That is the great unwashed, people with mental health issues, people with alcohol problems, people with drug problems, but we are very happy to see them. We are salaried so if they do not turn up, because they are incredibly unreliable, it does not matter. I will just see someone else. My wages do not depend on them turning up. We can be really flexible.

We have mainly walk-in services. I get paid extremely well. I am actually paid as a visiting specialist, which is a little loophole they have just closed in Queensland Health. I got an email the other day telling me my position would be defunct when I retire—hopefully not before. I get paid very well. I get all the conditions that I used to get in the UK. I get superannuation, I get holiday pay, I get sick pay and it is just a joy to have those benefits. Yes, you can say as a GP you should save up money, but nobody does, right? I did not pay any super for the first 10 years in Australia. The conditions are better, the sense of team work is better, we can triage patients and we really do. We have Indigenous health workers. We can use all sorts of levels of skill appropriate to the patient and do not have to worry that it must be the doctor, it must be the doctor, all the time. I really enjoy that environment much better than the grind when it is just you and the patient, you and the patient, and nobody else can be involved, nobody else can take responsibility or share the load.

Mr WATTS: You said that the organisation you are in now is far superior to the GP world. Do you think Queensland Health should have more facilities like yours available throughout Queensland?

Dr McNamee: I suspect so. There are community clinics. We are in a building with a diabetic clinic, but they can only take the very extreme diabetics. The vast majority of diabetics are seen in general practice. I think in general practice you have the skills and often the interest to manage all these conditions. It is just that the way it is structured is not making their day rewarding. I think the lack of respect for GPs in the community is a big issue as well. I think GPs feel unrespected by, to a degree, their specialist colleagues and certainly by the community. I think you have the workforce there. I do not think Queensland Health needs to take over the whole lot because that would be a massive funding issue.

I guess one of the issues for you guys is what I see as a federal issue. Medicare is the real block to providing proper team care, and team care is what we need in the community. I went to the MBS review and listened to them. I brought up the point that the five-minute consultation is the basic problem with general practice because that is how you make money. If you see people every five and a half minutes, you will bring in a specialist's wages if you do that all day, every day. But that is not good care and that is not what gets people better. That is not what deals with complex diabetics. They agreed absolutely, yes, totally—and then they did absolutely nothing about it.

Mr WATTS: In the environment you are in at the moment, how long is a consultation? Obviously, it depends on the individual. All governments are looking for efficient ways to spend taxpayers' money. It would appear that the service you are working for is more rewarding for yourself and potentially the patient. I am trying to understand if Queensland Health can operate in that space and provide this sort of safety net sitting there, but at the same time it needs to be efficient.

Dr McNamee: Our service went almost entirely to walk-ins. We did a survey of the patients and asked them what they preferred and, because of the nature of our patients—who are often a bit chaotic—they preferred to walk in. The majority said that is what they wanted. We basically changed the whole clinic to walk-ins. I now have one booked clinic a week for my more complex patients and a few patients who have jobs and need that. They are half-hour appointments, which I feel is generally plenty for those patients. We have booked appointments for medical abortions because they take a bit of time. Apart from that, it is basically entirely walk-ins.

Mr WATTS: Do you feel that having a facility like yours is taking pressure off an ED?

Dr McNamee: The nature of what we deal with would not often end up in ED. The symptoms our patients have are not acute. Some of them do wander into ED if they cannot get care anywhere else, but yes it would. If you had similar clinics doing first aid type treatment, all these non-urgent ED cases, run by GPs and funded properly—maybe GPs who were salaried—then it would take massive pressure off the EDs.

There is lots of data to show that GPs within EDs are faster and cost the health system less than those who are employed at the moment. Junior doctors do a million tests because they are worried they do not know what is going on. GPs know to say, 'You don't need those tests. You're fine. We'll wrap it up in a bandage and you can go home. You don't need an X-ray.' There is lots and lots of data to prove that. I know there have occasionally been GPs employed in emergency departments. I think if you make their conditions the sorts of conditions that I am under, because I feel very privileged to have the job I have. I feel valued. I feel respected. I feel that my years of experience are being paid for appropriately.

Mr WATTS: But you said that Queensland Health has drawn that to a close now?

Dr McNamee: I think they have had GPs with special interest in emergency departments but I do not think it has been very widespread.

Mr WATTS: No. In your position, you said that at the end of your time—

Dr McNamee: Yes. I got an email—and I had a heart attack when I read it—telling me that my position was going to be discontinued. What it meant was that in future there will have to be a sexual health physician to do the job I am doing. For our clinic, that would not be good actually because we need GPs. We have people with HIV who see us for their entire health care, and a sexual health physician will not be that good at blood pressure, cholesterol or the things we have to treat our HIV clients for. That is not a positive step forward but that is not going to be my problem. I will be retired.

CHAIR: We are out of time. We are on a pretty tight schedule to get back to Townsville this afternoon. We thank you very much for your contribution. As usual, it was very concise. I remind members of the audience that the committee has travelled to Mossman today to hear about the provision of primary and allied health care, aged and NDIS care and the private healthcare system, and any impacts the availability and accessibility of these services have on the Queensland public health system.

SALLERAS, Dr Steve, Medical Educator and General Practitioner, College of Medicine and Dentistry, James Cook University

CHAIR: Welcome, Dr Salleras. Would you like to make an opening statement and then we can go to questions?

Dr Salleras: I am the lead medical educator for JCU General Practice Training in Cairns. I also work in general practice in Kuranda, which is between Cairns and Mareeba. I worked as a GP and practice partner in Port Douglas and Mossman for 18 years, finishing in 2019. Until 2009, I worked at Mossman Hospital doing shifts in the emergency department. I have been a medical superintendent at Clermont Hospital in Central Queensland for four years in the past. I have done a range of things. I also grew up in Tully on a cane farm, so I have skin in the game. I have also been 31 years as a doctor. I appreciate the opportunity to speak to you today about the areas of health which I am involved in and how they impact with Queensland Health. In general, I echo the sentiments of my esteemed colleague, Dr Heather McNamee, who is a legend in medical practice in Far North Queensland. I think she expressed the challenges of general practice as a field extremely well.

My biggest concern at the moment is that I care deeply and the organisations I am involved in care deeply about the health and wellbeing of the people we serve. I am continually reminded of the missed opportunities that we have in the health system as far as assisting people develop their optimal health and wellbeing. I am also aware that our enormous, complicated health system also causes significant harm when the system does not work to its capacity.

One of my biggest concerns is that the current crisis in general practice and the catastrophe in rural general practice will mean that Queensland Health ends up, by default, being the providing organisation. The fire hose of money that currently goes into Queensland Health will not be enough. The Queensland and Australian economies cannot pay for hospitals to deal, often very poorly, with health issues that need to be addressed in the primary health system. It is really bad for my patients and my friends and family.

In your roles in the political sphere, I understand that it is incredibly difficult to work out what on earth to do. The low-hanging fruit is to understand that, if we miss the opportunities in primary health, many of those things are not fixable once people reach hospitals. An enormous proportion of the whole lights-and-sirens phase—when someone has had their heart attack or stroke or they have developed their cancer—need not happen. By the time the hospital system is dealing with it, the people I know well in general practice are being treated by a series of strangers. It is very distressing and destabilising for that person going through that process. Also, the prevention factor means that that whole process can be avoided. Once they are in the hospitals, particularly larger hospitals, the tribalism within hospitals is very destructive. So a specialist's, a partialist's, approach to health care is very frightening for patients and means that the integration of their care is almost impossible, which compromises their health care enormously.

As generalists, as GPs, the fact that we are not involved in that process from the start and on the way through is ludicrous. Patients presume it is happening. The online medical record is helping with that. I think it is a great innovation that has occurred and it is working quite well. Without this dialogue, hospital people think that the hospital is the world and they do not comprehend that the people they are treating actually have not had their entire lives in the hospital. Their whole priority in dealing with the care of that person means they are often barking up the wrong tree. I feel that it is crucial for collaboration to increase or we will face consequences—which is impaired health delivery for people who deserve better and a budgetary tsunami that our system cannot afford.

CHAIR: Thank you very much. To put it in context, this committee did a huge amount of work in the aged-care and palliative care space. We made some 77 recommendations. We were able to lift the nurse-patient ratio in public hospitals, but we did not have an impact on the private. That is up to the Australian government to do that. I think today we are now seeing the impact of that in the aged-care sector, which leads me to a question about GPs.

If you have care in place and you get that primary care established in advance, you are going to keep more people out of hospital. I do not know if you have many residential aged-care facilities in this area. I know in Townsville we have multiple, but we do not have a bulk-billing GP and we do not have a GP who can go there and look after older people who have worked all their lives and paid taxes. It is the same in the home care package space. They would rather be at home, not in hospital, when they are unwell. We heard that time and time again throughout Queensland.

How do we fix that GP connection? I am lucky in Townsville that I have had my own GP for 20 years so I have built that relationship, but that is just one story. Every time we go to smaller centres we hear that it is harder and harder to get to a GP and people have to wait for weeks, which means

that what might have started as an abdominal niggle ends up with the person being rushed to emergency three weeks later with a significant event. How do we fix that GP care-in-place system? If you had the wand, if you had the control, how would you fix it?

Dr Salleras: This morning I read an article in one of the medical journals saying that 82 per cent of doctors in training want to go into non general practice specialties. That as a starting point is catastrophic and really causes me significant distress. As Dr McNamee said, the entire package of general practice is tricky. To start with, you are going to be paid less than half of non-GP specialists, and that is a disincentive. The fact is you will never have sick leave, holiday pay, superannuation or study leave. When people finish in Queensland Health, they lose all of those things—it is gone like that. In my role with JCU General Practice Training, we train for two colleges—RACGP and the Australian College of Rural and Remote Medicine. Almost all of the ACRRM registrars want to be SMOs in Queensland hospitals because they do not want to lose those capacities.

I will go back to your question. People want GPs to go and provide those crucial services. We are paid to provide a service that people want and need. The fact that we as a health profession are not delivering it is completely unacceptable. As a member of the health profession, I am ashamed that we are in this situation. As far as the registrars who we are training to be GPs, we are in their faces about the fact that being a general practitioner is a really important role and that general practice starts hard and stays hard for the whole time you are doing it, for multiple reasons. Our patients are all complex these days. The number of patients I see with a single problem would be less than one per day out of 30 or 40 patients. Everyone has multiple things that need to be addressed in every consultation.

As a training organisation, we make it clear that it is expected as part of our roles that we provide aged-care services and become involved in in-home visits. We are only paid while we are seeing patients—otherwise there is zero income—so the Medicare system needs to take this into account and start to do some heavy lifting, otherwise we need to suck up the consequences. It is not rocket science. It is like a mathematical equation. What exactly do we expect as an outcome? Of course it is going to happen. So the Medicare system is part of it.

QH hospitals are run by specialists who have never done general practice. They have no idea what on earth we are doing in general practice. Most of them have a slight element of contempt for general practice. I think one of our roles as a GP training organisation is to spend time in the hospitals with the hospital staff so they get to understand. If general practice fails, then their lives become infinitely more complicated.

If QH facilities in general are doing primary health care they do it really badly. Part of the element of primary health care is continuity. Without continuity and relationship you are really pushing it uphill. There is also the amount of trust that is needed in the relationship. If you are seeing strangers all of the time you cannot have trust, and then there is also the fact that most people at point of initial contact are very junior doctors. Apart from Medicare rejigging to incentivise these elements, I am not really sure what else can be done to improve that. I agree completely; it is an embarrassment to our society really.

Mr MOLHOEK: Thanks, Steve, for coming today and being prepared to open yourself up to questions and controversy and all of that. You have opened up so many areas that I would like to go into. I guess it would be interesting to hear some reflections on what it is like to be a GP today and perhaps what it was like in the past and what are some of the significant changes that have happened in the working lives and experiences of general practitioners.

Dr Salleras: It started hard and it has stayed hard. By the end of the day yesterday my brain was completely drained. The processing load of getting into the lives of the people I care for is high and that has stayed high. I just achieve more per consultation because I have been doing it for so long. As far as the changes over the years, the enhanced primary care system and Medicare have been great. That allows us to essentially develop management plans for patients which involves all of their issues and which can produce a document for patients that is a summary of their care and an agreed plan for the person, so that personalisation is great. Also, it is a significant Medicare payment associated with that.

In Kuranda where I work, the practice would be completely non-viable if it was not for the enhanced primary care elements. We can also refer to allied health people for five consultations a year. That is a great challenge for allied health people because their payments have not been indexed, so many or most of them cannot bulk-bill now but seeing a podiatrist or a physiotherapist or the OT or the diabetic educator is a fantastic thing that is available. Because most are now going to be facing having a gap payment, that has been a significant negative change.

I still find it an extraordinary job and privilege to do what I do. Medical tribalism and the separation of medical professional and patient I think is extremely unhelpful. This shared journey with my patients is a privilege in terms of the low-hanging fruit as far as the things that are happening in a person's life where you think, 'So you have truncal obesity, you're sucking 20 durries a day and you're having six full-strength beers at the end of the day. I know what's going to happen to you. You won't like it.' It gives me a sense of grief knowing what is going to happen. To be able to work with that person to change their trajectory in general practice is incredibly rewarding. If that opportunity is missed and that trajectory is not altered when we see people, then it is lights and sirens and drama and it is all a bit dumb where you think, 'That didn't need to happen.'

That is why I am passionate in my role as medical educator for JCUGP for the young doctors who are starting the GP training program for three or four years of GP training who we had last week in Cairns—actually on Zoom—and to be able to share that passion and privilege with them rather than being ground down by the 'woe is me' stuff. Having that fire within us as far as what we are able to do is fantastic.

Mr MOLHOEK: How long have you been a practitioner now?

Dr Salleras: Thirty-one years. I started an internship in 1991.

Mr MOLHOEK: Do you think the community's expectations of you and the demands for services have increased?

Dr Salleras: Yes, I think so.

Mr MOLHOEK: Do you think society just expects more from their doctors?

Dr Salleras: Life expectancy has been increasing by three months per decade for about 100 years, so we are seeing a lot of much older people who have a whole range of things. A lot of things that used to cause people to peg out in the past do not kill people now. A lot of blokes my age in their 40s or 50s who had their first heart attack would have all died within a couple of years. Now they have their first heart attack, they are fixed and they die of something else 30 years later, so we are dealing with older people with a wider range of issues. The expectation is that a lot of things that we can and should manage in general practice are being managed by specialists. That is at times a bit of a pain, because generally we would expect to be able to manage more than 95 per cent of things in general practice.

You need to be a great tradesperson who gives a stuff in general practice. You need to really have excellent knowledge and excellent practical skills so you can spot a melanoma and cut it out when you need to and that sort of stuff, but you also need to be in the corner for your patient and know them and their world. The relationship stayed the same because one of the things is that in our society a lot of people do not have anyone else particularly, apart from their GP. In the past it would have been a priest or an elder, but a lot of people are otherwise adrift and for some people—and it is sad and probably almost inappropriate in some ways—we end up in that role, so that has not changed.

Ms PEASE: Thank you so much for coming in, Doctor, and thank you for your years of service and your passion for your industry. It is really lovely to see. There was that ideal where the local family doctor was a very highly regarded and respected member of the community and worked all hours, did night shift and was always doing home visits and looking after the community. That has changed. There has been a real shift in that in the community. Would you agree?

Dr Salleras: Probably. In terms of that cradle to grave GP, there is the mobility of people going to multiple practices, particularly in urban areas. In rural areas it is not as much, but in urban areas that is very destabilising and unsettling. I do not particularly feel that in my practice.

Ms PEASE: No, but you probably keep your patients because you are a lovely man, I would say, so congratulations for that. There has been an attitudinal shift, I think, with the young doctors who are coming through in that they seem to be a bit more family focused in that they do not want to do the after-hours work, they do not want to do weekend work and they do not want to visit residential aged-care facilities. For example, in Townsville we found out that there is not a doctor who will visit a residential aged-care facility and I am not really sure why. Is it because there is no incentive to do that because there are no dollars associated with it and the Medicare rebate is not sufficient? Is it as cold cut as that?

Dr Salleras: I do not do aged care now, but I did until 2019 at the Port Douglas Ozcare aged-care facility and it was a very positive part of my world. To be honest, I think that the money it generated, with the visits themselves but also with some of the other work such as doing the annual

health reviews and things, was okay. It is complicated and going into a different system with split medical records and complications with providing prescriptions and things was an additional challenge.

A lot of our practices in Cairns have their registrars going into aged care as part of their whole training program, so it is normalised. I think normalising it is an important part and training organisations need to have it normalised and also to say to medical graduates, 'Suck it up. You said that you wanted to become a doctor so you could help people and a lot of the time it is not very convenient.' And maybe it is not that helpful if people are not going to suck it up and then it will not help the provision of service, but that is what we say to our registrars in Cairns: 'If you wanted an easy job, you shouldn't have signed up to be a doctor.' It has to remain a vocation in many ways, not just a job.

Ms PEASE: Thank you.

Ms KING: I think those are interesting points that you make, Doctor. One area of change that I am aware of over the last—what would it be?—generation is the increasing graduation of women from medical schools and I seek your reflections on that. As somebody with a vocation myself, I recognise the power and importance of that, but I do wonder if perhaps we are seeing different people come through—a different demographic come through—as doctors. Some may have life circumstances that do not necessarily allow them to do weekend or night work—for example, if you are a woman with children. I would just like your reflections on that.

Dr Salleras: I think that is an extremely important point. The feminisation of the workforce, which is not simply—

Ms KING: 'Tears and smears' I have heard, which is a disgusting term—derogatory, I mean.

Dr Salleras: Sure. In general for a standard blokey rural doctor they are saying that, as far as new graduates are concerned, when that person retires it is probably going to take three people to fill that person's spot because of their dedication. In some ways it was also a toxic martyrdom to be honest and there was also an enormous price paid by that person's spouse and family, so it was not as though it was necessarily a great deal. I think the fact that society has changed in this way in many ways means that we cannot change it anyway, but in many ways it is probably an advantage. Probably more than half—up to two-thirds—of what I do is mental health in general practice and a lot of that mental health is because I have a relationship with people, so whether women are better at this than us blokes I do not know. However, that is a crucial part of what we do because often there is no-one else to do it. Psychologists are great, but they just do not have the ongoing relationship.

As far as the medical workforce that is needed now, it is probably a greater number of people. One of the great challenges in urban areas for me from a rural background is if someone is from an urban area they are not going to leave an urban area. In the past 20 years there has been a doubling of the number of medical schools and a doubling of the number of medical graduates. They all go to urban areas. If they are from urban areas, they are staying there. They are not coming to Mossman or they are not going to Townsville; they are staying in Brisbane, Sydney or Melbourne. They become a trip hazard in the urban areas. Because they want to feed themselves, they potentially overservice, and that is bad for everyone involved. It is bad for the Australian taxpayer. Excessive medicalisation of human life is actually bad in every shape. The JCU approach of sucking in kids from rural areas, getting them through university and then training them in specialties, including general practice, means they stick in a way which just does not seem to happen elsewhere. As you are probably aware, the JCU General Practice program is at risk of ending in 12 months. It gives me a sense of dread to think what the hell is going to happen if JCUGP ends and the colleges take over.

Ms KING: Say that again. What is ending in 12 months?

Dr Salleras: In 12 months the colleges of general practice—RACGP and ACRRM, the College of Rural and Remote Medicine—will take over training and the 10 regional training organisations, including JCUGP, will cease to exist. There is an active negotiation about JCUGP being a special case but, as far as the momentum and the relationships that we have at this point getting doctors into regional Queensland and even the impact on Queensland Health, this will set the whole thing back five or 10 years no doubt. It makes me feel a little bit sick to think about it. I will continue as a medical educator in some shape or form because I am passionate about general practice and primary health care, but in terms of reinventing the wheel in a circumstance where you have a system which has worked we have better things to spend our time and energy on than having to do that.

CHAIR: Let us hope they retain it. We are experiencing a little bit of feedback, but we do need to stick to time. I am aware that we have the member for Mirani on teleconference. I do not know if you can hear me, Stephen, but did you have a quick question? Okay; he cannot hear me. With that,

we might end this session. We just need to keep to time. For a young man who grew up in Tully, it is great to see three decades of work in North and Far North Queensland. Well done to you. I love the passion. Thank you for your contribution today. Just before we call up the next lot of witnesses—some are on teleconference and we will try to fix the feedback—if anyone in the audience does want to speak, we will have registered speakers after this next session.

BECKHAM, Mr David, Organiser, Queensland Nurses and Midwives Union (via teleconference)

CRAM, Mr Shaun, Member, Queensland Nurses and Midwives Union

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

NAKATA, Ms Yoko, Member, Queensland Nurses and Midwives Union (via teleconference)

Mr MOLHOEK: For clarification, are the other representatives from North Queensland or are they phoning in from Brisbane?

CHAIR: I believe someone is from the Torres Strait; is that correct? That is excellent because we had a very good submission from the Torres Strait. Would you like to make an opening statement?

Mr Cram: Firstly, I would like to offer my acknowledgement of the Kuku Yalanji people and the Torres Strait Islander people as the First Nations peoples on whose land we meet this morning here in Mossman. I pay my respects to their elders past, present and emerging.

It is a pleasure to be here. I am a registered nurse at Mossman Multi-Purpose Health Service. I am employed by Queensland Health as a nurse educator. I am also the elected workplace representative and delegate for the Queensland Nurses and Midwives Union at the Mossman branch. I am in my 36th year of nursing, having initially trained in the UK. I immigrated here to Mossman in 2004 and have worked at Mossman Hospital since.

It is my pleasure to present to this Health and Environment Committee public hearing here in Mossman this morning. I would like to draw your attention to the issue of a lack of general practitioner services in the area. Ms Pease picked up that Steve Salleras is a lovely man; he is. You are very astute. It is a loss to our GP practice. He went off to work in medical education in 2019 and we lost him as a GP. He was personally my GP and he was absolutely superb. I pay tribute to Steve and his like. He has gone on to teach the next generation of medical trainees, so our loss is their gain. I pay tribute to Steve.

The community has been finding it very difficult to access GPs over the past few years. It is reported that most people are waiting for up to two weeks to see a GP. The GP is the gatekeeper; it is the pivotal gatekeeper role in primary health care. They are the lead and as nurses, midwives and allied health practitioners, we all dance to the same tune with the GP practice to get better health outcomes for our community.

It is especially difficult to recruit and retain GPs in the region. Many GPs work part-time due to, as you have already picked up, lifestyle choices and professional choices, such as they are doing further studies. There is one sole bulk-billing GP in the region. This has a major impact on the community as out-of-pocket expenses are prohibitive. As a result, the community utilises the ED department as a GP practice essentially out of hours and at the weekend, and we feel that very acutely.

The shire is home to about 12,000 residents with about 60 per cent of the shire living in Port Douglas and Mossman. There are an estimated 1.2 million international and domestic travellers passing through the region yearly. Obviously with COVID that has been impacted significantly. At the hospital we have not seen evidence of that because people still come, which is quite interesting. The impact on the emergency department, therefore, is very significant as we see a great many presentations that are triaged as category 4s or 5s. I am very happy to explain the category of triage processes if you wish. Essentially, we would deem category 4s and 5s as GP work, not as an emergency or life threatening.

We see many residential aged-care residents being sent to the ED department at all hours. That is mainly because there is not a registered nurse on each shift. There are unlicensed and untrained workers in the service and clearly they are not able to make that clinical judgement and they do not have the expertise to manage somebody who perhaps might have dementia or delirium on top of the dementia, so they tend to panic and dial triple 0 and send them to the hospital—quite rightly I might add. However, there should be a registered nurse on each shift, and I draw your attention to that which has been happening lately.

Since January 2021 the lowest monthly presentations of category 4 triage have been 392 ranging to a high of 493 presentations per month, with an average of over 400 per month and a total of 5,789 presentations of category 4 in 2021 to the end of January this year. Category 5 lowest

monthly figures have been 243 with a high of 346 and a total monthly figure of 3,676 up to January 2022. That is an average presentation of about 285 category 5s monthly. That has an impact on the service.

There is a nurse-led recall clinic at Mossman which nurses identified after asking, 'What can we do about these people who are category 4s and 5s and who are waiting way beyond the waiting time set by the triage scale?', which is an international scale. Basically they asked, 'How do we go about meeting the needs of patients attending who are otherwise GP work?' That has led to the category 4s and 5s being recalled to the hospital on an appointment basis. This has taken the pressure off the staff in the ED doing emergency work. That has significantly reduced waiting times for patients, so it is a win-win all round. Again, that is another nurse-led initiative.

However, the nurse-led clinic has temporarily ceased due to the current COVID state and pressures on the nursing staff at the hospital. The Mossman QNMU branch feel that there is a need for a nurse practitioner, either as a nurse practitioner candidate or to create and employ a nurse practitioner position, because they have an extended practice and could see those category 4s and 5s quite readily. That would take the pressure off the ED staff who would otherwise be seeing them. Certainly the branch would like to see the implementation of the aged-care royal commission recommendation to ensure there is always a registered nurse on duty in aged-care homes. It will stop people with dementia being taken out of their home at 3 o'clock in the morning and going into a very strange, alien environment. You can imagine their fears and how scary that could be. That has an impact on the nursing staff, because we see it.

I would like to talk about the midwifery model at the Mossman Hospital. There has been a review of the midwifery model of care at Mossman, which is now entering its third year. We had a midwifery group practice at Mossman, but that was disbanded about three years ago. It was extremely difficult to recruit and retain midwives as it is a non-birthing unit. Midwives want to be able to go from antenatal to delivery and then postnatal care. That gives them that holistic approach.

The community are very vocal in wanting a robust midwifery service and to be able to birth at Mossman; we hear that very loudly and very clearly. Currently there is an ambulatory model, which consists of three midwives. We have three midwives, one of whom is part-time. That has an impact on the care. Basically, there is an ambulatory model. We are waiting the review; it is awaiting a decision from Brisbane. The current ambulatory model expires in June this year and it has been extended twice.

The community want a return to birthing at Mossman. However, this would come at an enormous cost. What kind of costs am I talking about? Essentially, we would need the building of a new operating theatre; we would need the employment of a team of obstetricians and anaesthetists; and we would need an extraordinarily large team of nursing staff trained in peri-operative nursing skills because it is a skilled and risky process. It is reported by our midwives that the women receiving midwifery care at Mossman are very happy with the current ambulatory model. Currently, James Cook University researchers are investigating midwifery models in care in Far North Queensland in which midwives are going to be involved.

If we were to explore a return to a birthing model at Mossman, the nurses and midwives would be pivotal to full engagement at the table where and when decisions are made. Nurses and midwives have consistently shown creativity and initiative in problem solving to strengthen the provision of high-quality care provision and access to primary health care. This has been amply demonstrated in the response to the COVID pandemic, as we have seen globally, not least in Australia and the region.

Nurses and midwives are the backbone of health care. They are the largest professional group. We should empower them to manage budgets to be able to provide models of care aimed at providing positive health outcomes for our communities. Nurses and midwives are advocates for the communities they serve. They firmly believe that the Douglas shire community would benefit from local access to a computerised tomography scanner, a CT scanner, at Mossman. That would stop the need for our patients going to Cairns for such a scan when we believe it should be locally accessed here at Mossman.

As a proud delegate and activist for the QNMU and for the community at Mossman—because I do not feel I am just acting for members of the QNMU; we are working for the community as nurses and midwives do—I am delighted to support the nurse and midwife members to be able to continue their exceptional work in advocating for and providing nurse- and midwifery-led health outcomes. I thank you for the opportunity to speak to you this morning.

CHAIR: Thank you very much for the work that you and your colleagues do in this part of the world. You should be very proud of your three decades of nursing. We thank you particularly during the challenges that COVID has presented.

Mr Cram: It has been tough.

CHAIR: I do want to provide an opportunity to the people from the Torres Strait who are online to speak now if they wish or we can move to questions.

Mr Mills: I am more than happy to move through to the questions at this time.

CHAIR: Thank you very much for joining us all the way from the Torres Strait. I want to explore that nurse-led clinic you were talking about. Is that in a Queensland Health facility at the moment?

Mr Cram: It is actually in Mossman Hospital as part of the emergency department.

CHAIR: For how long has that been established?

Mr Cram: About a year I believe.

CHAIR: We heard from previous speakers that there are quite clearly opportunities to explore full scope of practice or expanded scope of practice to take the burden off the public system. Do you think that could be something that the primary healthcare network should also explore in the primary healthcare space where they could have a nurse-led clinic?

Mr Cram: Yes, I do. As a nurse educator, I am always advocating for nurses and midwives to work at the full scope of practice because you get better health outcomes for our community, for our patients and for our residents because we have an aged-care unit at the hospital. I think working in collaboration with all other areas that are providing health services is vital to what we do. It stops overlapping and it helps to create what I like to describe as a seamless service for our community. I agree.

CHAIR: You also made commentary about RNs. Was the aged-care facility that you were talking about a private facility?

Mr Cram: Not at Mossman; it is Commonwealth funded. Then you have Kubirri nursing home, which is half a mile up the road from here; there is a nursing home in Julatten; and there is a nursing home in Port Douglas as well. It is about working together I believe.

CHAIR: We conducted an aged-care inquiry at the same time the royal commission was sitting. We made some 77 recommendations as well. We were able to get nurse-patient ratios increased in the 16 state-run facilities but, in respect of private facilities, are you saying they do not have registered nurses?

Mr Cram: There are very few. Residents are brought to the hospital at Mossman. It has happened for years. Even when I was an RN in the ED department, you would have people with dementia being transferred from Ozcare in Port Douglas because there was not a registered nurse on duty. That has a major impact on those residents. They become very distressed. As a nurse of 36 years, I get distressed because dementia and dementia care itself is a specialised area of nursing. People think dementia is dementia. It is not; it is very complicated. You need very experienced, qualified nurses to deal with patients with dementia.

CHAIR: I have seen it in my previous practice with the Ambulance Service. We would take people just for a catheter change.

Mr Cram: Yes, that happens, too.

CHAIR: That should be able to be fixed.

Mr Cram: Yes.

CHAIR: Models of care in place could reduce the impact on the public health system.

Mr Cram: Indeed.

Ms PEASE: Thank you for coming in and for your passion and commitment to the community. I want to explore a little bit more about the residential aged-care facilities and the impact on the Mossman Hospital. You say that often the patients are transported to the hospital because there is not a registered nurse who can attend to them. Can I get some clarity around that? Is there a registered nurse who might possibly be on call at one of these private facilities or they do not have access to a registered nurse?

Mr Cram: I cannot answer that with any great authority, but I would suggest—

Ms PEASE: Anecdotally?

Mr Cram: Anecdotally, I would think there was not anybody on call. Certainly we know that recruitment and retention of registered nurses anywhere is very difficult. If I may, elderly care is not sexy for a lot of nurses and it does not attract people essentially. As I say, it is a very skilled area of nursing and it is vital that we have it so that our residents get the best possible care.

Ms PEASE: I agree completely. Unfortunately, I disagree about it not being sexy. These people have contributed to our economy and our great country so they deserve respect. I probably share your position. I am interested to hear about what then happens with the residents who are transported to the hospital. Are they admitted to the hospital and what is their length of stay?

Mr Cram: They often stay in the ED department overnight because it might be very hard to get an ambulance crew to take them back because they are on other calls. They will stay there until the morning and then you have your normal staff on in the aged-care facility who will look at transport back. It also depends on the availability of the ambulance crews.

Ms PEASE: Are they often admitted into the hospital following these stays?

Mr Cram: Yes.

Ms PEASE: Do you have people who present who are waiting for a residential aged-care bed?

Mr Cram: Yes, we do.

Ms PEASE: What is the impact on your bed capacity at Mossman Hospital?

Mr Cram: Fairly significant. We will have people on what we call stepdown from Cairns as well. They might have been in Cairns for weeks and weeks and weeks and then they will come to Mossman. We have a reduced social work capacity at the hospital, but of course it takes complex social work capacity to get people onto ongoing care such as a residential aged-care facility.

Ms PEASE: I can imagine that must make it very difficult for your capacity to see acute patients and ability to admit them because you would not have a bed capacity for them.

Mr Cram: Yes, that is true.

Ms PEASE: Would you be confronted with NDIS clients as well?

Mr Cram: We see NDIS clients, yes.

Ms PEASE: Would a similar thing be happening to them where they are admitted to hospital and waiting for somewhere where they can go to?

Mr Cram: I would say that is true.

Ms PEASE: Does that impact on your ability to be able to deliver?

Mr Cram: Yes.

Ms PEASE: Thank you very much.

Mr Cram: If I may, can I just come back to your point? When I said it is not sexy, the profession does not view aged care as sexy. It is very hard to recruit people to the service. That is the context of what I was saying.

Ms PEASE: I know, Shaun, and I have heard that all the way through. It is such a shame because it is such a privilege to be able to work with those members of our community.

Mr Cram: Of course it is and it is very rewarding.

CHAIR: It is a great point. I started in aged care in 1985 before joining the Ambulance Service. The QAS did give us some data in Brisbane. I think there were 35,000 transfers from residential aged-care facilities in Queensland in the last year.

Mr Cram: Phenomenal.

CHAIR: That is huge.

Mr MOLHOEK: Thank you for your time today. Along with my other colleagues, I thank you for your service and your faithful commitment to the people of Mossman and rural and regional Queensland. To understand the workings of the hospital, how many beds are in the hospital?

Mr Cram: We physically have 24 beds, but we are only funded for, I think, 13 currently because of nursing availability, to be able to work the nurse-patient ratios, which is one to four. We have bed capacity depending on the availability of nurses to keep patients safe.

Mr MOLHOEK: Are there effectively vacant beds in the hospital that remain unfunded?

Mr Cram: Yes, there are.

Mr MOLHOEK: In terms of the impact of aged-care or NDIS patients, on average how many patients a week or a year would end up in the hospital on a long stay, waiting for placement or requiring care?

Mr Cram: Quite a few. It depends on the circumstances of the individual and whether there is a family to support them. Often we get people on step down from Cairns because they are very complicated and there are lots of complexities in the discharge planning. We have a Commonwealth

community and home support program where nurses work very hard to keep in place people who are ageing at home, which is the best place for them to be. That is a wonderful service at the hospital and I pay tribute to them.

We heard Dr Salleras talking about the ageing workforce and people having a heart attack in their 50s who would have died 30 years ago. That was the case when I first started. If people had a heart attack, they died—and they were young; younger than I am now. People are living longer now. We have great improvements in health. We have better health outcomes. People are not just living longer; they have a better quality of life. I certainly have noticed a change. If I look at the bed state and the list of patients in the hospital right now, the average age would be, I would suggest, about 80. That has changed. I have been there for 18 years and there has been a huge change in that. People are living longer, they have multiple comorbidities and that adds to the complexity of patients and elongating their stay.

Mr MOLHOEK: In terms of those patients who are presumably taking up important beds in the hospital, on average would it be one a night or one a week? Would there be four at any one time? Would it be 10 a year?

Mr Cram: I would say between two and four a week, if I think about it. I have not looked at the bed state this morning, but normally I look. A good experienced nurse like me can just look and see, 'Oh, yes.' You can see the complexity just by the diagnosis or the diagnoses. I would say between two and four a week would not be an underestimate.

Mr WATTS: May I jump in to clarify something? You are saying that there are 24 beds, but 11 are not available?

Mr Cram: Yes.

Mr WATTS: And between two and four are taken up with people who could be cared for in other ways?

Mr Cram: Yes.

Mr WATTS: What about the other 11 beds?

Mr Cram: Eight of those beds are for aged care. There are four male beds and four female beds available in our aged-care unit, so that would take us up to 24.

Mr MOLHOEK: They are not currently in use or funded?

Mr Cram: The aged-care beds are, but with the other beds on the acute ward, because of the availability of nurses, we reduce our numbers to make sure we have a nurse-to-patient ratio that is safe care.

Mr WATTS: Those are Queensland Health beds that are not funded because you cannot get the nurses?

Mr Cram: Queensland Health beds on the acute ward, yes. The aged-care beds are Commonwealth funded. Does that clarify?

Mr WATTS: Yes, thank you.

Mr MOLHOEK: You actually have an aged-care facility at the hospital that is federally funded?

Mr Cram: Yes. It is a multipurpose health service, so it is Commonwealth and state funded, which we rely on.

Mr MOLHOEK: One of the discussion points has been the issue of patients having to be transported to the hospital from other aged-care facilities because of the lack of registered nurses.

Mr Cram: Yes.

Mr MOLHOEK: How often would someone be transferred from, say, the local aged-care facility to the hospital of an evening for urgent care or dementia care?

Mr Cram: Quite often, and you describe—

Mr MOLHOEK: Once a week, five times a week?

Mr Cram: I would say once a week would not be too optimistic or pessimistic. It happens quite frequently. We have three nursing homes in the area. As I say, we do not have registered nurses on each shift. When a resident gets into difficulty, the staff will just ring triple 0.

Mr WATTS: I am trying to get my head around this. Your facility does not have enough nurses and the aged-care facilities do not have enough nurses, so the basic problem is there is an acute shortage of nurses in the area?

Mr Cram: Of trained nurses, yes, and that is the issue. Recruitment and retention is very difficult. Of course, COVID has added the double whammy on that because we would rely on international nurses. I am an international nurse; I came from the UK. We rely on that. Because of where we are—it is a tropical region—it is a very transient population and nurses and midwives are transient as part of that. They pass through. We might have somebody for six months and then they move on.

Mr WATTS: What advice would you give us as state representatives who want to provide more nurses? How do we go about it? What should we do?

Mr Cram: Wow, you give me carte blanche! Seriously, if we truly have the ratios that we need to be able to deliver the care—nurses are a big workforce. We are the biggest workforce. We are not militant. Some federal MPs would have me described as a union thug. Most people in a union are women in their 50s, which is quite fascinating. There are almost 70,000 members of the QNMU here in Queensland and proudly so. If we truly had ratios met without a budget being the common denominator—the budget always gets in the way—I get very passionate and I get fairly fiery when people question the clinical judgement of a nurse or a midwife. If a nurse or a midwife says, 'We need these registered nurses and these enrolled nurses and we need these midwives to deliver safe care,' please listen to us. We are the clinical experts. We know our community. I know my community very well. It is very important that we listen to nurses and midwives who do not just say things because they want to just say it or they think they should say it; it is because we are passionate about what we do. I am passionate about what I do as a nurse educator. I am very proudly a nurse of 36 years. I do not know what I will do when I retire because it is a very rewarding profession.

Mr MOLHOEK: You are not allowed to retire. We need you.

Mr Cram: Did I answer your question?

CHAIR: The former health committee recommended nurse-patient ratios. I do recall the opposition actually did not. It was about 1 o'clock at night and we had a heap of nurses up in the gallery. We did get it through at that time. We can hear you and we have heard your passion today.

Ms KING: Thank you, Shaun. It has been wonderful to hear from you today. Were you here earlier when Dr Heather McNamee gave her submission about the use of nurse-led clinics?

Mr Cram: No.

Ms KING: She reflected on her early clinical practice in the UK where nurses lead well-women clinics, mother-and-baby clinics—a whole range of clinics—in conjunction with general practice. We are talking there about nurses working at a much higher scope of practice than is standard in primary care in Australia.

Mr Cram: Yes.

Ms KING: We have heard you talk about the acute shortage of nurses. Is it your view, from your extensive experience as a nurse leader and a nurse, that it would be easier to recruit nurses if nurses could work to that full scope of practice and lead health care in the primary setting and in the community?

Mr Cram: I think that is one of the attractions. Nurses want to work to their full scope of practice. We want to do our best for our patients. We want to be able to offer that holistic approach to our patients and, if you are a midwife, to your woman and her family. Working to your full scope of practice is really attractive for nurses and midwives. I think that is demonstrated when we had a midwifery group practice at Mossman and the midwives did not birth because we were not a birth service, and that answers your question. They moved on because they wanted to be able to work to their full scope of practice which includes birthing a woman and giving postnatal care and support to that woman and her family.

Ms KING: In relation to the nurse-led call-back clinic that has been established at Mossman Hospital, it is clearly an effective solution for the issues that have been seen, but I want to make the point that the problem that required that great solution was because of a failure of primary health care where people could not get GP appointments. My point is that nurses have had to effectively become hospital based providers of GP care.

Mr Cram: Essentially, yes. I completely agree. The emergency department is for emergencies. An emergency is an accident or incident that has happened in the preceding 24 hours. That is the rough definition of what an emergency is. In the UK we call it the casualty department—very dramatic. But essentially when we are seeing dressings and people attending for bloods to be drawn et cetera—all the non-GP work—that takes you away from your emergency work. If somebody comes in and they are a category 1, which is when they need to be seen now because they are going to lose their

life, an organ or a limb, the category 4s and 5s have to wait. Obviously we have to prioritise. That is what triage is; it is a prioritisation scale. Category 1s are seen immediately, category 2s are seen in 10 minutes and category 3s are seen within half an hour. What does that mean? Being seen means time in meaningful treatment. That is what that means. When you have people who are 4s and 5s and it is GP work essentially, it does take you away from your category 1s, 2s and 3s, if that makes sense.

Ms KING: Ultimately, these scenarios are emerging because the federal government is insufficiently funding primary health care.

Mr Cram: Yes.

Ms KING: Insufficiently remunerating GPs to provide primary health care.

Mr Cram: Yes, I believe so.

Ms KING: And nurses.

Mr MOLHOEK: Is that a question or a statement, Chair?

Mr Cram: If I talk to GP colleagues, these are the issues. As I have said, it is very hard to recruit and retain. There is a local GP practice, which is my GP now, and they have been trying to attract GPs for nearly two years that I am aware of.

CHAIR: We are nearly out of time.

Ms PEASE: Can I ask quickly: are you aware of the waiting time to be able to make an appointment to see a GP? We have heard in other cities and towns that it is two weeks, three weeks. Can you give any figures on that?

Mr Cram: The community are waiting about two weeks to get in to see a GP. It has been made worse by the COVID pandemic. GPs have been offering vaccinations, of course, and that takes them away from GP work. About two weeks is what is being reported.

Mr MOLHOEK: In the submission from the union you talk about the need for greater collaboration between state and federal services. I note the PHN have made similar comments around all the silos. Are there efficiencies to be made in the delivery of health services by better collaboration in this area between the two channels where we have duplication?

Mr Cram: I think so. I think if you let people do what their expertise is and what their specialisation is, that is really important. I think it is very important that we communicate what that is and then we fill the gaps with what else is in the local community. I am a big believer in getting rid of silos. They are dangerous. Let us really break down the walls of: you are the hospital, we are the GP, we are a private physiotherapy, we are a private nursing home. If we get rid of that and truly work collaboratively towards the health of our community, that can only be a good thing and that would make me a happy puppy.

Mr MOLHOEK: Very quickly, can you get dialysis in Mossman?

Mr Cram: Yes, we have a dialysis unit. There are nine chairs. It is a satellite of Cairns. That is utilised six days a week.

CHAIR: We have to pull it up there because of the time. I am aware that you have members trying to dial in. We will attempt to ring them tomorrow from Townsville and get a far better connection. For those people online from the Torres Strait, we will be in contact with you to try to speak again tomorrow. I thank you, Shaun, and the people online for your significant contribution today and thank you again for your work.

Mr Cram: Thank you very much for your time.

ALLISON, Mr Bill, Private capacity

CHAIR: Welcome. It is probably worth starting with your name and how long you have lived here to give us a bit of background.

Mr Allison: My name is Bill Allison. I have been here for almost 20 years. I have two daughters who are schoolteachers here. I have five grandchildren who were born in the area, at Mareeba Hospital, Cairns, Townsville et cetera. My eldest granddaughter is a nurse. She was at Tully Hospital but she has unfortunately gone down to Brisbane. I can only say that I can speak very highly of the medical treatment that I have received both at the hospitals here and by my GP. The people who work in these places are just fantastic, working under very difficult conditions, as I realise. I have been unfortunate in the last couple of years to have had a couple of injuries and health issues that required me to go to both Cairns and Townsville hospitals.

One of the difficulties here is getting to see your local GP. It is almost impossible. I have been seeing a female GP for about 17 years. I am worried that eventually she is going to retire and I will not have her anymore. It usually takes me three or four weeks to get in to see her. If it is really urgent she will try to get me in if she can, otherwise I have to go to the hospital. My grandchildren—I have two young ones, one aged three and another aged seven—usually have to go to hospital with minor things because we cannot see a GP. It puts pressure on the hospital system obviously.

For me to get a COVID vaccine I had to go to Smithfield. I could not get one here. I wanted to get one as soon as I could, but there was none here. I do not know that I can say much else.

CHAIR: It is interesting that you had to drive all the way to Smithfield just to get the vaccine. Obviously access to a GP is vital in this area. I think we heard there were around 12,000 people between Port Douglas and Mossman.

Mr Allison: Yes, that is right.

CHAIR: Do you know how many GPs are in the area, roughly?

Mr Allison: I do not know, but I do know that one doctors' surgery closed down downtown and another one across the road also closed down. She was only one lady on her own. I think she retired. I think we might have had some more come in. I know 15 to 20 years ago it was not so bad. You could usually see your GP within a week. It is just ridiculous now.

CHAIR: We heard yesterday in Cairns, and again from Dr McNamee, about the financial burden of setting up a GP practice. It costs quite a bit to establish that and pay staff. We certainly heard that yesterday. I will open up to questions.

Mr Allison: Could I just say that I agree with a lot of the other doctors. A bulk-billing doctor I think gets $38. Someone from Cairns charged me $190 to spend 10 minutes to fix my garage door. My doctor would spend a minimum of 15 to 20 minutes seeing me. Every time I go there she gives me a thorough check over. She does not rush me.

CHAIR: You can see how valuable it is having those relationships with your GP.

Mr Allison: Absolutely.

CHAIR: Any questions?

Mr MOLHOEK: No.

Ms PEASE: Thank you, Bill, for coming up and talking to us today. Do you have private health insurance?

Mr Allison: No, I do not. I do not believe in it. I think we should have a good public health system.

Ms PEASE: Has your doctor referred you or any of your family to other allied health services, such as physiotherapists, psychologists or podiatrists?

Mr Allison: I had physio. I am a pretty active person so I broke my hip a couple of years ago and smashed it all and I had a lot of physio after that, of course.

Ms PEASE: Did you have to pay?

Mr Allison: No.

Ms PEASE: Was that included in the hospital procedure?

Mr Allison: Yes.

Ms PEASE: That is good it was covered by that. If your GP referred to you a physio, would you be able to afford to go to a private physio?

Mr Allison: I would personally, yes.

Ms PEASE: How much would it cost you, do you think?

Mr Allison: I think $100 for half an hour or something.

Ms PEASE: That is a bit prohibitive for a lot of people in your position.

Mr Allison: Absolutely.

Ms PEASE: Because you cannot claim that on Medicare.

Mr Allison: No.

Ms PEASE: With an holistic approach to a patient, where it is patient centred with a GP, is it difficult to refer people on to get that specialist and allied health support and assistance?

Mr Allison: Absolutely.

Ms PEASE: If you have grandkids you would no doubt know they would have come across that in their time.

Mr Allison: Yes, and my wife has had issues. She has had to get specialist treatment and we have just had to pay for it.

Ms PEASE: Thank you for coming in. We really appreciate your time.

CHAIR: We heard some data in Brisbane in our very first hearing that 60 per cent of Queenslanders do not have private health insurance. It is out of reach now. The 40 per cent who remain are still using the public system because the gaps are so big that it costs a significant amount of money to get a procedure done privately. That is a real telling point, I think, when we are talking about the increased burden on the public health system.

Mr Allison: For me to get private health, because I have to pay two per cent for every year after 30, I think it is, I think it is probably around about $10,000 a year or something like that, it would probably be.

Mr MOLHOEK: Going back to your earlier comment, your belief is that the public health system should provide those basic services, right?

Mr Allison: Absolutely I do. Regardless of how much money you have, everyone should have a decent health system. This is not America.

CHAIR: We are very lucky to have what we do have.

Mr Allison: It is very, very good.

CHAIR: We just need to fix what we have heard about today and yesterday; fix primary health care and take some of the burden off the public system.

Mr Allison: Could I just say one other thing: my mother-in-law is in a nursing home here. She had a situation where she had to go to the hospital, but it was terribly distressing for her as she has dementia as well. In fact, my wife has told them not to take her to the hospital but just try and deal with it there, because she was so traumatised by it all that it just set her back. Although it is a lovely home here in Mossman, I do know they struggle for nurses et cetera and have trouble getting a doctor to go there as well.

Ms KING: Bill, I was going to ask you about older friends or family members you might have who are in aged care and what your thoughts are on that. You have already filled that in for me.

Mr Allison: That is right, Ali: my mother-in-law is there. The people there are very good and they do their best but they are short staffed. They had trouble getting a doctor there. They looked like they could not get one for a while. The doctor is really pushed, I know, to deal with the problems they have. I do know a little bit about it.

Ms KING: I grew up in a regional area myself so I know how incredibly grateful people in small towns and villages are for the health facilities that are in their area, and I can hear that from you.

Mr Allison: I lived in Pumicestone too.

Ms KING: Did you? Whereabouts?

Mr Allison: Bribie Island. I knew some of your previous members of parliament.

CHAIR: We had a public hearing in Bribie. That was one of our first ones. It is a really lovely area.

Mr Allison: It is. I had no trouble getting to see a doctor there. It is only up here. It is only in the last few years that it has really deteriorated. Probably there are more people moving here and more doctors moving away or getting older and retiring.

CHAIR: Thank you for being the voice of Mossman today. We really appreciate your contribution. It is nice to meet you. You are now on the parliamentary record, in *Hansard*, for the rest of days. We thank all of the people who have come here to listen today. Thank you all very much for your contributions. It is really appreciated. I now declare this public hearing closed.

The committee adjourned at 11.44 am.