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 NDIS CARE SERVICES AND ITS IMPACT ON THE QUEENSLAND PUBLIC HEALTH SYSTEM

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 9 FEBRUARY 2022

South Townsville

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The committee met at 9.02 am.

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

With me today are Rob Molhoek, member for Southport and deputy chair; Ali King, member for Pumicestone; Joan Pease, member for Lytton; Trevor Watts, member for Toowoomba North, who is substituting for Mark Robinson, member for Oodgeroo; and joining us via videoconference is Stephen Andrew, member for Mirani.

This hearing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Only the committee and invited witnesses may participate in the proceedings. As we have at our public hearings throughout Far North Queensland, we will invite people from the floor to speak after the registered speakers have provided their contribution. I understand the primary health network are absent today, which is a bit of a shame, so we might be able to bring more people through.

I remind members of the public they may be excluded from the hearing at the discretion of the committee. These proceedings are being recorded. Media may be present—they are present—and are subject to the committee's media rules and the chair's direction at all times. Please turn off any mobile phones or put them on silent mode. If any witnesses have documents they would like to table, we have to procedurally accept those as a committee. We will start this morning with Danielle Hornsby.

HORNSBY, Ms Danielle, Executive Director, Allied Health, Townsville Hospital and Health Service

CHAIR: Thank you for being here. We would really like to get an understanding of the Townsville picture. Could you start with an opening statement and then we will move to questions.

Ms Hornsby: It is a pleasure to be here. Our HHS is responsible for the delivery of healthcare services to 250,000 people in our region. We are really proud to provide some quite advanced, highly specialised, tertiary level health care at Townsville University Hospital as well as the secondary and primary healthcare services and community services in 20 facilities in our region. We stand ready as the largest tertiary referral hospital for the whole of North Queensland and the largest tertiary centre in Northern Australia.

Townsville University Hospital is the only tertiary facility in Queensland to offer all of the specialty services under one roof: kids, brains, spines, world-class cancer treatments, newborns, bone marrow transplants and the like. Our staff are really proud to be North Queenslanders and our organisation is proud to sustain a tier 1 performance status statewide due to our performance against financial, operational, safety and access performance targets. I am an executive director with the HHS and my divisional portfolio is responsible for providing the allied health services across our region.

Because of the work I do and the people I work with, I see almost every day the stress and distress that families and individuals experience due to being in hospital. It is distressing for our staff to have to care for so many people who have no medical reason to be in hospital but they are there because we cannot find a safe place to discharge them to. Hospital admission is often a result of a tipping point where existing supports just are not enough anymore. Our staff become the system integrators who piece together the systems, supports, welfare, accommodation and assistance for people to live outside the walls of the hospital.

This is just a typical week from some actual data from the end of November last year. Of people who were occupying an acute care bed but not needing acute care, 11 people were waiting for NDIS plan reviews and approvals, 26 people were in our hospital waiting for a residential aged-care bed

and seven were waiting for other elements like QCAT or guardian issues to be sorted. No-one was waiting for an ACAT assessment. In addition to that there were 24 mental health patients waiting for one or more elements of an NDIS support to be activated. Behind each one of those numbers is a person and a family.

In raw numbers, we have almost two whole wards in our hospital environment catering for people where their supports for aged care or disability have failed. We have tremendously helpful relationships with aged-care and disability providers and general practice providers in our region and many mechanisms to foster that.

For the elderly in our hospital awaiting placement, we find there are two fundamental insufficiencies. One is that there are just not enough residential beds available in our community to meet the demand. Secondly, there are not the places that can care for those with complex needs, specifically those who are quite high-care individuals with multiple, complex behavioural elements that need settings that cater for dementia, challenging behaviours, wandering and some gender specific environments for successful transition for them and other residents. We also struggle with a lack of GPs to service residential aged-care environments and that is another frequent barrier for placement.

In Charters Towers, by way of example, we activated a response to a disruption in the GP services there for our Eventide residents. They were cared for by a Townsville based GP who visited once a week until 2019 when the GP resigned and 95 residents were suddenly without access to primary care. The local practice was unable to take on additional residents due to the chronic GP shortage. Our hospital and health service worked on a solution and put in place a geriatrician and a nurse practitioner to work with the local GP practice. Subsequently, we worked with a Commonwealth initiative under the Rural Junior Doctor Training Innovation Fund and a junior doctor position has now been added to the mix for that whole community.

In Townsville, our HHS invested almost $900,000 last year for an additional 13 beds in a local aged-care facility to help cater for those awaiting placement so they did not need to wait in our hospital. In Townsville we have also funded a frailty intervention team operating out of our emergency department to provide 24/7 direct access for nursing homes in our region with immediate medical response for residents who become unwell but could be treated in their facility. Each month we have about 300 assessments and follow-ups that are provided in that service.

However, aged care is not all about residential care. Home Care Packages are a tremendous support for people as an alternative to residential. Allocation is based on a first in, first served basis and there is only a defined number of packages per level per region. For the highest level care packages, 3 and 4, we observe significant wait times, regularly approaching 12 months. Because places are capped, you simply wait and wait until a package that is suitable for you becomes available. That often means that consumers and their families are having to make difficult choices about accessing residential care earlier than they may have needed, further exacerbating the demand on residential care. While waiting for packages, of course health and functioning is declining faster, resulting in an increase in hospital admissions and healthcare burden.

I turn to disability. In terms of those accessing disability supports through NDIS a number of people—usually around 10 to 15 on any given day—in our hospitals are waiting for access, plans or approvals. Many of those end up in our care because of a change in needs and their providers simply cannot sustain the supports that person needs anymore. Most of the people are already participants in the scheme.

Our hospital system and staff are supporting the support coordinators to bring together the threads of accommodation, lifestyle support, assistive technology and equipment, and behavioural plans for very complex consumers. Our medical officers and experienced allied health professionals are providing health information and writing reports about a consumer's needs, but we are often finding that is not considered to be sufficient evidence for a higher level of support. Providers are then advised to obtain further functional assessments, which further delays the process as providers attempt to source the experts to complete the assessments and finalise the reports.

There is a tremendous amount of duplication of effort, leaving aside the fact that it is almost impossible to undertake a needs assessment about how someone functions in their environment in a hospital institutionalised setting that someone has lived in for the past 100 days. Unfortunately, we have had multiple cases in the past 12 months where this has resulted in avoidable stays in hospital of between 100 and 400 days. Jim, who is in the Queensland Health submission, is one of those clients. The challenges and issues described in the Queensland Health submission certainly resonate here in Townsville and there is a list of very practical solutions and examples that align very much with our challenges.

I turn now to the impact of the issues of interest to the inquiry on emergency departments, specialist outpatients and elective surgery. Last financial year our emergency department presentations increased to 91,920 at Townsville University Hospital, an average of 251 people a day and an 8.2 per cent increase on the previous year. About 30 per cent of those presentations are admitted to hospital. Our patients tell us that getting access to general practice is difficult, which often drives them to seek the emergency department. This is made even more difficult by the lack of after-hours availability.

Speaking to my colleagues in the emergency department, they tell me that, of the 50 or so general practices in our community, about six operate after 6 pm and only one operates after 9 pm, and it is in that order of magnitude. The private hospital emergency department operates from 7 am until 11 pm and patients incur a fee-for-service for their attendance. Our total surgical operations—both emergency and elective—grew by 6½ per cent year on year last year. Primarily, that was due to 1,345 additional elective, not emergency, procedures—which was a growth of 16 per cent. We also outsource to the private sector and grew that by 49 per cent for public procedures. Outpatient services increased by three per cent.

The term 'elective' is a bit of a misnomer because many of these procedures are absolutely necessary to sustain people's function and health. The need for procedures is often accelerated due to the lack of primary care and allied health professionals to provide holistic care for chronic conditions like joint pain, orthopaedic conditions, diabetes, cardiac health, gastrointestinal health, et cetera.

To access the partially funded MBS allied health item numbers under the chronic disease management plans, a patient must have a chronic disease for at least six months and then can only receive five allied health visits across all professions over a calendar year. Most will need more. The choice for many is for GPs to refer to a specialist in a public hospital—an orthopaedic surgeon, a gastroenterologist, a general physician—because alongside that specialist is a team of health professionals who can provide the therapeutic services that a person needs.

We do work cleverly together in regions. As a health system, we knit well together with GPs, PHNs, JCU, nursing homes, disability providers and of course the other very important NGO providers in our community.

Finally, our staff live, work and play in our communities. That is why it is not just about the financial and the operational impacts at play here. For many of our staff it is stressful, frustrating and personal. Thank you for the opportunity to address this committee and I would be happy to elaborate where I can with questions.

CHAIR: Thank you for those opening remarks. I will just make some observations and comments and then we will move to questions from fellow members. First, on behalf of the committee, we thank the thousands of people who work in our health system in Townsville—and it is a broad system—particularly for the challenges they have all faced with COVID over the past couple of years. I know a lot of those health practitioners personally and I know how hard they work. We thank them for their dedication and commitment to looking after North Queenslanders. We are really proud of our hospital. As a local member, I have to say that the Townsville University Hospital as a tertiary teaching hospital does remarkable work.

With that and your comments, it is very clear to me as an observation that the burden of 250 people a day through the front door—and I know it can go to 270 or 280 over the holiday period—does not seem sustainable. That is what the committee is looking at, that is, how we can better alleviate the pressure on the public system. We really do appreciate your very factual and well-articulated opening statement. We will move to questions.

Mr MOLHOEK: Danielle, I will add my thanks to you and your team and all of our frontline workers here in Townsville and across the state. I know it has been a very trying and challenging season for you all. Mind you, I think it was probably challenging and trying even pre-COVID in many situations. I do want to add my thanks to you and your colleagues. I had the great pleasure of spending some time at Townsville Hospital last year and got to see the mental health facilities and the new paediatric unit that has been set up as an adjunct to the emergency department, which is great.

As one of the underlying themes of this inquiry, we are trying to unpack why there is such increased demand on public health services and where the failings are in the system. One of the issues that has been raised regularly is bed block and the suggestion that too many beds in our hospitals are being taken up by people waiting for aged-care places or those with other complex disability needs. How many beds does the Townsville health service have in total? What proportion of those beds are actually occupied at any time on average by people waiting for aged-care placement or special needs around disability?

Ms Hornsby: At the end of last financial year we had 774 overnight beds in our whole HHS, of which 600 exactly are in Townsville University Hospital. The remaining are in our rural facilities and hospitals across our region. We have a system where once a person reaches about 30 days in hospital we look at their care arrangements and we reclassify them in our system as maintenance patients if their acute care episode is concluded. Their acute care episode is concluded when they do not need any more investigations, we have treated the condition as best we can, the person is medically fit and able to go home.

For those maintenance patients, there are around 50 at any one time who are either ready for a residential aged-care bed or waiting for some aspect of their care to be designed, organised and delivered as a disability participant. Obviously it changes and fluctuates day to day, but I would say that about 60 per cent are waiting for residential aged care, about 30 per cent are waiting for disability supports and about 10 per cent are waiting for some of those other arrangements to conclude—some complex guardian issues, some complex decision-making or capacity issues with QCAT et cetera.

Mr MOLHOEK: So about 50 beds at any one time in what you call a maintenance position.

CHAIR: I think there was about 70, as a breakdown.

Mr MOLHOEK: So 60 per cent of those are aged care and 30 per cent are disability. How does that compare as a proportion to, say, five years ago pre NDIS and then 10 years ago? Has it gotten better or worse?

CHAIR: You can take some of these on notice if you need to.

Ms Hornsby: I do not have those figures available to me. The issue is that 10 years ago we may not have had the ability in our systems to understand whether a person was waiting for disability specifically. We would have just classified them as ready for discharge or concluded their acute episode. It may be that that data is not able to be easily sourced because our system was not able to do that.

Mr MOLHOEK: I am planning to ask Queensland Health that broader question across the health service at some point so I will get that information from them hopefully. The other part of the question is whether there has been any significant increase in aged-care places in Townsville in recent years. The comment was made in Cairns the other day that there are actually plenty of aged-care places and in fact there had been a huge increase in places. I just wonder what the situation in Townsville is.

Ms Hornsby: I am not from the jurisdiction that can give you exact aged-care beds. What I can say is that last time we did look at this information, which was mid-2020, the Townsville region had just under a total of 1,900 aged-care places available. We did some comparisons across the state with some of our peer regions: Wide Bay had 2,200, so 300 more than the Townsville region; Darling Downs had 3,000; and Cairns had about 2,100. In all of those settings with similar population demographics and geographic distributions, our information from 2020 suggests that we do have a deficiency in the number of residential aged-care beds for our community.

Mr MOLHOEK: To be fair, the comment in Cairns was that there had been a significant increase in the number of aged-care places but the demand had also increased because of the ageing population. I should clarify that for my colleagues.

Ms KING: Danielle, thank you for being with us today and for your very to-the-point opening remarks. I want to tease out a couple of threads that you raised. The first basic question is whether, as the executive director for allied health in a HHS, it is difficult to recruit allied health workers.

Ms Hornsby: It is made more difficult in regional areas. We have spent an enormous amount of time trying to build our profile here in Townsville. In my opening statement, I spoke about the wonderful services we provide, the professional reputation we have and the uniqueness of professional experience that we can offer people. Five years ago, it was extremely difficult. We are finding it slightly easier now in Townsville at our university hospital, but I have to say that does not translate to community settings and it does not translate to our private providers who are trying to also recruit the same staff. We spend an enormous amount of effort to ensure that our rural facilities—where there is often a sole clinician, a sole speech pathologist or a sole physiotherapist working—recruit the right type of person with the skill set that is safe and adequate to deliver services in those communities.

What I will say though—and this is the difficulty here—is that quite often many sectors 'cannibalise' each other's workforces, if I can use that word. We find here in the public system that there is a great strain between community providers, private providers, NDIS and disability services, and those who work in aged care. Quite often we are circulating the same staff, just working in different agencies.

Ms KING: I also want to draw out a comment you made about home care packages. You said that the wait for a level 3 or 4 home care package is around 12 months, and correct me if I am not right, and that that is leading to early entry to residential aged care before it is required. You also noted that those home care packages are allocated on a first in, first served basis. In health care and community support, where so many services are allocated on a triage basis and the greatest need gets served first, is it appropriate that you line up and wait with everybody else however acute your need is? Is that the best care?

Ms Hornsby: What I will say is to confirm what you just said. In our healthcare environment, we do triage. Obviously in our emergency department the people who are the sickest get the service first. In our specialist outpatients, we have categorisations where patients who are referred from their general practice get categorised and their time waiting is actually about the clinically recommended time, rather than a capped first in, first out.

Ms KING: Townsville does provide ACAT assessments, does it not?

Ms Hornsby: Yes, correct. The Townsville Hospital and Health Service is the ACAT provider for assessments. We are really pleased to be meeting and certainly exceeding our KPIs for ACAT assessments. As you heard, no-one waits in our hospital more than 48 hours for an ACAT assessment and we have same-day turnaround for the outcomes of that ACAT assessment. The KPI on ACAT assessments from the Commonwealth is 40 days. Our average is 30 days. We triage those people in hospital for ACAT assessments first. It would be usual that people in our community would wait about two weeks, or 14 days, so less than half of what the Commonwealth KPI is.

Ms KING: The reason I ask about that is that clearly the assessment of people's needs is being done, including by the HHS, so that information is potentially available?

Ms Hornsby: That is not the barrier.

CHAIR: The ACAT team are at the Kirwan health precinct and I have visited them in my electorate of Thuringowa. They are a great team and they do extraordinary work. As a broad comment—and the member for Lytton will recall—we held an aged-care inquiry hearing in Hervey Bay and we talked about the home care packages. I will never forget a lady at the public hearing saying, 'My husband's home care package arrived but he died two years prior to that.' That made us look at the waitlist and there were 90,000 people waiting. We know the royal commission made several recommendations around that, but my goodness me—stark!

Mr WATTS: Thank you for your comprehensive introduction. You might be aware that the Auditor-General last year released a report about specialist outpatient services which we have spoken about a bit this morning. Obviously the nexus between primary caregivers and specialist appointments in tertiary care is fundamentally important. The report said that a few key projects, as part of the specialist outpatient strategy, remain unfinished. They include the clinical prioritisation projects and referral service directory. I am not sure if you are familiar with this report or not, but I am interested to understand how delays in these kinds of projects may be affecting patients getting the right care at the right time.

Ms Hornsby: I do know something about this topic. I am managing a project at the moment that is all about referral processing from GPs to specialist outpatients. I am not aware of the details of the Auditor-General's report, but I will talk to you about the Townsville experience.

We have a process that collects and collates every referral from a GP to specialist outpatients in a centralised way. That means that we can very accurately capture data around how long it takes us to process those referrals. We are processing referrals within two hours of those referrals being received from a general practitioner. We have KPIs around the time it takes then to pass that onto a specialist to look at the referral and to sign it as a clinical prioritisation categorisation, the CPC. The turnaround time for that is five days as the KPI, but we are at about two and a half days, I want to say. Certainly we are exceeding the KPI for turnaround times for the time it takes for our specialists to take a look at the referral, assign it a categorisation according to the clinical urgency and then it being applied to the waitlist. We are one of the most successful regions in the state for our performance around referral management from GPs.

Mr WATTS: That is excellent. I appreciate that. In terms of people on the waitlist for those specialist referrals, how is that going in the footprint here?

Ms Hornsby: We have a number of subspecialties that are only available or ostensibly available here in Townsville for the whole of North Queensland. They are some of the ones like cardiothoracic surgery, dermatology, ENT services, ophthalmology—those really subspecialty services. I have to say that the volume of referrals and demand that we get for those services outstrips our ability to supply that at the moment.

We have implemented a range of measures, though, to keep that waitlist under control, including general practice with special interests in the area of dermatology, cardiology, ENT—I think we have employed four of those. We have particular models in place where we have optometrists at the front end of ophthalmology waiting lists to be able to triage and take less urgent, more routine cases and do that work as a role substitution model. We have great role substitution models about to start for gastroenterology with dietitians at the front end of the waitlists, and the other ones around physios at the front end of neurosurgery waitlists being able to triage, take people and deliver care immediately rather than people having to wait several months for their appointment. I have some figures around waitlists if you would like me to share that with the committee.

Mr WATTS: I am happy for those to be tabled. We can put those in the report.

Ms Hornsby: Thank you.

Mr WATTS: Thank you very much for your answer. The key question is: in terms of people waiting for those specialist appointments, what advice would you have for us to give to the state government about how to reduce that waitlist time?

Ms Hornsby: We have some very good models where we put in place quite experienced allied health at the front end of waitlists and that has been extraordinarily useful. There is lots of assessment and evaluation on those models with good results around the ability to get people sooner to care, being able to release the specialists to do what only the specialists can do and release some of that time back to more urgent or higher complex care. That would be one piece of advice.

The other one would be about providing services in the community that would mean, as I spoke to in my opening statement, affordable allied health care in the community to support GPs to be able to deliver more holistic care in the community for people with those conditions because, as I said, a number of people are referred for our services because there is a wraparound service where people can get the treatment that they need from a holistic, multidisciplinary team.

Mr ANDREW: My question goes to the whole system itself through allied health care and the situation with the vaccine rollouts, the mandates, the loss of staff and a lot of issues with injuries from some vaccine rollouts—there are 105,000 on the TGA website. Does that affect the whole system and the way you roll out health care?

Ms Hornsby: It does not materially affect any of our demand pressures in terms of anything vaccine related. What we see, though, is that people in our community are less likely to need hospitalisation as a result of the vaccine.

CHAIR: We thank you for your contribution here today. It paints a very good picture from the HHS point of view. Thank you very much, Danielle.

CLEMENTS, Dr Michael, Chair, RACGP Rural, Royal Australian College of General Practitioners

CHAIR: Dr Clements, you are well-known to the committee, having provided submissions previously in other inquiries. We thank you. Would you like to start with an opening statement first?

Dr Clements: Thank you very much. I come to you speaking today as both a local GP and practice owner, and also as a representative for the College of GPs who are under the national rural chair. I hope to bring to a national rural perspective to these discussions.

As a local practice owner, I have two practices: here in Townsville City and one on Magnetic Island. Magnetic Island is an example of where both the state, JCU and private enterprise like me work together. We have turned what was an island with a locum-only service with one doctor—I am very proud—to this week where we have five GPs in my consulting rooms plus a permanent doctor in the hospital clinic, so six doctors on the island who are all fully recruited and we are actually turning people away. There are ways that we can work together to make sure that we solve some of these longer-term problems. I also do rural outreach clinics to Karumba in particular and Julia Creek. There I have a collaborative arrangement using federal funds and a state-based arrangement with our Mount Isa Hospital and Health Service, with a collaborative model of care supporting nurse practitioners and visiting services.

The RACGP, the other people that I am representing, is the largest professional general practice organisation. We represent over 40,000 members working towards a career in general practice or working in general practice. I am chair of the rural faculty. We have 10,000 members. Four out of five rural doctors and members are our GPs.

We know that too many people are presenting to emergency departments for health concerns that either could have been managed by a GP or prevented by good GP care. We know that many say that they cannot get in to see their GP or, in many cases, cannot afford the GP fees for that service, so they end up in hospital. We know that proper investment in general practice leads to significant savings overall. The average emergency department presentation is around a $540 cost to the government, but a 40-minute GP consultation if we use, say, WorkCover rebates would be about $150—a significant saving.

We did some modelling by PricewaterhouseCoopers last year to show that moving some of the $79 billion that is put into hospital care—if we increase the funding into primary care by $1 billion, you would actually get $5.6 billion in savings over the following five years. I spoke to the previous state health minister a number of years ago who often lamented that he could not get work done where it was cheapest. As the health minister, he could only control work done in hospitals and in the hospitals' reach. If he could only have paid for where it was to done cheapest, he thought he might be able to solve the problems.

We know that a lack of funding overall has impacted the appeal of general practice as a career unless people are choosing to become a GP. The AMA released a survey last week showing that only 15 per cent of medical students are thinking about general practice or have the intent to move to general practice. That is down from roughly 50 per cent back in its heyday and most of those doctors are now choosing to work in hospitals and are thinking of training in general surgery and as emergency physicians and anaesthetics. There is an absolute oversupply of most of those specialties, particularly in the Brisbane region and the inner city areas. We need to see investment and reward for moving into general practice.

About 20 or 15 years ago, doctors who left a hospital job to move into private general practice got a pay rise; right now it is a pay cut. One of the trainees that I have at the island practice was getting about $150,000 on a public health servant salary, which is pretty good, but the basic pay under the GP terms and conditions is $90,000, so they suffer a significant cut to then choose general practice. You can see some of the barriers we are fighting against.

We know that the health workforce shortages are an ongoing problem, particularly in rural and remote areas. We know that the number of services per patient decrease the further away from Brisbane you move. Townsville is not too bad, Cairns is not too bad, but we have just seen Mackay get DPA status and almost every person and their dog is applying for DPA status as an exemption as well.

We know that the solution does not come through trying to partition off parts of general practice work. We know that general practice care is holistic, it is longitudinal and it relies on continuous relationships with patients. Trying to pick off little bits of what we do, whether it seems like we are just

giving a repeat script or giving a script for an antibiotic for an UTI, if we try to hive those off to different areas then we are going to increase patient risk and increase that fragmentation and the patients will be the ones who end up paying with their health.

In closing, we know that primary care involves us in patient care, improves outcomes, lowers mortality rates, lowers hospital admissions, improves quality of life and decreases the use of more expensive health services. A couple of years ago I was brought into a meeting at the hospital where they lamented the avoidable hospital admissions and also readmissions. I sat there representing GPs. The PHN was there as well. They said, 'What can you do to help us avoid these readmissions?' I laid out a plan. I said, 'This is what we can do in general practice, but we need funding.' The hospital said, 'Oh, no, no, we need the cost savings, but we can't fund you.' Of course the PHNs have very limited scope and very limited funds, so they were not able to help either. We all have the solutions, but nobody is willing to reach into their pocket. Thank you for the opportunity. I am happy to answer questions.

CHAIR: Thank you very much, Doctor. We heard yesterday and also the day before in Cairns that the financial burden of setting up a practice when compared to those hospital paid positions is quite significant on GPs.

Mr MOLHOEK: Thanks, Michael, for making your time available to be here today. I have so many questions. In Cairns the other day we heard from one of the providers of NDIS services up on the Tablelands—and we have heard a little bit of discussion this morning around the cannibalisation of staff. They basically said there is more money in the system now to care for people with disability than there has ever been but there is an acute shortage of people who are actually able to provide the services. Are people with disability actually getting better care now than they were, say, five years ago and is it a case simply that supply of practitioners and specialists and physios and GPs just is not there to meet the demand?

Dr Clements: I cannot speak specifically for NDIS. One of the troubles that we have in primary care is we have been cut out of the NDIS package.

Mr MOLHOEK: Sorry?

Dr Clements: We have been cut out of NDIS, so GPs do not participate in NDIS funding. We are often required to fill out forms that support NDIS, but NDIS very specifically will not cover services that Medicare would normally pay for. GPs would love to take on NDIS clients and receive some of the similar funding to, say, WorkCover or DVA rates even, but given that Medicare covers it that is the only funding and these people do not get great services from GPs. We know that the funding per service, particularly in allied health in NDIS, is far above what is offered under Medicare rules or under those GP care plans so seemingly that should make for better access, but sadly many people do not have access due to rurality. We know that the access to NDIS allied health services gets lower the further out from Brisbane, Townsville, Cairns.

In terms of primary care services for NDIS clients and in fact all other clients, we know that what gets funded gets done and we know that patients who can afford private fees to see their GP get good service. Patients who have private health care and can afford to attend the private hospital get low waiting lists, get seen quickly, get the hip replacement done soon. So NDIS has certainly achieved some goals and I have certainly had a number of my patients compliment the service that they get and have got very good allied health services, but as a whole in primary care they are still not getting a great service.

Mr MOLHOEK: Has the NDIS actually improved access to services or have things gone the other way since the NDIS was implemented?

Dr Clements: I do not have a qualified answer for you on that one, I am sorry. My experience is that some patients do very well and do have a good service and experience, but it is dependent upon their providers and their case coordinators.

CHAIR: I think you have a solution there if GPs were part of that primary care, so you just need the Medicare rebate aligned to GPs; is that the situation?

Dr Clements: For example, I do veterans' health. Being an ex-military person, that is a large part of my work. DVA pay much higher rebates than Medicare does and they pay for comprehensive wraparound care. If we had NDIS rates matching, for example, what DVA do, then you would find a lot more doctors deliberately targeting them. DVA also pays for non face-to-face care and for coordinated team based care with allowances for the general practice. None of that is available to NDIS, so we certainly are aware that a lot of NDIS clients talk about difficulty in accessing general practice services.

CHAIR: That is really interesting.

Ms PEASE: Thank you very much for coming in today. I would also like to acknowledge Danielle from the HHS. Thank you for your presentation and thanks to your staff. Dr Clements, I am of an understanding that the colleges are going to be taking over the training of rural doctors and I am aware of how very successful the place based training has been for rural GPs at JCU. What are your plans to be able to meet those successes and keep those retention rates with your GPs?

Dr Clements: The good news is that the training going back to the colleges gives us an opportunity to build on the successes but also bring in a national perspective. One of the challenges that we have had with all of the different RTOs across the country is that your training experience differed depending on where you were placed. In fact, the JCU territory did have trouble filling all of its places and I think many of the places are underfilled whereas some of the RTOs were full. What we know is that if you are parked in one region you are actually prevented from moving to other regions under the funding arrangements, so one of the benefits of a national training program when we take it over is that we are going to be able to provide that national coordination and that case based management. We are going to work with the previous RTOs—so we are going to be working with JCU, working with the medical educators that have previously provided that service—and form an understanding of how to best provide that service moving forward. We have not been responsible for training before so this is new for us. We have been responsible for setting the standards and maintaining and examining them, so this is certainly new business for us. So we will be absolutely relying very heavily on working closely with the RTOs in how to do that.

Ms PEASE: I am really intrigued about what was the impetus for this given the success rates for JCU with their doctors and other universities that do it. You have mentioned that it is because you want to have a more consistent approach to what is being delivered. How will that work realistically and get up off the ground, essentially shutting down a system that is already in place and starting from the ground up again?

Dr Clements: Make no mistake: this is a federal government wish and this was flagged by Minister Hunt, I think it was five years ago. In 2017 he called for the training to go back to the colleges. The training used to be held by the colleges and then it has gone through a number of different iterations and one of the fears was that there was a waste of money and administrative costs in having so many different RTOs and barriers. JCU have had some wonderful successes. Their evidence clearly shows that if you take medical students from rural areas outside Brisbane and train them outside Brisbane they stay outside Brisbane. The data is very good at showing that doctors are staying in Townsville and Townsville is counted as rural under some of those statistics. I personally have benefited from many of the Townsville graduates. But it is still a qualified success. We are still waiting for more doctors out of the six and seven areas. We have Mackay just a little bit short south of us that has had to go to DPA status because of significant shortfalls. Cairns is a fight for the same status, so we still have not solved it yet. We are responding to the federal government request for it to go back to colleges, both ACRRM and us.

Ms PEASE: Do you understand why the federal government might have become involved in such a matter and what was the purpose of their involvement?

Dr Clements: You would have to ask them as to their motivations. It was certainly clear to us that one of the reasons was cost cutting, that they saw quite significant overheads in multiple boards, multiple CEOs, multiple administrative costs. What we also knew is that medical students and the supervisors had very different experiences across the country, so our supervisors and medical students in North Queensland had a very different experience to that, say, in Sydney or Western Australia.

As a college we are very proud of what we do and what we teach and train and we want to take that back again so that we can provide a nationally consistent approach and allow some of that geographic flexibility. Under the current rules, if you start off your GP training in Brisbane you are not allowed to come to Townsville or Cloncurry or Mount Isa to do part of your GP training because of those artificial barriers. So it is really important that we do not have any sort of partitioned off sections of the country or different areas where different rules apply. It is really important that if we are going to try and bring more people in there is a nationally consistent approach and that they are treated with respect as the professionals that they are to allow them some of that flexibility.

Ms PEASE: So how do you imagine it will impact on the universities' current training model and the students who are going through?

Dr Clements: There are a number of ways that we can move forward. For example, we have already signed agreements with the RTO in Sydney, GP Synergy, in terms of how we are going to work with them and transition them. We have had preliminary meetings with JCU talking about the contract terms and how we would work together. We have offered things like shared employment

arrangements where they might work for JCU half of the time and for us half of the time, so there are lots of ways of doing it. We do not have a workforce that is sitting waiting to come out and do this. We will absolutely be employing the people who are currently doing this work.

Ms PEASE: Can you just clarify that? So the training for rural doctors is going to be picked up by an organisation in New South Wales?

Dr Clements: No, sorry; I may have misled there. No, the training is going to be delivered locally. We have opened up our Townsville office. We have signed the lease and we have an office that started in the JCU building. We will be recruiting local medical educators, including out in the rural and regional areas, and local case based management to build on that, and we will be using the human resources and the corporate intelligence of the previous RTOs. We have been working with all of the other RTOs on this in Tasmania and the Northern Territory, just making sure that we can continue the good work that they have done.

Mr WATTS: I want to get your thoughts on the specialist outpatient service referral process and how long that takes. I come from the provincial town of Toowoomba, so I am interested in it from a rural, regional and provincial perspective. If someone is seeking a specialist appointment in a provincial or a remote area, can you run us through the process and how we might improve that interface between primary health and the specialist who is potentially public hospital based?

Dr Clements: It is remarkably frustrating and the further away you move from a city the harder it is. I can use Karumba as one of the examples where I provide general practice services, and I am going there tomorrow actually. One of the frustrations with healthcare funding in general is the silos—so it is the federal government saying that that is a state government responsibility and vice versa—but it is also the silos within Queensland Health. If I come up with a proposal that can save patient travel by bringing a specialist, say an orthopaedic surgeon or a physician, into Karumba and it can save $10,000 of patient travel support money but only costs them $1,000 for the travel costs, they still say no because it comes out of a different silo and those costs are not realised in the normal budgets.

At the moment many of the HHSs do not have as part of their instruments the requirement to provide care where the patient is. There are some good exemplar models. I know that in New Zealand the boards have included statements that require the hospital to deliver services as close to the patient as possible, but we do not actually have that written into our instruments so the hospitals continue to do their best to bring things into their centre. I was a director at a rural hospital—I will not say which hospital because it is a negative comment—and I came up with a plan to bring out endoscopies and colonoscopies to this rural site. I was told no by the bigger hospital because we were not activity funded at the rural hospital, so it actually cost them money; it was better for the hospital to make the patient travel down to the bigger hospital to be able to get that service because they got more money for it, so the siloisation is a bit of a problem.

One of the other challenges we have is culture. There is a culture within the hospitals of following up your own patients. If you order some bloods on a paediatric patient or a physician patient, a medical patient, you actually ask the patient to come back and see you in hospital in a month's time, mainly to check on the results and see if they are okay. We would love to see them actually have a relationship with a GP—hand over the patient to the GP and come back and see us and build our services. So there is a lot of self-generating activity.

One of the other things that we have proposed and that works in New Zealand—and, again, we can learn a lot from them—is a communication path between GPs and the hospitals. Many of the times that I refer and many of our doctors refer into the hospital we are just asking a question: is this woman's intermenstrual bleeding a problem? Should we investigate further? What tests should I order? Is this person's hip arthritis of such a bad severity that they might need a hip replacement? At the moment I cannot ask that question of an orthopaedic surgeon or a gynaecologist. In New Zealand I can send a secure message to the gynaecologist at the hospital and ask them the same question and then they have a turnaround of, I think it is, 48 hours and I will get a response, so we can even stop those referrals in the first place. There are solutions out there but we cannot use them due to systems and confidentiality and processes and silos in terms of funding. One of the comments when I suggested at a local hospital about being able to email a gynaecologist I was told, 'If our gynaecologist spends half a day answering your emails we don't get any funding for that so, no, we're still going to require you to refer them into us.' So remember that your funding tools are actually one of the barriers.

Mr WATTS: Sorry, just to clarify that: is that state funding for the specialist or federal funding? I am just trying to understand who is siloing which funding.

Dr Clements: It is activity based funding for the hospital—state funding. So if you have a gynaecologist who is answering emails, they are not generating activity and they are not generating rewards for the hospital. They might be preventing hospital referrals, but that is actually not generating any income for them. So there was no incentive for the hospital to commence a communication service with GPs financially.

Mr WATTS: But there would be for Queensland Health because potentially it saves the referral?

Dr Clements: Remember that the financial goals of the local hospital are very different to the financial goals of Queensland Health. If you continue to fund them based on activity, they will continue to protect their levels of activity.

Ms KING: Thank you so much, Dr Clements. I want to acknowledge the work that you have done to provide better health care closer to home for your community and communities right across this region, so thank you for that.

Dr Clements: Thank you.

Ms KING: Like my colleague the member for Lytton, I am interested in the takeover of rural general practice training by the college. We heard from JCU in other hearings that they are producing 60 per cent of the rural doctors here in Queensland at this time despite being a very small medical school and training organisation. What I am hearing from you—and I acknowledge that this was not your decision—is that the Commonwealth government, to create better flexibility across Australia, is intending to take that role away from them and locate it—where? Where is the college centrally based?

Dr Clements: Particularly in the age of COVID and telehealth, I am not sure that physical locations matter anymore. The training will be based here in Townsville. We have an office here in Townsville where we will be delivering it from. Just to clarify, when you say '60 per cent rural', what is the definition of 'rural'?

Ms KING: You would have to speak to them about it.

Dr Clements: I have read the stats. It is Townsville and Cairns. Certainly the Rural Doctors Association would not count—

Ms KING: They talked about doctors going all the way up to the cape and down as far as the Sunshine Coast.

Dr Clements: And we look forward to working with them to continue that.

Ms KING: It does concern me that to address a perceived lack of flexibility in other regions of Australia—the whole of Australia—GP training is proposed to be removed from an administration in this region when clearly it is delivering great outcomes for people in rural and regional areas as they are getting their healthcare providers trained in their region and they are going on to work in that region.

Dr Clements: And we look forward to building on that with them.

Ms KING: I also want to ask you a couple of questions about the fee-for-service model for GPs generally. One of the challenges we have heard from a number of submitters is the expectation that GPs are also businesspeople, that the funding model requires them to, in many cases, go and run a practice or try to get a salaried position in a practice, but that does not really often exist much. It seems to me—and I seek your comments on this—that, by providing a funding model that requires GPs to do all of that business administration work, that saves the Commonwealth significant amounts of money under the current funding model.

Dr Clements: Yes, certainly, but every town is going to need its own solution and I guess the private fee-for-service models suit towns like Townsville, Cairns and Mackay well in terms of I am able to charge a private fee for my service and provide a good one. The further out of the cities you move—so let us say Julia Creek or Karumba—those models just do not work. There are not enough patients to see. If, for example, I was trying to set up a fee-for-service clinic and I only accepted Medicare, I would need to pick a location where I can do a high volume of patients, I can move through patients very quickly and that is well supported by a big hospital nearby so that I can quickly do a referral instead of actually providing longer based care.

The federal government investing in primary care is the best bang for their buck. To be frank, investing in extra hospitals and extra positions is not where they are going to get their value for money, and that is what PricewaterhouseCoopers showed. We do not expect in general practice to see the Medicare rebates rise significantly. The freeze between 2015 and 2020 cost the average full-time GP

$105,000 a year. Over the time of the lack of indexation on Medicare, that is $1.5 billion removed from primary care over the same period whereas in federal spending on hospitals that has increased year on year. I certainly agree with you: fee for service is good value for money for the federal government, but every town is going to need a different solution.

Ms KING: Finally, there has been the Medicare rebate freeze since 2015. Since 2015, could you give us an estimate of what the costs of running a practice may have increased by, if they have increased?

Dr Clements: Yes, it is sad. Most general practices have either had to react to the Medicare freeze by seeing more patients per hour—and that is where you get the so-called six-minute medicine label—or they start charging privately. WorkCover is not a bad industry rate to look at—Queensland WorkCover rates. It is about $85, give or take, for a standard consultation. If Medicare was indexed to CPI from when it was first created, it would be $85 right now. We know that at the moment the Medicare rebate is $38, which falls short by $40. We know the average patient out-of-pocket cost over the last five years has increased from an average of about $21 or $22 per consult to $41 per consult, so it is just going to keep going up. I pay rental and that goes up every year. I pay staff and that goes up every year. One of the challenges that we have is the hospital does very well looking after its staff by giving them a pay rise every year and that is drawing doctors out of primary care. In the Mareeba-Tully-Mission Beach area you have a hospital full of staff—

CHAIR: No GPs.

Dr Clements: Yes, but no GPs. Remember, if you are a new GP and Queensland Health were offering you $300,000 to $400,000 a year as a salary Monday to Friday with some on-call work versus private general practice where you actually have to work pretty hard, you are creating the environment that we are already seeing on the ground. Mission Beach lost its last GP but there are plenty in Tully working for the hospital. Mareeba has a large number of doctors working out of the hospital—salaried GPs—who do not do any general practice work at all. Innisfail has had the closure of one of its practices but has a fully staffed hospital with rural generalists and GPs who just are not providing that community care.

CHAIR: In relation to the HHS that provided the data that there were 97 vacancies in the Cairns HHS—this might be difficult; you might have a view and we might have to write back to Danielle and see if we can get numbers for our region—we heard an example of a model of care put back on to the public health system, and it seems to be as the last resort, where a geriatrician and a nurse practitioner, I think was the example, were having to go to Eventide in Charters Towers because there was no GP available. In the western corridor we hear about the difficulty in retraining and recruiting GPs. Do you have an idea of the vacancies yourself in our region, and, Danielle, we might have to come back to you for some figures? What are your observations?

Dr Clements: It is a very wicked problem to describe. Remember that a hospital will look at vacancies normally in terms of covering their roster, so they will say that they have a seven-doctor vacancy if they are empty, for example, at Ingham because they have to cover a birthing roster with an anaesthetist and a GP obstetrician on call at all times plus run the ED. That is not a community need. The birthing is a community need, but it is not a service need. In general practice we can throw around numbers like one GP for every 500 to 1,000. One of the best ways of looking at it is about what is reasonable. Is it reasonable for Hughenden, Charters Towers and Ayr to have a lower number of GPs per thousand than Brisbane city? What should we be aiming for?

I represent the college on the distribution working group where we take applications from towns looking for DPA status saying that they are a priority. Almost everywhere says that they are a priority and that they are having trouble, but the data clearly shows that in terms of GPs per thousand or, more importantly, GP services per thousand population there is a very step-wise progressive decrease from the city areas out to rural. I would not like to give you a hard number because it would be wrong, because the other thing that is happening is our GP registrars are changing. Back when I was young it may have been that the average person entering GP training might be in their early 20s or late 20s. Now the average age of our GP registrars is early 30s. That is right at the age where they are thinking about children as a mum or a dad and thinking about settling down. The other thing that happens at that age is we start working less full-time hours and more part time, so I could tell you that we need 100 GPs but as soon as you get those 100 GPs many of them will cut down their hours and then you will actually need a lot more.

CHAIR: We are sort of running on time. Member for Mirani, do you have any questions for Dr Clements?

Mr ANDREW: Yes. Thank you, Dr Clements, for coming in and giving us some information today. I heard you talk about siloing. Do you have a different model to overcome that siloing effect? Obviously you were saying that even though the money is there it cannot be distributed properly because of the silos, so could you elaborate on that please?

Dr Clements: For example, one of the things that we have called for in the federal budget is that we get a longer rebate for every person who is discharged from hospital. Imagine if every time somebody was discharged after a long admission into Townsville Hospital they were funded for a long comprehensive consult with a GP and the nurse to be able to go through all of their medications, correct any errors and prevent any readmissions. That would certainly save the hospital money. We have pitched that to the federal government, but it does not really save them much money by funding us more.

Wouldn't it be great if the state hospital had a mechanism by which it could actually fund the general practice directly for every patient that it discharged and invested in general practice in a way that actually saved them readmissions? But at the moment every time we try and have those discussions with the state—with the hospital and health services—they come back and say, 'No, we don't fund general practice. That's not our primary goal.' That is a little bit ironic because if you do not fund us it is going to cost you anyway. If you do not fund us in aged care, it is going to cost you in ED presentations anyway. As soon as you get out to the rural and remote areas like Julia Creek and Cloncurry, you are funding primary care already. So we need a little bit of a culture change and we need a willingness to break down some of those silos.

CHAIR: We are a little bit over time. Thank you very much for your contribution, Dr Clements. We really appreciate you being here today.

Dr Clements: Thank you.

CAIRNS, Dr Will, Private capacity

CHAIR: Our next witness is Dr Will Cairns, who is very well known in the Townsville area for his work in the palliative care space and well known to the health committee as well. Thank you very much, Doctor. Welcome. Would you like to start with an opening statement before we move to questions?

Dr Cairns: Thank you for inviting me along today. I do not come wearing any particular hat, other than having had an invitation to come along. My background is that I retired from Queensland Health a couple of years ago as a palliative medicine specialist but I did spend the first half of my career working as a GP, so I have lived on both sides of the fence at various times and sometimes part of my career with one foot in either camp, if that is not mixing my metaphors a bit. I have always taken a fairly ecological view of complex systems like health care and I think that perhaps the thing I can contribute most is to think about the ecology of how the healthcare system works—the drivers and the challenges that are almost structural that I think really need to be addressed or we will go on having these kinds of committee meetings into the indefinite future.

I think the first one is the constitutional issue that money raising is a Commonwealth responsibility and the states are tasked with delivering health care. Although the Commonwealth is responsible for residential aged care, it is a very complex mix and we have already heard from both speakers this morning about some of the challenges that come with that. There has at various times been some discussion about one entity taking over responsibility for health care. I think it was Kevin Rudd who said it for about a week and then everyone said, 'Don't do it,' and I can see why politicians would be reluctant to have to take responsibility. So at the moment there is no real point of responsibility for health care and a lot of the time you see, irrespective of the party that is in power or the parties that are in power, that there is a lot of shifting of blame to the other, whoever it is, and I think that that is a real issue. In countries like New Zealand, which do not have a similar structure—and Michael alluded to New Zealand—there is one point of responsibility and the debate is between the government and the community, not between governments.

The second thing I think that has happened over the past 20 or 30 years particularly is our understanding of the complexity of human physiology and pathophysiology. What has come with that has been huge amounts of technological advances and complexity. So many of our patients now come not with just one disease, which our health system seems to be designed for—that is, fixing a problem—but people actually live with very complex interacting problems and see multiple different doctors and healthcare workers and their care is not well coordinated. That seems to me to be a primary-care healthcare responsibility, but it is not funded to be provided.

The third thing is we have been setting standards without thought to their affordability. The people who set standards now are the organisations that provide the care. They look at their best practice and then they write that down as being the norm. That then tends to get accepted as what we should be doing. No-one really talks about the question of whether that is affordable. I know when as a GP I would open a magazine that would come every month and there would be a new set of things that someone wrote down that I should be doing as best practice, but when I added up the amount of time that it would take to do all those things to all my patients according to what people wrote I realised that was totally impossible. I am sure that if we looked at things that we are supposed to do and added them up, it would be ridiculous.

Our community has learned and been educated to expect that they should have the treatments that have been invented most recently, many of which are very expensive. A lot of that has been driven by media that take up the latest technology as being a wonderful thing, but it is also partly funded by the people who market the technology as well.

We have not discussed resource allocation. I think it is pretty clear that, with an ageing population and all of the things I mentioned in the last few minutes, it is really not going to be easy to afford all the stuff that has been invented. We need to start thinking publicly, openly and candidly about what our community can afford.

Finally, as an introduction, I am very happy to talk about all aspects of the things I have mentioned before. The commodification of health care: health care is now seen in some quarters as a business opportunity, so is health care a business or a service? If you see it as one or the other you get a very different outcome and will have a very different approach. Michael talked about the financing of primary care. I think in the late 1990s there was a relative value study that was undertaken by the Commonwealth government. They liaised with doctors and they looked at trying to value procedural stuff with cognitive activities or procedural medicine with cognitive medicine because it

was felt that a cognitive practice like general practice or some physician-led practice—where most of the work is history taking, examination, talking to the patient and psychiatry—were undervalued compared to procedural stuff.

When I was a GP I had a patient who went off to see a specialist for a procedure. The procedure took about 15 minutes but the specialist felt they did not have the skills to talk to the patient and their family so the patient came back to see me with his family. We had a one-hour consultation, talking about the implications of the findings. For that I think I could bill $100 at the time and during that time the specialist, doing the number of procedures that they could do in that time, would earn $1,000. For the patient the test was important but the decision-making that followed it was more important, I felt. That was the kind of imbalance.

When the relative value study was completed, everyone agreed these values were really important and that the ranking of cognitive medicine should be advanced in comparison to procedural stuff. But the government said, 'Well, we're not going to increase the size of the pie; we're going to redistribute it,' at which point the proceduralists said, 'No, we're not.' And that was the end of that. I probably oversimplified the tale, but I think that is the gist of it.

These are a range of the complexities that exist in health care that make it really difficult to find answers that will change the way we do things. What I read and hear about the way that we are approaching the problems we have, they are more about reacting to the context in which it is being delivered than changing the context, which might change and achieve better outcomes.

Ms PEASE: Thank you very much for coming in, Dr Cairns. It is always great to see you. We value your great expertise and thank you for all of the work that you have done in the community in many areas. I am interested in your comments around how many of the responses are reactionary. Did you have any suggestions about what we could do differently?

Dr Cairns: I guess I have listed the kinds of problems that we face. The first thing would be a candid discussion about what we are trying to achieve with health care. Bringing into play my role as a palliative care doctor, accepting the normality of death is a really important part of health care. When I read the report of the aged-care royal commission and I did a search for 'dying and palliative care', there were very few mentions of it. They talked about care, but there was almost no discussion of the reality that actually all these patients were dying. The issue for me was that that should be integrated with the way we think of our lives. A lot of effort is put into high-tech medicine at the end of life and little into care at the end of life. That is not an argument not to provide resources to end-of-life care but they should reflect the realities of the stage of life that people are at.

Ms PEASE: You have referred to when you were practising. We have heard from a lot of GPs who are either going into training or are still operating as GPs. Part of the problem is that GPs see a patient and then need to refer them on for some allied health care. I know there is a package available but, as was discussed, they can only get five visits or 10 if they are First Nations people. Is it cost prohibitive for many of your patients potentially to be able to access possibly preventive health care that will stop them from having to go into hospital or have a chronic disease that might put further burden on the health system? Have you experienced that in your time as a GP?

Dr Cairns: My time as a GP ended in 2000. It has been 22 years since I did general practice. The first half was in general practice and the second half was in palliative medicine, with about 10 years of overlap in the middle.

Ms PEASE: Would you have seen palliative patients who would not have been able to afford access to that?

Dr Cairns: Palliative care has been fortunate in having dedicated funding for allied health. We have had a program where, when someone needed palliative care assessment for allied health, occupational therapy, physio in particular, dieticians and occasionally speech pathologists, we had people who were dedicated to that role and specialised.

Ms PEASE: Could you imagine then someone who did not have access to those services and being able to assist them before they became chronic in their disease?

Dr Cairns: Yes, I think a vital part of general practice is being able to optimise people's health care throughout and often that does mean allied health. Particularly for elderly people with developing disability or people with chronic disability, allied health is at the core of it. As Michael alluded to, we have this sort of compartment which is the NDIS and the compartment which is general practice. I have not had any patients who have been involved in the NDIS system, so I am not au fait with the system and how it works but I can appreciate that.

Ms PEASE: Where did you do your training?

Dr Cairns: I did it in London as undergraduate training. I came to Townsville after my intern year for 18 months and we never left. This is a nice place to live.

Ms PEASE: Have you come across or worked with many of the graduates or students at JCU?

Dr Cairns: Yes, many of them. Many of them have gone on to remain in regional areas. When the question was asked about JCU graduates, in the past they were working in rural areas. They may be either specialists or GPs or doctors working in rural and remote communities as true rural doctors rather than regional city doctors. In terms of their post-graduate training, after they finish at JCU—I think the article I read somewhere about graduates from JCU indicated that a very high proportion of them remain not in capital cities, but they may be working either in specialist or more generalist practice. I think the high proportion counts in both specialists and non. For example, I think a number of the haematologists in Townsville are JCU graduates and a growing number of the specialists working at Townsville Hospital are JCU graduates as well.

Ms PEASE: Do you have a position with regards to the college taking over the training of GPs?

Dr Cairns: Personally, no. I read that it had happened. I think in other fields of practice like medicine, surgery and so on, the colleges run it in terms of their expertise for the knowledge base that is required. For example, palliative medicine is run through the College of Physicians because specialist palliative medicine knowledge is part of that. We do accept as trainees general practitioners who bring a different kind of knowledge base and experience to the practice of palliative medicine, and it is suitable to the needs of our patients.

CHAIR: I want to ask a question on the palliative medicine side, which is something that you have specialised in. Members will recall that as part of our last inquiry into aged and palliative care we made some 77 recommendations. We were very pleased to see that additional $170 million allocated in the palliative care space. Getting back to the nub of why we are here, we are trying to see if we can reduce the burden of people in the hospital system. From your experience in the palliative medicine space, I want to draw you out a little bit on the home care packages, the level 4. We heard right around Queensland that people do not really want to go into hospital. They want to stay at home and be surrounded by their loved ones. They do not want to leave their community. What were your experiences in that space? Did you come across people waiting far too long to get home care packages to assist them at end of life?

Dr Cairns: For palliative care, again, we had separate funding so we were not so dependent on packages. For people who had long illnesses where their life expectancy was more than a month or two, it came to be a bit of a problem for funding because you were not funded for long-term care. Some people with motor neurone disease might live for a year or so and might need a package, so access to packages was a challenge for some of those patients.

In terms of people being able to stay at home, the really important things were nursing support from the community but, most of all, that they have a GP who is willing and able to do that. For palliative care in the community, specialist palliative care services cannot provide care for all the people with life-limiting illnesses in the community, even for the last three or four months of their lives, because it really requires that someone is able to come and go all the time. If it is distributed through the workforce, each GP does not really have to do too many patients over the course of a year.

I started off doing palliative medicine as a GP in the community. I found I had an increasing number of patients coming to me as their GP for palliative care. Then when I moved into the hospital I said that as the only palliative care practitioner in North Queensland I could not be the GP for everyone. We had a number of GPs who were willing to do it, but I think the culture of general practice has changed and not such a high proportion of GPs are comfortable doing that. That is partly driven by the corporatisation of medicine where you are looking at hourly cash flow. You would take off and see a patient for an hour when the rebate was not really sufficient to cover the costs compared to, say, a specialist doing the same tasks for the same amount of time; they were remunerated at a much higher rate. There have been disincentives for GPs doing home care and I think the same applies to residential aged care.

Certainly when we were looking at the response to COVID as part of the Palliative Care Australia response, we were thinking about who is going to look after these patients in residential aged care because many of them would choose not to be vaccinated or not to be sent to hospital with progressive disease. My mother died last year at 96 in the UK, not from COVID, but she had been locked up for 18 months. Early on in the lockdown time she said she and her friends were sitting around in the residential aged-care facility thinking, 'Oh, this might be the way that our lives end.' Given that they had a good acceptance of their own mortality, were quite at peace with their death

and did not really mind the idea of dying, for them it was seen as much more comfortable than some of the other ways that they could die. They were still concerned about who would be providing the care if they did not go to hospital because they did not really want to at all.

Coming back to the question of healthcare funding, one of the really important things for providing aged care is that the providers, the people who provide the services, assess the patients, are able to visit them in the place where they live, which is residential aged-care facilities, and be funded to provide the level of care that is often times about making good assessments so they can stay there rather than go to hospital. I know that, from the hospital's point of view, when many patients get terminal in hospital there is no-one to visit them or the doctor cannot come out for a period of time or there is no-one on call in the middle of the night or the weekend so they get shipped off to the ED and then they get plugged into the system.

One of my relatives in Townsville was in residential aged care. He had a stroke one night, was sent off to the hospital and arrived early in the morning, just as I was coming to work. They rang me up to say that he was in there. I zinged down to the ED department and had a quick talk to the doctor there. They said, 'Well, what do you want us to do?' The nursing home had not sent his paperwork, so they did not know what his goals were. They were about to plug him into the stroke assessment program. He was 95 or 96 at the time. I said, 'Actually, he doesn't want any of that stuff. Let's just keep him comfortable.' He was managed actually in the hospital and in the palliative care unit by another doctor—not me because I was a relative—and had a very peaceful death. The hospitals are very good at assessing goals of care but they need instruction. There was a bit of a failing on both sides but we were able to subvert that. Not everybody would have access to a palliative care doctor who knows the goals and wishes of the patient and could come down to the ED department.

Ms KING: Thank you, Dr Cairns, as always, for your really thoughtful contributions to these processes. I would like to ask for a little bit more information, a bit more of your reflections, on what end of life can be like worst-case scenario in terms of somebody who has a life-limiting condition and does not have good GP or community-based support for that? I have heard about people's revolving door admissions to hospital; people dying in a place that they do not choose; the way that a hospital can be the worst place for somebody in that circumstance when the person's goals are to die at home; and the cost of alternatively and against their wishes dying in hospital. Can you give us some more general reflections about those issues?

Dr Cairns: There are such a variety of ways that people can die and we do not get to choose what happens to us. I guess most of us say most of all we would like to 'wake up dead' in the morning—or not wake up in the morning, of course, that means! Leaving aside the physical symptoms of disease, so I will not talk about palliative care, pain management and all that kind of thing, but for people who are unable to look after themselves; people who find themselves in a place where they cannot control what they do; they are not understood by people who try to talk to them if they have had a stroke and are not able to communicate their wishes, their values and what is important to them; they are subjected to care that they regard as being undignified, so being in a room with a number of other people where they are not given personal interaction; where the people looking after them are overworked because there is inadequate staffing; where they require assistance with feeding and all aspects of care—I think many of us would feel that for us that would not be a quality of life that we would see as being sufficient or adequate.

Again, I refer back to my mother who I think would be very glad that she had a stroke at the end of her life, went unconscious and had good care. She was unconscious and she went into hospital because the residential aged care would not allow visitors because of COVID. This was in the UK and obviously this applies in Australia. In hospital they did allow visitors, so she was able to have friends and family with her when she died. There is the isolation, the lack of care.

One of the things in our community that has changed is that we do not have the family support. So many of us are spread across the globe or the country and sometimes it is a struggle for people to come to care for someone at the end of their life. With our modern technologies, people have so much life-prolonging stuff that they do not actually die from the first disease they catch; they often die from the accumulation of a number of ailments, each of which was treated medically very adequately but did not leave them in a place where they might assess their life as being of a quality that was acceptable to them.

Mr MOLHOEK: I do not think there are any other questions for you, Doctor. Thank you for appearing today. I certainly appreciated some of your candour, commentary and advice during previous hearings when we heard from you on voluntary assisted dying. Again today I appreciate your candour around some of the greater challenges that face the health system and, more importantly, patients in terms of their wishes.

Dr Cairns: Thank you. Can I just give a quote that I found in a book called *Deaths of Despair* by two economists from Princeton, one of whom is a Nobel Prize winner. It is a cautionary tale from the United States that reflects their health system, but you can see things here. The one-line quote that struck me when I read this book was—

Free market competition does not and cannot deliver socially acceptable health care.

CHAIR: An interesting read, but I did not quite finish it.

Dr Cairns: That is alright. I have read many books that I have got three-quarters of the way through and I know what the rest is going to be about and say, 'I can't go on.'

CHAIR: Thank you so much, Dr Cairns. I now call representatives from James Cook University.

JONES, Prof. Anne, Head, Physiotherapy, James Cook University

LARKINS, Prof. Sarah, Dean, College of Medicine and Dentistry, James Cook University

MURRAY, Prof. Richard, Deputy Vice-Chancellor, Division of Tropical Health and Medicine, James Cook University

CHAIR: Welcome to each of you. It is good to see you again. Would you like to start with an opening statement before we move to questions?

Prof. Murray: Thank you very much. I really appreciate this opportunity. My name is Richard Murray. I am the Deputy Vice-Chancellor of the Division of Tropical Health and Medicine at JCU. We offer a comprehensive range of programs of research, education and training, undergraduate and post-graduate, serving the communities of Northern Queensland, much of regional Queensland and beyond. We might speak a bit about that. My own personal background is as what these days we would probably call a rural generalist. I am a broadly trained remote GP with obstetric skills and, later, public health qualifications. The perspective I speak from is very much a multi-professional rural and remote health systems strengthening perspective. That is my role, really, these days. I will speak about that from a JCU perspective. That said, I should declare that I am also President of the Medical Deans Australia and New Zealand, which is the peak body of all the medical schools across the two countries—24 institutions and universities. I am also a member—and proud to be—of the Mackay Hospital and Health Service board and serve as the chair of the quality and safety committee and have a number of other roles. However, it is the JCU perspective that I will speak from.

Of course, Associate Professor Anne Jones is with me. We look forward to an opportunity to provide you with our broader perspective. She is a physiotherapist and the academic head of physiotherapy. Professor Sarah Larkins is the Dean of the College of Medicine and Dentistry, which looks after medicine, disciplines of medicine, dentistry, pharmacy and general practice. She might be able to provide any perspectives in those areas that might be of use to you.

By way of an opening statement, my colleague Dr Aileen Traves, in Cairns on Monday, gave a comprehensive overview of what it is that James Cook University does in service of the communities of this part of the world. I certainly will not reiterate that. I would like to try to make sure that we have as much time as possible to respond to questions from the committee. I might just reinforce the point—and I think we have heard a bit of it this morning: no workforce, no service. It is a necessary but not sufficient component of how we assure access to quality health care for people in this part of the world, or anywhere in the world really. You can have all of the funding and all of the buildings you like; if you have no people, you have no service. I think that is a fundamental point.

In that respect, I would underscore—and we have heard a bit about medicine this morning—that medicine is important but actually by far and away nursing and midwifery is the most important and certainly the largest and most critical workforce. There are some particular challenges around nursing and midwifery. You had an opportunity the other day with Caryn West, the head of nursing at JCU, to explore some of that. Of course, in terms of allied health there is dentistry, pharmacy, psychology and a range of professions and of course we provide education and training in all of those.

In terms of the 'no people, no service' argument, our emphasis—and the evidence backs it—is that educating and training people from, in, with and for the communities that most need those people is by far and away the most successful strategy to create a workforce. Yes, they need work that is fulfilling and appropriately rewarded with appropriate conditions. Yes, we need to arrange things so that effective care is delivered by teams and all that that entails with multidisciplinary teams, but the success factor is absolutely what we are really focused on doing 'in, from, with and for'. That is the secret really to JCU's success and, as I say, is backed by the evidence in this country and around the world.

The other thing I would emphasise is that we do have to find smarter ways of delivering health care with a focus on outcomes from a community and patient perspective—not outcomes from what we measure or pay, but from a patient perspective—and that brings in the research agenda. We have to find smarter ways of working and stronger healthcare systems. I entirely agree with my colleague Dr Cairns that these are complex systems and there are methodologies by which one can evaluate, plan and assess, and intervene in complex systems like health care. Research into strengthening healthcare systems, something my colleague Professor Larkins is very involved in, is a critical issue. For regional areas, the opportunity to be part of identifying, framing and solving problems from your

own perspective allows you to have tailored solutions and job satisfaction because you can combine often clinical care with scholarship, leadership, research and teaching. This makes for a well-rounded, satisfying career for retention.

Finally, I really emphasise the particular things we are looking for support for in this. We have heard a bit about general practice training reforms. I think that is all important and is a present issue. We would be happy to respond to any questions you might have around that.

The other item you touched on is that the federal government controls the number of places for medical training in this country. There has been a consensus for a time—really pre-COVID—that there were enough training positions in the country, notwithstanding the fact that each year we bring into the country just about as many as we graduate. Really, the opinion now is shifting that clearly we do not bring in enough and the regions having to be so reliant upon international medical labour, but actually also international nursing and dentistry labour, sells the regions short and ironically ultimately leads to oversupply of workforce in major cities, which drives up costs. We have to have a lot more emphasis on that and we are very keen to seek the support of the state government around our bid for additional places for what is Queensland's most successful medical program in producing doctors who go on to work in rural and remote regional locations whilst being Queensland's smallest public medical school. We would like to address that and provide an opportunity for more end-to-end training across Northern Queensland.

The final piece there is really the Queensland government seeing that the education and training of a future workforce—nurses, allied health professionals, doctors and others—is not a cost; it is an investment. If we are keen to provide that workforce in regional Queensland, we need to think about how we might better co-invest as a state government in the production in and for the communities of greatest need, rather than it being something that should not be on your balance sheet and you would like to be paid for by somebody else. I think we would be very keen to see that as a much more explicit desire and commitment in a much more whole-of-government approach perhaps to the production of a health workforce where and if it is needed. That will do from me, because I would really like to provide time and opportunity for you to ask us anything about what I have covered or not covered in that statement.

CHAIR: Thank you very much, Richard. I have to say—I said it in Cairns the other day—we have a very healthy regard for the commendable work that JCU does right across the spectrum. Last Saturday or the Saturday before in the *Townsville Bulletin* there was really good news on some rural training places. That really shines a light on the work that you do in the schools of nursing, dentistry, and pharmacy. I have visited just about everyone over there. There is some good research that is happening in that space. I want to provide the committee time to ask some questions. I am going to go to the deputy chair. Thank you for your submission around those training places as well.

Mr MOLHOEK: Good to see you again, Richard and Sarah. Thank you for your submission. Of all the submissions we have received it is the one I probably spent the most time poring over. By way of declaring an interest, my son is a rural generalist in Emerald, but a graduate of Griffith and not James Cook, so I am a huge fan of the program. In your submission you talk about the pipeline of willing graduates interested in pursuing careers in rural and regional health. I would be interested to hear your thoughts on how we could double, treble or quadruple that pipeline and how we overcome some of the challenges around that. Is it simply allocation of places or is it also the fact that there is a trend towards wanting to live in more urbanised areas?

Prof. Murray: I really like to approach these things from what is working, what are the strengths and how we can build upon them. One of the problems, I think, for rural, regional and remote areas is that it is often characterised in negative terms leading people to be pessimistic and gloomy about the prospects for change. I think our lived experience and the data shows that if you approach health professional education and training—as I have described—from, in, with and for then, in fact, you have fantastic results and it really gives the lie to, 'Oh yes, but generation X', et cetera, because in fact we have got fabulous young folk, young colleagues, in all health professions who are willingly and deliberately making for themselves lives in small rural towns, middle-sized towns and regional centres and are getting great satisfaction and enjoyment out of that. I am pleased to hear that is not a surprise to you and Emerald is a fabulous example of the payoff to a town of investing in its future.

There are some specific things though, and perhaps they are most extreme in medicine. Medicine has a phase that involves medical school of four to six years in duration, usually sometimes with a prior degree, followed by a period of what is called junior doctor training or internship. Beyond that it is often not terribly structured or well supported and is not linked in necessarily to any further or subsequent training. It is a bit of a no-man's land. It is a discontinuity. That is a workforce that is

very much relied upon by state public hospitals to cover rosters and provide services and so on. That is then followed by training in one or other accredited specialties. There are around 70 accredited specialties with about five more queued up to be recognised. There are many choices.

One of the challenges, I think, and really the basis for trying to have a joined-up pipeline of willing graduates pursuing rural, regional and remote careers, is connecting the pieces. These discontinuities are of our making. In fact, JCU's work in the medical field in recent times has been to really drive—including advocating at the national level, but particularly putting into practice in Queensland—joined up and connected education pathways that pick those three phases up and result in good outcomes. It means, for instance, that about half of JCU medical graduates pursue careers in general practice or rural general medicine. That is enormously different to the experience of the rest of the country and it suggests that we are doing something right in the way in which we are approaching that. The fact is that we are also uniquely the only university also delivering the general practice training piece across 90 per cent of Queensland and are able to show data on the difference that that makes, including what it looks like if you get a double dose of JCU, as a JCU graduate and then subsequently as a JCU trainee in general practice and rural medicine, in terms of where you end up and what you do. We have data on that too.

The short answer is that it works and we are very keen to see that continuity continue. We see an opportunity in that regard for the rest of the country to study and consider what might be able to be applied in terms of a joined-up approach to better serve regional areas. I would have to say though that this is just as important in nursing and the transition into staff nursing jobs as a new graduate and then on into further support training, be it into hospital or community practice; and how we retain nursing graduates rather than see them lost to nursing, which is what typically happens for too many who do not have support and transition into nursing careers. Certainly that is true too in terms of allied health and other areas. The particular piece in medicine, of course, the primary qualification, really is a halfway qualification medical degree. Really, you do not come out at the other end until you obtain your formal training and fellowship, so-called, in one or other specialty.

Mr MOLHOEK: In terms of places to do the programs through JCU, is the issue that there are not enough funded places for graduates and students or not enough pathways for them once they do graduate to actually gain the experience they need or is it just not enough people interested in taking up places at JCU? How do we get more students to JCU; that is really the question?

Prof. Larkins: We have a huge demand for our courses. In Queensland there are equal proportions of Commonwealth supported places. The issue is that 80 per cent of those Commonwealth supported places in Queensland are in the south-east corner. This is the problem. There is very good evidence that where people train is where they will end up.

Mr MOLHOEK: How is that allocated? Who decides it?

Prof. Larkins: That is the federal government.

Mr MOLHOEK: It is a formula that the federal government rolls out?

Prof. Larkins: Yes. Hence our desire to gain more Commonwealth supported places for Cairns and Mackay specifically—and I believe you have heard about those specific areas as areas of shortage—so we can deliver end-to-end medical training in a distributed model where those students will also spend time in smaller rural and remote places and in multidisciplinary training hubs, joined up with their physiotherapy colleagues and their nursing colleagues and other discipline colleagues and thus role modelling and learning about rural and remote practice and increasing their chances of practising in those areas.

Mr MOLHOEK: Are they actually university places at your university or are they funded traineeships beyond graduating from uni?

Prof. Larkins: What I am talking about there are Commonwealth supported places for studying undergraduate medicine. As Richard was saying, that then needs to be connected to the junior doctor piece in the hospitals so we do not lose them during that placement but keep them connected to rural generalist careers and other generalist specialist pathways that serve the regions—so a whole lot of pathways that we link them to—and then through into general practice training. At the moment we have got that pipeline well lined up and we are working very hard to keep that going.

Mr MOLHOEK: It is actually the pathway that is the challenge. You could take an extra 30 medical students, but you may not be able to provide them with opportunity beyond that?

Prof. Larkins: We are confident we can provide a whole pathway. There is plenty of room in the system. As I think you have heard as you get around the place, we have got a really wide network of willing practitioners who are our partners in delivering the programs, both undergraduate and postgraduate. People in practice—Steve Salleras is a good example—supervise medical students and also GP registrars. These people are really important partners in delivering our program.

Mr MOLHOEK: Perhaps this is a question on notice: it would be interesting to see a diagram or some further information on how the pathways work and how the places are allocated at each step on that journey, just to understand the process.

CHAIR: Could that be taken on notice? If you could you write to the committee to detail some of that, that would be good. We need it back by 14 February.

Ms KING: Thank you all for being here, Professor Jones, Professor Larkins and Professor Murray. I asked one of our previous submitters, Dr Clements, some questions about the GP training program as currently provided by you through JCU in this region. You have talked very extensively about the importance of that joined-up pathway to create the pipeline of willing and motivated graduates who can then be supported through the hospital junior doctor stage and then into the postgraduate training to qualify and stay in I the region. What threats do you see to that on the horizon right now?

Prof. Murray: As it was initially framed, the difficulty is that we would potentially go back to a general practice training model based in one—

Ms KING: am sorry, I will stop you for a moment. Can I just ask you to describe what is happening at the moment and then let us know what the implications of that will be, just so the record is complete?

Prof. Murray: Sure. Seven years ago JCU responded to a tender to deliver general practice training across 90 per cent of Queensland—really all of Queensland minus the south-east corner. We did so and really sold and had implemented a model of highly distributed, locally based and embedded training across a very large network. We have 14 local points of presence in towns and communities where general practice training is delivered. In about half of those we also fully integrate the medical student and other health professional student education and training in small rural towns and communities—in larger settings such as Mackay, for instance, and smaller settings like Mount Isa, Atherton, Roma, the Wide Bay and beyond Rockhampton. It is bringing people together and having that critical mass, including the multiprofessional focus.

Ms KING: What is being proposed now?

Prof. Murray: What is being planned now is that the funds that go into general practice training, rather than being commissioned by the federal government through a series of regional providers—JCU is one of them—would instead go to the two colleges to directly deliver their program, that is, the Australian College of Rural and Remote Medicine and the large college, the Royal Australian College of General Practitioners. The risks, I guess, to the successful model we have provided is that we would see general practice training become once more siloed, located in a few large centres, losing the connection and connectivity across the training pipeline that we had spoken of earlier and losing its embeddedness, really, in a multiprofessional environment, and that would be the loss. The situation, however, is that the federal minister and the department have now let a tender for the two colleges to respond to that opportunity and in regional Queensland there is an expectation in that process that JCU will be part of the delivery partner in that regard. That is a live process at the moment. We are yet to see how that is going to play out. We would certainly hope that the colleges, the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine, would see the value in partnering to deliver and deploy a training model that is embedded in local communities across regional Queensland.

Ms KING: So then if it ain't broke don't try to fix it?

Prof. Larkins: The other thing that I think is important is that this inquiry is about primary care. We are thinking about the broad range of primary care which might be delivered by private general practitioners. It might be delivered by rural generalists. It might be delivered by salaried doctors in community controlled health organisations. It is also delivered by our allied health colleagues. It is a team based event and needs to be viewed as such in considering the training. I think that is the other part of the puzzle that is at risk if we go down a very narrow model. I think it is important that we maintain that.

Ms KING: That just provides training for GPs as opposed to training nurses and allied health professionals and rural generalists and so forth.

Prof. Larkins: We need to be training primary care doctors who can fulfil all of those roles. They are general practitioners. They are doing those roles but they are doing all of those other roles as well. They are all important parts of the system.

Mr WATTS: We are talking about the supply side here of medical practitioners whether it be nurses, allied health, dentists or doctors. Obviously there is a symbiotic relationship between Queensland Health and an educator because you need people to go on placements to be able to get the experience and the practice as well as have the training in situ. I am interested in understanding

in provincial towns particularly, in regional and remote areas, what role accommodation might play. When a student is at university and they get a placement, how long do they get placed somewhere? How does that impact on them making the choice to have that regional and remote experience simply because they have a lease to pay? Is there an opportunity for the Queensland government to fill some of that accommodation void near its facilities? Obviously the Queensland government wants the students and we would like them to stay. Could you expand on that or explore that a little bit for me?

Prof. Murray: That is a really important insight, isn't it? If we do want people to train in, with and for communities—and you cannot assume they are living at home necessarily with family as you would if you were in the south-east corner potentially—then providing on-site accommodation in small towns, often in small hospitals, is necessary. There is support from the federal government through the Rural Health Multidisciplinary Training Program that funds rural clinical schools and university departments of rural health, but I would say that that cannot do all the lifting.

What has happened over maybe a 20-year period is that Queensland Health, along with other state and territory government health departments, have tended to extract themselves from the business of providing accommodation on site such as student quarters and so on. Mostly we have seen a loss of stock that is available. That said, we have some fabulous local partnerships with our hospital and health services in different areas where we have been able to secure and co-invest in accommodation, but it is a rate-limiting set. It is particularly rate limiting for allied health and nursing students.

I think we will often see quite significant inequities in access to supported accommodation for a nursing student who might be undertaking a placement in a town where that town may well benefit from that person's employment the following year but these students may find that they are looking to stay in a caravan park and what is more they also have to forgo their part-time job back in town that they are using to sustain themselves. Greater support for those practical requirements of students on placement in small towns I think is a critical issue, and you are quite right to highlight it. Associate Professor Anne Jones from an allied health perspective would be able to provide some detail too.

Prof. Jones: Thank you to JCU and to the committee for allowing me to speak. I feel a bit scared. I am the head of physiotherapy. I am also the head of the Allied Health Rural Generalist Program. I can talk across allied health but obviously specifically I can focus on physiotherapy. From a James Cook University point of view, from an allied health point of view in our undergraduate degree, we do in physiotherapy require our students to undertake a rural placement. When I say 'rural' I am not talking about Cairns or Townsville. They do not count as rural.

Students do five-week placements. This is on a national timetable so that everybody starts and finishes their placements at the same time. In rural locations most of our placements are undertaken in Queensland Health facilities mainly because of funding models. Private practitioners cannot charge a patient for a student seeing that patient if the student is doing the whole assessment and treatment, if they are under Medicare, if they are under DVA and if they are under workers compensation or third-party insurance. The only funding model that allows them to have a student treat them from start to finish is NDIS. That funding is supposed to be at a reduced rate. Private clinicians financially struggle to take students. Queensland Health have been very good with regard to placements but, yes, accommodation is the big issue. For example, we get placement offers for physiotherapy that go through a central allocation process in Queensland Health. We have placement opportunities in Ingham. There is no accommodation in Ingham.

Students, yes, are basically working while they are undertaking undergraduate degrees because of the costs associated with paying for their courses. The fact of the matter is that they are all going to come out, even with a Commonwealth supported place, with a HECS debt. When they go rurally, they do not get refunded or bonded to go back to a rural location. There is no recompense which happens in other disciplines. I have students who undertake rural placements—they may be five-week placements—who may be paying $3,000 for accommodation. That does not include their travel. If they happen to fly, for example, to Weipa, they have to drive from here to Cairns or fly to Cairns and fly from Cairns to Weipa. Allied health gets second choice with regard to accommodation.

Mr WATTS: That was very carefully worded.

Prof. Jones: Whilst there is accommodation in some rural locations which JCU, in my opinion, has funded—I could be wrong about that—there is not enough accommodation. For example, there is a program that is locally run which was supported through the rural clinical school at Mount Isa but it is run in Weipa. It is a great lifestyle program and it is a wellness program and it is developed for that community. Physiotherapy cannot be involved because there is (1) no supervision and (2) no accommodation. Whilst we would love to place students there, we cannot. The only placements that physiotherapy can do in Weipa are through Queensland Health.

With regard to Queensland Health placements, as has been said previously, in a lot of rural locations there is only one health professional. Be it, for example, in Ayr, a physiotherapist there has left or gone on maternity leave. We have just had our placement cancelled for a student who has been allocated to Ayr because there is no-one there to support them. A lot of our rural placements, whilst we do our best and we have lots of providers—we have been very lucky. For example, the UDRH at Mount Isa has developed a multiprofessional, interdisciplinary rehabilitation service out there that is student led. It works brilliantly. We provide placements there across our allied health disciplines for a continuous service that basically runs 48 weeks, if not more, a year.

Mr WATTS: I am trying to distil it down. The issues are: is there a training provider available to supervise? Is there accommodation? Then there is the expense of them taking that placement. It seems almost a self-fulfilling prophecy. If there is no service provider there to provide the training then nobody is going there to experience the potential lifestyle.

Prof. Jones: Yes.

Ms KING: Professor Jones, thank you for your contribution. You did not need to be nervous. Your expertise and passion absolutely flew off you as you spoke. I wanted to pick up on a thread of something you stated about the lack of cost centres for provision of services by students. Is it your view that there needs to be a scope of practice adjustment so that students can provide valuable services by fully trained and almost qualified students in a way that can be remunerated to the practice that is supervising them? If you think there is a different solution, feel free to tell me what that might be.

Prof. Jones: It depends on where you are and what sort of service you are providing. For example, we have a student-led musculoskeletal physiotherapy clinic at James Cook University in Townsville. We employ two clinical educators and we have 10 students go through at a time. We charge $15 per student service. If you are in a Queensland Health facility then, yes, the student can be providing the service for patients within that facility, be it inpatients or outpatients. If you are in a private practice, it comes back to it being a business. Therefore, it is very difficult to have a business model where you can take students unless you are charging the university on top of that for students.

That occurs not only in private practice but also in the private health system. For example, Queensland Health charges roughly about $105 to $110 for physiotherapy placements per week. If we are talking about a private provider, they are charging about $10 per hour per student per placement. The reality is that a placement in Queensland Health would cost me about $550. If I go to a private provider, it is costing me over $2,000.

CHAIR: Richard, did you have some closing remarks?

Prof. Murray: No. I think that point in relation to funding models—that it would support provision of service by students absolutely—is particularly acute in rural and regional areas because we need to have that teaching health system, not just a teaching public health system. This would be an area in which I think Commonwealth and state governments could fruitfully work to think about how student delivered and supervised services might be able to be financially supported in such a way that it is a win-win—patients get access to better care, there is a workforce being invested in and services are provided. It is, I think, a really attractive proposition and I think something that could well be taken up.

Prof. Jones: May I briefly add something about that particular approach. The Allied Health Rural Generalist Program came about through Queensland Health. Queensland Health, the Allied Health Professions' Office, came up with the allied health education pathway and then put out to tender—which JCU won—to develop the Allied Health Rural Generalist Program. There are two levels. There is a level 1. It is a two-year program for new graduates and the second year is out. Then there is a graduate diploma level.

Queensland Health funds positions for rural training for specific positions for that training process. The federal government is now supporting 90 funded positions over three years through the non-government organisations. The problem that we have is that we are talking allied health. What is allied health? I can talk about it. Mainly when we say 'allied health' we are talking about physiotherapy, occupational therapy and speech pathology because they are the biggest ones. The rural generalist program not only covers those disciplines but also social work, psychology, dietetics, pharmacy, podiatry and medical imaging. That is only nine. It is excluding other things such as exercise physiology, which we are hoping now to bring into the program.

There is a huge range of allied health services that do not even have that sort of training pathway to go down. We are a heck of a long way behind what medicine have. Medicine funding is a heck of a lot more than ours. Obviously I am very passionate about allied health. I think the disparity

about what happens for allied health across both state and federal governments seriously needs to be looked at, but I recognise that it is a huge issue. When we keep talking about it in terms of allied health, we are also missing the point. It is different for different disciplines. Physio does five-week placements; occupational therapy can do 14-week placements.

CHAIR: This is a good opportunity to summarise the contribution, particularly in the allied health space. The member for Pumicestone will remember in the Bribie Island hearing the passion for the physios. You talk about preventive care. Perhaps if a person in a residential aged-care facility is not getting physio, occupational therapy and speech therapy following a stroke, the result is that the person declines and ends up in the public health system.

Prof. Jones: It is like that, yes.

CHAIR: Some of the submitters have identified PHN funding to deliver models of care. We heard from the South West group that had funding for a couple of years and were able to deliver services. They were really emotional when that funding was withdrawn and all of those people then went back to the public health system, which is at the core of what we are trying to prevent right now with this inquiry. Thank you so much for your passion. Thank you for your contribution. We are hearing so much more about the allied health space. It certainly is part of the inquiry. We are out of time, although I think we could keep going for hours. Thank you to James Cook University. You do commendable work. Thank you for your contribution today.

GILLESPIE, Mr Kevin, Director, Healthlink Family Medical Centre

CHAIR: Kevin, it is good to have you here. Healthlink has been around for a very long time.

Mr Gillespie: We have.

CHAIR: I will get you to start with a little of the history of how long you have been established and how many GPs you have.

Mr Gillespie: Thank you. I am Kevin Gillespie. I am the owner and operator of Healthlink Family Medical Centre and also the Northern Beaches GP Superclinic in Deeragun. Between those two centres—I will say 'employ', but they are not employed—a year ago we were employing 23 GPs. As of today, we have only 15 GPs. I will talk a bit more about why in a moment, but that is a drop in workforce of eight GPs which is a crisis, really, for us.

The superclinic has been operating for seven years and Healthlink has been open for 30 years; I have operated it for 20 of those years. My background is in business. The medical centres are businesses. We employ receptionists and nurses and provide computer systems, and the doctors treat the patients. The doctors are paid by Medicare if the patients are bulk-billed, although some of the doctors have now started to privately bill to try to make ends meet because of the fact that the Medicare rebate has not kept up with inflation. Probably a year ago we would have been bulk-billing 100 per cent of our patients; it is now probably 80 per cent. A year ago the waiting time to see a doctor was often the same day—certainly for emergencies; now it can be up to two weeks before a patient can get an appointment, and that is purely because of the lack of GPs.

The reason the GPs have left us is because they have generally left Townsville, often to move to capital cities. In some cases it has been because of retirement and in some cases illness, but the large majority have left Townsville entirely. They come from all sorts of places. Probably three-quarters are international medical graduates in our medical centres and, frankly, without our international medical graduates, even now, our medical centres would not be operating at all.

The federal government controls entirely the number and remuneration of GPs, and the university the trainers and the graduates, and the RACGP sets the standards and the exams for training. The problem for us basically—and we are not alone in this—is that there are not enough registrars trained currently by the university to replace the international medical graduates who we can no longer recruit. The number of GPs in Australia is not sufficient for us to recruit them to Townsville to replace the doctors leaving. It is basically one-way traffic. They leave Townsville to go to Brisbane, New South Wales, Melbourne—all over Australia, really. Some even return to their home country, which could be the UK or it could be anywhere, and we cannot attract them to Townsville. There are a number of ways of trying to do that and it is usually through commercial recruitment agents that specialise in medical recruitment. There are many of them. I have engaged 20 or more over the past five years and currently they are all basically saying the same thing: there are not GPs willing to relocate to Townsville. Recruitment agencies are basically now becoming locum placement agencies. There has been a 'locumisation' of general practice in particular because of the ability to earn more money, because GPs—and good on them—can name their price basically at the moment because it is an economics supply-and-demand issue.

The final problem for us, which is the major problem, is that the government policy currently nearly completely does not allow recruitment of international medical graduates to Townsville; that pipeline for us is cut off. The federal government is reviewing that at the moment because they have realised—and as is always the case there is a wave to this—that they have gone a bit too far in their restriction. The idea behind that was that it is a distribution of GPs, a distribution of workforce policy, where they tried to push more GPs out into more rural and remote areas. However, that put the squeeze on areas like Townsville that are regional and not as appealing as a CBD. However, because we then have not been able to recruit from overseas to Townsville, our workforce has just about caved in over the past 12 months. I am trying to speak to the federal health minister about this. I have written to them many times and their response to me is generally, 'You have enough GPs in Townsville', but that is not our experience.

The consequences of that for the state government is that if a patient cannot see a GP then he is more likely to go to the ED. I do not know the statistics about that but I do know that we cannot treat urgent cases. We cannot treat people with chronic diseases whose illnesses then deteriorate, and that type of thing is going to put pressure on the hospital system. That is our situation. The federal government could quite easily resolve it by restoring the distribution priority area status to Townsville. It is the stroke of a pen. They cut it with the stroke of a pen; they can restore it with the stroke of a pen. It is purely a Department of Health decision.

Another reason—it is probably well documented—that there is a lack of registrars who are interested in general practice is the inadequate remuneration and the pressure on them in terms of workload. I am concerned for our GPs who are remaining that they will suffer burnout. There are the same number of patients trying to see a much smaller pool of GPs. In the end we have to say to patients, 'Sorry, unless you are an absolute urgent case we cannot treat you and in some cases even if you are urgent you are going to have to rely on the hospital system.'

CHAIR: Thank you very much, Kevin. That was well articulated.

Mr MOLHOEK: You just said that it would be helpful to restore the DPA status of Townsville. What does that actually mean? Does it mean the Medicare rebate goes up? What does it mean in dollar terms for GP practices?

Mr Gillespie: It means a number of things. It means, first of all, that in order to practice medicine as a GP and to be paid for it you need a provider number from Medicare. To get a provider number you have to be registered with Ahpra and you have to be approved by the Department of Health. Australian graduates and GP registrars who are trained through JCU-GP automatically have a provider number from Medicare. There is no problem for a registrar. An international medical graduate cannot get a provider number unless they work in a DPA. They literally cannot work in that area.

The reason for setting out DPA areas is to push the distribution of IMGs in particular to areas where there is a workforce shortage. There are also some incentives to work in a DPA in terms of financial incentives as well. There is a higher Medicare rebate, which is actually more based on the modified Monash model of the area, so that depends on the town size. Townsville is MM2 and so there is a certain level of rebate for Townsville. Then in more remote areas there are other incentives paid by the government. They call them rural retention payments and other payments that are made by the government to encourage people to move to smaller towns. The modified Monash model is all based on the size of a town.

Mr WATTS: Is that schedule fee available in terms of those different levels of payment?

Mr Gillespie: Yes, it is in the MBS. The Medicare Benefits Schedule is online, so everyone has access to that, as is the DPA locations and the MM locations. They are all online via the Department of Health.

CHAIR: I will get the secretariat to provide the committee with that.

Ms KING: Interestingly, hearing your remarks I could have been listening to a practice manager in my own community. I represent Pumicestone, which is Bribie Island and into Caboolture. These exact stories are told to me on a weekly basis by my local medical professionals and practice managers. I want to compare those situations. I know that DPA only started in 2019, but prior to the new system of distribution priority areas coming in in 2019, did you have that ability to recruit internationally trained doctors?

Mr Gillespie: The DPA system replaced what was called the DWS system, the District of Workforce Shortage. DPA is almost entirely the same as the old system. It is not really new; it was just a rebranding and a little bit of a boundary redistribution, so it has not changed anything. The one thing that did change in the past year was that international medical graduates, unless they work in a DPA, have to be a temporary resident of Australia. We can replace doctors under the DPA system, but we cannot recruit new ones. The temporary resident visa required by a GP requires the Department of Immigration to issue a Health Workforce Certificate. They will no longer issue them for Townsville so that basically is the reason why we have been completely cut off. Also, again purely by a ministerial decision, it can change tomorrow if the minister wants it to.

Ms KING: I note that federal Labor recently made a commitment around restoring that distribution priority area status for a range of areas. To clarify, the number of GPs you had employed at your practice has gone down from 23 to 15. Has that been since you effectively lost your DPA status?

Mr Gillespie: No, it has actually been since the Health Workforce Certificate changed. Prior to that, we could still replace doctors who were originally recruited under a DPA. Townsville was a DPA seven years ago—or DWS as it was then—so we were able to recruit up to that number seven years ago. Over those years, as doctors have left, we have been able to replace them.

Ms KING: So you have held that number of positions even though you lost District of Workforce Shortage status, is that what I am to understand?

Mr Gillespie: Yes:

Ms KING: You had a set number of positions?

Mr Gillespie: Yes, exactly.

Ms KING: Then it was the introduction of the Health Workforce Certificate that was the real issue?

Mr Gillespie: Yes. With those replacements, you are only allowed 12 months by the Department of Health. If you do not replace them within 12 months, you lose that opportunity to replace them so that can cause attrition as well. It used to be that it would take about six months to recruit a new GP. Now it is 12 months or longer. The reasons for that are basically that the processes, which include pre-employment interview for the doctor to make sure they meet a certain standard which is good; Ahpra registration to make sure their qualifications are acceptable, which is good; immigration visa requirements are taking a lot longer now; and Medicare provider number registration is taking a lot longer now. So instead of six months, it is now 12 months or more. The absence of immigration due to COVID has also caused an extension of that time frame as well.

Ms KING: Let me clarify: if you find an internationally trained GP to work in your practice, the bureaucratic processes from the federal government will take 12 months—

Mr Gillespie: At least.

Ms KING:—to get that person on the ground and delivering care in one of your practices?

Mr Gillespie: Yes. In terms of workforce, a doctor might give us one month notice. We ask for three months notice, but the reality is they will often give you one month notice. We lose a GP in one month and 12 months later we replace them, so there is always an absence. To a certain extent, you have to have enough GPs so that you can manage that gap.

Ms KING: And the blade is at your throat that if you do not get it done quickly enough you will actually lose the ability to re-employ anybody at all?

Mr Gillespie: Yes.

Ms KING: That clearly has happened in the trajectory that you describe?

Mr Gillespie: Yes. It has been unusual in the past 12 months to lose that many GPs. I tend to try and have a pipeline because I know that two or three are going to move on every year, but eight leaving in 12 months is unusual. We would manage that, except that those time frames for recruitment and replacement having extended and the potential, as you say, loss of the ability to replace them at all is really putting pressure on us.

Ms KING: You used a phrase that I thought was very interesting and I have not heard before—'the locumisation of general practice'. In my own community, we lost whole GP practices where providing locums to fill those positions was the last resort and then finally even that became unavailable. Can you tell me what the impact on your business is financially if you need to employ a locum?

Mr Gillespie: Absolutely. We have employed locums in the past to try and fill those sorts of gaps that I have mentioned. Because of the short supply of GPs, locums require you to pay the flight to the town, they require you to pay their accommodation, they require you to pay for a vehicle and they require a higher proportion of earnings than a permanent GP because practices need them. Practices are almost relying on locums to staff their practice. The other problem with locums is the actual term—one to three months. The locum will come, they will treat the patients who would not otherwise be seen, then all of the tests that they order that come back—if they are not there after three months, those tests have to be reviewed and picked up by another GP. Continuity of care that is expected from a GP is just completely absent with a locum.

We decided a few years ago, because of that, to stop employing locums. We suffer a cash loss in the practice from employing a locum because the cost of providing the facility service to the locum is more than what the GP pays the practice. That loss-making, and added to the absence of continuity of care—even though it is a bit ironic because at least some patients will be seen, but it will really only be in an emergency or acute capacity. It became a medical liability in as much as tests would be ordered and the locum would leave and it would be, to excuse the colloquialism, a nightmare to try to make sure that all the tests ordered were followed up and the patients were properly treated. We decided it just was not worth it for all those reasons—cost, medical liability and the absence of continuity of care.

Mr WATTS: My interest is with the international students and the situation there. They have come to Australia and they have done their training here; they have spent probably six or more years living in Australia. It seems almost incomprehensible that we would not then be trying to encourage them to stay in Australia whilst we have a shortage. I understand the federal government's motivation

in trying to send them out into regional areas. Are you aware whether we are losing them completely in terms of them going to the UK or going to Abu Dhabi or somewhere else once they have got their qualifications?

Mr Gillespie: The international medical graduates all arrive in Australia with a medical degree, so they are not trained at the university. Up until the past 12 months, what they had to do in Australia was pass the GP fellowship exam, so they are effectively GP registrars without government support in Australia. In respect to a GP registrar, it generally takes about two years to pass the GP fellowship exams to be a fully qualified GP. An international medical graduate, because it is basically self-study unsupported, until the past 12 months, takes four or five years to pass those fellowship exams. They are already a doctor when they come here with an MD.

Mr WATTS: I misunderstood then. This is not someone who has come to, let us say, JCU to study a medical degree?

Mr Gillespie: No.

Mr WATTS: It is someone who is already a medical graduate and they have come here to do their internship, for want of a better word.

Mr Gillespie: Yes, effectively.

Mr WATTS: What happens to the international students who go through the program at JCU?

Mr Gillespie: I cannot answer that. It would be a question for them. I presume that they follow the same pathway as any undergraduate at JCU: they study medicine for five or six years, do a hospital intern year and then decide on a specialty. We do not employ them directly. If it was a JCU graduate, we would employ them through the JCU GP registrar program.

To answer your question as to what happens to, say, those international medical graduates who then pass their GP fellowship exams, mostly they stay in Australia. Mostly they have come to Australia because they want to live in Australia; they like the Australian lifestyle. The problem for Townsville is we can recruit them to Townsville and we generally retain them while they are studying to qualify for their exams, but as soon as they have the GP qualification that allows them to be a permanent resident and then 90 per cent of them want to live in a capital city.

Ms PEASE: With regards to that training, is it fee-for-service so that the overseas doctors have to pay for that training themselves?

Mr Gillespie: Yes, they do. They have to pay for any courses that they undertake, unlike a GP registrar, and then they have to pay to take a fellowship exam. The cost is usually tax deductible, but the cost is tens of thousands of dollars. In the meantime, they are a temporary resident without access to Medicare. I personally find it shocking that the government would employ a doctor and say, 'But you can't be covered by Medicare,' but that is a personal issue. Effectively they cannot very easily move because they are sponsored by the medical centre. It is possible to move, but usually they do not want to leave our medical centre, they want to work with us; it is just we cannot retain them in Townsville often. My personal recruitment policy is to try to employ doctors with children who want to go to school and they are here for four or five years and the children like school and they like Townsville and they like the outdoor activities. Once you spend four or five years here, if you like this kind of tropical climate, you will stay. The people who leave tend to be the young singles or couples who want to live in a CBD.

Mr ANDREW: I was wondering if you run a private practice, Mr Gillespie.

CHAIR: It is a private practice.

Mr Gillespie: Is that the question? Yes, all general practices are private except for the Aboriginal and Torres Strait Islander health services. The way they are structured is the GPs are all independent practitioners, they are paid by Medicare and the GP pays a facility a fee for providing the medical centre.

Mr ANDREW: There have been a lot of people asking about staff shortages during the mandates. Are you seeing that in Townsville?

Mr Gillespie: I did not quite hear. I heard 'staff'.

CHAIR: I will probably rule it out of order. He is talking about the mandates. It is not relevant to the inquiry. I have ruled on this in previous hearings. I will allow some latitude if you want to answer it.

Mr Gillespie: Sorry, I do not understand the question.

CHAIR: Member for Mirani, we will adjourn unless you have a question, member for Lytton?

Ms PEASE: I wanted to ask about patient numbers. I know that you talked about losing a number of doctors. Have you seen an increase in your patients or is foot traffic diminishing and they are going to the public health system as we have heard?

Mr Gillespie: It is a good question. Each GP would see about 30 patients per day which is 150 patients per week on average or 7,500 patients per year. With eight GPs not being available, the other GPs cannot take up their patients, those consultations, so our practice is treating about 50,000 fewer patients per year at the moment. Some of those patients go to other practices. In the past month we have had 20 requests from patients to go to other medical centres—a tiny amount. From that, I surmise that those patients whom we would normally treat are not being treated in general practice at all. I cannot say that for certain, but we have not had 10,000 requests to go to another medical centre; we have had 20. That means that those patients are either not being treated and are getting sicker and eventually going to hospital, or—I do not really know. I cannot actually speak to it. We are not the only medical centre with this problem. There are a number of medical centres in Townsville,

In terms of registrar placements, my understanding is that there are at least six or seven other practices in Townsville that cannot place enough GP registrars in their practice to adequately provide the service that they need to and they equally cannot recruit international medical graduates and cannot recruit GPs from elsewhere in Australia for all the reasons that we have been through. This is not unique to Townsville. It is the same in Toowoomba. It is the same in a lot of regional areas.

Interestingly, when I talk to Ayr Medical Group which is a DPA, and I talk to Bluewater Medical Practice, which is a DPA, they now have enough GPs. It is not because the GPs from our practice have gone there; it is because the international graduates have gone there and have bypassed Townsville. The policy has sort of worked in as much as those smaller towns have got their GPs, but it has squeezed them out of Townsville and is causing a crack, basically, in the number of GPs that we are able to employ.

I do not have a criticism, by the way, for JCU. I think the GP registrar program is great and I think they do the best they can with what they have, and I am not commenting at all on the quality of the education. The federal government does not fund enough places and does not make general practice attractive enough for medical graduates to seek a position. Also, interestingly, a lot of GP registrars, we have found, will leave Townsville. Even though they aim to recruit in the local areas, they do not necessarily stay. I do not have complete statistics on that, but that has been our experience. We just need to keep adding. Townsville loses doctors overall and we need to keep adding in doctors, and not in huge numbers but enough that over time—if you do not replace them, you end up closing down basically.

CHAIR: Thank you very much for your contribution. It has been really informative. We are picking up more of those themes about training places wherever we go. We will adjourn for till 12 o'clock.

Proceedings suspended from 11.45 am to 12.03 pm.

ADAMI, Mr Peter, Chief Executive Officer, APR Disability Services

CHAIR: Thank you very much for being here today. Would you like to start with an opening statement and then we will go to questions?

Mr Adami: Yes. APR Disability Services has two residential care SDA five-room properties and we are developing another property with four residential care facilities on that property at Rangewood. I would like to discuss the problems that we have. I was originally building houses back in 2004 for disability services, supplying houses for Cootharinga and others. When 2016 came along I decided to convert two more houses that we had into SDAs, which I have done, and also run as a provider, which Queensland disability services wanted me to do all the way along. I was involved with other things, like being the postmaster on Palm Island and so forth.

Since we have been running we have had problems with NDIA in funding. We started off with a client that was two on one—very high care, complex needs. I basically wanted to be a provider, providing for people of complex needs who have been stuck in hospital and nursing care homes for two years. That was my aim. We got that first client back in March 2020. Since then, we have been operating. We have 30 staff, all highly trained in high-care, complex needs. At the moment we have six clients in the facilities. One facility is for women, where we have three clients, and the other facility is for men, where we have three clients, all with high, complex needs.

Other investors come to us and ask, 'What is it worth?' and 'Does it work?' Unfortunately, we have to say, 'Well, if you believe the advertisement that you will make money by having a house built for SDA, you have to consider that you will be waiting for a year before that client is approved for SDA. On top of that, you do not get payment. When the approval does go through, you are lucky to get the full amount of approval.' One client had 10 per cent sight, weighed 260 kilograms and needed oxygen 24 hours a day and full care. He was not classified to be able to go through robust. Therefore, of the $28,000 that we would get for an SDA payment they only agreed to give us $20,000. As an investor, that would absolutely cripple anyone who wanted to get into SDA.

We started off with one client. We had another client who was high care and had complex needs. He was a gentleman. We naturally put him in the gentlemen's home. The ruling from NDIA was that, because we had vacancies, we had to cover two-thirds of the cost of care. It is in the rule where vacancy costs are borne by the provider. The problem is: as far as I was concerned, NDIS is there to supply the funding for participants but in actual fact the provider has to provide the cost of care and cover those costs as well as try to operate an SDA and not get any payments from SDA. You have 12 months of non-payment of SDA—and it can be longer, which we have. We have six clients there. They have been there for well over a year. We have been operating for two years. We are only just starting to get the SDA approvals. Therefore, the advertising blurb that is going on every day trying to attract investors into SDA is a real problem. If they keep on continuing that, you will not have anyone investing in SDAs.

I was on the steering committee with Coralee O'Rourke and Cathy O'Toole from the beginning and my job was to promote SDAs. Since I have been in the industry doing SDAs. Unfortunately, I cannot really recommend it.

CHAIR: Thank you very much, Peter, for your contribution. We were hearing about these problems yesterday at Mossman, particularly around the assessments taking so long. I commend you. You are getting people out of long-stay. People should not be in hospital for 400 days. Thank you very much for that.

Mr Adami: The other situation is: with the profits that we have, if any, we hire nurses. The nurses are hired by us. We have two nurses working virtually full-time, which we believe is a necessity to look after extreme complex care. Of course, they are not funded, because they say that is the responsibility of Queensland Health. We just say, 'Okay, that is fine. We will just put it as an admin cost.'

We are a family business and we struggle. It has cost me another $2 million to solve the problem of what they are doing to us by having another property. We have four dwellings on that. They are two-bedroom, so they cannot go back and say it is five on one, three on one or whatever. It is just two on one. Two of the dwellings there are single occupancy, so they cannot do anything there to us. That gives us the ability to take one of the houses out, move them to Rangewood and completely rebuild the house. It is another half a million in changing it to two flats and two two-on-one units.

I do not believe that anything is going to change, so we are actually changing. We are forced to do so; otherwise, we are out of business. Thank you very much for listening to that. We hope that something can come out of this meeting that may change that, because the SDA program is in real problem if this keeps on going.

Ms PEASE: Thank you very much, Peter. I really appreciate you coming in. Thank you for your great work. I am in great admiration of what you do supporting the community. It is a wonderful thing that you are doing. We have heard a lot that patients on NDIS are actually left in hospital for long periods of time. You did mention this. Would this be part of the problem that you are experiencing as well in that you might have somewhere for them to stay but because their packages are not coming through they cannot come to you?

Mr Adami: That is correct. I believe that SDAs are very much needed—not just us; we need a number of them—because these people are stuck in care. They need high care. You really need to have really well trained staff to look after them. At the moment there is a preference with NDIA going to SIL houses, which are a three-bedroom home. They do not have the backup to be able to cater for high care, but the NDIS have been saying, 'Well, you are an SDA; therefore, you have to conform with the SIL houses.' Their preference is to have one worker 24 hours a day looking after three clients.

We are experiencing one client who came in on STA because they could not do STA, which is short-term accommodation. He stayed with us for 28 days. He went from a white sheet to colour and being able to communicate. He was a level 3 in swallowing, which we are specialising in. He went to a SIL house with three. He had over 12 hospital visits in three months. The support coordinator, who knows us quite well, insisted on him coming back to us. We have had him for four months. He has not been to hospital. He came to us as a level 4. He is now level 3, which is great.

We have another client who was virtually going to palliative care. He was level 4—eating disorders and all the rest of it. We have him now at level 3 and he is running the place! We do have successes. If you want any information on exactly what is happening, we have email proof of what is happening to us. We have to do one client on his own and get paid one-third of the cost of care, which means that APR are actually funding him in that home.

Mr MOLHOEK: Can you reflect on how things work now and perhaps how they have been in the past? We heard from one provider in the Tablelands who has gone from 40 clients to 150 since the NDIS came in. Are things better under the NDIS or was it better before in terms of access to services?

Mr Adami: We only opened in March 2020, because it took so long for our two premises to be registered. They are registered with council as residential care facilities. We have gone through the whole spectrum of getting those houses rebuilt and put together since 2016, so it was a three-year thing. With me being on the steering committee as well, it gave me insight into what was happening. Where we are today is where we are. We find that there is a lot of misconception about SDAs. People are going to get burnt. If the NDIA take what they are doing to us to other people, you will not have too many SDAs in Australia.

Mr MOLHOEK: Is APR a not-for-profit or a for-profit?

Mr Adami: It is a for-profit. We are a family business. I have my wife. My son is a manager and my two daughters are carers. One of my daughters has her diploma of psychological science. My wife has been a carer since 1999. We have that experience behind us. Also, I have been building disabled homes since 2004.

Mr MOLHOEK: For the benefit of those of us who are not as up to date on how the whole system works, can you explain what the role of an SDA is and the services you particularly provide?

Mr Adami: The SDA was created so that we could have a proper house, especially designed for complex needs, to be able to get people from hospital who had been there for two-plus years and give them a life. That is what we are all about.

Ms PEASE: SDA stands for 'specialist disability accommodation'. That means it is specifically built for housing people with a disability?

Mr Adami: Yes. These homes can cost close to $2 million each.

Ms PEASE: I can imagine. Your residents would be funded through NDIS for their accommodation?

Mr Adami: Yes, totally. If they funded it properly, we would make more money. We could then get more people out of hospitals and give them accommodation. As a profit organisation it is a really good situation to be in but, with the way that NDIA are handling it and cutting any kind of profit that we make, we do not have the ability to advance, except that we have long pockets and we can put in another $2 million.

CHAIR: For the benefit of people in the audience, I will share information we received in terms of how many people with disability are staying in hospitals. They either should be in residential aged care or in specialist disability accommodation. It is about 500 people. That is a hospital the size of Townsville's.

Mr Adami: That is right.

CHAIR: Spread across the state.

Mr Adami: One company like APR cannot handle the whole lot. It needs to encourage other people to come in and build SDAs and stop SIL houses being used. They are unregistered. They go under the radar in every respect. By being a three-bedroom, they do not have to conform with Queensland fire or health. We are accredited with the board of works, Queensland Health and Housing, which is a requirement of an SDA. It is not a requirement of a SIL house.

Ms PEASE: Can you explain what a SIL house is? What does that stand for and who runs it?

Mr Adami: A SIL house is just a three-bedroom home that anyone can go out and buy and put clients into.

Ms PEASE: What is SIL?

Mr Adami: Supported independent living. If I turned around and said that instead of spending $6 million doing SDAs, which only gives me six properties, I am better off to do SIL houses, the quality of care I could not do. We have proved that. We are getting people back from these SIL houses because of lack of care.

Mr MOLHOEK: At the risk of offending you, one of the criticisms in previous years of residential care facilities in other sectors is—and I have even heard people say this of youngcare which I think is quite sad—the suggestion that by creating these sorts of larger homes with high-needs care we are almost recreating the institutions of old.

Mr Adami: It has been capped at five clients in an SDA. Depending on the layout of the house—we have made sure that we really look after the independent living side of the clients by having a huge entertainment area. We have 14 car spaces, which you need to cater for that amount of clients. They are building SDAs that have no car parking, so they cannot do high care because they cannot get the workers there. They have a three-bedroom SDA that does not have a separate toilet for guests and staff. I do not know how they do it. Anyone can build an SDA as long as you have the right configuration in bedrooms and pathways. That is not what it is really all about. It is about being able to build an SDA that caters for staff as well as clients and gives them enough room to be independent.

Mr MOLHOEK: In terms of rigor and regulation, what are the rules and requirements of operating an SDA? We have heard in recent times concerns around care in the aged-care sector and unscrupulous owners.

Mr Adami: We are successful because the design allows us to look after the clients and give them the quality of care that they need.

Mr MOLHOEK: Are there requirements around the number of carers and the sorts of people who are there?

Mr Adami: Sure. You have to really assess the whole complex. If you have five clients—we find that that may be too many. That is why we are going to spend half a million rebuilding our existing units. We feel that, with five clients in a house, it is very difficult to have each one on the same page. Therefore, our new buildings have only two clients in one house. We feel that will be a very easy way of solving that problem.

CHAIR: Thank you very much, Peter, for your contribution. We really appreciate it.

Mr Adami: We hope that this might change, because I do really have great concern for people who want to get into SDAs as investors as well as providers. Something has to happen.

CHAIR: We want to see the people get out of hospital and into appropriate care.

Mr Adami: That is the reason I did it all.

CHAIR: Good on you, well done—a good local.

APAYDIN, Ms Rukiye, Townsville Multicultural Support Group

NAUNTON, Ms Stephanie, General Manager, Townsville Multicultural Support Group

O'TOOLE, Ms Catherine, President, Management Committee, Townsville Multicultural Support Group

CHAIR: Thank you for being here today. Welcome. Cathy, do you want to start with an opening statement and then we can move to questions?

Ms O'Toole: Thank you, Chair. On behalf of the Townsville Multicultural Support Group, I would like to acknowledge the traditional owners of the land upon which we meet, the Wulgurukaba and neighbouring Bindal people, and express our gratitude for the opportunity to share this wonderful land with them. I also thank the committee for the opportunity to make this presentation.

The inquiry into the provision of primary, allied and private health care, aged care and NDIS care services is really critical in regional Queensland and also in rural Queensland, particularly for those from culturally and linguistically diverse backgrounds. At the very centre of TMSG's submission, we put people at the heart of our recommendations. If you could sit for one minute and consider that you may have been in a camp for 25 years before you came to this country, you can imagine how scared and frightened people might be. For too long there have been many barriers faced by our large CALD community with regard to the delivery of health services, especially the delivery of and access to those services in regional and rural Queensland.

Our refugee community love Australia. They just love the fact that we are safe. They can walk down the street and they are safe. They especially love to live here in regional Queensland. TMSG carries out a significant amount of work when a person arrives in our community. This work ensures that the person knows they are safe as we work through the process of settlement. This feeling of safety and trust can be unwound by not adequately funding health, not allowing for reciprocal training and upskilling of health professionals within funding models and not being able to access the vital support services they need. A very clear example here is for torture and trauma support services. People can wait up to 12 months. Importantly, there is the lack of understanding and inadequate funding of the community organisations that our refugee and CALD communities trust.

Stephanie, the general manager of TMSG, will outline for the committee the background of the refugee community that we serve, TMSG's services and supports, the current challenges, and our expert recommendations to improve health services to better support and meet the needs of refugees and CALD communities and how these recommendations will have a positive impact on the health system. I am very proud to say that our employee rate is well above 90 per cent in terms of people with lived experience, which I am sure Stephanie and Rukiye will talk about. Rukiye Apaydin, manager of settlement engagement and transition service at TSMG, will provide a couple of examples for the committee to relay the real lived experience of many of our CALD community members as they engage in the health service.

Ms Naunton: Townsville is a proud refugee resettlement city, with 7.1 per cent of the Townsville population speaking a language other than English. When you compare this figure with our First Nations population here, which is 7.9 per cent, you can see how very high our multicultural community is here in Townsville. TMSG is the only North Queensland service to deliver the humanitarian support program through our subcontract with Multicultural Australia through the Department of Home Affairs. Through that we deliver humanitarian support, so that is when somebody would first arrive into this country. It is a very intensive case management support, and that would be up to two years. We deliver settlement, engagement and transition, which is where Rukiye is a manager, and that is for somebody who has been here for five years or less. That is where we can see that ad hoc needs basis. We see an increase in housing and people becoming homeless through that and helping them through applications.

We deliver the Queensland government program Community Action for a Multicultural Society. That is more in social cohesion further out into community as well. We deliver a number of different events. We present with Department of Employment and Small Business and do events with them. As well it is English conversations, gardening and cooking, so skill development as well for a person to seek employment. We deliver Safer Pathways, which is a domestic and family violence support service, and Head to Health, which is complex mental health support and a pilot for Queensland here in Townsville through the PHN. We also have bicultural support workers who are our interpreters but also community language support.

TMSG is key to supporting refugee and CALD communities, especially during COVID-19. We were the integral service to deliver information and interpret it across multiple languages, deliver information sessions in language and deliver vaccination hubs at our centre, because our community trusts us. Townsville receives 350 refugees per year, all through TMSG. Another unique fact is that Townsville has a very unique language. About three years ago we started to receive people from the Republic of Central Africa and they speak the unique language of sango, which nowhere else in Australia speaks. I think that also speaks to the talented staff, who have had to also support people with that language barrier.

Obviously we live in regional Queensland, so there is a lack of availability across all health services that are culturally appropriate, despite our high and growing populations. The ABC recently reported that one in five GPs has left the medical health profession in Townsville alone since the start of the COVID pandemic. This has placed extra pressure on our GPs which has added to access issues in communities which are further exacerbated in our CALD communities. The freezing of Medicare has meant GPs focus on time. When there are language barriers, you need a more significant amount of time to ensure it is interpreted correctly and to ensure that informed consent is always given. It is unethical and culturally inappropriate for a family member to be used as an interpreter, but, because of the time focus, ease and accessibility—a family member is there—we often see this being used. This can then also exacerbate the Queensland health system. A recent example would be of a couple where the husband was used as an interpreter for an incident of miscarriage. The situation became very exacerbated due to cultural fears. Wanting especially to have children, he was very upset. She became suicidal at the time and then we needed Queensland Health and the emergency department supporting that couple.

In relation to the lack of services for trauma and PTSD, as Cathy mentioned, the Queensland Program of Assistance to Survivors of Torture and Trauma has over a one-year waiting list. There are significant literacy and numeracy issues. That is not to say that all refugees that we receive have literacy and numeracy issues. We can have people arrive who are doctors and lawyers; then others are unable to read and write. This means that any health professionals trying to give information and saying, 'Well, go and read this in a pamphlet. Here is a pamphlet. Go away,' is very hard and can not only not be read but obviously in language but also would not be able to at a later point anyway. We do a lot of hours through video and sending through our Facebook.

Just because somebody speaks another language does not mean that they should be treated as what we would call second-class citizens. Gestures and things like that where people feel rushed mean that they then obviously turn to services they trust. In Queensland Health there are refugee health nurses and support through that as well, so they start coming to us especially first and then through that they are referred through to the hospitals.

We are asking for there to be reciprocal learning for our health professionals. We say cultural response training, not cultural awareness training, because what we are asking and what we are after for our CALD community is for there to be that response and not just an awareness of it. We would suggest there be funding models. Current funding models limit the ability of health professionals to access this sort of training. This can cause further medical and mental health issues by not being delivered culturally appropriately, as I have used in the example.

In terms of place based services, health funding restrictions limit the possibility to explore these sorts of service models. Our community trust us. We have walked with them since they first arrived on this very important journey of theirs so we are the first port of call for everything. During the COVID pandemic we saw a lot of media attention around the CALD community not accessing vaccinations. We decided to hold our own vaccination hubs and on the first morning, before we had even opened our doors, there was a massive line. This is clearly not about that. It is not that people are not wanting to be vaccinated, but it is about who they trust and delivering health services differently based on that trust.

These recommendations together mean we would see a decrease in the CALD community accessing emergency services as, from our experiences, despite incidences where there is an actual emergency, medical and mental health problems are exacerbated due to a lack of cultural understanding, with more CALD community members then later presenting at hospitals.

Ms Apaydin: Thank you for the opportunity. I will just give a couple of examples to demonstrate Stephanie's points. As a migrant I have my own lived experiences where I have had to interpret for my family in very awkward situations—like very personal private matters in front of a male doctor for my sister-in-law, which was very awkward. I was living with my sister-in-law so it made some interactions afterwards very awkward, because I found out some information about her health matters

that I never wanted to know. Thirty years after, I am still thinking about those things. It has had a long-term impact on me. It is nothing severe, but it would have been nice for me not to be in that situation.

The other example that I would like to give is from one of my clients. Our aim is to encourage people to become independent and build life skills. This family was very independent. They were accessing the medical centre independently, making their own appointments. Some members had to interpret for family members but, aside from that, when this person was actually advocating for their family member the doctor did not want to engage further and he said, 'In the time that it takes me to serve you, I could easily see four or five other patients.' This person came away from that situation feeling like they were not worthy of the doctor's attention. After looking forward to a life of safety and being able to access services in Australia, this was very sad for her. I do not want to exaggerate, but in a way it was a little bit traumatic in that that actually deterred her from accessing that particular medical centre and we had to help her find other services nearby. She wanted to make a complaint but found that she did not think that would achieve anything, so she lost hope. This incident actually caused her to lose hope as well. She ended up not making a complaint, but it stays with her.

In terms of mental health services, as I have mentioned before, there is a long queue. There is a specialist service called torture and trauma survivors. GPs do their best to refer people to other mental health services, but they do not seem to have enough knowledge about who can deliver culturally appropriate services. GPs usually have a working relationship with a particular psychologist or a therapist and they tend to refer to them, but most of them do not use interpreters. In fact, I am aware of only one service in Townsville that actually uses an interpreter. I work with a client who was referred to this centre. They saw a psychiatrist there. The psychiatrist recommended continuing psychological therapy. After the first session the psychologist said, 'There is too much of a cultural difference or gap between us and I cannot continue to work with this person,' but she was not in a position to refer this person to anywhere else so that was the end. Even though this person had not only the previous trauma but also lost his wife and child and really was in need of treatment, he could not get that support. That was the end of that.

There was another example of a client who had to have physiotherapy and, again, the GP referred them to a particular service. Again, they were not using an interpreter. The physiotherapist could not deliver the service without language support and the person was expected to bring a community member or a family member to translate and that was not possible. People do not necessarily want to share their issues with other people. There was no language support, the person could not get any help so they had to wait several months to be referred back to a public service where they could access interpreters which meant that this person continued to be in pain for that period of time.

You can see why people lose hope sometimes: 'What is the point? I am happy I am going to see a physiotherapist, but I can't see one because there is no language support.' Health services are a basic human right.

CHAIR: Thank you very much for that. It was very insightful. You can see that it would absolutely delay people getting care if you did not have the appropriate cultural language.

Mr MOLHOEK: Thank you for coming today, and Rukiye in particular for sharing your experiences. Catherine, the broader terms of this inquiry are a little bit overwhelming when you start to listen to all the evidence that is being given. My parents were migrants. They arrived in 1952. My father survived a number of years in a German concentration camp and had significant health issues. He could not speak English. He came to Australia. I never heard my parents talk about that as though they were disadvantaged, it was a really terrible experience or they had PTSD or reflect that the government should have provided more help for them in terms of counselling and support. My dad returned to Holland to find that my mother had moved on because she had not heard from him. They cobbled their marriage back together. I guess my question is: are we expecting too much of government? I understand, as you said, that it is a fundamental human right to have access to health care, but it just seems to me that the government cannot do everything. How do we change this up so that we create a society that is a bit more resilient and self-sufficient as well as well supported? The answers seem very complex. I would be curious to hear what some of the other solutions might be.

Ms O'Toole: It is very interesting, because in 1952 doctors could come to your home. Doctors could see the circumstances you lived in. We were not time poor when we went to the doctor. You could have more than one ailment when you went to the doctor. Today's regime is too focused on an amount of time a doctor can give you. I think we could think about that.

Mr MOLHOEK: And specialisation I daresay, from what you are saying.

Ms O'Toole: Absolutely. Our whole context of health has changed. I sometimes wonder whether we have moved away from people. At the heart of the health service we are talking about human beings like you and me. I have some experience. My mother is a first generation Australian. My grandfather was a migrant. He was Lebanese and they were not terribly popular in this country around the Second World War.

Not only have the times changed, but could we take a serious look at not how much we spend but how we spend it? For example, I do not think it is realistic for us to sit here and say, 'The government can just pour in more money.' To your point, that is not realistic. What we can do is say, 'Are we getting best bang for buck?' For example, if you look at community based organisations such as TMSG and the support we can provide in the community, that is far cheaper and more efficient than some of the expense that goes into the specialisation. How do we get that balance? I think that is a conversation we have not had.

We talk about a society that is multicultural, which means we are all here in our little blobs, but we need to start to think about what an intercultural society looks like where we all contribute, we all understand each other and we all support each other. We are not sitting hear saying you need to find money from a bottomless pit. I know that is not possible. Can we look at how we spend our money? Can we look seriously at the not-for-profit sector, which would be far better called the for-purpose sector because there is very little difference in the running of those operations other than where the money goes if there is any profit?

For us, particularly at TMSG, the expertise that sits in our workplace is astounding. To give just one example of where a person was not utilised well, one of the people in our workplace has a PhD in community development and someone on the board found her in a nail bar. She could not get a job. I suggest to you that it was because her name was so long no-one could read it on an application, so she was doing pedicures. That is outrageous. Can we have that conversation?

If government comes to the community in a genuine way and says, 'Okay, let's have a think about a holistic approach—community and clinical—how can we spend our money where we support each other?' We do not want to de-skill them. Clinicians doing the sort of work we do in community is de-skilling them. It is a different set of skills, so how do we do that so that everybody gets a fair share? If we build people's capacity, we reduce the pressure on the government. I think—and you would know from your parents—it would be very hard to find more resilient people than people who have been in a camp or our First Nations people. It would be very hard to find more resilient people.

Mr ANDREW: Hear, hear! I 100 per cent agree.

Mr MOLHOEK: I have a couple of multicultural support groups in my patch that are funded by state and federal governments. Where does TMSG receive their funding from, if at all?

Ms Naunton: We receive funding through the Department of Home Affairs through a subcontract with Multicultural Australia; through the Queensland government with our Community Action for a Multicultural Society; through the PHN with our new Head to Health, a consortia partnership; and through the Department of Social Services as well.

CHAIR: Rukiye, did you want to make a contribution?

Ms Apaydin: I take your point about being resilient. We can be resilient but does that mean we have to be open to inappropriate services? All of our clients are probably more resilient than anyone else here. They have seen many things in their life, but how much resilience does a person need every day? As a person I know—not necessarily through health but there are other things—that I am tired and exhausted of being resilient. That is one thing.

I think we are doing a disservice to the health professionals themselves when we do not conduct the medical service in a culturally appropriate manner. For example, if we use a child to interpret for a health problem, the child may not have the capacity, the language or the understanding of the concepts. They may not even understand what they are translating, and they should not be exposed to that information. It is just like in any other situation. If you have a domestic violence situation and you have to use children to interpret, I do not think that is appropriate. Yes, I work with the most resilient people I know, but how much more do they need to be exposed to?

CHAIR: Thank you, Rukiye.

Ms KING: I will make a comment from an earlier submission today and I will ask you for your responses. We heard earlier today from a general practitioner who runs three local general practices including one at Magnetic Island. He spoke at length about providing DVA services, making his

general practice viable by being able to access a specific funding stream. Clearly, as a veteran himself, I gather, or perhaps a medical practitioner in the services, he then had a safer place to stand to work with the specific needs of that community.

It led me to consider the contrast that the people you work with are not accessing specific services through a specific funding stream when it comes to their health care, that they are sometimes poorly accommodated in terms of language support and they are trying to access mainstream health care that is in some cases delivered by practitioners who do not have good cultural competency to deal with those communities. Could you reflect on how people's experience of coming to Australia might be different if they could access health care that was about delivering the right care to the right person at the right time by the right practitioner? I know those are general comments but if you have anything to add I would love to hear it.

Ms Naunton: Absolutely we have a very large veteran population here. There are, DVA say, about 20,000 veterans. To compare, we have 15,000 people who speak a language other than English. We are not far behind in the largest garrison city number. We are always looking for ways to be creative. To do that, and to support Cathy, we start first in the community because they come through us and then we connect them with those different health services.

We start with training of course, but by not having those interpreters or that support there we are missing issues in that they then become exacerbated to the point that people are ending up in emergency departments at higher rates through our community. Like any problem and just like we see in allied health for the general population, if you put it off and put it off it gets worse and worse and you end up in a hospital. Those language barriers, not having access to that, just exacerbate the problem and then it becomes a lot worse and we end up in the public health system because of it.

If there is the opportunity for that unique health funding, absolutely it would be beneficial because it overcomes that—or at least even a recognition within the current health professional funding to allow more time to be given for our multicultural community for language.

Ms O'Toole: I think it is risky sometimes to compare cohorts. I think that is risky. One thing that we at TMSG are very passionate about is not congregating and segregating because that has not worked. We can look at our First Nations population and see that that clearly did not work. I think the reciprocal training is really important. By that I mean a fair go of reciprocal training. If you look now at some of the allied health training at uni, they will get someone from a culturally diverse background to come in and talk to them for four hours about cultural competency. They cannot even get to a response. Four hours in a four-year degree—hello!

We need to think about what is genuine reciprocal training. We have been speaking about this in the mental health space, where I am also involved. There is nothing that can be learnt in a textbook or at any university that can replace lived experience. Listen to these people. They will tell you what will help. Then, as concerned, responsible and morally skilled people, we can say, 'Okay. What are our options?' We would like to know options. We could help you with some options but we do not profess to have the right answer. If there were options and we thought about how we can fund those appropriately—people come here because they want exactly what you and I want. We want to be safe. We want our kids to have the best chance. We want a safe house to live in. We want a job. We want to eat every day. That is why they come here. Honestly, they are so grateful to be here but they have knowledge that we are not tapping into.

Ms PEASE: Thank you very much for coming in. You tell an amazing story and you must have other amazing stories from all of your clients. I would like to acknowledge the tragedy and hardship that they would have undergone to get here. It must be very hard. I am astounded that 7.1 per cent of Townsville is a refugee hub. It is amazing. Given that you are obviously a hub—everyone knows this is going to be a destination point—it leads me to think about why there has not been more consideration given to preparing the health services for that. Given that you are so linguistically diverse and there are so many different cultures, why hasn't there been any preparation at government level? Obviously you have been funded to provide very much needed and great support. It is staggering to me that that has not been a consideration—or has it been and it has not worked?

Ms Apaydin: Sometimes people have to be settled in a location before preparations can take place. They cannot wait in a refugee camp any longer. I will add some statistics here. There are 65 million displaced people in the world. If we had no more new refugees, at the rate that we are settling them now it would take 100 years to settle every single refugee. Imagine there are no more refugees coming. It would take us 100 years to settle the existing ones. If you had to wait for some pre-planning to happen before people could come here, I think that would delay it even further.

One thing I would like to add is that, for example, as Steph mentioned, we are the only city in Australia that settles people from the Central African Republic. They speak a language that no other groups of people in Australia speak, being Sango. Queensland Health did do some great work. There were no interpreters in Australia for that language. You could not even learn the language online. I have tried. I went online and I wanted to learn. It is not a written language. There was nothing on YouTube or anywhere else that I could learn to make it easier for me. Luckily most of them speak a second or third language like French or Arabic, but there are still issues there as well. Now we are training support workers who will hopefully become interpreters in those languages. That is one thing that we are doing. Queensland Health has done a couple of great things like finding interpreters internationally.

Ms PEASE: Your funding is a federal government arrangement. I would also like to acknowledge our First Nations people because culturally I do not think that community is looked after particularly well in the health system.

Ms O'Toole: I sit on a lot of community boards at the national, state and local level in a purely voluntary capacity—white male middle class. With no offence, we have to start to say that our communities are more than white, particularly our First Nations people. Where is their voice? Now where are the people we are welcoming here who will contribute significantly? I think we have to look at the make-up of boards. We have to look at the make-up of the decision-makers and ask—I do it all the time—'Where is their voice?' I think that would help.

Ms PEASE: I agree.

Mr MOLHOEK: We need to open up our immigration policies, too.

Ms Naunton: I want to acknowledge that it is very much the dedication of the team that we have been able to build at TMSG that has done that. Cathy has touched on the fact that we have a lady with a doctorate of social work who is delivering our humanitarian support program. We have a lady with a doctorate of economics who is delivering our job-ready programs and employment. They could probably be earning squillions of dollars elsewhere, but they are here for their passion. Everybody has a degree. I do not want to say just a degree overseas—it should not be overlooked for that reason—but they have their degrees here locally as well. I say that just to give you the high level of expertise and service that we deliver. It is purely because of their passion and dedication to work with Queensland Health, and they go above and beyond their duties to do that.

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

Mr ANDREW: No, Chair, but I would like to commend the ladies on their work. I am helping a young Iranian doctor bring his mother and sister here from war-torn areas. I hear their stories and about things that are happening. Thank you very much for your contribution to society. It is so important.

CHAIR: Well said, member for Mirani. You took the words out of my mouth. Thank you so much for the work you do in our community and in our multicultural community particularly. It is commendable. Thank you for your contribution today. It has been very insightful and helpful.

ROBINO, Ms Erin, Private capacity

Ms Robino: Thank you for inviting me to speak today at this public hearing. I have some handouts for you. They are not to frighten you; they are to enlighten you.

CHAIR: Is leave granted to table them? There being no objection, leave is granted.

Ms Robino: I also have a folder which I will give to Rob to give to you, Chair. You and your committee, Chair, can determine what you want to know, what you want to see, what you want to cross-reference and what you wish to table.

CHAIR: It looks like a fair bit of work there. We will work through that.

Ms Robino: Do not be frightened. A lot of it is verification of information that I will give you. Do you all have this information in front of you which says, 'Sequence of events—Michael Robino'?

What happened is that my son Michael, a healthy young man in his thirties, just out of the blue doubled up in pain. This was on Sunday, 12 September 2021—just after dinner at 7 pm. The pain got to the cramp stage and he said to me, 'I think I have a stomach blockage.' I had to ring triple 0 four times. They were really busy. They said to me, 'There are no ambulances available.' The pain was intensifying and the blood pressure was rising. Eventually after 40 minutes an ambulance arrived to transport Michael and me to the Townsville University Hospital emergency department in Douglas. This is his first admission. That was at 8 pm on the Sunday.

We arrive at the ED and his pain gets worse. His cramps get worse and, as you can see, he is not well. He reports deterioration three times to admin only to be told, 'Sorry, there are no beds available. Go sit down again.' Here he is in pain and he is sitting down. He eventually gets an ED bed after 11 pm. He had a blood test. This is how it has been reported by the clinician who was extremely busy. The staff are so good there but they are so busy. There has to be an easier way for them to do things. He reported that the white blood count was mildly elevated. There was a predominance of neutrophils. What I understand by that is that there would have been some infection or a blockage—some decaying or dead tissue that would have been found somewhere in his blood. The clinician hands Mike his report. He is discharged about 1 am. There is no medication provided. You can see what the diagnosis is.

At 10.30 pm—this is on the same day, in the evening—Mike has to go back again for a second admission. This time we drove him in the family car. We do not wish to wait for an ambulance in case they are held up. His stomach blockage and his stomach pain are more severe. Here he is given copious and potent unknown medication by triage. Then he is told he has to go and sit back down in the waiting room. He is so exhausted. It is so powerful that it knocks out the pain but it also knocks out Mike. He is there sitting in the seat—you can visualise it—falling asleep going, 'I think I'm nodding off.' I said, 'Use my shoulder as a pillow if you need to.' Another young man had the same problem. He used his mother's lap. It was quite common.

He eventually gets a bed, but the very busy registrar cannot see him until well after 1.30 am. She feels his stomach. She reads what has previously been recorded about his pain. She suspects he has gallstones. I said, 'I have never heard of our family having that, but this is interesting.' She reported he had abdominal pain, upper quadrant and upper back pain but he did not undertake or have a further blood test or radiology test. In fact, she told him, 'Could you go and see your GP and get him to organise the ultrasound stomach scan?' and she would send her report. Mr Chairman, if you have a look at her report for the second admission—it is written there—she writes it very clearly. It is comprehensive. She fills it out at 5 am. I actually felt so sorry for this lady because she still had a waiting room full of people.

She does all of that work but it does not get sent over in time for the GP appointment. If she had taken the time to get a pathology test and a radiology test done, those tests would have assisted her to make an up-to-date and accurate diagnosis. From my recollection from the last time I was an inpatient at the ED, the radiology department is in very close proximity to the emergency department. Medicare paid the previous night's pathology cost and they would have rebated most of the radiology cost, if there was any at all.

This hardworking registrar prescribed Buscopan, which is used for gall bladder obstruction pain and to relax minor stomach cramps, and Maxolon, but she did not give him any antibiotics. He was discharged after 3.30 am. His diagnosis was abdominal pain. Although she had the suspicion of gallstones, she did not have the diagnosis confirmed by diagnostic testing.

Mike goes to the GP the following day—this is on the Wednesday. This is the first available appointment but he cannot see his regular GP. He has to see a locum because everyone is booked out. Consequently he sees the locum. He gives him the clinician report of the first admission but he

does not have the second report—the comprehensive one that has been so well written by the registrar. As a result, the doctor said, 'Look, it is probably just a bacterial problem. Come back if it continues. You'll be okay.' There was no scan arranged.

Later that day he is doubled up in pain again. This time I thought, 'I cannot stand sitting at the Townsville Hospital ED for another four to five hours,' so we go to the Mater Hospital ED in Pimlico. We take the family car. His pain has returned with a vengeance. He is quickly admitted and given a bed because he had difficulty walking. He is given a stomach X-ray. He is given a blood test and a stomach scan that was quickly arranged. They cannot do them at the Mater ED, in that actual facility. They have to go into the Mater Hospital to Queensland X-ray. They are two separate entities—the ED and the hospital. What happens is he goes in there and he has to go twice. As soon as the information comes back, the very busy Mater ED doctor devises a care plan. He prescribes clear fluids, Endone and intravenous antibiotics which are used to treat life-threatening infections.

Mike is immediately referred for admission to the Mater Private Hospital for emergency surgery by a gastrointestinal and general surgeon. His diagnosis is confirmed as acute gangrenous cholecystitis. Please excuse my pronunciation; I am not a medical person. He has gangrene of the gall bladder. One of the gallstones was infected and his gall bladder was thickening and swelling. He has his emergency surgery the next day. During that time the infected gallstones and numerous other gallstones and the gangrenous gall bladder were removed. He is then inserted with a bile drain. He also has to have nasal tubes. His brilliant life-saving surgeon's post-operative comment was, 'If we'd waited much longer Mike would not be here.' What happened? He needed five nights hospitalisation and five weeks sick leave to can recover from the ordeal.

Your help is needed. You are state parliamentarians. You need to rectify the staff and resourcing shortages of the Queensland Ambulance Service. You also have to look at the Townsville Hospital's emergency department including its diagnostic policy because these delays that happen, in my opinion, led to Mike's life-threatening situation. The policy needs urgent amendment. My submission has been referred for your information and remedial action.

CHAIR: Sorry to interrupt you. I appreciate that this has been a difficult experience for you and Mike. It is slightly outside the terms of reference of this inquiry which I will take you back to. I am going to draw on some of the commentary you have provided. We are looking at the primary, allied and private healthcare system. I note in your tabled document that you have lodged a complaint with the CEO of the hospital. I imagine you are working through that. As I said, it is slightly outside the scope. You have mentioned that he was unable to see his own GP so he saw a locum. Access to primary care is very important. I am trying to make a link and help you here and give you as much latitude as we can. Do you have private health insurance?

Ms Robino: We have. Mr Chairman, I rang the office as soon as I saw your ad in the paper to check that I could talk on this. Because we are locals, so many people in the community have said to me, 'Go in there and say something for God's sake.' There are so many people being fobbed off and major problems occurring, which I will cover shortly. They said, 'We need this primary care. We need someone in there to help us. We do not need to be fobbed off. When we try to get to our GPs we sometimes have to wait for days.' We would have had to wait five days if we wanted to talk to the original GP who Mike sees.

CHAIR: That is interesting because in a Brisbane hearing we had a medical director talk about his own brother or a relative, from memory, who had abdominal pain. If he had been able to access his GP—now we are coming back to the terms of reference—and get an early diagnosis, it would not have turned into the significant rush to an emergency department three weeks later. I am trying to give you as much latitude as I can here.

Ms Robino: That is okay. We got in three days later. We were moving quickly. In fact, I was getting to a point where I thought, 'If I cannot get any sense of the medical fraternity here'—and I usually can—'I might even have to take him to Brisbane.' At one stage that thought went through my mind. I thought, 'Will I go to the Wesley Hospital or to Greenslopes Hospital, where our family members have been treated very well?' Then I thought, 'I will just give the Mater Hospital ED a try.' I had never even been there before. I did not even know where it was.

CHAIR: Out of interest, you have written here that the Mater ED closes between 11 pm and 7 am.

Ms Robino: That is right. They have eight hours where you do not have any other facility to go to except the Townsville Hospital.

CHAIR: The public hospital. That is what we are trying to articulate—how to take the burden off the hospital. I will put this question to you: would you support the Mater Hospital emergency department being a 24-hour facility?

Ms Robino: I was going to ask you a question. That is what I was going to ask.

CHAIR: No, we want to hear from you.

Ms Robino: I would love the Mater Hospital ED in Pimlico—those wonderful doctors who helped us there, who saved my son's life—to be a 24-hour service. That would be fantastic because they are there every day. They are there on weekends. They have to outsource the X-rays to Queensland X-ray though. You have to be mindful of that. That is in the hospital building near the admissions. That is a good question.

CHAIR: I am mindful that we have the last group here.

Ms Robino: This is very quick, this last bit. I lodged a complaint with the CEO of the Townsville Hospital, Mr Kieran Keyes—that was on 15 October—at the request of several people, including doctors. Then I had to go and send a second request. I got a response. That was sent over, the second request, on 26 November 2021. One of his executive directors responded. She apologised for her delayed response. She apologised for the delay letter going over from the registrar to the GP. She apologised for my distress and Mike's long wait in ED, but more communication and feedback delays continued.

The same day I sent her an email, I tried to ring. I sent her an email and I asked for clarification of her response and also the Townsville Hospital's restrictive ultrasound scan policy. This is a tertiary hospital, Mr Chairman, with a state-of-the-art imaging facility that operates 24 hours a day. It needs to be used to properly diagnosis patients' illnesses. I was advised in her report of November that Mike's blood tests were normal. It contradicted the clinician report of the first admission that confirmed that he had a predominance of neutrophils. There was bacteria noticed. An ultrasound scan was not performed as Mike had no ongoing pain documented during his examination by the registrar, but if you have a look at her discharge letter—that is the second admission letter—this same highly talented and very overworked registrar stated, 'Mike presented with abdominal pain. He had right upper quadrant and upper back pain.' She prescribed Buscopan to relieve his gall bladder blockage pain and her diagnosis was abdominal pain. Mike's ongoing pain was why we returned to ED and sat for hours to get him pain relief.

The same executive director then sends me her response eventually—this is in January this year, 2022—and she puts the information in there. It is concluded that all the assessments and investigations undertaken were appropriate, but there weren't too many investigations done because they had no pathology and no blood test. She has kind of evaded my question, in my opinion. Had they had these tests done, that would have assisted the registrar. She could have been able to diagnosis and treat Mike's infection, his internal blockage, his ongoing and elevated pain levels. Antibiotics could have minimised severe inflammation and infection. Mike needed three ED admissions before he received the correct diagnosis at the Mater ED. There his blood tests showed that his white blood count was elevated. There is a protein test that is called a CRP test. It was a high range of 70. It is there to determine infection and inflammation. He was quickly referred to the Mater Hospital for emergency surgery, and thank God the Mater ED doctor decisively acted, with Mike's life-saving surgeon, to provide outstanding and timely critical health care.

Mr Chairman and committee, you may wish to sight the documents; you may even wish to table whatever is relevant: the responses from the Townsville Hospital and also the Queensland Ambulance Service review which was done—is your wife Amanda?

CHAIR: Yes.

Ms Robino: Yes. Amanda contacted me.

CHAIR: Thank you. You are reading from the tabled document which the committee does have. We thank you for that. You have taken us through the steps.

Ms Robino: I am sorry, Mr Chairman. You have my submission. My speech is a little different, and what it says is that Mike and I are Queenslanders. We are taxpayers; we are locals. We deserve appropriate and timely health care instead of being fobbed off by frontline overworked medical staff. The Townsville Hospital board posted a $4.5 million surplus last year. The Townsville University Hospital is a public hospital, not a private business. It has a duty of care to prioritise patient health. The ED is very busy as it is the only 24-hour emergency department. More diagnostic tests are urgently needed to treat complex cases after hours—like you suggested before, Mr Chairman.

Now, state members of parliament, you are our elected representatives. We are taxpayers. We vote. You have to remember the constituents need to have their health concerns addressed. Please act now. Lives are jeopardised while waiting for urgent health transport and proper primary care. It was distressing for me to have to ring triple 0 four times for an ambulance. There are more paramedics

needed. It is a positive step by the state government to appoint 74 interns to the Townsville Hospital, but you need more ED beds to stop ambulance ramping. Sitting there in the state hospital emergency department and waiting for hours to be examined by a doctor while my son is vomiting and suffering excruciating pain on two consecutive nights is unacceptable and inhumane.

With regard to the amendment of the diagnostic policy, could you please refer that to your health minister, because it is very important? Another thing is that there are three—and this is something you will need to look at, and there is newspaper information that will confirm it—Townsville University Hospital patients I am aware of who presented last year with life-threatening conditions. They needed urgent ultrasound scans and these were delayed. Mike was one. Another was an employee. She stood her ground. She said, 'I am not moving until someone looks into my case.' She had to have an emergency surgery at 3 am. Unfortunately, that other little one—it is very sad, and this is what you need to look at—did not survive. You have to look at it not only from the patient's perspective but also from the mother's perspective. We are there; we are helpless. We are just looking at our kids deteriorating. It is absolutely dreadful. Please could you do something? All this happened before the Omicron outbreak. You may have to refer to the member for Mundingburra, because the Townsville Hospital is in his electorate, so he can be involved in the action plan as well.

CHAIR: Thank you so much. Thank you for your time and contribution today. We appreciate it. We have your papers and we will deal with that as the committee determines where to go next. We will now go to our final speakers, who have been very patient and waiting all day.

Ms Robino: No problem, Mr Chairman and committee. Thank you for your time. Please take some action on behalf of the community of Townsville.

AKEE, Mrs Angelina, Chairperson, ABIS Housing

PATTEL, Mr Graham, Director, Wulli Wulli Indigenous Disability Services

TAPIM, Mr Francis, Community Elder, Torres Strait

Mr Pattel: Thank you for the opportunity today to speak to you. I would like to acknowledge our elders past, present and future. I was going to initially talk about Wulli Wulli, but I thought we would have a coalition of all of us. We come from different parts of the community. I would like to hand it over to Aunty Angie Akee, a very highly respected community member, and Uncle Francis Tapim up the end there. Aunty Angie is also a traditional owner here. I will hand it over to her.

CHAIR: Thank you both for being here. I remember that you both presented in front of our committee when we were doing the Torres Strait Islander meriba omasker bill. Thank you for that. That was a great outcome that was achieved through the parliament. Over to you.

Mrs Akee: I would like to thank especially Graham for giving us the opportunity. We just came here today to listen. I am a little bit disappointed, because I would have thought there would be more of our mob here from the medical centre, from TAIHS, as well as the other service providers. I do have an apology from the Aboriginal and Torres Strait Islander Corporation for Women. They have some issues happening there with NDIS clients, so they gave their apologies.

Mr T and I—you will have to excuse me, because culturally I cannot call him by his first name and vice versa so it is Mr T and Mrs A to us. I just want to say that it is a privilege to come here to quickly give you a bit of an update on what is happening in our community. Mr T, Graham and I are also active members of our Townsville Aboriginal and Torres Strait Islander Elders Group. Both these two gentlemen are chair and co-chair of that organisation—we are not an organisation; we are just a community organisation that addresses issues that are impacting upon not only our elders but our community as well.

Mr T and I have just been appointed to the Townsville Hospital Aboriginal and Torres Strait Islander Advisory Board, but we are not here talking about that; we are talking about our local issues. As Graham said, we are here basically to address a few issues and concerns that we have. We have not presented a paper, but we will get some sort of submission in to you as well.

I will hand over to Graham, seeing that he has a few issues, and then Mr T and I. I am also the chairperson of the ABIS Housing cooperative here in Townsville. I sit on the Queensland body for Aboriginal and Torres Strait Islander housing in Queensland. It has just been newly formed. We have a lot of work that we need to do in addressing housing and accommodation for our people. I also sit on the North Queensland Land Council in terms of native title issues. I am an executive sitting on that committee as well. I will hand you over to Graham and he can give a bit of background on himself as well.

Mr Pattel: We started the Wulli Wulli Indigenous Disability Service in 2018. We saw an issue out there that our people needed addressing. They were missing out in the disability sector. Four years later we are here in Townsville. We started off in Bundaberg and we are back here in Townsville. There is an issue that we are having here with the OPG. How it relates to health is: a lot of our clients come through the mental health institutions and when we take them over we work on their emotional and social wellbeing and try to get them back on track. A lot of the counsellors or psychologists they work with cannot relate to our people. They do not understand that when they are talking to them they are talking to them in medical terms rather than cultural terms, so they get really frustrated and they just shut down and go into meltdowns and we end up getting into mental health and cutting and medical stuff and it becomes a big problem.

Despite the fact that we talk to those mental health workers about what it is that is missing in their dialogue, they are not listening to us. They do not listen to us. For example, we had a young girl who was released out of prison. She had three months incarceration. They let her out with no underwear. She had no underwear. They gave her a handful of pills and said, 'Have a happy day.' They gave her a flat—this is one of the providers. There was no food, nothing. There was no linen, nothing. There was nothing in there. She had no clothes—just the clothes that she walked out of the prison with. You cannot treat people like that. That is really disgusting human nature to treat people like that. She is not the first one. There are quite a few going through. When you start questioning people, everyone wants to pass the buck: 'It's not our fault. That is so-and-so's fault. That's over here.' Somebody needs to grow a set and take some responsibility here, you know? It is really frustrating.

The impact upon Queensland Health is huge. Rather than these big providers or these mental health workers engaging key people in the First Nations community and trying to deal with the issues

of having problems with their clients, they do not engage us. It is that professional jealousy. We do not carry degrees or whatever. They just do not engage us. It is really frustrating. We have Close the Gap. Nobody is closing any gap. The gap is getting wider and wider. We are not even involved in the process.

Again we were last today. I am not having a go at you guys, but we were last again today. We are used to it. We are used to running last. It is not having a dig at you guys; it is just saying that we are used to it. In the process in the dialogue, we all get lost in it. The bureaucratic process takes over and we do not get a say.

For the NDIS, I reckon they should restructure it. They should scrap what it is now because it is not working. The minority groups are not getting serviced. The federal government needs to scrap it and start to redesign the model so that they include the minority groups. In Townsville here you have 23,000 Indigenous people—First Nations people who are on a disability. We all know who has got them: the church mob—the same mob who stole our children. If I am getting political I am sorry, but I am not sorry for it. That is the way it is. It is ironic that they stole our children and now they are stealing our disability clients. They are making a lot of money out of it, I can tell you right now. I believe that for the 23,000 the federal government provided $550 million to cater for that group. Now, I mean, Jesus, somebody is making a lot of money here, but there are no outcomes. It is all about profit. It is not about outcomes or the wellbeing of anybody. It is just profits. I better step down off my little chair here before I start getting wound up. I will hand it back over to Aunty.

Mrs Akee: Just to give a bit of background, when NDIS first came out my daughter, Tanya, put together a program in Townsville to engage with the Aboriginal and Torres Strait Islander organisations as well as community. She brought up a team of people from down south, from Brisbane. They were a couple of doctors and nursing staff. Through ABIS Housing, we engaged with them in terms of putting this program together. It was to educate our people about what NDIS was and how it was important for them to get access to it. We went around and we invited organisations to come along and bring their clients and so forth and start registering them. The doctor then registered some of our people. We had part of the team go down to Happy Valley to address people down at Happy Valley. For those of you who do not know, it is like a little community. Back in the days when we had no accommodation and we had camps around Townsville, Happy Valley was one of the camps where a lot of our people went. The local government then put up a section 51, which meant that people could not drink and so forth in the park. They ended up building up with the state department and community organisations—community people—and we started building up Happy Valley so that we could relocate the people from the parks to Happy Valley to drink and kill themselves, but anyway that is what they did. We ended up sending a team down there. They registered some of the homeless people down there for NDIS.

NDIS is not working for us as First Nations people. What is happening is that you have to go through a process of referral, and those referrals are not coming through to the Aboriginal and Torres Strait Islander organisations that are NDIS providers. That is my biggest concern. It is culturally inappropriate because the people who are making the assessment do not engage with the service providers as well. We see a lot of our people going through mainstream services.

What is happening at the moment is ABIS has given up a couple of their houses—as the gentleman before us was talking about, the SIL program—and we accommodate people into those homes. ABIS Housing funding came through when we had the old ATSIC in place. Now that ATSIC is no longer in existence, all throughout Queensland and nationally, where ATSIC had provided Commonwealth funding for these houses they have never been supported by the state. Now they have what they call One Social Housing, where the Commonwealth then provided the funds into the states and provided housing, but you have to register as a One Social Housing. ABIS decided not to do it because it still comes under the state government which means you have to register with Queensland Housing and then the referral goes out to Yumba-Meta, which is the only service provider here in Townsville. We felt that because Yumba-Meta was getting One Social Housing, what would happen if people got evicted? If they got evicted out of Queensland Housing, where would these people go? ABIS Housing and the chair at the time, Mrs Tapim, decided that we were not going down that road.

We are a community housing organisation with no funding. We have about five blocks of vacant houses that urgently need doing and about three of them that urgently need to be built. At the moment we have funding to provide one house that we are setting up as a six-bedroom house for students. Some of our students who are coming down and going to university are living with families who are overcrowded. We also have problems where there is domestic violence in the homes with their parents. We are finding that a lot of our kids are in grade 11 and 12. We need to get them out of that

environment and get them into a safe house where they can see through their grade 12 and then go on to university. ABIS is trying to close the gap in terms of doing some of these things like that. Mr T has been engaged by ABIS as our housing manager, and when we do get funding in then we start repairs and maintenance on these houses.

We see a bigger need now for the SIL program to accommodate some of our people to get back into having some independence and then going back out and getting accommodation, which we are happy to do as well. If they go through a program like SIL, they can come in and we can provide housing.

Apart from that, we are also looking at the statistics on closing the gap. We do not get it as a community organisation. We have to make sure that people like Queensland Health are providing that sort of statistic to us as community organisations, us as a community and us as elders who are in the community and need to know whether we are actually closing the gap in terms of Aboriginal and Torres Strait Islander health and wellbeing.

When I come back to the Aboriginal and Torres Strait Islander Medical Centre, there is Commonwealth funding. But look at how much money the state is giving to them. Community-wise, we are saying they are a health service; they need to concentrate on health. As one of the people who started that medical centre many years ago, I can see that we are not closing the gap in terms of health through a community controlled health service because they are too busy providing accommodation for homeless people, which should be the housing responsibility because it is providing accommodation. They are too busy providing accommodation for youth. Again, it should be a housing responsibility. Let them get on and provide the help that is required. Primary health care is so important for our people.

I was involved with the health service. I have been CEO, acting CEO and have been involved in social and emotional wellbeing. We were the ones that lobbied to get Aboriginal and Torres Strait Islanders employed through Queensland Health. We were the ones that got Aboriginal and Torres Strait Islanders trained up to be mental health workers. We were the first ones that lobbied to get Aboriginal and Torres Strait Islanders into Centrelink. We had one man—and that was Ernie Hoolihan—but we need more Aboriginal and Torres Strait Islanders in these specific areas and identified positions so that we know that our people are going to get employment opportunities but also be there for our people.

Today it is all mainstream. All the funding is going through mainstream to provide services for Aboriginal and Torres Strait Islanders. When they cannot provide the services, like mental health clients, like people who are chronic alcoholics, then they ship them off to Aboriginal and Torres Strait Islander people. We have a shortfall in transport. People like Graham and the program that he runs should be getting access to dollars so that he is providing that service for Aboriginal and Torres Strait Islanders.

We had a dialysis patient. We got a dialysis unit around North Ward. When it rains, these people have to go from the dialysis out into rain. Sitting on this new board, as an adviser, we will be addressing this with Queensland Health, but it is culturally appropriate—well, it is inappropriate as well, never mind whether you are black or white, to be around that North Ward service and have to run out or walk out on crutches or in a wheelchair in the rain to get to their transport. There are gaps, and the gaps are all around about our people.

There are people who are flying in from remote areas. They are being put up into motels. They do not have money for food. These are people who are coming in after hours. Why are we not engaging more with Aboriginal and Torres Strait Islander community based organisations? We could have set up a house so that when the spouses or the carers come to Townsville they could be put up into emergency accommodation through ABIS or some of the other services so that they were being accommodated.

My nephew is in a motel in Cedar Lodge. They brought in a lady that was medevaced from Torres Strait to the hospital. Her husband came in. He had no money. He came with the clothes that he was working with. He had no money. Lucky my nephew was there. He took that man down to McDonald's to get him a feed and gave him some money so the next day he could get himself something to eat. The $100 they had in their bank account was taken out because they had bills coming out of their bank account and it left them with no money to live on in that period of time that the wife had to be medevaced. Basically, all I am saying is that we need more Aboriginal and Torres Strait Islanders working in our health system.

We need interpreters. I have heard people here today talk about interpreters. Amongst Aboriginal and Torres Strait Islanders, our people, English is maybe their second or third language,

so we need interpreters as well. I am talking about the access to primary health care. Once upon a time when Townsville was set up, when we lobbied to get more of our people engaged in the health sector, they had a specialised team that would do a lot of primary health care. They do not have that anymore. It is not out there. They used to visit our people in the homes and do a lot of the education stuff. Why is it that a lot of our people are still sick? We have a high percentage of our people who are diabetics and a high percentage of people receiving dialysis. Why is this happening? Because the intervention is not happening, primary health care is not happening to them through a place like the Aboriginal and Torres Strait Islander health service.

That is why somebody who has been involved—I have been on QAIHC and I have been on the state body that looks after AMS, but AMS is not just about health. Housing and Health need to have a formal partnership because we have the overcrowding in the houses. Our people cannot get housing in the private sector. When they do go to the private sector, they are only given a two-year or 12-month lease. After that then they are homeless. Where do they go? They go back to living with families. We have had up to 12 people, 14 people living in a house. It is unhealthy for them. The kids are not getting the support they need in terms of their education. Then there is violence in the homes. Then we do not have enough emergency accommodation.

What we are wanting to do is get funding to set up a safe house for children who are experiencing violence in the home. It is no good putting them into foster care because the children are not aware of why they have been placed into foster care. What we need is a safe house. I have been talking to Graham's wife and we are now putting together a design so that we can have a safe house. It is about the children going back to their parents. It is not putting them into foster care. It is about making them understand the healing process that they need to go through because they are experiencing the violence. Our children are growing up with violence. Townsville has a very high percentage of youth stealing cars and breaking and entering. Why? It is because their houses where they are living are overcrowded. They are getting out and they are doing these things. They do not have enough money because their parents are alcoholics—their parents are drinking the money—and their parents are gambling. The social impact that it is having on our community involves health. From a holistic point of view, you cannot just address health without bringing everybody else into it. That is the frustration that I have.

Realistically, we want to hear what the data is in terms of closing the gap, whether you be a mainstream service or whether you be a service that has been provided by Aboriginal and Torres Strait Islander programs or whatever. We as Aboriginal and Torres Strait Islander people really want to know about closing the gap. Is it relevant? Is it meeting the needs of our people? Our people need a voice.

The other thing that ABIS is wanting to establish with the support of the state is setting up an advocacy role for our people, because a lot of our people who are going into NDIS are also being controlled by all these services and they are not meeting their needs. We have heard people providing the services arguing with the department—all these people who look after their money. They cannot got their money out of them. They want basic hygiene. Women who need basic hygiene cannot get—

Mr Pattel: Public Trustee.

Mrs Akee: Public Trustee I am talking about, yes. Sorry, I had a mental blank. Where are these people getting registered for Public Trustee? It is through the hospital system. It is the social workers at the hospital and they are putting our people under the Public Trustee. Once they get under that Public Trustee—our parents and our forefathers have been under the act. You look at the history of Aboriginal and Torres Strait Islanders. They have been under the act. They have been governed by white protectors.

Mr Pattel: Just on the OPG, they had a review recently—an in-house review, not a public review—and that was not released to the public. Is that right? Am I right in suggesting that?

CHAIR: I do not know about that.

Mr Pattel: They had one just a while ago, because I remember. If you have the hide, the temerity, to question their decisions, my God, especially if you are a provider, they will cut you down. You will get no clients. Most of our clients come from the OPG, the Office of the Public Guardian, and if you question them, my God, they will bully you and they will cut you off from clients; you will not get any clients. The thing is: when you get them to explain how they made decisions, it is just a closed shop. These people have to be held accountable to somebody. Somebody has to hold them accountable. You guys here are the health committee. Somebody should be asking them questions. They are not involving the community members, the key community members. There are people out

there who are not capable of making decisions—we understand that—but there are people out there who recover from mental health problems. They recover. They are in the position to make decisions for themselves, but the OPG—once they have mental health issues and they have been in the mental health unit they are branded as incapable of making decisions for themselves. That is wrong. That is absolutely wrong.

CHAIR: I want to commend you, Angie and Mr Tapim, for your work in this space. I am really pleased that you have both been appointed to that Indigenous advisory board with the Townsville health service. You have put a lot of time into the Townsville Aboriginal and Islander Health Service. I just want you to explain that that is quite a big facility that looks after a lot of people in the local area. I know you have spent a lot of time and effort and put your heart and soul into that.

Mrs Akee: I sure did, yes. I just want to say that it is very frustrating for us as elders in this community, coming back from when we did start a lot of these organisations. I have been involved not just in health but also in the legal service—you name it. I have been overseas as a representative of the SDI resilience programs with New Zealand and Canada and Australia through TAIHS, New South Wales and Western Australian, so I have been around in the health sector. My daughter spent 20 years in Queensland Health providing cultural competency training for health workers as well as doctors and nurses and you name it.

My passion is because I have seen it. My mother used to walk from Garbutt, where the airport is, all the way round to North Ward to the hospital—not just my mother, but all the mothers who had to take their kids to the doctors had to walk from Garbutt to North Ward and back home again. I went to Yarrabah. Because Yarrabah gets state funding for housing, there was a gentleman who lived in a house that was purchased by Yarrabah council through Commonwealth funding. They cannot spend state funding to fix that house up. He must have lost his wife. It was a family home and he lived there by himself. There were holes everywhere in the house. He walks down to the freshwater river with a bucket and gets the water to come up to bathe himself and use the water for hot water. What is the Commonwealth and the state doing in terms of signing off on agreements and things like this? You cannot have these people living in the conditions that they are.

My grandfather was sent to Yarrabah. My father was born on Palm Island. My grandfather was sent to Palm Island because he was inciting the people to stand up for their rights. That is what they did: they sent them over to Palm Island as a penal settlement. In saying that, we are a generation where we should be seeing improvement, but we are not seeing improvement; we are seeing our people still living in appalling conditions, especially with housing and access to health. The Aboriginal and Islander Health Service: our people are not utilising it to its full potential. Do you know why? If you want to go and see a podiatrist, you have to go and see a doctor. If you want to go and see a dentist, you have to go and see a doctor. Do you know why that is? They are wanting to generate the Medicare. It is not about money; this is about them getting access to a service. That is the frustrating thing. We hear it out in the community. We hear it amongst ourselves when we are sitting in our meetings with the elders.

Once upon a time we used to have doctors go up and visit the patients that were referred from the medical centre to the hospital to check up to make sure everything is okay. We used to have health workers go up there and talk to the patient. Yes, we have Aboriginal health workers that are employed by Queensland Health, but it is not the same. They need more. If they had more health workers in Queensland Health in the wards—and it is culturally inappropriate. Mr T's wife is my sister. They sent a young lad to come and see her and she had her leg amputated. When he went she turned around and she said to me, 'How can I talk to that young brother about my health problem? I am a woman.' Culturally, it is inappropriate. They do not know the cultural aspects of dealing with Aboriginal and Torres Strait Islander people in the hospital system. It is very important. I thank that us two are on that board. Now we might be able to bring a lot more cultural aspects into it, but when we deal with people in our own community the first thing we do is identify where they come from and make sure that we are culturally appropriate—that, whoever we send out there to service them, they be serviced by somebody they feel comfortable with.

CHAIR: Taking you back to primary care—and there is no doubt that when you get that right you keep people out of hospital—in Thuringowa, off Riverway Drive, there has been a funded centre through Yumba-Meta, and Uncle Ernie Hoolihan is on that board, I understand. That is a primary healthcare centre. People who come from remote communities will come down for renal treatment. That is quite a big site. They have plans to do some housing as well. We have had Minister Enoch there. I just wanted to share that with you to see if between the levels of government we can deliver something. You were talking about housing. They are doing work in the DV space there as well. It is

quite a big site with some opportunities and it might be worthwhile exploring what those opportunities are to get that primary care right.

Mrs Akee: When people apply for government funding and they are putting submissions in on behalf of their organisation, there needs to be collaboration with the rest of the community because we are doing the same thing. We have vacant properties. The major one is over there near Castletown. That house has been standing up there for that long and we have been lobbying. We have even spoken to Chris Sarra, who is supposed to be the worker there that is in charge of DATSIP.

CHAIR: Aboriginal and Torres Strait Islander Partnerships.

Mrs Akee: Yes. We go to people like that to express our concerns but we do not get any feedback to say, 'Well, look, I've spoken to the department of housing' or 'I've spoken to this politician about your needs,' or anything like that. In the meantime, we have five properties that are vacant that could be built on to provide housing for youth. It could be built on for aged care.

CHAIR: NDIS.

Mrs Akee: NDIS clients—although we are giving up two houses now that is in existence. These five properties could be multipurpose properties that could be built there for NDIS clients. The other thing I want to say about NDIS is: when it comes to registering, I do not know whether you know how much paperwork they are requiring for you to be a registered NDIS provider.

CHAIR: You set up your own business.

Mrs Akee: Yes.

Mr Pattel: It is horrendous. It is really horrendous. It took me about nine months on my own to set up some clients. It was horrendous, it really was. I was nearly going to give it away.

CHAIR: I am glad you did not.

Mr Pattel: I just kept battling away. My partner said to me, 'Give it away.' Every time you would submit something they would say, 'You've got to do this and you have to do that.'

CHAIR: We have heard from others on the regional tour so far exactly the same thing.

Mr Pattel: Apparently it is worse now.

Ms PEASE: Not just for the providers but for the clients as well.

Mr Tapim: Can I say something?

CHAIR: Yes. I was going to say that before we go to questions I would like to get a contribution from Mr Tapim, who has been patient.

Mr Tapim: Thank you. I just want to follow on from what Graham and Mrs A have said. I think it is a lack of consultation around gaps in the services. The services are not taking advice from us, people in the community, especially elders. When our people go into services, those people working in the services do not understand Aboriginal or Torres Strait Islander. Like Cathy O'Toole said, you do not get it on a piece of paper at uni when you go; you get out in the community and learn it by them talking to you and sitting down and listening to what they are saying.

I come from the Torres Strait. The Torres Strait has five groups up there: eastern, western, central, top western and NPA. I come from the eastern group. I cannot talk western island language. Just because I am a Torres Strait Islander—the majority class us as Torres Strait Islanders, all of us, and we talk one language. Yes, we talk broken English, yes, but language wise I cannot talk western island language. I am a Murray Islander—I come from Mer—so only can talk Meriam language. Those people in those organisations and services cannot understand that. They just think they know them culturally because they are Torres Strait Islanders, but when you get down to the nitty-gritty you have to look where that person comes from. When a person from up in the islands comes to specialist services here in Townsville, you need to get that person's family or someone who knows them to come and talk to them because it is no good getting me if a western island person comes here.

The other thing is language. You get the language that is in the professionals because they do not understand the languages so they need, like we said earlier, interpreters or someone in the community like myself. I can talk to them, talk their own language, because the jargon that the professionals use is not in layman's terms to us because some of the language in English he doesn't comprehend, don't know about our language.

I was talking about the consultation about the gaps in the service. They need to understand that. In terms of the funding criteria, the funding that is directed to mainstream versus community organisations: when you give the funding to, for example, the Salvation Army to provide services for

Aboriginal and Torres Strait Islander people, it is not getting out to our people because they do not know how to get out there and talk to them. One of the conditions someone needs to put in there is to maintain that you talk to those people in the community, the First Nations people in that community—talk to them about how you are going to deliver that service to them. Most of the time, all the services are going towards administration costs and there is filtering, a little bit, coming down towards our people. They do not understand why. You try to ring us up and say, 'Can you come here and do this? Can you come here and do that?' 'You got money to pay for that, so why don't you come out and talk to us? Sit down and have a talk to us. Let's converse in that situation about our people so you understand where I am coming from.'

In the NDIS there is a lack of cultural consideration in planning and development. They do not talk to us—again. We need more Indigenous Torres Strait Islander support and conversation about how to develop those programs. We are in this era now where we need to look forward at what we want to do to improve the health services of our people in the community, not only in this community but everywhere in Queensland. Aaron, you were asking about the health service. I will tell you where it first started from. The health service started from when a mothers union, a church group—

Mrs Akee: Island women.

Mr Tapim: A Torres Strait Islander mothers union, Church of England, formed a committee and they applied for funding. It was in the time of 1973, when Gough Whitlam was in power. He was Prime Minister then. They got funding to establish the health service and the health service was established up on Wills Street, right up on the hill there.

Mrs Akee: The old house.

Mr Tapim: The old house which used to be where the Catholic Church is on the top of the hill. That is where the first medical centre was established. My parents, my mother especially, were the first ones there to establish that organisation. Then it moved from there to opposite the railway station. That is where it was until they shifted it out to Garbutt. That is the history of the health service. I was involved from that time onward with the health service and, like Mrs A, the legal service—

Mrs Akee: Garbutt Magpies.

Mr Tapim: Garbutt Magpies football, Aussie Rules, Rugby League. I have been there and I have had a look and in that time while I was there—when Borbidge was the premier then and Mike Horan was the minister for health and he established the Aboriginal and Torres Strait Islander Advisory Board and I was the chair of that advisory board, we went through all the obstacles around Queensland to talk to all the chief directors and the board members about including the health of Aboriginal and Torres Strait Islander people. One of the things that I achieved at that time was establishing the Aboriginal and Torres Strait Islander liaison officers in Queensland Health which was around North Ward. My sister and another lady were the first liaison officers and now we have liaison officers everywhere. I am glad that I was one of the ones with the chairman establishing that.

I put it to you as members of parliament: is there a body such as an advisory council, an advisory board, to your health minister? Have a look at it. That is another way of moving forward, getting that advisory board established so that they can advise the Minister for Health on improvements for our people in the community. Those people who are elected on that board will be able to explain and get the minister to understand what we were just talking about. I am all about improving, to look at what has been done in the past. Let us work on that and move forward. I have done three years in social work at JCU. I have been on the JCU council for 12 years. I got a little bit of common sense up there to understand what has been happening with my people around this country and especially in Queensland. All I want to say is: let us have a good conversation to see where we can move forward and improve the health of our people in Queensland. Thank you.

CHAIR: Thank you very much, Mr Tapim, for your passion and dedication. There is an old saying: you do not know where you are going unless you know where you have been. I am glad you took us through the history of establishing that Aboriginal and Torres Strait Islander health service here in our community. I know that each HHS has been asked to make sure they have an advisory board locally connecting communities so that we are listening and able to hear that. It is fantastic news to hear that you are both on that. I have taken note of what you were saying about maybe coming together and sitting down. Fair enough. One thing I did learn in previous work going to the Torres Strait—we had the pleasure of going up there and talking to the communities in that other work that we passed in the parliament—is how important language is. I did pick up one thing on my travels, so big eso!

Mrs Akee: Eso.

Ms PEASE: You talked about lingo and medical terms that people do not understand. Today a term has been raised that I do not understand. Mrs A, you raised it. It was AMS. What does that stand for?

Mrs Akee: Aboriginal medical service.

Ms PEASE: Thank you. It was raised a few times and I just could not work out what it was so thank you. Eso—thank you very much. I remember dealing with you both in previous inquiries and it is really lovely to see you again. Thank you.

Ms KING: What does OPG stand for?

Mr Pattel: Office of the Public Guardian.

Ms KING: I wrote it down with a question mark and then I picked it up as you went along.

Mr Pattel: There is the Office of the Public Guardian and there is the Public Trustee. The Public Trustee looks after their money and OPG looks after their mental and social wellbeing, supposedly. They have developed a culture of bullying and arrogance. They do not involve key family members in the decision-making. They are just disregarded. Some of the family members actually have numeracy and literacy problems. They cannot read and write. They are signing documents. I was always taught that if you sign a document and you do not know what you are signing for, that is fraud. Is that fraud?

Ms KING: It is pretty bad.

Mr Pattel: That is what I was taught. Anyway, if you do not understand a document, they ask you whether you understand what you are signing. They had a review. As you can see, I have got it in for them because I have had some fights with them. They had a review, apparently, not long ago. They had an internal review; it was not a public review. The results of the review were not made public. I find that very interesting to say the least. They are a public organisation, so why was their review not made public? What are some of the recommendations they have made? I do not know. You are on the committee. Maybe you should ask in the parliament what is going on.

Mr Tapim: I think there might be a breakthrough because at our last meeting I invited the Public Trustee—the Public Guardian. They came and they talked to the council of elder members and explained to us, just to give us an idea, what their organisation's process is so we can explain to our people in the community. So there is a breakthrough there, but it is not enough.

CHAIR: We are going to have to be careful and listen here. The member for Mirani has been patiently waiting to ask a question. We need to concentrate on listening to him for a moment.

Mr ANDREW: Thank you, Chair. It is lovely to see you all there today. It is sad under the circumstances that the health of First Nations peoples is being used as merchandise for others' gain and not taken seriously, like it should be. I have asked one of our guys from the secretariat to take your numbers so I can speak to you outside the committee if that is okay, Chair, down the track. We suffer similar problems up and down the coast. You may not know, but I am Kanaka born. My family is Kanaka people, Australian South Sea Islanders, from the Mackay area. We have similar situations here. I sympathise with what is going on there. There is not much I can actually ask you now except to say that it is very sad to hear your story. What you are saying is obviously 100 per cent common sense. We do need to look at it in a different way and set it up for these young people. They are going to fail if we don't; you are dead right. I will talk to you one-on-one.

Mr MOLHOEK: Mr Pattel, you mentioned there are a number of other disability service providers in Townsville. I am curious as to how many service providers are specialist in that they only provide services to Aboriginal and Torres Strait Islander peoples, or are you the only one who has sought to do that?

Mr Pattel: The best way I could answer that is: no. They will all claim that they have because it complies with the funding—NDIS compliance—but I have not seen any evidence. I do not know if Angie has, but I have never seen any evidence that they specifically target Indigenous people. Apart from the money value, I do not see any services—and I am not saying there is nothing out there that exists; I have never seen any evidence of it. I have specifically said I am targeting Indigenous people, but I will also work with non-Indigenous people if they are comfortable working with us. Because of your mixed marriages and so on, if they are comfortable working with us we will work with anybody, but we specifically target Indigenous people. To answer your question, I have never seen any evidence of it apart from us and Angie's organisation.

Mrs Akee: The only Aboriginal and Torres Strait Islander service, and the first one to be registered, was the Aboriginal and Torres Strait Islander Corporation for Women. They were in receipt

of aged-care funding as well. The clients used to go through the portal and then they would get referred out, and because they had 'Aboriginal and Torres Strait Islander' in their name they were not getting the referrals; they were not coming through. The Commonwealth department was getting on their backs because they were not meeting their KPIs. The reason they were not meeting the KPIs was they were not getting the referrals. This is why I am so adamant that, whether it be in aged care or NDIS, there needs to be a unit specifically for Aboriginal and Torres Strait Islanders, because those people would know how to send the referrals through. At the moment, like I said before, when they cannot cope with them then they refer them on to the Aboriginal and Torres Strait Islander NDIS providers. At the moment ABIS has been approved as an NDIS provider as well.

Mr Tapim: It is a bit late then, because you have missed the boat; our patients have gone.

Mr MOLHOEK: I am just trying to understand how it all works.

Mr Pattel: There are a lot of Indigenous prisoners in prison at the moment who have a disability. They are being ignored in our state prisons. They are being ignored. They let them out the gate and say, 'See you later, mate. Have a good time.' They have to re-engage. They have to go and look for a provider, and there are a quite a few of them. Sisters Inside do all the women, but the males are just let out the gate. A lot of them have serious disabilities—learning disabilities and emotional disabilities—but they are let out the gate and just patted on the head and told, 'Be a good boy.'

Mr MOLHOEK: For example, in Dalby there is an Aboriginal and Torres Strait Islander service called Goondir that is really the focus for a whole range of First Nations services. They do telehealth and I believe they are an approved disability services provider under the NDIS and all that. Is there an equivalent peak body or a main organisation in Townsville that umbrellas specialist services?

Mr Pattel: This is the best way I can explain it: there are two parts of the NDIS. I do not know if you know much about the NDIS. You have the coordination and then you have the support. The coordination looks after their programs. They look after the budgets; they do all the budgeting for the programs from their planned budget. The support comes in and does the shopping, takes them to a doctors and all those other things—cleans their homes, mows their lawns. The money is in the coordination. What happens is that when the coordinator sees that they are Aboriginal and Torres Strait Islander people—they have this nice saying: you have a choice. Everyone has a choice in the NDIS. Yes, they do and they should, but what happens is that the non-Indigenous coordinators do not tell them about the Indigenous providers. They tell them nothing. They just put them under their wings and grab them. They do not give them the choice by saying, 'Hey, we know of an Indigenous service that can support you.' They do not tell them that. There goes the choice out the window. There is no choice; it is just words.

CHAIR: That is a really good point.

Mr MOLHOEK: Is your service the coordinator?

Mr Pattel: No, mine is support. In other words, I work with a coordinator. I rely on a coordinator. They say, 'Righto, Graham, can you do the support program?' That is less money but it pays the bills. I am not going to complain about that.

Mr MOLHOEK: But there is not a peak Indigenous service provider that just looks after the coordination in Townsville?

Mrs Akee: No, and that is what I am saying: there needs to be that.

Mr Pattel: I cannot afford to pay coordinators at this stage because they are on about 85 grand a year, a good coordinator.

Mr MOLHOEK: That has been helpful, thank you.

Ms KING: Thank you all for being here today. I know it has been a long day. We have covered a lot of ground. You have given us a lot to think about and we appreciate it very much. My question is for Mr Pattel. I think I know the answer, but I would like to hear it from you. Would you like to see NDIS clients, when they get their package approved, directed straight to an Indigenous-led service? Is that what you would like to see?

Mr Pattel: I would like the opportunity, put it that way. I would like the opportunity to talk to that client—

Ms KING: See what they want?

Mr Pattel: Yes. They can make their own choice, but I would like to have the opportunity so that they are aware that we have a service there if they want to use it. It is about choice. At the moment we are not getting that choice. They are cutting us off at the pass. They are not even

mentioning Wulli Wulli or any black organisation. They are just grabbing them and putting them under their wings. Then they get to a stage where the client is saying, 'I don't like you guys. I can't talk to you. I don't feel comfortable.' Then they get us in. Do you see what I am saying?

Ms KING: Yes. So they take the easy, profitable ones and when the system fails then they suggest that they access an Indigenous service.

Mr Pattel: Because they want to keep the client, see.

Mrs Akee: Can I just say that the organisation that has the assistance program here has been sending young people into accommodation for independent living, but they have alcohol problems and they have drug problems. If it was me dealing with our own people, from the very start I would have said, 'This person needs to go into a rehab program first.' They have to get over their substance abuse and then you put them into independent living. What they are doing is just shoving them in there. Then when the worker or the coordinator sees that this person has an alcohol or a drug problem, they say, 'That's okay. It's their choice. They can go down to the park every day and drink.' But the worker has to go with him and sit down there and watch him while he drinks his drink. He is a chronic alcoholic.

They had a young girl who went in there. She was on drugs. 'Oh, it's alright; she can take the drugs but she can't smoke dope on the property.' So she has to go somewhere else. Then she gets geed-up because she wants to stay home and smoke dope. These are all the problems, but they are not getting properly assessed. Only we can get it through to them. When non-Indigenous people are trying to talk to them, they are just saying, 'Get them out the door! Get them out the door!'

Mr Pattel: The bottom line is that we need a seat at the table to take part in the process—that is what we are saying—whether it is at the federal level or the state level, because it affects both of us. It affects both state and federal. To me it is a no-brainer because you are sitting and talking about people and you are letting them know that they have mental health issues, they have alcohol problems, they have drug problems. Straightaway you are identifying the issues so you can design a program around their needs and their families.

Mr Tapim: There is a lack of consultation, like I said earlier, amongst all of us. We are trying to improve everybody's health—our own health and everybody in Queensland—but to improve our health you have to have a conversation with us. You need to sit down with us and have a good conversation with us so that then you can understand where we are coming from and you can get a good idea of what we want from you.

Mrs Akee: But the Commonwealth has the responsibility in terms of aged care. I do not believe that they are doing a good job in that particular area.

CHAIR: That is being highlighted right now with COVID. On that point, I would say two things. Thank you very much for your contributions. I am going to learn a lesson here and say to the secretariat that we might start our future hearings with the traditional owners and elders. We will reverse the order so we get you guys to sit at the table first. Thank you for being so patient. On the plus side of going last, we have gone for an hour so you have had the most time.

Mrs Akee: Yes, that is one good thing about it.

CHAIR: There are pluses and minuses to that. I cannot thank you enough. We have learnt so much in terms of the valuable contribution that you have shared with us today. On behalf of the committee, thank you for your work. We are looking forward to hearing how your work goes on the advisory committee. I want to thank you very much for your contributions. I now declare this public hearing closed.

The committee adjourned at 2.22 pm.