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HEALTH, ENVIRONMENT AND INNOVATION COMMITTEE

Members present:

Mr R Molhoek MP—Chair
Ms SL Bolton MP
Ms K-A Dooley MP
Mr JP Kelly MP
Mr DJL Lee MP
Hon. MC Bailey MP

Staff present:

Ms K Jones—Committee Secretary
Miss A Bonenfant—Assistant Committee Secretary

PUBLIC BRIEFING—QUEENSLAND HEALTH PORTFOLIO AREA BRIEFING

TRANSCRIPT OF PROCEEDINGS

Wednesday, 4 March 2026

Brisbane

WEDNESDAY, 4 MARCH 2026

The committee met at 9.30 am.

CHAIR: Good morning. I declare open this public briefing for the committee's portfolio area briefing with Queensland Health. My name is Robert Molhoek MP. I am the member for Southport and chair of the committee. I acknowledge the Aboriginal people and Torres Strait Islander people of this state and their elders past, present and emerging. I also acknowledge the former members of this parliament who have participated in and nourished the democratic institutions of this state. Finally, I acknowledge the people of this state, whether they have been born here or have chosen to make this state their home and whom we represent to make laws and conduct other business for the peace, welfare and good government of this state.

With me here today are Mr Joe Kelly MP, member for Greenslopes and deputy chair; Ms Sandy Bolton MP, member for Noosa; Ms Kerri-Anne Dooley MP, member for Redcliffe; the Hon. Mark Bailey MP, member for Miller, who is substituting for Dr Barbara O'Shea MP, member for South Brisbane; and Mr David Lee MP, member for Hervey Bay.

This briefing 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. Witnesses are not required to give evidence under oath or affirmation, but I remind witnesses that intentionally misleading the committee is a serious offence. I also remind members of the public that they may be excluded from the briefing at the discretion of the committee. I remind committee members that officers are here to provide factual or technical information. Any questions seeking an opinion about policy should be directed to the minister or left to debate on the floor of the House.

These proceedings are being recorded and broadcast live on the parliament's website. Media may be present and are subject to the committee's media rules and the chair's direction at all times. You may be filmed or photographed during the proceedings and images may also appear on the parliament's website or social media pages. If you have not already, please turn your mobile phones off or onto silent mode.

HEBSON, Ms Naomi, Deputy Director-General, Healthcare Purchasing and System Performance Division, Queensland Health

LEPPER, Mr Blake, Deputy Director-General, Health Infrastructure Queensland, Queensland Health

ROSENGREN, Dr David, Director-General, Queensland Health

CHAIR: I now welcome representatives of Queensland Health who have been invited to brief the committee. Please remember to press your microphones on before you start speaking and off when you are finished. I invite you to provide a brief opening statement, after which committee members will have some questions for you.

Dr Rosengren: Thank you very much, Chair. Good morning, everyone. To commence, I would like to reinforce my appreciation to the committee for giving us the opportunity to attend and present today. It is always for me an extraordinary privilege to be part of an organisation like Queensland Health, and I do wish to up-front acknowledge the extraordinary work that is done on a daily basis across Queensland by the approximately 140,000 people who take ownership and responsibility for the delivery of health services to the community across the state of Queensland. Queensland Health is a very large organisation. There are over 100 reporting hospitals. We have an infrastructure portfolio of over 2,000 buildings and, as I said, a workforce of approximately 140,000 people, and substantial service delivery depth and breadth across the state.

Queensland Health as an entity is, as I have said, very large. The Department of Health, whom we are representing through the annual report this morning, is the system leader or the system manager. Through the contractual arrangements we have with the 16 hospital and health services, we support and oversee the delivery of health across the state. In addition to that, we also have Brisbane

significant partnerships with other sectors, including the private and the non-government sector, and in particular our agreement with Mater Health Service around the hospital and health services that they provide, and then there are a number of statutory agencies that, while not part of the Department of Health portfolio, work alongside us through the Minister for Health and Ambulance Services' portfolio.

Queensland Health is a very large contributor to the delivery of health services. We are not the only contributor. We do work in partnership across the state to ensure health service is available and delivered, and we have strong interconnected relationships with the Commonwealth and, notably, in particular around their primary roles with primary health care and also aged and disability services and, as I have already mentioned, we have significant interactions with the private sector and the non-government sector and community controlled healthcare providers.

The Queensland Health leadership oversees the delivery of a strategic plan. That strategic plan has recently been refreshed and renewed. There are five core underlying priorities through the strategic plan which you will see are demonstrated not only through the annual reporting but also through the priorities that we are focusing on. Those five priorities are: workforce, sustainability, access to care, innovation and health asset management.

Again, I would like to ensure that the extraordinary work done by our healthcare workforce across the state is well recognised. Obviously, I like to call out our frontline clinicians—doctors, nurses, midwives, allied health professionals—but also recognise that much of the healthcare service is supported by a critical support workforce that ranges from security protective services to kitchen staff to gardeners to patient support officers, all the way through to finance, legal and all the other components—payroll et cetera. On that note, Chair, I would like to make ourselves available to respond to any questions and to support the committee.

CHAIR: I note in the report that over the past five years rising costs and shortages of materials and labour have delayed completion of major health projects. Were there any other contributors to increasing costs in health projects over the last five years?

Dr Rosengren: I will start providing a response and then refer to Mr Lepper. Essentially, the delivery of an extensive health infrastructure program does present numerous challenges. Shortly after commencing in my role as the director-general, we recognised that the capital expansion program that was committed to had substantial challenges around the delivery, both within the cost aspects of it as well as in scope and timeframes. We commissioned a detailed, independent review of the program at that time, and the recommendations and the findings from that review very clearly called out the challenges that we face with regard to the delivery of the program. Cost of materials obviously is a major contributor, and we have seen that not only in Queensland but also nationally and globally although, pleasingly, some of those pressures have stabilised in the last 12 months. That has been helpful to us with regard to our planning.

One of the other challenges we had with the infrastructure program was that in various aspects—and this was identified very clearly in the capital expansion program review—there were deficits associated with the engagement across the system such that many of the projects lacked many of the key elements that were essential for the delivery of the services that the community required and based on the service needs and the assessment. A substantial amount of work is needed to be done to re-engage, reassess and sense-check against the clinical service needs and the demand growth profile to reframe a number of those projects and then recommit to them. As part of that process, not only have we been able to absolutely commit to the entire program but also we have had the ability to substantially expand the program with additional capacity and ensure that those unmet needs, whether they be things such as pathology services or kitchen services et cetera, can be delivered. In the context of key drivers for cost, I will hand over to Blake to add further detail.

Mr Lepper: Fundamentally, we can only deliver hospitals at the speed that there is the market capacity to deliver. Hospitals are a very unique and specialised part of the construction market, and a history of lower levels of investment into health infrastructure in Queensland meant that it really was a growth curve that the Queensland industry needed to come up.

We now look at where we are sitting, as we head into the next round of projects, feeling that we are in a really fortunate position. The work that is well underway on Logan, QEII, Princess Alexandra and Ipswich hospitals has started to develop that highly skilled workforce that we need to deliver the health infrastructure pipeline of the future, and we are seeing really strong desire from firms, subcontractors and individuals that have been engaged in those projects to continue to stay and invest in Queensland and support the program going forward. We are grateful for that momentum and really focused as a department on how we continue to build on that—continue to make Brisbane

Queensland the most attractive place for people to be locating their companies and their skilled workforces so that we can continue that positive momentum and deliver the forward pipeline of work we have ahead of us.

Mr BAILEY: The Audit Office report outlines rising costs and shortage of materials and labour for health infrastructure projects as they compete with other projects in the lead-up to the Olympic and Paralympic Games. Director-General, is it a concern that that decision to delay hospital expansions beyond the forwards and to prioritise Olympic transport and infrastructure builds has an impact in terms of dealing with health demand?

Dr Rosengren: It is absolutely essential, if we are going to be investing such a substantial amount of funding into building infrastructure for the healthcare system, that it meets the needs of the community from the point of view of the service profile and the future demands. As we know, when we create health infrastructure we need to create that infrastructure with the expectation that it will serve that local community for many decades to come. We appreciate, through lived experience, the implications when we design infrastructure that is not fit for purpose or does not meet the needs, and then the longer term cost on the community to address those deficits and to meet the needs is substantially higher.

We are recognising the critical significance of the demand pressures we face at this point in time. We understand the criticality of having capacity to meet community needs, and we balance that out with the recognition of what the demand forecast is for the future and the need to meet those services. In particular, if we are trying to create infrastructure with additional bed capacity that does not have the support infrastructure such as pharmacy supply chains, medical imaging services and kitchen expansions to be able to provide food for the patients in the hospital then we certainly do not meet our obligations to the community about providing infrastructure that is suitable and fit for purpose.

The other thing we have to understand is that we need to be able to create an environment where we can optimise the efficiency of the workforce when we understand very clearly that there is a workforce challenge as we move forward. If I can pick two particular projects—and these were clearly highlighted through the independent review into the capital expansion program—they would be the substantial programs in both Toowoomba and Bundaberg, where there was a proposal to create smaller scale hospitals and deliver our public acute hospital services across separate sites in the same community. It was very clear from the advice that that would create substantial challenges in workforce sustainability and cost sustainability. Reprofitting the projects in order to meet the future needs of the community is a commitment that we have made, and we are very confident that the implications of that will ensure the communities get long-legacy benefits as a result of the infrastructure. Blake, do you want to add to that?

Mr BAILEY: I am fine with that. I am happy to ask a follow-up, if that is alright, Chair?

CHAIR: That is fine.

Mr BAILEY: Director-General, you just outlined that you believed there were some adjustments that were required on some of the plans for hospital expansions. As the chief operating officer, you were one of the key people involved in the capital expansion program in the first place; is that right?

Dr Rosengren: No, that is not correct. Infrastructure was not part of the portfolio of the chief operating officer at the time.

Mr BAILEY: In your response to the Audit Office report, you said—

Queensland Health is aware of these challenges and is continually developing and reviewing strategies to contain costs across the delivery of the portfolio.

Can you outline what those strategies are, for the committee's benefit?

Dr Rosengren: To clarify: are you specifically referencing strategies to control cost escalation in the forward program? Is that the question?

Mr BAILEY: Yes, that is right, in terms of delivery of the portfolio.

Dr Rosengren: We are making some substantial changes to strengthen the capacity of Health Infrastructure Queensland in order to deliver the program within the timeframes and budget that have been established. Many of those are being worked through in a methodological manner as a result of the recommendations that were presented and accepted by government as part of the independent review of the capital expansion program. That has included a restructuring of the way we run Health Infrastructure Queensland within the Department of Health and clarifying the responsibility

relationships between the department as the deliverer of health infrastructure and the hospital and health services as the commissioning and operating agents with the infrastructure once it is completed.

There has been a substantial amount of work done to address issues around the contracting model between Health Infrastructure Queensland and the industry, in particular looking at issues around productivity and addressing challenges around the cost overheads associated with the contractual model that we had committed to previously. That is not completely unique to Health Infrastructure Queensland. Across all government agencies there have been adjustments to the contracting models in order to optimise the ability to get a productive workforce for the efficient delivery of our infrastructure.

The other thing that is particularly important is to ensure we have a rolling pipeline and a forward program of infrastructure that provides clarity to industry around the future pipeline of work in Queensland in order to not only attract but also retain a heavy infrastructure workforce. In fact, the clarity and the strength of improvements between Health and the industry has been a substantial benefit from the point of view of Queensland being an attractive location for major construction industries to establish themselves, and that will be very helpful as we ramp up infrastructure in other components such as the Olympics program that you have referenced. I will hand over to Blake to see if he wishes to add anything further.

Mr BAILEY: I am happy to take that and hand over to the member for Noosa, if she has a question.

CHAIR: I was going to go to the member for Redcliffe next.

Mr BAILEY: I am happy with that.

Ms DOOLEY: First, I want to say thank you to Dr Rosengren. Looking after 140,000 staff is no mean feat. Thank you for the work you have all done for the report. In particular, I want to put on the record my thanks to all of the staff at Redcliffe Hospital, which is in my electorate. As we look forward to the new Redcliffe Hospital and as we look at workforce development, your report does say that a lot is being done to look at that commitment and growth. Could you outline some of those strategies for us, please?

Dr Rosengren: It is very clear that Queensland Health's most significant asset is our workforce. We have just been talking about the significance of our infrastructure program across the state. Notably, over the next four to five years we are committing to bringing on an additional 2,600 beds as well as many of the other service improvements and expansions beyond the capital needs.

In order to meet not only the needs of the additional infrastructure but also the rise in community demand as we have an aging population with increasing complexity of disease, we predict we will need to grow our workforce by over 45,000 people over the next four to five years. That is an extraordinary challenge for us. When you take into consideration the changing demographic of a workforce that has less of a tendency to work the same proportion that we are familiar with from previous workforce data, and when we take into consideration many other competing industries that provide good job security and good return without requiring a 24-hour-a-day, seven-day-a-week commitment, it is challenging to recruit a workforce.

We have just completed a very detailed workforce gap analysis—and it is publicly available—and it clearly identifies the challenges that Queensland Health faces. They are not unique to us. We recognise that these are challenges that we must face within Queensland from a workforce supplier perspective in a highly competitive environment at a national and international level. The workforce gap analysis has shown very clearly that if we focus on our forward needs by simply continuing to implement the programs that we currently have in place we will have substantial gaps over the forwards with regard to many of our professional subgroups. More concerningly, we will have an increase in the maldistribution of workforce supply in rural and regional Queensland compared to the metropolitan areas.

The workforce gap analysis has been very clear. We are in the final processes of articulating a detailed workforce strategy in response to our gap analysis. We are working very closely with Queensland cabinet and Treasury to formalise that through part of the 2026-27 budget process, but we are not waiting to get moving on some of the initiatives.

I will not go into the broad range of strategies around improving our pipelines of recruitment into the workforce and making sure we have retention strategies to keep our workforce once we recruit them. It is very notable in the gap analysis that we can be very effective at recruiting people into health care, but the attrition rate in the early stages, particularly in our clinical workforce, is quite

high. In fact, it is not just in our clinical workforce. In many of our support workforces, including our tradespeople, we find that at the two- to three-year mark we have an attrition rate. One of the strategies is about creating pathways for career development, career progression, career diversity and optimising scope of the practice of the particular employee.

The final component of it is about making sure we create pathways to ensure the professional workforce that we do have is operating at their maximum scope. It is very likely that, moving forward, we will need to identify new strategies for new workforce models, and that will be a very strong focus of our workforce strategy moving forward.

CHAIR: At the beginning of your statement you mentioned the changing nature or behaviour of the workforce. Could you perhaps explain that? Does that mean people are working less, are working more to rule or are more focused on work-life balance? What is the change that you are observing?

Dr Rosengren: It is a very multifactorial issue, and I hesitate to go into too much depth and make myself sound old and prehistoric. However, it is very real that the expectations of the emerging workforce continue to evolve. It is not unique to us. I remember hearing those concerns being raised when I was a junior doctor in the emergency department, where my senior colleagues would frequently berate me about different approaches to things. It is something that we understand well. It is something that requires us as a system to always be alert to—the need to be adaptive and responsive in the way we support our workforce, create our infrastructure and provide pathways for career progression that meet their needs.

One of the biggest challenges for the health workforce is the fact that we operate seven days a week, 24 hours a day. It does not matter what is going on in the world around us, our hospitals and our health services will always continue to operate independent of anything. We saw that roughly this time last year when the cyclone came across the coast, particularly on the Gold Coast and in the metro region, we saw the substantial challenges in Townsville and Ingham earlier last year when they had torrential flooding, and we saw that in Central Queensland and South-West Queensland during the unprecedented flooding as well.

Attracting a workforce, retaining them and giving them a value proposition in a very complex and challenging environment is difficult. We do have extensive strategies, and some of those are already in place with regard to attracting people into training pipelines and attracting people into working for Queensland Health. We also have a range of attraction, retention and other strategies to support people, particularly around the geographical distribution and the rural and remote challenges that we face because that is where there is a very disproportionate issue.

Notably, in the last 12 months we have successfully negotiated and signed off on five major enterprise agreements with the vast bulk of our workforce. They include a whole range of improvements around recognising the challenges. Both our MOCA agreement for our medical officers and our agreement for nurses and midwives have included adjustments for recognising the challenges of working night shift across a 24-hour cycle, for example.

Through all of our arrangements, we have also been investing in strategically targeted improvements for rural and regional areas around recognising the difficulties and the challenges. We have incentive programs for nursing students to do placements in locations, and we have been very active in supporting incentive programs for general practitioners to enter into GP training to try to grow that rural and regional general practice workforce as well. Again, the list of issues and the list of initiatives is extensive. I will stop there, but I am open to any specific questions you might wish to follow on with.

Ms BOLTON: I too would like to say what a fabulous job you do. It is a huge one with a huge responsibility, and we do really appreciate it. The annual report outlined some targets that were not able to be reached in infrastructure and the workforce. Did anything else contribute to some of those, including emergency care? What types of strategies are being implemented to address those?

Dr Rosengren: If you have any particular performance metrics, I am happy to respond to them specifically. When we look at the data in the annual report, in particular the SDS performance data, very pleasingly, despite the challenges that we face, Queensland Health has demonstrated improvement in many of the performance areas. In some of those we have held the line and there are some areas where we have certainly struggled to hold back the tide.

Ms BOLTON: I can give you an example. Almost all SDS measures for emergency care did not meet the target.

Dr Rosengren: I think it is very important to recognise that we do a comparative measure of performance, and we do need to take that in the context of the growth in demand and the challenges we face with regard to substantial growth in community expectation. We have done an extraordinary amount of work at investing in whole-of-system flow. When you look at emergency department performance—and that emergency department performance might be in the form of an emergency length of stay, ambulance off-load times et cetera, which are frequently referenced and discussed—they are in fact a reflection of the system capacity in our inpatient wards and in our discharge pathways. So we have been very deliberate and very strategic in our target investments across the entire spectrum of the patient's episode of care, not just specifically in strategies at the front door which might potentially give a technical improvement but do not improve patient experience or patient outcome.

We have certainly in the last three to four months seen substantial improvements in all of our throughput indicators. I think the most recent publicly released data around our emergency department performance showed substantial improvement in ambulance ramping as an index marker of ED performance, and we are very pleased with that. While the strategic investments across the patient journey take some time to anchor in and have an impact, we are seeing definite signs that that whole-of-system investment—and we can work from the front into the back or in reverse order.

We have committed to investments in discharge transit lounges to support people being discharged from hospital. We are investing in additional medical imaging capability in our community sites to try to reduce the competition for access to diagnostics inside our acute hospitals by creating alternative pathways for our ambulatory patients to receive care. We are investing additional resources into our individual hospitals with regard to acute medical admission units and other workforce strategies. We have committed to an additional 500-plus beds in the subacute sector to support the outflow of patients experiencing delayed discharge while they wait for access to residential care.

If I can comment specifically on one part of your question as to the sorts of factors that underpin that, very clearly the market failures in aged care and the inability of the Commonwealth to rise to the challenge and provide access and capacity in aged care are substantial challenges for us. Nationally that is a challenge. It is notable that Queensland proportionately has had the largest impact of all states and territories with regard to the delayed discharge of older patients. In our most recent census we have seen a further five to 10 per cent increase in the number of patients who are currently in our acute hospital system not of their own cause but simply because there is not a pathway out for them to access residential care.

This is further complicated by the fact that in our acute public hospital system the patients that tend to have greater struggles to access residential care are also the patients who are the highest demand with regard to behavioural, cognitive and other health related circumstances, so that is a substantial burden. We have the equivalent of the Royal Brisbane Hospital plus Redland Hospital approximately that are occupied 24 hours a day, seven days a week with people who are simply stranded because of the inability to find them an appropriate place for residential care. That is a completely unsuitable situation for those patients, for their families and for the acute hospital system as well.

Mr LEE: I want to take you to page 26 of the annual report where it speaks of capital maintenance being historically underfunded. Can you give me some practical examples of the infrastructure and maintenance issues being faced at Gladstone Hospital?

Dr Rosengren: Gladstone Hospital is certainly an example, and I will pass to Blake in a moment to provide specifics. It is notable that much of the infrastructure at Gladstone Hospital is quite aged, with the main blocks at Gladstone Hospital being 40 or more years old. There have certainly been challenges with regard to keeping up with the maintenance needs of Gladstone Hospital relating to the capacity to fund through the pre-existing sustaining capital program. It is also notable that in 2020 a decision was made to purchase the Mater Private Hospital in Gladstone which was co-located on the site. It is now called block 7, or the west wing. At the time that was purchased there was an inability or a failure to undertake the necessary due diligence until the hospital had been handed over. At the time that occurred it was very apparent that substantial components of the infrastructure were beyond end of life, and that has then resulted in substantial challenges for the Central Queensland health service with regard to investments to bring that infrastructure up to the level that is required.

The most important challenge with some of our infrastructure is that the sustaining capital program was commenced in 2012, I think, with an annual commitment of \$325 million over an asset base which was estimated at the time to be about \$8 billion across Queensland Health. Over the next 10 years the asset base essentially quadrupled to about \$32 billion to \$35 billion, but the base

allocation through the sustaining capital program was not increased at all and was still \$325 million a year. As a result of the growing demands for deferred capital and maintenance requirements, certainly at the time I became director-general it was apparent that in order to meet those emergency needs the \$325 million a year was grossly inadequate. There had been a forward draw on all of the subsequent years in the forward estimates and expended, and there was a commitment of over \$3 billion worth of infrastructure with no capacity for us to fund that. We have done a substantial redesign of the entire program and established a new program. In the short term there has been a commitment to more than double the investment through that program. I will hand over to Blake to expand on that.

Mr Lepper: Gladstone Hospital is a great example of the challenges we are facing in the system and the compounding effects when operational maintenance is not carried out and when capital maintenance is deferred. A hospital building will last 70 to 80 years if we can keep it dry and weathertight. A roof will last 25 years if we paint it, clean it and keep it going. If we fail at those simple early tasks, if we do not paint the roof, it will last 15 years and not 25. If we do not replace it as it starts to age, the weathertightness of our buildings will fail. Look at the issues we have observed around mould build-up and early damage to services because they are operating environments for which they were not designed. That is the challenge we are facing across the system.

We are now at this point where lots of little decisions have added up to these really significant challenges we are facing within our campuses that are going to take a period of time for us to resolve. That really is what we have been focused on with the Timely Investment Infrastructure Maintenance program—that is in the program—which is really trying to line up not only getting that additional funding required to start to shift the dial on these but also looking at how we do that with the right incentives. How do we make sure we are empowering those within our facilities closest to the front line who really understand this infrastructure to make those prioritisation decisions around what are the most acute and important things to be investing in, but wrapped within a framework so that we can get confidence across the system that it is going to the right asset classes and the right amounts over time so we can start to get ourselves out of these challenges?

Mr LEE: The report also notes that Queensland Treasury provided \$800 million to the department to address cash flow challenges across the health system.

CHAIR: Do you have a quick response to that?

Dr Rosengren: The quick response is that the \$800 million was to support the departments to ensure cash flow viability of the health services as a result of substantial commitments of healthcare delivery that were being committed to that had no funding source allocated. There is a much longer answer. We can come back do it.

Mr J KELLY: I would probably dispute the notion that if you keep a building watertight it will go on forever. I have worked in plenty of old hospital buildings, and I think back to a lot of the ones I worked in that just would be no longer fit for purpose for modern health care.

CHAIR: Do you have a question?

Mr J KELLY: I do, Chair. Since the introduction of the department's ramping and ED stay KPIs, have there been changes or additions or HHS training for paramedics, emergency doctors and nurses around these KPIs?

Dr Rosengren: I am not sure I quite understand the question about training-specific KPIs. We do not train people to KPIs. Clinical staff are trained according to the clinical services they deliver. I am not sure whether there is a clarification you can provide on what you are requesting.

Mr J KELLY: Director-General, the Premier made an election commitment to deliver year-on-year ramping targets. Can you outline the KPIs for 2025-26 and 2027, please?

Dr Rosengren: I might hand over to Naomi, who oversees the service-level agreements.

Ms Hebson: The commitment is to reduce ramping to 30 per cent by the end of term, which is 2028, so that is the goal and the target that we are working towards. We are obviously working with HHSs individually to understand where they currently sit and where they need to improve in order for us to deliver that system. In terms of targets, the target is the 30 per cent reduction by 2028.

Mr J KELLY: The new satellite health centres, formerly known as hospitals—big change—mentioned on page 31 were established by the previous government, and they are noted as successfully assisting in drawing demand away from emergency departments. Given this is an independent, positive assessment of them by the Audit Office, has the department modelled an expanded concept to more areas, including regional areas, to take further pressure off EDs?

Dr Rosengren: The satellite health centres certainly have been well received by the communities within which they are located. We are in the process of finalising a structured review into the impact of the satellite health centres, so I am reluctant to absolutely commit to findings until that proper analysis is completed and available. It is very clear that the satellite health centres are busy and that the demand, particularly on the minor injury and illness clinics, is substantial for people who are struggling to access health services in other locations.

The impact on emergency departments is still being assessed, but we have not seen a significant reduction in demand of any sort on our emergency departments. We have seen a difference in the profile of the lower urgency cohort of patients, which are the triage category 4 and 5 patients in the emergency departments, where we have proximate access to a satellite health centre. The purpose of the satellite health centres is not to reproduce or replicate emergency departments or hospitals but to provide an alternative site for the local community to access care for minor injury and illness. To all intents and purposes, our understanding at this stage is that it is very effective at providing that support, but in fact it is more likely that it is meeting an unmet demand for health care in the community rather than being a primary pivotal reduction in demand on our hospital emergency departments.

Mr BAILEY: When will the evaluation that is being conducted by Health Infrastructure Queensland on the impact of satellite health centres be complete?

Dr Rosengren: The evaluation is not being undertaken by Health Infrastructure Queensland. It is being undertaken by Clinical Excellence Queensland. It is an evaluation into the impact from a demand perspective as well as a patient experience and a clinician experience perspective. I do not have an exact date when that will be due, but it is underway currently.

Mr BAILEY: Do you have a ballpark figure?

Dr Rosengren: It would be inappropriate for me to propose that in a committee hearing when I do not have clarity around that. It is underway.

Mr J KELLY: You mentioned building 500 more subacute beds. Could you outline the nature of those? Are they going to be rehab beds or are they just going to be a holding pen for people who are ready for discharge?

Dr Rosengren: No. I referenced that we have purchased capacity for 500 beds. We are not building those beds. We already have patients in them. Those are patients that have subacute—

Mr J KELLY: Where are you purchasing those from?

Dr Rosengren: From a variety of different providers according to the location.

Mr J KELLY: Are they being pulled from private hospital beds and aged-care providers and so consequently exacerbating the problem that you are trying to fix?

Dr Rosengren: No. It is buying capacity that exists in the system that otherwise is not being utilised. The private system has every motivation to run its own business and fill its capacity. Where we are purchasing that additional capacity, we are doing that for a two-year time period while we give the Commonwealth reform around aged care an opportunity to embed and have an impact.

Mr J KELLY: Can I ask a question on notice that we get a list of where you have bought those additional beds from?

Dr Rosengren: Naomi may wish to—

Ms Hebson: I do not have that in front of me.

CHAIR: You are happy to take that on notice. We will go back to the member for Hervey Bay.

Mr LEE: I want to take you back to the issue of the historically underfunded capital. Page 26 of the Auditor-General's report states—

In the 2025-26 budget, \$671.9 million has been allocated compared to \$215 million last year, to help address these needs and balance the shortfall.

That is referring to capital. Can you explain why such a significant investment was needed and what funding was previously available in the forward estimates?

Dr Rosengren: That refers back to my earlier answer around the previous sustaining capital program. That is where \$325 million was allocated per year and had been the same amount over a 10-year period. It was further complicated by decisions that had been previously made that a range of other programs would be funded from the sustaining capital program and in particular they were

funding the Building Rural and Remote Health Program, as well as the Accelerated Infrastructure Delivery Program, which are two new capital programs that did not fall within the domain of the sustaining capital program but a determination had been made to fund it.

Through the budget process last year, the Queensland government not only increased the sustaining capital program funding to \$670 million for this current financial year but, in addition to that, separate funding was provided for the Building Rural and Remote Health Program and the close-out of the AIDP program as well. The additional investment into our capital program was far more substantial than just the increase in our maintenance because the other non-core components that had been funded were funded separately through the Treasury process in the last budget.

On top of all of that, with regard to the forward estimates, all of the forward estimates allocation for the sustaining capital program had been bought forward and expended, and there was still a substantial deficit that we were facing with regard to commitments without a funding source. It is a very complicated scenario, but we have completely reframed and reformatted our program, as Blake referenced, through the Timely Investment Infrastructure Maintenance program, the TIIM program. We have a much more structured program with the hospital and health services where they have an allocation according to the proportion of asset that they are required to maintain. They get an allocation on a rolling two-year basis so that they can run their program with more confidence over the timeframes and deliver improvements. We have seen a definite substantial improvement in the way they engage and deliver that program as a result.

Mr BAILEY: I want a clarification based on a previous question. Director-General, you mentioned that Clinical Excellence Queensland is conducting the review in terms of satellite health centres. Page 34 of the audit report says that Health Infrastructure Queensland is conducting that evaluation. Does the Audit Office have the wrong agency attached to that? That was the basis of my question which you said—

CHAIR: You can take that on notice, if you want.

Dr Rosengren: I cannot answer on behalf of the Audit Office. That would be a question for the Audit Office. I can provide you with the answer to the question. It is being undertaken by—

Mr BAILEY: Page 34 makes it clear it is Health Infrastructure Queensland. You are saying it is Clinical Excellence Queensland. If we could just get an answer on notice, that would be great. I would appreciate that.

CHAIR: I declare this briefing closed.

Mr LEE: Chair, in relation to my question about Queensland Treasury and the \$800 million cash flow shortfall, in the interests of a more fulsome response, can you please take that on notice?

CHAIR: Yes. In closing these proceedings, I note that answers to the questions taken on notice are required by Friday, 13 March. We have three questions: one is a clarification, one is about the \$800 million and the other is where the beds were bought. I declare this briefing closed.

The committee adjourned at 10.20 am.