HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

Members present:

Mr AD Harper MP (Chair)
Mr MF McArdle MP
Mr MC Berkman MP
Mr MA Hunt MP
Mr BL O'Rourke MP
Ms JE Pease MP (via videoconference)

Staff present:

Mr R Hansen (Committee Secretary)
Ms A Beem (Assistant Committee Secretary)

PUBLIC HEARING—INQUIRY INTO THE QUEENSLAND GOVERNMENT'S HEALTH RESPONSE TO COVID-19

TRANSCRIPT OF PROCEEDINGS

MONDAY, 13 JULY 2020

Brisbane

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The committee met at 10.15 am.

CHAIR: I now declare this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee open. I would like to start by acknowledging the traditional owners of the land on which we are meeting today and those right across Queensland. Today's proceedings are being conducted using videoconference facilities so I ask all of our participants or anyone watching the live broadcast to please bear with us if we encounter any technical issues. I also ask everyone participating in today's proceedings to please turn your mobile phones off or switch them to silent and mute your microphones unless you are speaking to prevent any audio interference and background noise.

I am Aaron Harper, chair of the committee and member for Thuringowa. The other members of the committee with us here today are Mark McArdle, member for Caloundra and deputy chair; Michael Berkman, member for Maiwar; Marty Hunt, member for Nicklin; Barry O'Rourke, member for Rockhampton; and joining us online is Joan Pease, member for Lytton.

The purpose of today's hearing is to assist the committee with its inquiry into the Queensland government's health response to COVID-19. This hearing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath, but I remind everyone that intentionally misleading the committee is a serious offence. Hansard will record the proceedings and you will be provided with a copy of the transcript.

BENEDET, Mr Gerard, Queensland Branch Director, Pharmacy Guild of Australia (via videoconference)

CAMPBELL, Mr Chris, General Manager Policy and Queensland State Manager, Pharmaceutical Society of Australia (via videoconference)

MacDONALD, Mr Shane, Queensland President, Pharmaceutical Society of Australia (via videoconference)

TWOMEY, Professor Trent, President and Senior National Vice-President, Queensland Branch, Pharmacy Guild of Australia (via videoconference)

CHAIR: Good morning, gentlemen, and thank you for being here. In view of the hearing today being broadcast via videoconference and given the absence of name plates, I ask that you please identify yourself by name when speaking, particularly speaking for the first time. I might ask the Pharmacy Guild of Australia to start with a brief opening statement and then we will move to the Pharmaceutical Society of Australia. It might be worthwhile, gentlemen, if we also give a brief overview of the two different bodies and what you both do before we start. I invite Professor Twomey to make an opening statement.

Prof. Twomey: Thank you for that, Chair, Deputy Chair and members of the committee. I would like to start by acknowledging the traditional custodians of the land on which we meet and pay my respects to elders past, present and emerging. In doing so, Chair, on your left hand side you will note the print on the wall. If I am not mistaken, that was done by Deann Grant, who is the sister-in-law of the Speaker of the parliament. She is a Yarrabah woman and she is from the footprint that I represent in Far North Queensland. I was pretty pleased, when I dialled in, to see that on the wall.

The Pharmacy Guild of Australia is the registered organisation under the registered organisations act that represents community pharmacies, the infrastructure that employs some 70 per cent of the 6,000 pharmacists who work in the state of Queensland and 70 per cent of the 16,000 pharmacy assistants who also work in the state of Queensland. I would like to thank the committee for hearing from the Pharmacy Guild of Australia today. We have had a great working relationship with you and the committee, specifically regarding the 2018 inquiry into the establishment of a pharmacy council.

Some of our submission, which I assume all of you have read, touches on a few of those points today but basically in summary there are three recommendations that I would like to focus on. One is the extension and the expansion of those measures that the Queensland government and the Commonwealth government put in place in response to the COVID-19 pandemic; making available to pharmacist vaccinators in the state of Queensland those vaccinations funded under the National Immunisation Program which is within the control of the state government and, thirdly, the implementation of the travel health measure, the travel medicines measure, that was within the aforementioned inquiry that is yet to be implemented. I am happy to leave that as an introductory remark.

CHAIR: Thank you very much. We might move to Shane McDonald, Queensland President of the Pharmaceutical Society of Australia, for an opening statement.

Mr MacDonald: I will pass straight to Chris, our state manager, to give an opening statement.

Mr Campbell: Thanks so much, Shane, and thank to you the committee and thanks to Trent for his opening remarks. I acknowledgement the Queensland government's overall response that has helped Queensland so far contain the pandemic. PSA is the only Australian government recognised peak national professional organisation and we represent all of Australia's 32,000 pharmacists working in all sectors and across all locations. In Queensland that is over 6,000 pharmacists working in community pharmacies, hospitals, general practice, aged care, government consultant pharmacists and within private sector organisations. The PSA is also the custodian of the professional practice standards and guidelines and ensures quality and integrity of pharmacy practice.

We would like to say in general that the Queensland government's response was exemplary and in many areas the envy of the world. Specifically we would like to acknowledge the Premier and the Deputy Premier, as well as the Chief Health Office, Jeannette Young, for their leadership, their continued communication to the public, their grit and their speed to action. We would also like to call out members of parliament, including the committee, who in times of crisis provided leadership at a local level. We call out Liza-Jane McBride and Dorothy Vincenzino who have done everything they can to provide as swift a response as possible for the pharmacy profession and consumers that we serve.

In terms of the COVID response, no doubt legislative amendments and policy decisions, as well as funding initiatives, contributed to significantly lower infection rates. However, from the PSA's perspective there are several lessons to be learned and we highlighted in our submissions where improvements could be made to ensure that Queensland consumers are better protected and pharmacists and other healthcare providers are better supported to do the essential work that we do.

In our submission we highlighted areas where there were unnecessary barriers to downstream effects of policy decisions and where they were not fully considered. One of the biggest opportunities for improvement is by placing a pharmacist in a senior position in Queensland Health. The legislative changes, such as digital image prescribing, caused a tremendous amount of unnecessary strain on pharmacists and they were abused by consumers and medical staff for attempting to adhere to Queensland legislation. You will see references in this to the guild's submission as well as our medical colleagues.

Queensland also still has not passed e-prescription legislation and is the last state to do so, a major safety initiative, fast tracked nationally due to COVID but delayed in Queensland. These delays did not happen in other jurisdictions, including South Australia, New South Wales, Tasmania, WA and ACT. Other decisions made in haste and for the right intent hindered pharmacists in assisting patients from fulfilling their professional obligations and there were even cases where the law had to be circumvented in order to provide the care that consumers rightfully expect from pharmacists.

As far as PSA is aware, of all of the 1,200 community and hospital pharmacies in Queensland not a single one closed. Every pharmacy remained open throughout the pandemic to provide clinical pharmacist care, primary care, immunisations, medicines and supplies to Queenslanders. PSA believes it is necessary to raise these concerns and to ensure that Queensland is prepared for future public health emergencies, including a second wave of COVID-19.

CHAIR: Thank you very much for those opening statements, gentlemen. I think it is worthwhile for both bodies to feed back to pharmacies that right across our broad state they have assisted in the COVID response and that might be right down to making sure people got their flu vaccines. That goes back to some of the work we did in 2018 with both organisations in the previous inquiry. The committee thanks and acknowledges those front-line healthcare workers. They are considered front line.

I was disappointed to hear of examples, we will perhaps ask you both to expand on, of pharmacists being abused or confronted in regards to what is a serious global pandemic. When you walk into a pharmacy you need them to be part of the healthcare system. They are part of the healthcare system. I thank them for the work they have done. With the restrictions that were put in place in terms of essential supplies, even our retail staff were getting abused. This is a call to all Queenslanders to respect everyone as we progress through COVID-19. We are not done yet. We still have a lot of work to go. Today we heard UQ talking about a vaccine and starting human trials. I can only think that the broad pharmacy network will play an important role going forward should Queensland lead the way or when a vaccine becomes available to treat people or prevent them from catching the coronavirus. I just wanted to put on record I do consider our pharmacists as frontline health staff.

To the guild, you made four recommendations, one being that the Queensland government permanently extend and expand these initiatives during the recovery and beyond the pandemic to support Queenslanders to better access medicines and primary health care through Queensland community pharmacy networks for continuity. Did you want to expand on that at all before we move forward?

Prof. Twomey: Yes, thank you, Chair. The No. 1 medication misadventure, or medication safety issue, and the PSA referred to this also, is people actually running out of their medicine because of unnecessary red tape. This is not pharmacists prescribing—we talk about pharmacists prescribing in other recommendations—this is about pharmacists just keeping Queenslanders on the medication that the prescriber has intended. Whether it be in a first wave, a second wave, whether it be indeed not in a pandemic situation, Queenslanders, Australians in that respect, run out of their medication every week.

In fact, the continued dispensing arrangements which have been expanded by the Commonwealth and enabled by the Queensland government, saved 75,000 ED presentations and GP presentations between the months of April and May this year alone. That is a nationwide figure. It had zero cost to the taxpayer. It did not have just direct savings to the taxpayer, both at a state and a federal level because of those prevented admissions and presentations, but also it had increased productivity benefits and increased health benefits because Queenslanders and Australians were able to stay on their medication.

What we would ask is that the Queensland government call on the Commonwealth—because this is a Commonwealth initiative—to ensure that that particular mechanism does not expire on 30 September as it is currently scheduled to expire. This is something that you can do, that cost you nothing, but puts the pressure back on the Commonwealth government to ensure that Queenslanders will be able to receive their medication when they run out from their local community pharmacy.

CHAIR: Did PSA want to make a comment? I saw some nodding and agreement.

Mr Campbell: For clarity, it does require a continuation of the legislation to allow it. Currently it waits for a declared public health emergency or a declared emergency. We are in agreeance with the guild and Trent's comments. That will help to alleviate some of the hassles that happened, regardless of whether there is a declared emergency. This is the second one that Queensland has had this year. It will allow for improvement in that legislation. Shane might have some examples at his pharmacy.

Mr MacDonald: Yes. I am from Townsville, North Queensland, just to let everyone know, so in a regional centre. We have one of the largest tertiary hospitals here, so many people from around the Mackay, Cairns and Mount Isa areas come to Townsville for significant treatment. I had a patient come into my pharmacy whose husband had been transported to Townsville Hospital and the patient had run out of their blood pressure medication. They contacted their doctor in Mackay while they were in the pharmacy with me and the doctor had told them that, no, they wanted to see them again before they were happy to issue another script.

All I was able to do during that time—this is pre COVID—was give a three-day emergency supply, which is not beneficial to this particular patient being 300 or 400 kilometres away from home. What continuing this measure would have allowed is to give that one PBS supply to that patient and notify her doctor, giving her some ease while they are going through that personal emergency. It is fantastic that these are in for significant emergencies like COVID, the floods in Townsville—if something like that happened again—and the fires earlier this year in New South Wales, but there are also these personal emergencies that are occurring, especially in regional Queensland, quite often that can be taken into account as well.

CHAIR: Thank you very much for that, Shane. You should give your pharmacy a plug, being a Townsville local as well. Which pharmacy were you representing there?

Mr MacDonald: At the time it was an Allied pharmacy at the university—

Prof. Twomey: No, I think it was in Mundingburra!

CHAIR: Thank you for clarifying. I had an experience myself with pharmacy and telehealth in the last couple of months having to get some boosters—MMR—and a number of other things and I saw definite benefits, and I am sure you will both talk to telehealth and the benefits of that. Going to the pharmacy to pick up the particular vaccine or boosters and then going back to the GP to simply get them injected, that kind of did not sit comfortably. Can you both speak to the benefits of giving the vaccine, whether they are travel or whatever they might be, in the future so you can avoid the doubling up, if you like, of having to go back to your GP for a simple injection?

Prof. Twomey: Yes, happy to, Chair. The first thing is we should acknowledge that where we currently sit today Queensland has the largest scope of practice in terms of pharmacist-led vaccinations in the Commonwealth and that was a direct result of the recommendations and work of this committee, so thank you to all of you for everything that you have done so far. Alas, there is a lot more that needs to be done to ensure that Queenslanders have the greatest level of access to vaccinations, and that includes through their local community pharmacy.

Whilst we may be leading the Australian Commonwealth, we are in fact the holders of the wooden spoon in the OECD. This is something that (inaudible) takes two points. First, are Queenslanders able to access that vaccination from their local community pharmacy because of the red tape that currently exists forbidding them from doing it? The second one is the cost, because cost is a barrier to access and that is access to the Commonwealth government National Immunisation Program. Currently Western Australia, Victoria, ACT and Tasmania—all of the residents of those states and territories—have access to Commonwealth funded vaccinations through their local community pharmacy. However, Queenslanders do not. This is something that is completely within the remit or control of the Queensland Department of Health. It is something that the (inaudible) could do with a simple swipe of their pen, because, as you know, being able to provide it is something that you can do under the pharmacist vaccination drug therapy protocol, but whether or not the person can afford to get it is another measure of access.

With regard to the drug therapy protocols that currently exist—and we are not going to use the word 'expanded' here now—what we simply want is the restrictions removed where if a Queenslander can receive a vaccination from their nurse and a Queenslander can receive a vaccination from their GPs, why can a Queenslander not receive the same vaccination from their local community pharmacy? Why is it that a nurse or a GP can give a broader spectrum of vaccinations than a local community pharmacy can? Basically we are talking here about full scope of practice, not extended scope of practice. I am sorry I am labouring here on language, but language is important.

We have seen some terrible behaviour by some other peak medical groups in the past week slamming the initiatives of this government as bargain basement health care and role substitution and a whole heap of negative commentary which is not patient-centric and which is just self-serving, and that is not something that you will see from the Pharmacy Guild or the pharmacy profession more broadly.

The two specific things in answer to your question, Chair, is that the pharmacist vaccination drug therapy protocol that currently exists should have the same level of scope of practice as a nurse or a general practitioner. The second thing is that those vaccinations funded under the National Immunisation Program should be available not just through a community controlled health organisation and a general practice; they should also be available to Queenslanders through their local community pharmacy.

CHAIR: Thank you, Trent. Does the PSA want to comment?

Mr Campbell: An extension of that—and what would have solved your scenario where you had a prescription for an item—is for the pharmacist to administer that, that is, any legally obtained medicine, whether it is an immunisation or not, or it could be a cold chain item. To Trent's point, if we look overseas, pharmacists can administer medication. We have the competence and the competency to do so for a legally obtained medicine. Whether that is prescribed by a prescriber or supplied by a pharmacist, there is an opportunity to improve that work flow. You could have arrived at that pharmacy with a prescription for any entity that required an injection and the pharmacist would be able to administer that, so it is within the scope but still inhibited by current legislation.

CHAIR: I note that both submissions talked about the availability of PPE for community pharmacies, particularly around the Primary Health Networks, to the point where some were hesitant to provide PPE to pharmacies. Can you speak to that? That is concerning.

Mr MacDonald: I can talk about my experience with that and some other pharmacists that I have spoken to. Yes, that was the exact issue. Initially we were not considered that frontline worker, and I know by reading some of the other submissions in general practice the RACGP had that issue initially as well from the PHNs. The point that I would like to make with that though is the PHNs do not necessarily hand out consumables or anything like that in a regular setting, so it would be much better to utilise existing methods, whether that is through our current wholesale arrangements and that type of thing for more equitable access.

CHAIR: Thank you.

Prof. Twomey: There was just one more thing on the injecting that would be remiss of me if I did not highlight it. One of the anomalies currently in the drug therapy protocol is that a pharmacist can vaccinate but we cannot inject, which is nonsensical really because you have to inject to administer the vaccination. Two specific examples that I had in my pharmacies personally but also direct reports from multiple pharmacists around the state are vitamin B12—and I know this was raised during the parliamentary inquiry—and also Prolia, which is an osteoporosis treatment which needs to be injected.

Even though a patient can receive both the vitamin B12 and the Prolia—we can dispense both of them—currently they have to take those back to their GPs to have both of them administered, so the recommendations from the general practice network during COVID was that patients simply did not get them. We had patients going without their osteoporosis injections and patients going without their vitamin B injections because GPs only wanted to provide telehealth services, not face-to-face services during the pandemic. That was completely nonsensical seeing as our workforce are trained to inject both subcutaneous and intramuscular injections, of which both of these are. However, the drug therapy protocol only allows us to do those two things if it is for the purpose of vaccination, not for the purpose of administering a drug.

CHAIR: That is a very good point that you have made given that a lot of GPs were hesitant to have people in their clinics, so you can absolutely see a benefit here to making sure we stop people going to hospital unnecessarily because they have missed their medications and you could provide a broader role, particularly in a health emergency such as COVID.

Mr HUNT: My questions have really been answered. They were around the PPE availability and the extent and impact of that. Can you confirm whether any pharmacy staff contracted an infection in the workplace?

Prof. Twomey: Because that does cover an industrial relations issue—I know the answer to that is yes in Queensland—if I could hand over to my branch director Gerard for him to handle that response, if that is okay.

Mr HUNT: Thanks.

Mr Benedet: Yes, we did. We had two pharmacy assistants test positive at the height, if I can put it that way, of the COVID pandemic. One was in Ipswich and the other one was north of Brisbane. Both pharmacies were closed and cleaned thoroughly at the cost of the owner proprietor and the original source of both of those infections was not actually community transmission but returning travellers who were family members of those staff members, so we were quite lucky in that regard.

To the point made around PPE before, the PHNs do not, as it was noted, regularly distribute stock or items, so it was very clunky and there was a comfort factor for staff which went against the public health guidelines and even the CHO's advice in terms of the use of masks and the like, but it was a comfort factor for staff. It is the same with the sneeze guards and a lot of other things that went into stores and have remained in stores just to ensure that we could remain open and service the patients who were travelling into our pharmacies.

Just for the committee's knowledge, there was a group—the department of state development as it was then under Minister Dick—put together and I think they were from KPMG or PwC. I apologise that my memory does not serve me correctly there, but they actually got in contact with us to understand the need for PPE across the network should there be a larger number of cases should we have to push patients out of hospital ICU and into a range of other community scenarios. That was a very worthwhile exercise. I am not sure whether the committee has been availed of that in the past, but the state development department undertook that work to understand the need for PPE across the state.

Ms PEASE: I would like to echo the words of our chair about all of our great community pharmacies. I know that locally they have done an outstanding job. One of the questions I was going to ask was about the increased workload. I know how much the workload has increased and under difficult circumstances because of the pandemic. I would like to make a comment that we did lose a pharmacy here on Tingal Road. It closed during COVID and has not reopened. Unfortunately, we have an oversupply of pharmacies in our little patch. How did you manage the increased workload and how did you help your staff amongst the pharmacies that you represent to make sure that they were well trained and had the most up-to-date information because it was changing so rapidly? How did you obtain the information and when were you getting information provided to you?

Prof. Twomey: That is a great question. I know a particular pharmacist in your footprint has also raised the issue of therapeutic substitution with you as well to help ensure medication in the community. We can talk about that later if you wish. To answer your specific question, we did an awful lot. The Pharmacy Guild of Australia, as you know, worked with 80 per cent of the network. That is quite a high percentage for a voluntary organisation. We established a specific COVID-19 resource section on the members' component of our website. We released that to the public so you did not have to be a member to access all of that information that applied to the pandemic.

We made sure that communication was simple and regular. We made sure that we collated all of the different information that became available from all of the different state and federal agencies. As you know, information was coming thick and fast during the height of it. It was so easy for frontline professionals, whether that be the proprietor, the employee pharmacist or the pharmacy assistant. The guild tried not to add to that confusion but rather act as a focal point for the collation of all of the different information that was coming out of both the Queensland and the federal government. It was very much a communication strategy. It was not just about frontline epidemiological help to our patients. It was also about the moving feast that was the industrial relations framework during that time.

Ms PEASE: Did the PSA provide a similar service?

Mr Campbell: Yes, we had a site that was viewed over 30,000 times during the pandemic. That was specifically around the legislative changes and how quickly they were changing. We were having almost daily updates from different states. There was a level of confusion where the federal government would make claims about some of the behaviours of the states. We would have advice that certain activities could occur like digital image prescribing would be automatically legal because it is on a federal piece of paper. In fact, it was one of the most impressive modes of communication. We had multiple faxes of that one document to our pharmacy saying, 'You must do this because Medicare has said this.' We said, 'We abide by state legislation in Queensland.' We had to have conversations that were not focused on the patient; they were more focused on the nuances.

One of the other things we did was we had a pharmacist specifically take calls from pharmacists who were on the front line around legislative interpretation as well as mental health. There were some pharmacists put in unbelievable high-pressure scenarios, particularly when they needed to split their teams to ensure they stayed open. It is such an important question. I know that I speak for all pharmacists who were on the front line. We are incredibly proud of the profession in how they stood up during that time. A lot of them went through a lot of mental anguish.

Ms PEASE: I can imagine. I know locally how committed they are to our community. They know their customers. They are family. They provide that frontline care that many of them lost through telehealth. Given that you were both providing a similar service, was that another layer of confusion for pharmacists? Was it the same information that you were both putting out?

CHAIR: You might have to make your responses brief. We are running out of time.

Prof. Twomey: There is adequate overlap between our two memberships. We had communication at a federal level. I know that in my senior VP role I was dealing with Chris Freeman, who is the national president, if not on a daily basis then on every second day and the same thing was happening at a state level. I should also say we had a Q and A with the CHO. Dr Jeannette Young made herself available to all Queensland pharmacies in a dial up so she could give a presentation update firsthand and answer any questions that people had.

Mr BERKMAN: Mr Campbell, I think you mentioned earlier that there were certain circumstances that arose where laws had to be circumvented and there is a similar observation made in your submission. Could you elaborate on that or give us any more specifics of why that was the case?

Mr Campbell: Specifically, the digital image prescribing. It was announced that the federal government would fund a digital image prescription based on a fax or a photo sent to the pharmacy. That information disseminated quite quickly, but the delay in Queensland was two months. It was the understanding of the practice—practice managers and those who work within the practice—that that was the case. They were mentioning to patients that the pharmacist must provide this. Whilst we waited for the state legislation to be enacted, they were putting in a scenario that to provide continued care to the patient we needed to circumvent the law. Thankfully when that was put in the legislation was retrospective, so it protected pharmacists who acted in the best interests of patients.

The thing about pharmacy is that we have legislation covering a lot of entities in terms of different schedules of medications and how they are delivered and also legislation on how we interact with those. Hopefully that provides a clear enough answer to what was a complicated and quite stressful time for pharmacists.

Mr BERKMAN: Thanks. I just wanted to check there were not any other circumstances beyond what you touched on before.

Mr McARDLE: I want to go back to a comment made by Mr Benedet. Either KPMG or PwC came to discuss the issue of PPE with the guild. Could you elaborate on what that contact was all about? What were they trying to assess your information about?

Mr Benedet: They were looking at the scenarios of increased infection rates and what that would do to the PPE stock in Queensland—what was needed, when it would be needed and what type of PPE would be needed in a community pharmacy setting if the virus and the hospital admission rate, mortality rates et cetera had exceeded the original estimates or the original plans. That was a very collaborative process where we worked with them for them to better understand the network, stores, locations, number of staff in each location, the split team shifts and how that was working. Those findings were handed back to State Development to ensure that there was enough PPE including hand sanitiser, the base ingredients of ethanol et cetera, for production across Queensland.

Mr McARDLE: Professor Twomey, are you at liberty to table a copy of that correspondence to State Development?

Prof. Twomey: Yes.

Mr McARDLE: Thank you for that. I take it that this was a wideranging review by State Development. It was not just the guild. There were other bodies as well. Mr MacDonald, did they contact you at all in relation to your thoughts on that?

Mr MacDonald: No, they did not contact the PSA.

Mr McARDLE: Things moved very quickly from mid to late January this year in relation to ramping up the issues—PPE, ventilators and the like. There have been a myriad of organisations established both state and federal in relation to looking at the COVID-19 impact, the fallout from that, the requirement to deal with the medical necessities that derived from that. Which of those bodies is the guild on and which of those bodies is the society on?

Mr Benedet: Taking you through the bodies that we sat with ministers on: Minister Jones was looking after the Care Army of which we were involved through the department of communities at the time—which was very helpful. That was in and around home deliveries. Then the Commonwealth introduced a home delivery mechanism and payment in the community pharmacy setting. Most of our members have now developed their own delivery method for patients who are self-isolating or staying at home.

Minister Dick and his department ran the Essential Services Working Group. That was a culmination of transporters, pharmaceutical companies and a range of other organisations. That was a weekly process which was very efficient in terms of sorting out some of those very early issues that, Deputy Chair, you rightly pointed out came about very quickly, particularly around supply and the shortfall of stock. Toilet paper aside, there were also medicine shortages. That was a very handy coordination body to help us.

Ongoing, there is a Medication Pharmacy Planning and Response Group, which Chris will not mind me saying the PSA is also part of. That is being run by Professor Ian Coombes out of the RBWH. That brings together all the chief pharmacists across the HHS network and the community setting. They are doing a range of work in and around the initial modelling, drug shortfalls, the use of particular drugs or lines of drugs in primary care but also in ICU and what that would do to the total stockpile across Queensland and liaising with central pharmacy, which hold a lot of that information. A lot of really important and detailed planning was undertaken by that group and continues.

The last thing is the increased engagement with the HHSs. As a result, because of the community pharmacy model and the fact that we remained opened, particularly Hospital in the Home, when elective surgery was put on hold, ramped up quite substantially. Those relationships are ongoing, particularly in regional and rural areas where it is not as easy just to send a patient home for Hospital in the Home. There needs to be a proper handover to the community pharmacist so that there is a continuance of good medical care.

Prof. Twomey: To segue from what Gerard said about our own profession's interaction with the HHSs, it is specifically good in the north which you will be heartened to hear, not just in Townsville, Cairns and Mackay but in all five of the northern HHS footprints. I was invited as a representative of the profession to participate in the strategic planning workshop run by those northern HHSs in Townsville last Tuesday which focused on how in a time such as post-pandemic Queensland Health more broadly can respond to the challenge put down by the Deputy Premier of being innovative, of ensuring that we can utilise all aspects of the primary healthcare workforce in Queensland to practise to their full scope of practice to avoid those category 3, 4 and 5 presentations in Queensland Health facilities so funds can be reinvested into those higher order secondary and tertiary healthcare services.

There is an example in our paper of running an autonomous prescribing pilot in regional Queensland, consistent with what pharmacists have the existing skills and knowledge to do and what pharmacists are already doing in the United Kingdom, Canada and indeed most OECD countries—to not just vaccinate but inject, to not just dispense but also to do continued dispensing and therapeutic substitution and to look after minor ailments and chronic disease management. This initiative requires no financial investment on behalf of the state government. What it does is enable the full utilisation of all of the skills and knowledge that the 6,000 pharmacists and 16,000 pharmacy assistants in the state of Queensland have to relieve the pressure on our healthcare system and to ensure that in the post-pandemic world Queenslanders receive First World health care.

I would commend that particular trial that we are doing in conjunction with your HHSs to the committee for your consideration. I know that that is the recommendation on behalf of the pharmacy profession to Professor Stephen Duckett who is doing innovation work on behalf of Deputy Premier and which will hopefully be handed to the government for consideration in the coming weeks.

CHAIR: I was going to talk about that trial. Thank you for mentioning that. Flying the regional flag, I think it has merit. The other thing we have run out of time to deal with is what was in the PSA submission around a chief pharmacy officer. There is no doubt coordination is required when responding to a global pandemic. I think there is some merit in that as well. We have run out of time, unfortunately. I thank the representatives from both the Pharmacy Guild and the Pharmaceutical Society of Australia for their time and commentary this morning. If we have any supplementary questions we know we can contact you at any time. Thank you so much for your contributions today.

PERRY, Dr Chris, President, Australian Medical Association Queensland (via videoconference)

CHAIR: Good morning, Dr Perry. Thank you very much for your time today. It will be of significant benefit to the committee in relation to our inquiry around the COVID-19 health response. Would you like to make an opening statement before we move to questions?

Dr Perry: Thank you very much for the opportunity. The AMAQ's position on how we went with COVID-19 is that we believe it has been handled very well. We think the Premier, the health minister and the Chief Health Officer have done things appropriately. We really cannot criticise how Jeannette Young has gone and how the Commonwealth's Chief Medical Officer and his office have behaved during it. They have been quite knowledgeable. Their knowledge of what was going to happen was really quite good. We are happy with that. We are happy with the border closures. We think they needed to happen. We think it was right time for them to be open. We will have to see what happens with Victoria now.

The big issue for us was PPE being available to our members, especially GPs who really were the frontline workers in the early days of this. They were not regarded as frontline workers so they could not get PPE for themselves and their nursing and other staff in their GP clinics. They were told that the PPE was going to be available through the primary health networks and it just was not. That is something to learn. I know that PPE was in short supply all over the country and it was being saved for public hospitals, but that was a potential major time bomb.

I remind the committee about what happened with frontline workers in Italy. Nurses are very much frontline workers. I have had a very good relationship with nurses in the 43 years I have been a doctor and the 33 years I have been a consultant surgeon in public hospitals. In Italy after the first 100 doctors died there were only 30 nursing deaths. Remember that with this virus doctors are the real frontline workers. They have to get in very close—within a foot or two of the mouth and nose. In terms of my own speciality, ENT, anaesthetists and intensive care workers, after the 147 doctors died in Italy there were about eight ENT surgeons who had died. We are about one in 200 of the medical workforce. That is eight times the mortality we should have had. It was quite scary being involved with it.

The public-private partnership was somewhat of an issue. Obviously the PPE was not available. We had to see whether we were going to be overcome like Europe and North America were. We thought the partnership would be easier to negotiate because Queensland has had Surgery Connect around for about 15 years. It seemed to be a satisfactory relationship between the public and private hospitals and the public and private providers. We had a lot of toing and froing about that and a little bit of angst, but, at the end of the day, good sense prevailed and it has been very good.

It has probably been used more in the places where COVID-19 has knocked around the tourism industry more. On the Gold Coast, the Sunshine Coast and North Queensland the private hospitals are quite empty. People were not sure that they would have a job next week and so they did not want to spend money on routine procedures. The government did use the Surgery Connect model to populate those hospitals. Although it did not pay terribly well—obviously the doctors and their practices are not the important thing here—it was certainly good for the public waiting list and things like that. Generally, the public-private partnership seems to have worked quite well.

We will have to see whether the public waiting lists are going to be an issue in the state election. I do not think they are going to be. I think the electorate will be quite understanding of waiting list blow-outs. The government has been very good at trying to get those waiting lists under control. I have been asked whether I would be happy to do a list of 12 cases—public-private—interfaced in the children's hospital between now and Christmas. Myself and the other 14 or 15 consultants seem happy to do it. The waiting list will be knocked around and brought more under control. With Surgery Connect we do not have much of a waiting list. My colleagues in New South Wales and Western Australia tell me it can be three years for a child to get a grommet in those jurisdictions. In Queensland it is under 12 months, which is still too long, but compared to other jurisdictions it is very good.

I was the chair of the college of surgeons committee when Surgery Connect was floated in about 2005-06. The first list I did from the PA Hospital was about eight cases—they were major ears and a nose. The ears had been waiting 10 years and the major nose case had been waiting 16 years to get his nose unblocked and straightened. They were the waiting lists of 15 to 18 years ago and now at 12 months they are being farmed out privately and getting down. My first list at the children's hospital kids were waiting three years for grommets.

Surgery Connect has been a very successful model. It was quite controversial amongst medical circles. People thought that private health insurance would go out the window and that the private sphere would be what makes our public lists manageable. It is a bit of both really. In that regard, I think Queensland is way ahead of the other states. They are the main things—PPE and the public-private partnership.

We would love to see telehealth continue and electronic prescribing continue. Others have suggested maybe banning leaf blowers to stop dust getting into the air and knocking around people's lungs. I am not a respiratory physician, so I will leave that one. The AMA has been very happy with the Queensland response.

CHAIR: Thank you very much, Dr Perry, for those introductory comments. We just had the Pharmacy Guild and the Pharmaceutical Society of Australia also talking about not being able to access PPE from the PHNs. I think there is a glaring gap there if they cannot logistically supply them. We heard in Townsville, where I am from, GPs were absolutely struggling to get PPE to treat their patients. I think it would be remiss of the committee not to recognise the frontline role of our doctors so if you could please pass on to your members our appreciation of the work that was undertaken by GPs right across this state, particularly during the coronavirus, that would be appreciated. The cardiac, diabetic, respiratory—all the normal, everyday—GP appointments still had to be made, albeit mostly via telehealth, which I think was a great success and should continue. I had my first telehealth appointment with my GP. It was great. It was nice and easy.

Dr Perry: They do it quite well. They cannot examine you, but they can do a lot of things. They can arrange investigations and all the drug prescriptions.

CHAIR: I think we probably need to look at the PHN role of distributing PPE for frontline workers such as GPs and pharmacists. We have just had the guild appear. You talked about electronic prescribing. I think there is a great role to play and to advance there. You talked about vaccination campaigns and called for a strong pro-vaccination public education campaign and for action to be taken against people who stand up and promote anti-vax theories. Do you want to very briefly talk to that and then we will open up to questions?

Dr Perry: It is an issue, isn't it? In terms of the coronavirus vaccines—Ian Frazer obviously knows a lot more about it than I do—they are suggesting that probably only about 60 per cent of people are going to get an good immune response from two vaccinations and that is on the border of adequate herd immunity or not. In terms of the anti-vax group, I believe that there are about 400 dyed-in-the-wool people, but there are a lot of people who run alongside and see what is going happening. They are really quite destructive. They still do not understand what happened in Samoa with 60 children dying of measles.

Can you take stronger action against people and address the free speech argument around the anti-vaxxer people, if the parliament can work out how to do that it would be great. I am not a lawyer or policemen, but they are a real problem. Perhaps there needs to be a public education campaign. The anti-vaxxers and the antifluoride people should be put together and held to account for some crap ideas which are interfering with the health of people.

CHAIR: I am going to move to questions.

Mr O'ROURKE: The committee has received some conflicting advice with regard to the use of digital prescriptions. Could you explain the current prescription system in Queensland and what risks electronic prescriptions present?

Dr Perry: I am not sure it will have an awful lot of risk. One of the things could be that people do not get the appropriate examination and investigations. As a group, we are very much against urinary tract infections getting straight off antibiotics. Hopefully telehealth will stop that. Antibiotic resistance is going to be an issue the more widespread the use of antibiotics. That is accepted. That has been around for 40 years.

It will probably extend into kids having a bit of a temperature and kids having a bit of a sore ear. If they are not examined properly they will get inappropriate antibiotics and they can have quite serious ear pathology which is missed. Between 30 and 50 children each year in Australia have true mastoiditis and of those two to three die. That is a completely avoidable condition.

As far as how electronic prescription works, you can write out your prescription, take a photograph and send that to a pharmacist. Personally, I prefer to do it by fax. It is more secure. That has been around for a little while. I get my patient to go to their local pharmacist, get them to tell me their fax number and we can send a secure fax straight away and the real prescription goes by mail.

Under the new laws you can take a photograph and send it and the doctor has to keep the piece of paper. That gets a bit clumsy after a while. It is a big improvement as long as patients are still getting examined, as long as it is not fragmenting their care and their medical records are sought so we know what reactions they have had to previous drugs and we know what drugs can interact with what you are suggesting they have. It could be a problem for us. However, electronic prescribing will not go away.

Mr O'ROURKE: I must say that I recently had surgery in Brisbane and I have been dealing with a specialist from Rockhampton. Everything has been done through faxes et cetera. I cannot fault the service and the support that I have received over the last couple of weeks.

Dr Perry: It is a big improvement. It should cut down the budget of Queensland Health through Qantas and isolated patient travel allowances.

Ms PEASE: I would echo the words of the chair. Thank you to all of your members. I know you are all frontline workers. My husband's family are all local GPs down here in Wynnum. I hold you all in very high regard. Like the member for Townsville, I have also had to use telehealth services myself during COVID. It has been fantastic. One of the things I would like to hear about is: whilst we have seen its success in terms of not being able to visit your GP during COVID, has there been a great uptake or, alternatively, any resistance from your members about using telehealth because, for example, they might not have access to the technology or want to participate in it? Can you comment on that at all?

Dr Perry: The technology can just be a telephone. I do not think you need to be an expert in Skype, Zoom or GotoMeeting et cetera. That is fine. Some of the GPs did not like the fact that they could not do anything except bulk-bill. The bulk-billing rate is $34 and sometimes the telephone consultations are quick. When I first started doing them they were taking half an hour or more. In terms of the cost of having a practice open, 25 years ago it was $225 an hour. These days it is probably close to $400 an hour just to have staff, depreciation and rent and whatever. If you are seeing only two people at $35, that is not viable so things will close.

It would be better if people were able to raise the fee for everybody and not restrict it to people over the age of 16 and not on a healthcare card if we want this to continue. Hopefully, that will get up with the federal health minister. I think it is great, so long as the financial viability is maintained and so long as patients do come in to be examined when they are asked to when telehealth is not enough.

Ms PEASE: Have you had any feedback from patients? Has there been resistance from patients to engaging with telehealth?

Dr Perry: No, it is very, very popular.

Ms PEASE: The reason I ask that is that, for many people, a visit to their GP is their outing. It is something that they do.

Dr Perry: It is a bit of that and people miss that. When you went to your GP two or three months ago, there were startled deer in the headlights in little clusters sitting metres apart and outside in the car park and whatever. I do not think they wanted to go to the doctors then. With community transmission hopefully staying down with Victoria and a 1,000-kilometre gap between us and the Murray River, hopefully we will not go back to those days. People should still go to their doctors. They cannot do their own blood pressure, urine tests et cetera.

Ms PEASE: The other thing I want to hear about is the constantly changing information. With updates, it was changing—

Dr Perry: Yes, it was a problem, but then it is a brand-new virus. The Spanish flu killed young people, children, more than it killed adults. It was quite scary to have kids coming home from school but children of healthcare workers having to go to school otherwise the hospitals would close. I think our national agency did very well stopping essentially Chinese tourism and, unfortunately, the international students somewhat early on. It was very, very well done, so we did not get the blowout.

Mr McARDLE: Congratulations on your appointment—I think.

Dr Perry: Commiserations I think.

Mr McARDLE: I did not say that.

Dr Perry: Everybody is a servant now.

Mr McARDLE: You spoke earlier about PPE. You state in your submission—it might have been by you; I do not know—it was announced that doctors should go to the nearest PHN to source adequate PPE. Who made that announcement? Do you have an idea of the organisation or body?

Dr Perry: I do not know. I did hear that, but the world was full of rumours three months ago. I do not know.

Mr McARDLE: Is it a certainty in your mind or you think it—

Dr Perry: I think the health department did a lot of our webinars early on.

Mr McARDLE: When you say the 'health department', there are two health departments: state and federal.

Dr Perry: I think deputy DGs might have said something like that.

Mr McARDLE: State body?

Dr Perry: Yes. I do not want to get anyone into trouble. I cannot say. I do not know.

Mr McARDLE: They then went to the PHNs and they were turned away because they were not 'frontline workers'. 'Frontline workers' has a meaning to us here, but I do not know what it means to the organisation you are referring to who said they were not frontline workers. Is there a distinction between the two terms in relation to the body you approach?

Dr Perry: I do not know what they were thinking. Obviously a lot of us are on the same page. A GP is very much a front-line worker—

Mr McARDLE: I am not questioning that.

Dr Perry:—as are the people in accident and emergency in a public hospital and the nurses and the doctors in a public hospital. I would like that recognition to be there. I know the CSIRO have got into the business of making masks, and Australia is going to become less reliant on masks. I think China knew about the virus months before it became public knowledge and the World Health Organization admitted it was a pandemic, and Australia was on the front foot of that. Hopefully we will have adequate PPE storage.

I know Drager, a German company, were thinking of spending $130 million to get a PPE factory started in Australia. I do not know if they are going to do that. I know CSIRO are looking at putting out more than enough N95 masks for Australia. I do not know whether they actually did that. Some of the dental supply companies—my wife is a dentist and she was quoted $27 for a mask at the same time the medical companies could sell them for about $6 or $7. There could have been some attempts at profiteering, but generally there was not.

I spoke to one of my friends who has quite a big business in medical supply and has a very good reputation for being honest and straight forward. He was saying that masks that previously cost 5 cents—usually less than 20 cents—would now cost $4 or $5. They needed a premium for their loss, handling costs and whatever, so they were looking at $7.50. Hopefully, that is a thing of the past and there are decent stores that will be available to everybody next month. We have been caught with our pants down this time, but I do not think it is going to happen again.

Mr McARDLE: That raises the next point. I get the sense that we are locking ourselves into what has happened, which is important. However, looking at Victoria, we now need to be certain as to what could happen by way of a second wave coming. What will the AMAQ highlight as the points that the Queensland government—Queensland Health—must take into account in learning from the past to move forward? There is no vaccine for this—there is no cure for it—and it could be some time before we get one. Victoria is a prime example of what happens if you take the eye of the ball; we will be in trouble. Where would the AMAQ see the ball has now been placed to plan for the future?

Dr Perry: It is not the AMA's position on this. I had an ABC interview—

CHAIR: There is a technical glitch. We cannot hear Dr Perry at the moment. Dr Perry, we seem to have lost audio with you. Can you hear us? Give us a thumbs up. We might have to pull that one up for now. Sorry, Dr Perry. We have an audio problem. We might have to write to him. He can take that last question on notice if he cannot hear us. Dr Perry, can you hear us now?

Dr Perry: Yes, thank you. I do not know what happened. We have to watch social distancing in nightclubs and restaurants and for those waiting outside the nightclubs. That might need to be policed a little bit more. The *Courier-Mail* brought that to people's attention. We will watch to see what happens in Victoria. It is not completely out of the question that our borders may need to close again in the next week or next month, and the nightclubs may need to close down. I think it is beholden to the hospitality industry to make sure they do the right thing, otherwise a second lockdown is going to be terrible for them.

Mr McARDLE: The point, though, is if a second wave hits, how do we in Queensland Health need to prepare for that next wave? Do you have any idea in terms of PPE, ventilators or ICU beds?

Dr Perry: Do not close anything down. Keep the numbers up with PPE. Do not deconstruct the ventilators into CPAP machines. Just be prepared for the next couple of years to put up the borders again. Put out the message that if we want the hospitality industry to keep functioning—almost all the cases in Victoria are in people under the age of 40. It is nightclubs, restaurants, lack of social distancing and people hugging and kissing their 50 best friends. We have to put out the message to be vigilant—social distancing. No PPE, no masks are required when walking down the street at the moment, but we will have to see what happens in Victoria and New South Wales.

Ms PEASE: I was trying to get some more detail. You spoke earlier in your submission about the number of doctors that had acquired the disease around the world. Do you know of any doctors in Australia that have acquired it through community transmission?

Dr Perry: No, I do not. Certainly quite a few health workers in Victoria have it. They do not put out what the numbers are between doctors and nurses. Italy made a mistake of asking retired doctors to come out and be frontline workers without PPE, so they had an extraordinary number of older doctors. Victoria could probably give us those figures of how many nurses and doctors, not that it matters; they are all health workers.

Ms PEASE: We had the PHN talking to us last week and they discussed their website that is valuable to all of the local practitioners to get up-to-date information. Are you aware of your members making use of that website?

Dr Perry: You are probably talking about Dulip Dhupelia, the most recent president of the AMA Queensland. He is often responsible for keeping the primary health networks up to date. Dulip could give you more information on that than I can. He is a very, very good president and is very good at his job.

Ms PEASE: Thank you very much. Again, thank you for everything. You were also talking about Surgery Connect and reducing the waiting list for surgery. You said that you are going to knock that on the head by end of the year.

Dr Perry: That is all figurative. The waitlist is definite. In AMA circles, Mike Horan was a tremendous health minister. The figures that the AMA were putting out said that before Mike was the health minister in the early 1990s there were 40,000 people added to the waitlist in Queensland a year, had been so for 30 years, and about 40,000 operations done. Mike went out and said, 'We'll knock off the waiting lists and do 60,000 operations in a year and 75,000 people joined the waiting list. Virtually everybody has a nasal condition. Virtually every kid gets ear infections. When you tell people the waitlist is being knocked on the head it gets bigger, so it is always a balance between private insurance and what you promise people.

Ms PEASE: You are working towards bringing the numbers down given that we had to close down non-urgent surgery—

Dr Perry: It would be nice to see our category 3 list get down to less than 12 months. People have a problem because they want their operation done pretty quickly. We can be like Germany. The waitlists in German public hospitals are about three to four weeks. They spend 11 per cent of their gross domestic product on health and we spend about nine. The more we get an increase in what we are willing to spend to try to bring it down further—but once you do that then the private system goes and funding from outside of government sources decreases, so I do not know. We have a reasonable balance. It would be nice to see our waitlists down over the course of things to maybe three or four months rather than 12 months. It might be the right balance; who knows.

CHAIR: Dr Perry, thank you very much for your contribution today. It has been most helpful for the committee. We look forward to hopefully seeing you one day in person before the health committee. It has been great to meet you.

Proceedings suspended from 11.32 am to 11.46 am.

DEL FABBRO, Ms Letitia, Branch President, Queensland Branch, Public Health Association of Australia (via videoconference)

FOX, Ms Melissa, Chief Executive Officer, Health Consumers Queensland (via videoconference)

GORDON, Associate Professor Louisa, Member, Queensland Branch, Public Health Association of Australia (via teleconference)

SLEVIN, Mr Terry, Chief Executive Officer, National, Public Health Association of Australia (via videoconference)

CHAIR: I now welcome representatives from the Public Health Association of Australia. Until we get Ms Fox from Health Consumers Queensland back, we might start with the Public Health Association of Australia to make a brief opening statement.

Mr Slevin: Thank you for the opportunity to present this morning. I am sure you have a very big task in front of you in preparing a report on the biggest public health challenge for 100 years around Australia. The Public Health Association's submission is consistent with the submission we put to the federal Senate into the COVID-19 response and is summarised fairly simply by the fact that clearly there has been a strong and largely successful response to COVID-19 in Australia. We are sending the message that prevention works and it is a very important tool in our arsenal when it comes to the health of the nation.

We reinforce and recognise the importance of initiatives like telehealth, the capacity to upscale our testing and the increase in community service responses from Queensland Health in terms of COVID-19 planning and border closures. All of these very substantial public health measures have not necessarily been welcomed and there has very clearly been an adverse effect as a result of them, but by the same token it has been essential in response to the pandemic that has struck enormously to a much greater extent around the world.

On the downside, of course, there are a whole range of adverse effects that we know about. Apart from very substantial levels of unemployment and economic disruption there are delays in terms of care for patients with non-COVID conditions, potential worsening health outcomes for those who are most disadvantaged and also potential worsening health behaviours, for example, such things as alcohol consumption. We are yet to be clear in terms of the impact on diet, levels of physical activity and the like. These are things that need to be monitored closely and carefully. Also, there are a whole range of challenges in terms of the ongoing delivery of primary care. These are things that are unfolding. We are getting close to six months since the first case of COVID-19 was identified within Australia, so there will be a very substantial level of review of the impacts that we have had.

In terms of moving forward, there is a lot of work to be done. The management of chronic diseases in particular is an important thing for all health services around Australia to keep an eye on. Also, a review report with regard to the costs and impacts of the decisions that have been made. It is worth recognising that the Public Health Association has made recognition of the successful public health response in Australia. We have awarded our president's award to the members of the Australian Health Protection Principal Committee—Chief Health Officer Dr Janet Young being the Queensland representative on that committee—and the entire membership of that committee for their very strong and successful response.

The other things that we want to try and talk about are more broadly in terms of impact with regard to issues around our most vulnerable Australians, our first Australians. A response for Indigenous communities has been important, but I see that you have the Queensland and Islander Health Council speaking at the next session so we will leave the experts in that sphere to speak on their own behalf.

One important point to be made when it comes to the response with regard to COVID-19 in Australia and Queensland in particular was the issue about capacity in public health. We start from a position by pointing out that, in terms of investment in health across a whole spectrum of public health issues, public and preventive health takes roughly two per cent or less of the budgets of most jurisdictions, both nationally and states. While we do not have a precise measure of that relative investment in Queensland, we would be very surprised to learn if it was much greater than that two per cent. So $2 in $100 is going to public and preventive health. I think now is a legitimate time for all jurisdictions not only around Australia but beyond to look at the relative investment when it comes to preventive and public health.

One of the key factors that has played out here is the issue around the training and employment of people in the public health world and the public health workforce. Clearly, like never before that workforce has been stretched and we have seen that various people without necessarily the relevant public health training have been brought into the response in terms of a whole range of issues such as contact tracing and many other important responses to COVID-19. It is also important to point out that, unlike some other jurisdictions, Queensland does not have a public health officer training program. That very substantial and sophisticated program operates in New South Wales. There is a less sophisticated program with less history in Victoria. That is something that Queensland certainly should consider in terms of developing a more highly trained and expert workforce in public health responses. It is certainly something that we think Queensland should consider into the future.

Similarly, we think that Queensland should give appropriate support to the development or consideration of the development of an independent designated public health agency nationally. The centres for disease control in the US was the original national model for this. It has been taken around the world. Now Australia is the only OECD country that does not have a CDC or its equivalent. While one might point to the greater success of the COVID-19 response in Australia compared to some of those other jurisdictions, there are a whole range of potential benefits that could be gained in considering the establishment of a CDC in Australia with, very importantly, a very substantial state and territory jurisdictional involvement in the CDC.

We have put our submission forward and you have had a chance to view that. I would summarise simply by saying that we do believe that now is the time to consider a greater investment in public health training, and the public health officer training program is a worthwhile model to consider. The evaluation of the costs and benefits of the response to COVID-19, both in the clinical and public health world, is important. The advancement of developments in telehealth which have been in train for more than 10 years, having been implemented now, is certainly something to consider in terms of the future healthcare infrastructure around Queensland and nationally. The importance of Aboriginal and Torres Strait Islander self-determination and the community control sector, which has done an outstanding job in response to COVID-19, is something that also deserves strengthening and support.

Those are a couple of opening comments and we are happy to discuss any of those further. I can see our branch president, Letitia, on the screen. I cannot see Louisa Gordon. I am guessing she is having technical problems getting in. It would be valuable to get her on board. Louisa, being a highly trained health economist and one of Australia's leading health economists, could also make a valuable contribution. I hope that is useful as an opening statement.

CHAIR: Thank you very much, Mr Slevin. I can see also Ms Fox from Health Consumers Queensland has joined us. Can you hear us?

Ms Fox: I can, yes. Can you hear me?

CHAIR: Yes, we can. In terms of opening statements, it might be timely if we can ask for yours as well before moving to questions.

Ms Fox: Thank you, and apologies for my technical difficulties before. It is good to see you all. I think you would all agree that Queensland finds itself in an incredibly fortunate position both globally and compared to other states in Australia. We have rapidly reduced the cases to so few and thankfully no community spread that we are aware of, unlike our interstate counterparts.

Our organisation has been fortunate to support some very powerful engagement; namely, around the development of the new adolescent extended treatment facility which opened during this time and the pelvic mesh clinic on the Gold Coast. This has been a fascinating, inspiring, sometimes frustrating, but ultimately impactful and empowering experience of amplifying the consumer voice. We have been privileged to support the response. We pivoted our work early on, as you will have seen from our submission, to support Queensland's response to COVID-19. In the four months since then we have done almost 50 consumer consultations with over 500 health consumers across Queensland, beginning daily early on with 26 consumer conversations as well as 20 bespoke rapid consumer focus groups. Messages and the needs of those Queenslanders were fed through to Queensland Health and informed their response.

We were able to draw on strong pre-existing relationships, partnerships and pre-existing mechanisms for consumers to have a say in the response. Early on in the pandemic response we did experience some frustration—having been used to having a seat at the table and consumers working with the health system—that circumstances early on in the pandemic meant this did not happen. I believe this was due to unusual and very unique circumstances with nationally led policy creation, an

extremely rapidly moving situation with evidence sometimes changing hourly, and structures that supported a central command and control approach without a consumer voice at the table. This was not unique to Queensland.

I am now pleased to say that we are streets ahead of other jurisdictions with having consumers supporting the response. We are glad and grateful that the system responded with a mechanism for the networked response the DG described in his evidence at the previous hearing. At the beginning daily opportunities for clinicians, consumers, HHSs, infectious diseases and departmental reps to discuss implementation and messaging was vital to ensure that Queensland had the best response possible.

Throughout this time we have seen relationships and partnerships strengthened, opportunities sought by the system and driven by us to facilitate rapid and ongoing consumer feedback, and that feedback was valued and acted upon. We have been particularly pleased by the desire of the system right now to listen, reflect and adapt. That is reflected by this inquiry and other internal mechanisms that are making sure that the learnings of this time are captured and inform the ongoing response. This reflects a culture that we expect and see the benefit of—valuing the many important perspectives in our system—most importantly, that of health consumers—a culture of continuous improvement and a wish to ensure that Queenslanders' wellbeing is maximised during this time.

CHAIR: Thank you very much, Ms Fox, for your opening statement. I would ask both organisations to talk to the strengths of the Queensland Health response. I know that some have been touched on in some of those remarks, but what do you think could be improved in terms of the health response? Is there anything that is glaringly obvious? Ms Fox, whilst you are on do you want to go first?

Ms Fox: For me, the answer is the same for both of those questions. It is around stakeholder engagement and particularly partnerships with consumers. We are, as I said, miles ahead of other states. Some of our interstate equivalent organisations have had absolutely no role in supporting their health department responses at this time, which we find mind-boggling given the benefits of working with communities, but especially being important at this time when we are asking so much of them and really needing a concerted and coordinated effort. That is in the context that we are very, very fortunate, but we would always like to see that improved.

We know that it is difficult at a time when things are rapidly moving, but that is something that we would love to really see embedded at every level of the system in every hospital, in every health service, in every part of the department to make sure that the response gets the support of that consumer voice, what works and what does not, and what is needed out there.

CHAIR: We might go to Letitia, from the Queensland branch. Did you want to make any comments on behalf of the PHA?

Ms Del Fabbro: I really just want to reiterate what Terry said and take any questions you may have for us.

CHAIR: Amid concerns of a second wave of COVID-19, what public health promotion strategies are important to ensure that people stay vigilant during the pandemic? I am sure you have read today's *Courier-Mail* and seen some images of nightclubbing. Is there any commentary around that, given what has happened in Victoria?

Ms Del Fabbro: It would be the consistent application of those guidelines in terms of physical distancing and ensuring that we have enough trained personnel who are undertaking the task of enforcement and training.

CHAIR: We have lost audio with Terry Slevin. Whilst we wait for Terry to come back, Mel, did you want to talk to that?

Ms Fox: Another thing that is important is recognising that blanket messaging does not work. That was something that we heard early on, particularly from the members of our network when they or their loved ones live with multiple complexities in their lives and pre-existing health conditions. They really needed that nuanced messaging—and they still need that nuanced messaging—about how to remain socially engaged and active and have a full life whilst also protecting themselves. It is challenging when we see that restrictions are lifted and certain things are possible within the confines of social distancing, but that is challenging in some environments. We see people not following those rules. It is difficult. We think that that messaging for different parts of the population is really important.

CHAIR: Terry, can you hear us now?

Mr Slevin: Yes, I can hear you. The point I was going to make is that the issue of communication about health has a longstanding core of expertise within the public health world. If you reflect on our work in the area of tobacco, sun protection, diet, physical activity or whatever else it might be, there is a core of expertise about behavioural research and about communication expertise that exists within the public health world. It has had a frustrating history in as much as programs in that sphere have often been kind of add-on and discretionary, rather than a core part of the health infrastructure. But those specialist health communication skills are fundamentally important at a time like this when appropriate behavioural research can be applied so as to give a sense of the community understanding an attitude. Once those basics are understood, better designed and more effective communication can then be employed.

As the pandemic evolves—and we are six months in and we probably have many, many months to go—drawing upon that expertise will be more valuable when it comes to potentially the submarket, if you like, or subpopulations within the community and the kind of attitudes that might exist on what kind of communication will best help to influence their behaviour.

The management of this pandemic is a long game, not a short game. We have gone through that first phase, but the challenge about retaining people's vigilance and focus on the avoidance of disease spread is a challenge that faces us at least over the next 12 if not 18 or 24 months. It is that expertise that draws upon and tests the community understanding and attitude, and then designs appropriate communication at the right level of subpopulations that is going to play an important role. To have that in place you need to have the infrastructure, the expertise and the training to be able to provide that in an ongoing way.

I will point you to a recent experience in Queensland. There was a diminution in the health infrastructure in 2012 under a previous government that saw more than 4,000 so-called desk roles, rather than frontline roles, being removed from the health infrastructure in Queensland. What that did was take out expertise in the public health sphere, as well as other spheres within Queensland Health, and diminish the expertise available to Queenslanders to deal with a response of this kind. While eight years ago sounds like a long time, that public health expertise has not been adequately built up over that period. Now Queensland will pay the price for that diminution in its expertise and capacity and it has to be recovered quickly.

Unfortunately, a training program is not a quick fix. It does not happen overnight. It takes some years of planning and for the training process to come into place before that expertise is immediately available. That is part of a challenge that faces not only Queensland but certainly also the rest of Australia. That is another consideration that I think is worth being included in your find report.

CHAIR: Thank you very much, Mr Slevin. You raise some very good points. We have managed to dial in, via teleconference, Associate Professor Louisa Gordon. We will go to her now for any statements or commentary.

Prof. Gordon: I am Louisa Gordon. I am a senior health economist and a member of the Public Health Association of Australia. I am also employed at QIMR Berghofer Medical Research Institute. My work concentrates mostly on the costs and benefits of new interventions in health care. My role here and what I would like to emphasise is that it would be very valuable for the Queensland government to assess the health and economic consequences of the pandemic response. That would be a very transparent way of really understanding what the response has meant for Queenslanders and to better plan different scenarios going forward.

I would like to highlight that we have some experience and expertise in health economics, infectious diseases and public health within my own institute, the QIMR Berghofer, and certainly in the universities around Queensland. There are some economists starting to do this already around the country. They are looking at the federal government policies and statements that are coming on board.

I think that the Queensland government has made some very difficult decisions with border controls and all sorts of difficult decisions. I think there has been this tension between public health and economic activity. From my perspective and from many years of doing this work, it is quite clear that there really are not trade-offs, as such. They often move in the same direction. It is not to ignore the terrible cost of businesses and jobs lost, but, as Terry said, it is a long game and not a short game. Actually, the best thing for economic recovery is to have done what the Queensland government has done and come down quite strictly on borders, travel restrictions and so forth. I think that has been a very strong policy response. That is all I would like to say.

CHAIR: Thank you for that. Over the past few months, I have quite often surmised that you cannot have an economy if you do not have your health. It is paramount in this response. I will open up to questions from the committee.

Mr HUNT: My question is to Ms Fox. In your submission, under the heading 'Suggestions for Improvement', you outlined feedback that you received in relation to overreliance on digital communication. In electoral offices we have found that we became the interpreters of the Chief Health Officer's directives around what people could and could not do under the restrictions. Do you have any feedback on that?

Ms Fox: Absolutely. In one of the final consumer conversations a few weeks ago, one of our consumers reflected that they had not received any written material—no letter-box drop; no material in that way. It made them concerned to think about who is missing out on information. We rely on digital technology so much, but who is missing out? Your point goes back to Terry's point around the absolutely vital need for an informed, evidence-based public health workforce, but that policy needs to be translated in ways that the community can understand. What we have attempted to do with our consumer conversations is feed through feedback on what is not getting through to consumers, what could be said in a different way to different populations. You are all living that in needing to play that role yourselves.

Mr HUNT: One of the issues that I have found in the electoral office is the interpretation of what is essential. 'Essential' was actually defined in the Chief Health Officer's directive as anything not listed under nonessential. It was actually defined, but people tended to interpret it as its everyday meaning, which confused people about what they could and could not do. Did you receive feedback on that?

Ms Fox: Yes, absolutely, even in terms of who would self-isolate and who would be able to go to work and who would stay home. There was a comment made about the very strong response from Queensland. There was a really strong sense from people that they wanted a lockdown early and that people wanted to do what was necessary to stop this in its tracks. However, it is confusing when there is messaging that is not really clear. You had some people being forced to go to work when they really wanted to do the right thing and stay at home.

Mr O'ROURKE: My question is to the Public Health Association. To put some context on this, the next people to present are from the Queensland Aboriginal and Islander Health Council. In your submission, at pages 6 and 7, you broadly discuss the impacts of COVID-19 on the Aboriginal and Torres Strait Islander communities, with reference to the Australian Senate inquiry on COVID 9. Could you comment specifically on the Queensland government's response to COVID-19 in relation to Aboriginal and Torres Strait Islander communities? In particular, what were the strengths of the Queensland health response and what do you think could be improved about Queensland's health response in that space?

CHAIR: We have lost audio.

Mr Slevin: I am back. I will offer some general comments and then defer to my Queensland members, if they are able to join in, subject to the technology, for a specific local Queensland response. We ran a webinar a few weeks ago. We had leadership of the Aboriginal Community Controlled Health Organisation where there was a clear recognition of the superior response from Aboriginal controlled health areas, particularly in rural and remote Australia. We quoted the figures—and we think it is still the case—that less than one per cent of cases diagnosed in Australia are amongst Aboriginal and Torres Strait Islander Australians. That is largely because of the very active and, in some cases, quite aggressive response from the Aboriginal health controlled sector, entirely appropriately. I should make clear that we do not and would not speak on behalf of the Aboriginal communities, but rather defer to their own expertise and commentary with regard to that. Generally, the answer to the question is that because it was in community and in Aboriginal controlled hands that gave it, in the first instance, as a principle, its greatest opportunity to be successful.

I was aware of various discussions, and some of it was in Queensland, with regard to a modality of testing available in remote communities. Dr Mark Wenitong was in engagement with Queensland Health to try to deal with a means of doing testing that was more appropriate because of the remote communities being responded to. The technical details of that I am not able to provide you with today, but if needs be I can follow up. I understand that was resolved. I would defer to Letitia in Queensland to offer a more local perspective, if that is okay.

Ms Del Fabbro: I would reiterate what Terry has said. In our report, we suggested having Aboriginal and Torres Strait Islander representation on advisory boards going forward, to make sure that that is a direct link to those communities.

Mr BERKMAN: Thank you all for being available this morning. I wanted to go to the use of telehealth. Obviously the increased use of telehealth has been somewhat inevitable and also potentially a very positive outcome of the change in circumstances. Some of the evidence we have heard this morning has been generally very favourable in terms of the use of telehealth, but I guess I am curious from both a consumer and a public health perspective. Can either of you speak to the sorts of limitations or risks that maybe come with an increased use in telehealth and how those could best be addressed?

Ms Fox: I would love to answer that question. This is a bit of a double edged sword. For many consumers they really saw this time as removing the barriers to a widespread expansion of telehealth that they have wanted for a long time. Some specialties that really had resisted delivering care in this way just needed to. Actually it would be worth seeking a briefing from the department. It actually was not as much telehealth as I had expected. I think more people experienced a pause on their appointments and a delay rather than everyone moving to telehealth, but there was a rapid expansion.

We heard from many of our consumers in our network their concern around the digital divide. We heard about some of them having negative experiences in terms of privacy, in terms of needing to wait four hours to receive a phone call for a specialist appointment for their child, it is just not workable, and not having the technology that they needed to be able to seek care in this way. Whilst we could see very much that there were benefits to this happening, we have continuously said there needs to be a process for the department to have an ongoing oversight of what the patient experience is of this technology and a process to continually improve its use, both in support for healthcare providers, but also for consumers and the technology that they access so that everyone can get the benefits of this care.

Mr Slevin: From a public health point of view I think Louisa Gordon might be best placed to answer but I think she might be on the phone so if we give her some air time she might have something to throw in.

Prof. Gordon: Yes, I do, thanks, Terry. I do not have too much to add in this area. I think overwhelmingly the telehealth items have been successful. I have spoken with specialists in the hospitals and they have said it has just been fantastic to have that access. Before COVID there were patients who did not particularly need to come into hospital and they could have had these telehealth appointments from the beginning. I think there has been some efficiencies there. It has been very good in some ways. On the downside, as Letitia was saying, I think we need to be very careful and evaluate what is going on because there has been some negatives around still having a lack of coordinated care: is there some script writing over holistic patient care where you want to talk to different team members, particularly in patients with chronic disease. A very challenging thing to do is to coordinate team based care, which we are not sure has happened very well with telehealth so it is something we would need to evaluate going forward.

Mr Slevin: Perhaps if I could add just one note and that is I have been aware of the discussions around the potential benefits of telehealth for probably more than 10 years in the healthcare system in Australia. There are a whole range of very substantial potential benefits, but as Melissa mentioned earlier there has been some blocks in the system and some hesitancy.

The circumstances of COVID-19 all of a sudden brought all of the preparation, the thinking, the planning and the projects in that area into fruition very quickly. A rapid adoption of a new form of healthcare delivery under these extreme circumstances was inevitably going to create and demonstrate some holes in the system, but what it does do is allow us to work from the point we are now in the learnings from that experience and ensure we retain the good components of telehealth where there are a whole variety of benefits, particularly in a state like Queensland with a very substantial rural and remote population, while improving those areas that were shown to be less successful.

It actually creates an extraordinary opportunity for potentially more timely, potentially more cost efficient and potentially ultimately better health outcomes from the best adoption of the successful components of the telehealth change while addressing those areas where it has been less successful. I am very hopeful it has been a good research base being put in place so data is captured so that that can drive improvements into the future, but it should be considered as a very substantial opportunity to improve the healthcare system more broadly in Australia as a result of these circumstances.

Ms PEASE: Thank you very much everyone for coming in. I wanted to just ask Melissa, and perhaps the public health group as well, about the impact that the removal of elective surgery had and also preventative medicine such as BreastScreen Queensland et cetera and the influence that has had and the impact that that might have had on consumers?

Ms Fox: That is a really important question. I was reflecting on this the other day and thinking that really we were so lucky to get the pandemic under control so quickly so that really that window has been much shorter than I think was anticipated which has been great but it has meant that people have not accessed care at the time that they needed it and it does mean that we now have a backlog and it does mean that there needs to be creative ways to ensure that people get the care that they need in an equitable and targeted way so that those who most need it get it now and get it in a timely way and know what is happening. That is the other thing: a lot of people did not know what was happening so we have been really bringing home the importance of communication.

Mr Slevin: The response from a public health point of view is that that is yet to be determined when your question is what has been the outcome of that and I guess we do not know that yet. The reality is in dealing with chronic disease, when you see a delay of, let us call it six months or potentially longer when it comes to early diagnosis with regard to screening programs, when it comes even to programs like immunisation and then the longer-term preventative health programs, when those have largely gone on hold, and the reason they have gone on hold is that people with any public health expertise, pretty much any health department around Australia, have been taken off their normal duties and put on to the response to COVID-19, that is understandable and appropriate, but what it does is highlight that public health workforce problem as the pointy edge of that and then what it does is highlight that paucity of broader investment in public health that I raised in my opening comments and that is the stuff that we are genuinely concerned about.

Again I have made the observation to our members, and the members of the Public Health Association are people who are working or studying in the public health sphere, that they need to ensure that they capture the best possible data about the impact of this pandemic because unless they do they will not be considered an expert in their field and it does not matter whether they work in alcohol or immunisation or tobacco control or whatever else it might be. There is inevitably going to be a blip in the curve in any public health measure as a result of this experience. I think what it will do is show out the importance of a solid, ongoing investment in public health and prevention.

The point we often make is that when public health works nothing happens and when public health prevention works you do not see an increase in cases, you do not see a crisis, you do not see an emergency and so that makes it a less political imperative to ensure an ongoing investment in that sphere. Your question really has highlighted that basic challenge we have to ensure that the infrastructure is in place in an ongoing way for public health program development, delivery, evaluation and the workforce to drive that that is appropriately expert.

The short answer to the question is we do not know yet but we fear it will not be a good result and we fear that there will be an increase in mortality from chronic diseases as a result of the kind of hiatus that the system has gone into as a result of COVID-19.

CHAIR: Thank you. We will need to go to the deputy chair in the few minutes remaining.

Mr McARDLE: Thank you, Chair, and thank you for being here today. Mr Slevin, you made comment earlier that in 2012 there were 4,000 people let go from Queensland Health, that knowledge has not been replaced to date sufficiently to capture what was retained or had at that time. Are you equally concerned about the Treasurer's announcement of Public Service jobs and saving $3 billion over four years and what that may mean to Queensland Health as well?

Mr Slevin: I do not want to get into the local politics of Queensland when it comes to recent Treasury announcements in the lead-up to an election in particular, but I guess the broad position I would offer is to say that a strong Public Service with strong regulatory infrastructure is also a vital component of that and a skilled public sector has never been so clearly highlighted in terms of its importance. At this time in this international crisis we have actually turned to governments and turned to government infrastructure to respond constructively and effectively. All governments should reflect upon the decisions that they are making now to ensure that that fundamental infrastructure is solid and sound.

I do not know the details of the Treasury announcement that you have referred to, but as a broad principle the Public Health Association of Australia is going to consistently reinforce the importance of that public infrastructure and expertise to ensure that there is a capacity to respond in times of greatest need. We have had that shown loudly and clearly now more so than at any other time and perhaps all of our lifetime.

Mr McARDLE: Would you agree with me though that if there were reductions in Queensland Health numbers of public servants, be it on contract or otherwise, that would give you cause for concern given your earlier statement about the necessity—

CHAIR: It gave them concern in 2012, Deputy Chair, that is for sure.

Mr McARDLE:—to ensure the continued knowledge retention; would that be a concern to you?

Mr Slevin: Firstly, I will make clear that I do not know the details of the announcement that you are referring to, but I would make a broad statement and the broad statement is that now is not a time to diminish public health infrastructure anywhere in the world—not in Australia, not in Queensland, and nowhere in the world.

I mentioned earlier in relation to the broad response that we are going to look for ways of exploring the capacity of establishing a centre for disease control in Australia, and if we go down that path we think the contribution of a state like Queensland will be vitally important to consider, firstly, whether that is the best way forward and, if so, how we might do that to make the best possible results so that Australia can take a legitimate leading role internationally in public health. That means having a solid foundation with appropriate investment in the public sector.

Mr McARDLE: Ms Fox, I think we can all accept that when the pandemic broke in January of this year the first turn of Queensland Health would have been to secure the hospital sites, secure the PPEs, the ventilators and the beds, et cetera. That would not be unusual. Of course, there were organisations such as yours critical but maybe not taken into account in the first blush. That was then picked up and you are now part of that process. Could you outline which of the government committees you sit on, or your organisation sits on, in relation to feeding into the recovery, the future development, et cetera, in relation to COVID-19?

Ms Fox: Absolutely. There is quite a list, but the key ones around the COVID response right now are PHRIAG, the Public Health Response Implementation Advisory Group. That is the one that Dr Wakefield referred to in his evidence previously that is continuing on to bring together that public health system response. I also sit on their System Management Committee and the Queensland Health Leadership Board. They are the committees above that committee. In particular, the Queensland Health Leadership Board is concerned with the big picture, whole-of-system response. It is fantastic to have a seat at that table. I am also fortunate to sit on the Reform Planning Group which has been pulled together for a very short period of time but again with that real desire to keep what is good out of this time, to listen to many, many stakeholders and make some fantastic recommendations moving forward so that we can come out of this as a state with the best possible health system.

If I can just go back to your question around workforce and also the previous question around elective surgery and outpatient appointments, we think that this time has really provided the opportunity to reflect on the care that Queenslanders are given. This is a prime opportunity to ensure that we have mechanisms in place so that people are receiving timely care from the most appropriate health professional, no matter who they may be, as close to home as possible but utilising technology that means that they do not have to travel if they do not need too. There are so many exciting opportunities out of this time.

Mr McARDLE: What is the full title of the reform body you referred to?

Ms Fox: I believe it is the Reform Planning Group.

Mr McARDLE: That is under Queensland Health or DPC?

Ms Fox: Queensland Health.

Mr McARDLE: Headed by Dr Wakefield?

Ms Fox: No. Meegan Fitzharris is the chair. It is an independent planning group. There is a public facing website which called for submissions which I am happy to provide to the secretariat.

Mr McARDLE: Would you mind? Do you have a reporting date to the government?

Ms Fox: I cannot recall it right now, but I will chase that up and feed that through.

CHAIR: I will finish with a closing comment. I am very thankful—and I am hearing it from Queenslanders and people I have connected to in my electorate—that we have managed to have thousands of additional nurses and doctors and public health officers re-employed since 2012 to do the contact tracing—

Mr McARDLE: They could be gone again, Mr Chair.

CHAIR:—and run the fever clinics as part of the magnificent health response by the government. We have heard that time and time again through the submissions. Thank you for your contributions today. They are welcomed. We look forward to talking with you again in the future. Thank you very much for your time today.

YOUNG, Ms Angela, General Manager, Policy and Research, Queensland Aboriginal and Islander Health Council (via teleconference)

CHAIR: Angela, can you hear us? Standby. We cannot hear you at the moment. We have had this happen throughout the morning. Sorry, Angela, we still cannot hear you. We can see you are trying to talk. We will work through this. Otherwise, we might dial in via teleconference if we have to. Can you hear us now? Standby. We are going to call you and try to put you through via teleconference. Thanks for bearing with us, Angela. It has been a bit of an issue this morning with people dropping in and out. We only have 25 minutes. Would you please make an opening statement on behalf of the Queensland Aboriginal and Islander Health Council? We will then move to questions.

Ms Young: Thank you very much for the opportunity. I would say it was great to see you all again—and I did briefly. It is great to see you all again and all healthy. QAIHC is very grateful for the opportunity to discuss these important matters with you today. I might cut my opening presentation really short so we can have a good opportunity for discussion now that we have less time. It is absolutely important for me to acknowledge my ancestors, the Kullilli and Koa peoples, and acknowledge the Jagera and Turrbal people whose lands upon which we are all meeting today. I pay my respects to elders past and present and look forward to working alongside those emerging.

QAIHC is incredibly proud of the leadership demonstrated by our sector throughout the COVID-19 pandemic. Our members have again demonstrated their value, their flexibility, their ingenuity and their resourcefulness in the face of a crisis and have been successful in keeping our families safe. Before we get into a nitty-gritty discussion of the strengths and weaknesses of the COVID-19 response, I think it is important to congratulate ourselves as a health system and a community that out of the 180,000 Aboriginal and Torres Strait Islander Queenslanders only nine have contracted COVID-19, and there have been no fatalities, although as a nation we are clearly not out of the woods yet. This is a remarkable achievement compared to the other much more unfortunate indigenous populations around the world.

As Dr Young shared with you in her opening statement, there has not been one case in a discrete community in Queensland. We know that we have our Aboriginal and Torres Strait Islander community controlled health services to thank for this, leading the charge with health promotion, prevention, isolation, testing and treatment. I understand that you all have received QAIHC's written submission and that you have had the opportunity to hear from all of our colleagues across the health system. Without further ado, I am very happy to open the floor to discussion.

CHAIR: Thank you very much, Angela. I have just talked to my local Indigenous community, Palm Island, off Townsville, which is where my electorate of Thuringowa is. We are very proud to have seen self-determination, with them recently opening up a health clinic and taking over that role. The biosecurity measures that were put in place around COVID have been necessary. Is that correct?

Ms Young: Absolutely. We agree.

CHAIR: This is to protect some of the most vulnerable people who might have comorbidities. In fact, I saw some data—it might have been in your submission—

Ms Young: Yes.

CHAIR:—where around 50 per cent of Aboriginal and Torres Strait Islander peoples have some form of medical history.

Ms Young: Yes, living with chronic conditions and the vast majority of those have multiple comorbidities.

CHAIR: Looking at those numbers out of 180,000, the measures taken were necessary. I want to know about those nine people you spoke of. Have you dialled down to which particular communities were affected?

Ms Young: Yes. It is a really good question because we know that seven of the nine were in major cities which from the ABS statistics is Brisbane and surrounds. The other two were regional—no remote, rural or very remote. It is an interesting point. One of the weaknesses—I do not generally like to use deficit language—is the lack of transparency of the data. One of the very early lobbying pieces from QAIHC with the national COVID advisory group was around getting greater visibility to Aboriginal and Torres Strait Islander data. That information came from the Commonwealth. We have had quite a difficult journey in trying to ascertain community level data through the Queensland government to ensure that our member services can be as responsive as possible on the ground. It is an interesting question that you raise.

CHAIR: I mentioned Palm. Your submission says that communities were better prepared in areas where meaningful partnerships existed—I would put Palm up there as one of those—between hospital and health services and Aboriginal and Torres Strait Islander community controlled health organisations. What were the strengths of these relationships that assisted communities to be better prepared?

Ms Young: That is a very good question. One of the improvements that we would have put in our submission is around the fact that health system reform needs to centre on mandated partnerships between hospital and health services and the primary care sector in general but specifically, for Aboriginal and Torres Strait Islander communities, with our members.

Perhaps if I could use an example—in the Cairns and Hinterland Hospital and Health Service we have four Aboriginal and Torres Strait Islander community controlled health organisations within that HHS catchment. Very early on, the CHHHS, if I can say in short, engaged our community controlled members in an Aboriginal and Torres Strait Islander COVID working group. That meant that right from the beginning of the pandemic our member services were advised about access to isolation and quarantine procedures. They were engaged in public health unit data. They were able to set up clinical pathways so that their communities did not miss out on core services with the hospital and health service. There was just greater information sharing in terms of data and access to services so that the Cairns and Hinterland Hospital and Health Service also understood what the community was saying in terms of what they were not getting throughout the pandemic.

Another example is in the south-west. Our member service Charleville and western areas Aboriginal community controlled health service has always had a very good tripartite relationship with the HHS and the PHN. Again, that was really evident throughout the crisis. One of the more innovative practices was the HHS engaged our member service and trained them all very early in contact tracing for Aboriginal and Torres Strait Islander patients so if the time ever came that there was community outbreak the people who were on the ground who knew the communities best would be engaged in the testing and control infrastructure that was set up for that region.

In contrast, it might be a good idea to give you an example of other regions where there was very limited contact with the community controlled health service where there were not Aboriginal and Torres Strait Islander COVID-19 plans. We have found a number of our communities often without information about how to access isolation and quarantine accommodation, how to get tested, where to get tested and general public health information such as what does social distancing mean and what is this pandemic and how do I know what my risk categorisation is? Unfortunately, that seems to be more of the norm than the stronger partnerships where we saw seamless health delivery.

Mr O'ROURKE: My question is in regard to community controlled health organisations. In your submission you speak of instances where there was violence and aggression towards the staff there. It was more related to the lack of Aboriginal and Torres Strait Islander health messaging, particularly as restrictions began to ease. Could you explain that further please?

Ms Young: Yes, I absolutely can. One of our criticisms of the response—I probably should preface that by saying that the interactions between the Queensland government leadership and the discrete communities in terms of the Premier, the then deputy premier and the Chief Health Officer were good. They were strong. They had weekly conversations with Aboriginal and Torres Strait Islander shire council mayors in terms of making decisions for their communities. What we thought was really missing was that public facing messaging.

Every time we saw the Premier or the Deputy Premier or the Chief Health Officer addressing the media we found it very difficult to find where Aboriginal and Torres Strait Islander people fit in that messaging, apart from constantly reiterating that our communities were high risk. What that meant when the restrictions were easing is that residents in some of the biosecurity zones in particular did not understand when the Premier went on TV and said, 'Congratulations, Queensland, you have earned the right to move around our great state,' and the residents in those communities were not told that that did not apply to them and were not advised why. That often left our services and the local councils right in the middle of it. As you can understand, residents in those communities got very frustrated and took their frustrations out on local services because there was not that opportunity to publicly support residents of those communities with basic information.

Mr BERKMAN: I appreciate your time today, Angela. I am interested in any insight you can give us into the impacts of the health directions, particularly the lockdown, on remote communities. You have already touched on this to a limited extent around the communication of changes. Are there any particular impacts on remote Indigenous communities that the committee might benefit from hearing your insights into?

Ms Young: Absolutely. There are some unavoidable things when you live in a remote community and your access to services is restricted. Some of those are really poor health system needs. A really big one is access to renal dialysis that you would normally get in a hospital setting. Out of those needs we have seen some innovations. For instance, in Yarrabah for a number of years now they have been advocating for greater funding so their renal dialysis chairs can be available to the community longer, over more days and for more sessions. For a number of reasons we have been unable to successfully do that over a number of years. Because of this, the Cairns and Hinterland Hospital and Health Service has supported the Yarrabah community to have renal dialysis more frequently and across more chairs for a period, so that the community can access that dialysis closer to home.

What I think has been most revealing for our member services in the discrete communities because of the lockdown is the lack of access to mental health, social and emotional wellbeing, alcohol and drug services and other social services that are vital in any period of crisis. The lack of specific attention to Aboriginal and Torres Strait Islander culturally appropriate services for those needs has become particularly concerning at this point in the pandemic. We are very concerned about what the data is going to tell us over the next couple of months about the increase in mental health incidents and access to services and, in particular, how it has materialised in people unfortunately taking the option to take their own lives or die by suicide. We are concerned about the increase in a reliance on alcohol and other drugs without access to services to help support people throughout that time.

Mr BERKMAN: In the evidence this morning we have heard a little about the expansion of telehealth and the positives that might come from that. Does that translate into benefits for remote and discrete communities as well? Have you seen the same sorts of uptake and benefits there?

Ms Young: Yes, absolutely. The great hero out of the pandemic for Aboriginal and Torres Strait Islander people will be the reliance on virtual medicine. For a long time, because of the remoteness of a number of our communities, our sector has been a heavy advocate for a greater reliance on virtual medicine technologies. QAIHC is involved in a number of research studies for virtual medicine platforms, from telehealth and Project ECHO with the Children's Hospital to mobile health monitoring platforms.

We are very enthusiastic about expanding the reliance on telehealth and virtual medicine to allow us to be closer to home. The community controlled model of care is all about providing family centred care closer to home, so that communities are able to access health services in a way that is relevant to and comfortable for their communities. This increase in tele and virtual medicine is really in line with our model of care and is something that we will be pushing to retain in the long term. It also means that it breaks down a number of barriers that are historically plaguing Aboriginal and Torres Strait Islander people in accessing services. Of course, one of those is transport, but the other is institutional racism, which I had the opportunity to talk to you all about before. Diversifying and decentralising health care out to community on the ground and family centred modes of care is exactly the way that we need to go to achieve Aboriginal and Torres Strait Islander health advancement.

CHAIR: We will move to the member for Nicklin because one of our members has dropped offline.

Mr HUNT: Thank you, Ms Young, for your time today. Referring to page 13 of your submission, you talk about public health messaging. You note that Queensland Health does not have the capacity to develop culturally safe communications about COVID 19 and you contrast that with the Commonwealth response, which engaged an Indigenous organisation to prepare that. You also comment that you and another organisation were subsequently engaged to coordinate and distribute a series of health communications and that you were required to do that at your own expense. Has that been rectified? Obviously the pandemic is not over so there will be more communications to come. Has that situation been rectified?

Ms Young: That is a yes. We have a commitment from Queensland Health. One of the things I should say upfront is that we have a very good relationship at QAIHC with the Chief Aboriginal and Torres Strait Islander Health Officer, Haylene Grogan, and the first nations health division. In saying that, however, there were a number of instances where QAIHC was very clear about our inability to continue to provide services as an agent for the government without effective resourcing. It was not until a couple of weeks ago that we were given the green light that Queensland Health would be funding QAIHC for some of the expenses that we outlaid to do, particularly the public health communications, but we have not received the funding yet.

CHAIR: That was a good question. Thank you very much, Angela. We have Joan back.

Ms PEASE: Someone disconnected me, but I was here. Thank you very much for coming in. Angela, how much has your organisation been involved and participated in the response to COVID?

Ms Young: That is a very broad question. In terms of our engagement with the Queensland government, our organisation has had most predominantly our conversations with, as I just mentioned, the Chief Aboriginal and Torres Strait Islander Health Officer's division in terms of responding to the specific Aboriginal and Torres Strait Islander response. In saying that, that in itself was strong, but in terms of engagement with other elements of the health system it was a little haphazard. For instance, in the example that I gave earlier with the Chief Health Officer, the Premier and the then Deputy Premier meeting with the Aboriginal shire council mayors, QAIHC repeatedly asked to be invited so that we were able to provide a parallel health response. I think we only ever were able to go to one of those meetings, which meant that we were always chasing the information from the tail, as it were.

Our member services have been highly critical of the health system's lack of information sharing, specifically with the data that I have already mentioned. Our member services met with our clinical leaders every week and every week our clinical leaders were concerned that public health units were not able to share critical information about testing and clinical pathways, because they were advised that that information was being held centrally in the state public health units.

We were invited very early on by the State Health Emergency Coordination Centre to join the primary healthcare response teleconference, which was twice a week. That is where we got a lot of our primary care information from. That was helpful, but again it was not relevant to on-the-ground regionally responsive information that we would have needed if the situation was worse in Queensland.

A lot of our members feel that they got more information about the primary healthcare response from the Commonwealth government, particularly in the early parts of the pandemic. There was not necessarily a deliberate attempt to keep QAIHC and the sector out. I guess the frustration for us is that there was not an active attempt to keep us in. Where we knew there were mechanisms and where we knew that there was information-sharing infrastructure set up, we asked to be a part of it and often the answer was yes, but our arguments and our sector's point of view was that we should always be central to that, particularly when we are dealing with the most vulnerable members of the population.

Ms PEASE: Angela, in your submission you talk about being a voice for your 26 members. Who are they? What sort of organisations are they?

Ms Young: We have 40 members, but 26 of our 40 members are delivering Aboriginal and Torres Strait Islander specific community controlled primary health care. Those are primary healthcare services all over Queensland. We operate out of 70 clinics in Queensland. I am not sure if that is what you meant. Did you want specifics of what those particular organisations are in each of the regions?

Ms PEASE: I am trying to get an understanding as to who your members are.

Ms Young: They are comprehensive primary healthcare providers, specifically for Aboriginal and Torres Strait Islander communities and they are community controlled, which means that they are run by community controlled boards in each of the areas in Queensland, of which we have 26 across the state.

Ms PEASE: The Institute for Urban Indigenous Health, IUIH, would be one of your members, for example?

Ms Young: Yes, IUIH is one of our regional members. IUIH covers South-East Queensland. They are essentially a South-East Queensland version of QAIHC. They represent the five member services in the south-east, but each of their members—Kambu in Ipswich, Kalwun on the Gold Coast, Yulu-Burri-Ba on Straddie, Moreton ATSICHS in Brisbane and Brisbane ATSICHS—all are members of QAIHC, also. IUIH is a regional member of QAIHC, if that makes sense.

CHAIR: We only have a couple of minutes left, so I am not sure if you can answer this question in that time, Angela. There is no doubt that COVID-19 has highlighted areas of potential health reform. Your submission discusses the issue of health equity. In practical terms, what are the key areas and strategies that would improve health equity in Aboriginal and Torres Strait Islander communities in Queensland? We know about the broader reforms of Closing the Gap and the Making Tracks policy and programs are in place. Is there anything else that you can identify in the time remaining?

Ms Young: This is a perfect opportunity to reiterate the discussion that we had with you when we discussed the health equity legislation, which absolutely needs legislation. We need to mandate the accountability for health equity in our health system. How we achieve that in terms of embedding

it in the system is through integration. You cannot have integration in the health system between the community controlled primary healthcare sector and the hospital and health services without resourcing. We need to be able to develop network funding between the hospital and health services and the Aboriginal and Torres Strait Islander primary healthcare sector to ensure that the journey that we are providing to the most vulnerable population is a seamless one.

From our perspective, it is about embedding in legislation that health equity is the responsibility for the entire health system and not just for the Aboriginal and Torres Strait Islander services industry. It is about ensuring that leadership is held accountable for health equity at all levels. Hospital and health service boards all need to have health equity at front of mind. We need to ensure that funding is dependent on hospital and health services prioritising health equity mechanisms. We need to make sure that partnerships between the hospital and health services and the community controlled health sector do become part of their funding agreement, so that they are not just reliant on relationships that already exist or in regions where it works well out of necessity. We need to make sure that there is significant political will that is sustained over a period, so that health equity does not become a thing that is consistently discussed as something that is needed but is actually embedded as a core belief system in Queensland.

CHAIR: Thank you, Angela. We are madly looking up the recommendations from the Health Legislation Amendment Bill 2019, which we think will go some way towards hopefully answering some of the issues.

Ms Young: We would be very happy to re-forward that to the committee.

CHAIR: No, I think we have it. You have come before us before, but I cannot remember the last time we had a face-to-face. Was it with DATSIP?

Ms Young: I think it was in January on the hospital and health boards legislation about health equity. Institutional racism was the preface of our presentation and how we work together to eliminate it.

CHAIR: There are a number of recommendations in there to provide greater clarity and certainty. That has to hit the floor of the parliament and we cannot control that. We do thank you for your ongoing advocacy. Today's contribution has been very informative. Thank you so much, Angela. We look forward to hopefully seeing you face to face some time in the future.

Ms Young: Thank you. I really appreciate the opportunity and I look forward to seeing you again soon.

CHAIR: Thank you, members. I declare this public hearing closed.

The committee adjourned at 1.00 pm.