COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

General practitioner and related primary health services to outer metropolitan, rural and regional Australians

(Public)

THURSDAY, 17 MARCH 2022

EMERALD

BY AUTHORITY OF THE SENATE

[PROOF COPY]

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Thursday, 17 March 2022

Members in attendance: Senators Chisholm, Hughes, McDonald [by audio link] and Rice

Terms of Reference for the Inquiry:

The provision of general practitioner (GP) and related primary health services to outer metropolitan, rural, and regional Australians, with particular reference to:

a. the current state of outer metropolitan, rural, and regional GPs and related services;

b. current state and former Government reforms to outer metropolitan, rural and regional GP services and their impact on GPs, including policies such as:

i. the stronger Rural Health Strategy,

ii. Distribution Priority Area and the Modified Monash Model (MMM) geographical classification system,

iii. GP training reforms, and

iv. Medicare rebate freeze;

c. the impact of the COVID-19 pandemic on doctor shortages in outer metropolitan, rural, and regional Australia; and

d. any other related matters impacting outer metropolitan, rural, and regional access to quality health services.

WITNESSES

WITNESSES

DENNESS, Dr John, Private capacity [by audio link]

McPHEE, Dr Ewen, Private capacity

Committee met at 08:32

CHAIR (Senator Rice): I declare open this hearing of the Senate Community Affairs References Committee's inquiry into the provision of general practitioner and related primary health services to outer metropolitan, rural and regional Australians. We acknowledge the traditional owners of the land on which we meet, the Gayiri people, and pay our respects to elders past, present and emerging. These are public proceedings, and a *Hansard* transcript is being made. The hearing is also being broadcast via the internet.

I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It's unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee, and such action may be treated by the Senate as a contempt. It's also a contempt to give false or misleading evidence to a committee. The committee prefers all evidence to be given in public, although the committee may determine or agree to a request to have evidence heard in private session. If a witness objects to answering a question, the witness should state the ground on upon which the objection is taken and the committee will determine whether it will insist on an answer, having regard to the ground which is claimed. If the committee determines to insist on an answer, a witness may request that the answer be given in camera. Such a request may also be made at any other time. The committee understands that all witnesses appearing today have been provided with information regarding parliamentary privilege and the protection of witnesses. Additional copies of this information can be obtained from the secretariat.

We have also had a request from the media to film this morning's sessions, and the committee has agreed to this. I remind the media that this permission can be revoked at any time, and the media must follow the direction of the secretariat staff. If a witness objects to being filmed or photographed, the committee may consider this request. The media are reminded that they are not able to take images of senators' or witnesses' documents or of the audience. Media activity may not occur during suspensions or after the adjournment of proceedings. Copies of Senate resolutions concerning the broadcasting of proceedings are available from the secretariat.

I now welcome Dr Ewen McPhee and, via teleconference, Dr John Denness. Thank you both for appearing before the committee today. Do you have anything to add to the capacity in which you appear today?

Dr McPhee: I'm appearing principally as a local Emerald general practitioner and rural generalist.

Dr Denness: I am a GP in Innisfail in Far North Queensland.

CHAIR: I now invite each of you to make a brief opening statement if you would like to do so, and then we will ask you some questions.

Dr McPhee: I invite Dr Denness to take the floor first, if that's appropriate.

Dr Denness: I'm guessing you've already had a look at my submission. I am an Australian-born and trained GP working in Modified Monash 4 and Modified Monash 5 in Far North Queensland. This is the summary of my submission and the issues that I've identified. No 1: private GP numbers are dropping in our region despite active recruitment. The number of Aussie trained GPs coming to and working in this region in the last 10 years or so is about 3½ full-time equivalent; leaving is about eight. There are in the order of three Aussie trained GPs likely to retire in this region in the next two to three years. The number of IMGs that have come into this region in the last 10 or so years is about five, and out is about seven. In terms of practices in our region we have had four private practices close down in the last six or so years, with no new practices opening and one pre-existing practice sort of reopening. GP numbers have dropped despite active recruitment, and forecasts are continuing to drop.

No. 2: it's virtually impossible to gain Australian trained doctors. As mentioned in my report, for the last three-plus years of actively advertising in multiple ways, including paid ways to do so, we've gained zero Australian trained doctors.

No. 3: it's virtually impossible to gain IMGs directly at the moment. We've had a zero per cent success rate since ACRRM has had the monopoly on allowing IMGs to private practice in Queensland. From that end, I no longer expect any IMGs to come through the standard pathway. We think the chance of success is about zero. We're no longer trying to obtain doctors through this pathway. Another GP in this area said they gave up on trying to get IMGs. Also, IMGs and recruitment agencies are giving up on getting work with private GPs in Queensland. For example, two recruitment agencies I deal with have given up on going through PESCI. They're wondering about the future even with the specialist pathways. We've almost completely given up trying to get IMGs.

No. 4: it's difficult to retain doctors once they are here. There are a few things that can be done to keep them here. For example, we have an IMG here who we gave sponsorship, training, financial aid and all that sort of

stuff, and now, as soon as they got fellowship and their citizenship, they're moving to an urban centre less than three years after being with us.

No. 5: cost is a significant factor and set to worsen. The costs to IMGs and practices are significant, and that's outlined in my report. An extra financial hurdle is now also in place for IMGs who wish to become fellows of RACGP. They used to have the subsidy of the PEP, Practice Experience Program, from the Department of Health, but that intake is now ceasing and this will transition to self-funded, so it will be another block for IMGs who want to get fellowship. The pay inequality between public and private sector is not encouraging private practice. For example, I talked with an SMO from our local hospital who's with ACRRM who said: 'Why would I ever go into private practice? I get paid really well. I don't have to work many hours. I get different types of paid leave: sick leave, conference leave, study leave—all sorts of leave.'

The other thing is No. 6: stress and mental health stress on current GPs. I was talking with some GPs yesterday, and one of them said they would like to retire but they don't feel they can because there's a doctor shortage. Another GP said it was difficult to take time off as it's expensive and hard to find a suitable locum. Rural doctors are made up, roughly, of about 50 per cent IMGs, and that pipeline has largely been cut off.

My recommendations are in that report. Currently, it's difficult to recruit doctors to our region and the situation looks likely to worsen. As I've said, there are two options currently: to try to get IMGs in, or Australian trained doctors. Australian trained doctors are unlikely to come here in the current situation and IMGs are, basically, unable to come. Somehow, we'd like to encourage Australian trained doctors to work here. That may need to come from more incentives or by focusing more on people who love the country areas, or who have a background in country areas, working with the registrars. Work, lifestyle and equality between the public and private system will need to be addressed.

IMGs make up approximately 50 per cent of the rural workforce and have done so for many years, I'm told. Unless more Australian trained doctors move to the country we'll need to look to IMGs to help our area. The risk with this is that IMGs will move to metropolitan areas as soon as they can, leaving a more needy place behind. The IMG process is currently almost completely likely to result in failure to recruit to our practice, plus it makes the IMG feel like a lousy doctor so we see them going elsewhere. One doctor went to Canada and another went to England; they felt like they were lousy doctors after applying here.

The process for getting an IMG to Queensland rural general practice needs to be assessed and amended—specifically ACRRM's test in Queensland and ACRRM's specialist pathway process, which has resulted in a zero per cent pass rate for us. I think that having an alternative avenue so that ACCRM does not have a monopoly for testing in Queensland would be advantageous. Just a note on that one: one of our doctors sat the ACCRM test and failed it. I think they've got it at level 2 university. They then went to the health workforce one in Victoria and passed that one, and they have since sat for fellowship exams and passed on one shot.

That's my opening statement.

CHAIR: Thank you. Dr McPhee?

Dr McPhee: I'd like to welcome the senators and the team to Emerald, which has been my home town for some 32 years. I'd also like to acknowledge any Aboriginal or Torres Strait Islander people who may be here with us today.

Emerald is a very vibrant community, with the triple pillars of agriculture, cattle and coal. It is a very vibrant and active community, and we do have very similar problems to those of Dr Denness. I'm not actually going to revisit the critical issues that we're facing with rural workforce from that perspective. I'd also like to acknowledge that Emerald lacks an Aboriginal community controlled organisation and that Emerald and this district is one of the examples of one of the greatest tragedies against Aboriginal people with the massacre following the Cullin-la-ringo event, where over 300 Aboriginal people were slaughtered in the outcome of that unfortunate guerrilla war. Those sorts of historical and cultural barriers exist right across rural, inland and remote Queensland and Australia.

Having said that, I welcome this opportunity. I want to start with one sentence, which is that people do what they're funded to do from afar. What I mean by that is that I have personally been involved in attempting to achieve health reform now for over 20 years. I come here representing myself as a general practitioner in this community; I've been here for 33 years and I have been on many local, state, national and international committees. With due deference to Dr Denness, I have been the president of the Australian College of Rural and Remote Medicine, I have been the president of the Rural Doctors Association of Australia and I have been the president of the Rural Doctors Association of Queensland. I have served on the local Medicare Local, I have served with the Division of General Practice prior to that and I now sit as the chair of the clinical council for the

Primary Health Network which covers this whole area. It's an area that goes from one of the most populated doctor-per-patient areas, the Sunshine Coast, to the least populated areas in Emerald and this region.

With that context, I want to reflect on the last 15 years and, in particular, on the last seven, where I've been involved in some integral and very broad consultation processes across Australia involving consumers and all sectors of the healthcare system. In August 2015 we released a draft report from the primary care advisory group. Subsequently I sat on and was part of the 2019 10-year primary care plan consultation committee. I left that when I left the role of ACRRM president. I want to just briefly summate the findings of those studies.

What we need is a one-system focus supported by appropriate funding reform with local approaches to the delivery of care that are contextually and culturally relevant. Dr Denness is a key example of what we need to do. We need to listen to our rural doctors about what they need to do their job. We also need a re-envisioning of primary care beyond a fee-for-service Medicare focus. We need to empower our nurse professionals. We need to empower our allied health professionals, our physios, our OTs and our psychologists to work together with us; not to listen to lobby groups such as some of our pharmacists at the moment embarking upon, 'Well, if you can't do the job, we'll do it for you,' with some two or three months worth of training to become a doctor. That is not the path we need to go down.

At the moment it is my understanding that one of the key platforms of the current 10-year primary care plan that's been abandoned was voluntary patient enrolment, where you started to link patients back into their primary healthcare service so that those patients could access the appropriate enhanced primary care item numbers through a known GP and a known general practice. We reduced fly-by-night and churning of Medicare item numbers. I believe we've abandoned that, and I'm not sure of the reason why.

We need good data and we need good infrastructure and good IT. If I could share with you a story, one of my roles is as chair of the force committee, which is a group auspiced by Queensland Health that brings together every major player in the primary care workforce in Queensland to try to start to join the dots to address the issues that have been very clearly highlighted by Dr Denness. When you try and talk to the Commonwealth on a Teams meeting, you actually have to ask the Commonwealth representative to pick up their mobile phone and dial in on Teams because we cannot speak to the Commonwealth from Queensland Health using the same common videoconferencing technology. It's a very, very minor and small example of some of the real disconnects we have in what we're facing.

I'll come back to my opening comment: people do what they are funded to do from afar. You may hear from some of my Aboriginal and Torres Strait Islander colleagues later today, 'Nothing to us without us'; nothing to be done without a consultation process. This is an important part of Aboriginal community controlled organisations. We need to look at how you build capacity and confidence and strength within rural communities by doing the same thing. 'Nothing to us without us' is a critical message I'd like to bring to this today.

There are some extraordinary challenges with the rural medical workforce before us, and it's an incredibly difficult situation where our overreliance on international medical graduates over the last 20 years has fundamentally failed this country. Absolutely no disrespect to the enormous number of international doctors who have come and bailed us out of an extraordinary disaster. It cannot continue. We fundamentally have a number of organisations, health workforce agencies, medical schools, learned colleges and all sorts of people trying to address this issue. But, as I've found, no-one is pulling together, no-one is joining the dots, no-one is linking it together. We need to look at that. We need a one-system focus.

I'll leave my remarks there. I've made some high-level remarks around my journey in high-level reform. We have a lot of the answers already. We have the mechanisms and the agencies available to us, but we need to turn it on its head and look at what our communities and our GPs need in their communities and who they need with them to make that work. As much as this is about more doctors, that is because they are the front end. The only way you can fund a general practice properly these days is by churning numbers and having more doctors. We need to challenge that. We need to re-vision what regional, rural and remote general practice and hospital medicine looks like to capture the imagination of our young doctors and our medical students.

Having said that, and with due respect to Dr Denness, the Australian college of medicine has an 80 per cent five-year retention rate in rural Australia. We are only enabled to have less than 10 per cent of the rural numbers under the Australian general practice program. That is a travesty, because we know that we can get people to stay. Dr Denness has identified very clearly that terms and conditions are important to young people—terms and conditions and transferable entitlements. The ability to know that you have maternity leave, that you have someone's back, that you have a safety net—that all disappears when you leave the hospital health system. Dr Denness is very clear in what he has said about the reluctance of young doctors to leave the hospital health system because they leave without a parachute. I'll leave my remarks there.

CHAIR: Thanks very much, Dr McPhee. I'll start off with a few questions, and then other senators have also got some questions. I'll start with Dr Denness. Hearing you this morning and reading your submission, it is alarming as to how recruitment is just totally failing both Australian trained doctors and overseas trained medical graduates. I was interested in the issues with IMGs and how you've said you've given up on the standard pathway and the fact that applicants aren't passing the ACRRM PESCI. Can you talk us through why that's the case? It's not an issue that we've heard in terms of getting IMGs into other parts of the country where we have had hearings. I'm interested to know whether it's different in Queensland. Is the test different? What's the barrier there?

Dr Denness: I've never sat a PESCI, so I'm looking at the system as someone who has asked doctors to sit it and then is looking at their results. One of the first was a doctor who sat the PESCI for ACRRM in Queensland. The only PESCI that's allowed in Queensland is ACRRM. This doctor sat the PESCI, and they put him at year 2 university level, so he had to go back to university, basically. That was when HWAV in Victoria was still providing testers for Queensland. They sat that one pretty much straight afterwards and passed that and then that doctor has then gone to fellow with one sitting, and he hasn't had to resit any exams. So I think, at the start, of course, if you want to sit PESCI, go for it and I would [inaudible] with doctors, but since doctors haven't been passing, they've been trying to get doctors that have a high chance of passing—so doctors, for example, who have worked in Canada in the past but they graduated from Russia and one doctor recently was from Sri Lanka who sets the GP exams in Sri Lanka and was on the board of the international GP program in the UK—whatever it's called—the MIGP. He's on that board as well. They were looking at relocating to Australia. So there are people I thought had a good chance of passing and they all get failed. Basically their level is not good enough for here.

They've done a bit of observership with us too. They've sat with our Indigenous health workers. A lot of the times they get rejected, I think, on multiple things, but one of the things is Indigenous experience. Some of them have tried to do some Indigenous courses to try and help and they've also sat, like I said, with our own health workers here to see what they're doing. Some of it is that they say: 'You don't have enough Indigenous exposure.' We thought a lot of that would be learnt while they're here. A lot of it's from that, I think. We're not really quite sure as to why, because we think these are doctors who are experienced and have had experience overseas as well. So we're not completely sure of the answer to that question of why we don't have any passing. That's through the PESCI system.

We tried through the specialist system through an agency in the UK to get a South African doctor who's got a masters in medicine in family medicine from South Africa. They said that, basically, they didn't have enough rural experience, which we would have thought would have been picked up on in the application. Apparently it changed in between the time they applied and the time they got interviewed—which was about nine months—because they took a long time to do that. We're not really quite sure as to why they're not getting through. We would have thought maybe one or two out of eight might get through.

CHAIR: Do you think there needs to be reform of ACRRM PESCI, or is there more a need for better training and support for IMGs to get the experience and the exposure? I agree that it's difficult for them to get that until they get here, if, for example, Indigenous knowledge is something that's a barrier.

Dr Denness: Some of them have had Indigenous training and they've spent time with the health workers. Then they went to the PESCI. It's a role play: they have someone who comes quite close to them and, they said, was quite antagonistic towards them. They said that was in an Aboriginal and Torres Strait Islander sort of setting, and they were quite taken aback. They thought they were going for an interview; they didn't expect they were going to have someone come close to them and get upset at them.

It's quite interesting that someone who fails at a level 2 university stage with the ACRRM PESCI in Queensland can then go and pass HWAV, go on to sit fellowship exams and pass without again having to sit those RACGP exams, with no less than a 50 per cent pass, in one go. I figure that maybe it would be good if there was another organisation in Queensland that could do PESCIs as well—not just one method. There's not a monopoly on it. I'm not quite sure, but it's very frustrating.

CHAIR: I can hear that frustration!

Dr Denness: And it's very frustrating for these people. I've had one doctor who's at AMC 1 and 2—they have their AMC certificate—who saw the statistics for the ACRRM PESCI in Queensland and said: 'Forget that. I'm going to go to the hospital system.' We're just a little bit concerned that maybe the ACRRM PESCI and all that is more trying to help ACRRM and maybe not private practice as such.

CHAIR: Thanks, Dr Denness. Dr McPhee, with all of your background and being involved in so many consultative processes, as you've said, over proposed changes over decades, to me, hearing the evidence that is being presented to this inquiry—and I'm not an expert in health policy—it seems there is a need for a complete

overhaul. Would you say that there should be a process for a complete overhaul of the way that we manage and fund primary health care?

Dr McPhee: I'd say yes. That's the answer. I think the further you move away from the coast the greater that need is. But how do you do it with sufficient gravitas and will to actually make it stick? Sometimes I feel I'm doing and saying the same things over and over again and expecting a different outcome. At some point you think: 'Well, what's the point?' But, yes, fundamentally, we do need to rethink what we're doing.

We've created a number of mechanisms over 50 or 60 years now to fund, in particular, primary care, which have certainly met the needs over that period of time, but they are becoming irrelevant and archaic. It's a bit like the old Ford F100—you keep sticking bits on it and replacing parts and changing the tyres, but eventually it's all going to fall to bits, and that, in particular, is what's going to happen with Medicare. We've had a wonderful Medicare review. We've reworded a whole bunch of item numbers, but, fundamentally, we still have an open-ended, fee-for-service based way of funding medicine which supports high levels of activity, is based on loss leading work through general practitioners, particularly as you move further west or north or east, wherever you are, where activity is impossible, complexity is increasing and access is fraught. So, fundamentally, you have to do something different.

CHAIR: I'll leave it at that. I certainly heard in opening statements of the need for a one-system process—funding reform, beyond fee for service, working as teams. My colleagues may have some further questions on that, but otherwise I'd really be interested to know in a bit more detail, which you've probably already put together in submissions to other inquiries, what that would look like for you. But I'll pass to my colleagues and maybe come back to that at the end if it hasn't been covered. Senator McDonald, I understand you have some questions.

Senator McDONALD: Yes. I will start by thanking both of you doctors for your commitment to Queensland and the communities that you love and are part of. As somebody who grew up in Cloncurry and still has family there and is based in Townsville, I spend a lot of time talking to doctors about this issue, and I'm delighted that we're going to shine some more light on it through this Senate inquiry. I too am intrigued by the IMG process and understand that we are currently—or we were, prior to COVID—bringing in 3,000 overseas-trained doctors every year. We were having a net increase, after retirements and people leaving the country and whatever else, of about a thousand doctors a year. But, of course, they're not in regional places. We have James Cook University and we know that, if we take people from regional places and train them either close to home or closer to home, we will have greater opportunity to have them stay in regional places. Also, I think that, particularly for Indigenous young people, we're moving towards encouraging more into allied health as well into the GP roles. We have capped the number of Australian-grown young people who we're training into medicine in this country. Has that been a result of the AMA's influence on government policy? Perhaps I could start with you, Dr McPhee.

Dr McPhee: I might start my answer by saying that I was a child of the eighties, in as much as it was the time when the AMA was very, very vocal about how there were too many doctors in Australia, we were all going to be on the breadline and we had to cut numbers graduating out of university. I think that, fundamentally, we have had too much of listening to lobbyists and lobby groups driving our health reform and too little of actually looking at what we need and where we need it and having that real truth in conversation. I do believe that, at that time, we saw some real lack of vision, protectionism and anxieties that were driven more by protecting certain specialists and craft groups than it was by addressing what was actually a critical community need.

I would also like to state, though, that, fundamentally, one of the key impacts that has happened since the early 2000s is the way we've driven GP training and the dichotomy that increasingly appears between what a GP is and what a doctor who works across other spectrums is. This is coupled with a failure of growth of Medicare to meet not just CPI but also the costs of doing business. It's a complex issue. I certainly think in the late eighties, early nineties, there were significant impacts. These things have an extraordinary lag time. We are reaping the benefit of that now.

Senator McDONALD: Exactly. When I raised this issue with someone recently, they said, 'If we were to change that policy today, it would be 12 years before we would see a noticeable result, by the time these young people have gone through their university studies.' I must ask Dr Denness for a response to that same question. Do you think there has been an active policy by industry to restrict the number of Australian-trained young people, and should we be changing that policy setting as a matter of urgency?

Dr Denness: I must admit I'm probably not a good one to ask that. I'm sort of on the coalface and I'm not into a lot of the policies. I see that we're struggling, we're losing doctors and we're not gaining doctors. We haven't had any Aussie-trained apply at all. I'm probably not the one to ask about if policies are working for this or that.

Senator McDONALD: Fair enough. I thought I would just ask. My next question is with regard to the discrepancy of pay between private practice and public practice. My understanding is that Queensland still remains fairly unique in that you can have a private practice and practise in the local state government hospital. Am I correct in understanding that Queensland is a little bit different to other states?

Dr McPhee: That is only true in your smallest rural centres. I could speak to places like Springsure, which is 60 kilometres up the road, where there is a doctor who is what they call a 'medical superintendent with a right of private practice' to a small population, where he covers the hospital as well. There are few examples of that left. To be honest, west of Emerald there is no general practice that is not run by Queensland Health, because general practice is no longer viable unless it is propped up by a state health system. When you move west of here, you will see general practices established by an entrepreneur and staffed by Queensland Health employees.

Where I am, I am the only visiting medical officer to the Emerald Hospital, where every other general practitioner, apart from my training registrars, only works in general practice. In Queensland you cannot work in the Emerald Hospital unless you are a VMO with an advanced scope of practice. Most general practitioners here are very reluctant to work anywhere outside the four walls of their practice. The people that are bridging the gap are our rural generalists. These rural generalists are RACGP and ACRRM trained doctors. They work in my practice under a fee-for-service Medicare system but have part-time fractional appointments with Queensland Health.

We've been able to retain some 17 to 18 doctors in this community. The thing that will not bring them into general practice is the fact that their terms and conditions at the Emerald Hospital are extraordinarily more attractive than they would ever be in general practice. What I mean by that is: we've had some seven or eight or even nine babies to doctors in this community now, because we are predominantly a female workforce of extraordinary young women. Those young women want to be able to have their families and their children. If they left the hospital, they would not be able to lean back on their maternity leave and their other terms and conditions. That, fundamentally, is what keeps them there. If you leave the hospital, you're on your own. There is nothing to support you. People are not necessarily out here for the money. They're out here because this is where they want to be and this is their home. We have managed to train and retain some very wonderful young people who have lived and grown up in the communities around this area and even own cattle stations here now and have been here for seven to eight years. It's a good-news story, but they're not in general practice full time, because of the terms and conditions that exist.

Senator McDONALD: I might stay with this. I was going to move to the Modified Monash Model, where we have some bizarre discrepancies—like Cloncurry, which is a six, while it's surrounded by sevens everywhere else. Of course, it's very difficult to compete for doctors there, and the Flinders Medical Centre there is really struggling to compete with Richmond and Hughenden and other places. But I'd like to stay with this issue. The state government is providing terms and conditions that private practices are unable to compete with. How many times would Medicare need to increase by in order to be comparable? It would have to be threefold or fourfold, wouldn't it, to be able to provide maternity leave, the ability to book holidays—and actually take them—and so forth?

Dr McPhee: I might answer just briefly first. I think that fundamentally we need to rethink what Medicare is meant to be doing. Medicare is not there just to fund doctors; it's also to fund general practices and healthcare delivery. To fully fund a rural generalist clinician would require substantial increases in the fee-for-service component of Medicare to enable practices to take the risk to have the extra doctors that are required. You're looking at three, four or five times. That would not be necessary if we rethought how we manage terms and conditions, and there is both Commonwealth and state thinking about how this would happen. The departments, and the Rural Health Commissioner at the Commonwealth level, have already started to think very carefully about these things, but it requires the will to deliver it.

Senator McDONALD: Just to briefly follow up on that, what you're talking about is something that would recognise the complexity of rural and regional practice, compared with urban practice, so that you didn't end up with a continuation of the great expense of overservicing urban communities and underservicing regional communities. Do I understand you correctly?

Dr McPhee: I think that speaks to it very well. The current policy settings have attempted, through the Stronger Rural Health Strategy, to look at some of that by increasing the margin on the bulk-billing incentive, which for me is about 60c, and to make that more weighted towards rural. However, it still fails because of the fee-for-service component of that, and we need to rethink how we structure practice support, practice enablement and the other people in the team as well. We need transferrable entitlements so that clinicians have confidence that if they're sick they will be supported with sick leave, if they want to have a baby they can do so and if they

want to take family leave they can. If they want a holiday, they should be able to have one, without an extortionate amount of locum fees.

CHAIR: Senator Chisholm.

Senator CHISHOLM: Thanks, Dr Denness and Dr McPhee, for giving up your time to share your vast experience in community service over such a long period of time. I was just wondering, to start with, whether you could give us a sense of the practical impacts on your ability to treat patients. Dr McPhee, you mentioned the decline of doctors in your practice over the last couple of years and the impact on patients—how long people have to wait before they can get in to see a GP. I'm interested in what the community impacts have been.

Dr McPhee: I'd like to reflect upon the fact that it takes three months to get an appointment with me.

CHAIR: Three months!

Dr McPhee: Yes. I'm a training practice. I have medical students and interns through the Rural Junior Doctor Training Innovation Fund, soon to become the John Flynn Prevocational Doctor Program. I have general practice and rural generalist training registrars, so I rely on those clinicians to be able to see people in a more timely manner. Through them, if they have issues or concerns, with my constant supervision I can provide support. Regardless, if you are acutely unwell, you have to go to the emergency department because there is simply no general practitioner available to see you. We have one other practice in town that can provide some on-the-day appointments. We can provide on-the-day appointments as well, but they're limited.

We are noticing that our people are becoming sicker. They're presenting with problems later. I am diagnosing more cancer, more diabetes and more severe mental health problems. Maybe 30 years ago, when I came into general practice, I could see 100 patients a day with coughs, colds and runny noses. I can probably see 10, 15 or 20 a day with highly complex, difficult problems, and I am their first and last stop because I cannot refer them into the public health system. There are now two- to three-year waiting lists in some specialties in the public health system regionally. That complexity is driving a shift towards longer consultations but also towards higher complexity, higher needs and higher cost care.

We have not been at any greater time of need than we are now. General practice is a highly professional specialty which requires a high degree of knowledge. We are placing extraordinary demands on our young doctors to support them at a time when supervisors are getting older, crotchetier, greyer and retiring. We've got some real challenges before us, and I think that later in the day you may hear from one of the universities speaking about end-to-end programs and whatnot.

Right now we need to support things that work. I'd like to acknowledge that I'm a senior fellow with the James Cook University GP training program. Where you actually join the dots, you can get great outcomes, and we have certainly been able to achieve that in the Emerald region with our rural generalist programs here. That has not met the needs of other regions such as that of Dr Denness, who cannot get a GP. That's because you're putting out bushfires by pouring water here, there and everywhere. We can't get the systems enabling that to become a complete response. We keep looking for short-term solutions. We keep looking for solutions with a one-size-fits-all approach.

I might stop there before I start rambling, but I will say that I really love and enjoy what I do, and the clinicians I work with love and enjoy what they do. What burns us out is that we know there is an extraordinary unmet need that we cannot meet. We can do one of two things: we can keep working until we fall of our perch, make a mistake and injure or harm somebody; or we can say, 'No more.'

Senator CHISHOLM: Thank you. Dr Denness, could you give us a sense of what it's like for the communities in Innisfail and Babinda, where you service, and the impact on patients?

Dr Denness: Sure. There is probably a fair bit of despair amongst people around town. On Facebook and other social media, you get people saying that basically no doctors in town are taking new patients. We are accepting new patients, but that's not what goes around on Facebook. Basically, people have tried to call up multiple general practices and have got the idea that no-one's accepting new patients. We've had two doctors who have been in the area for 30 or 40 years who have just retired from a practice down the road here, and so all their patients are trying to find somewhere to go. A lot of people travel an hour to an hour and a half to see a GP just because they feel like they can't get in anywhere in this area.

We try to leave quite a few appointments every day for sick people. As Dr McPhee was saying, they're limited, but we try to keep quite a few. They generally all get taken up, and more people would like them than what we can offer, but we try to fit people in as we can. That means that wait times sometimes balloon out in the day as well. Most people are being understanding, because they realise there's a doctor shortage, but sometimes people can be waiting for a couple of hours.

As Dr McPhee was saying, we tend to find that people leave things, so they come in quite sick. Someone who had a mild urinary tract infection, for example, called up to tell us, 'It's an emergency right now.' We said, 'We'll try and fit you in in three days time,' so they came in in three days and they had fevers; it had gone, basically, to a kidney infection, and they were quite unwell. If they'd been seen at the start, then it would have been a lot [inaudible], but the person was quite polite, realising that there was a doctor shortage, which took our wait to three days.

We see things like that quite frequently, and the community is quite concerned about it. Trying to find doctor's appointments, care and those sorts of things is quite difficult for them. It's quite common for them not to even bother calling up the practice in town; they'll just drive straight to Cairns for help.

CHAIR: Senator Chisholm, are you done?

Senator CHISHOLM: I've only just started!

CHAIR: I know.

Senator CHISHOLM: We are running short of time, but I just wanted to thank you both for coming along and giving evidence. I'm sorry we couldn't spend much time on it. Your submissions are both very thoughtful as well, so we appreciate that.

CHAIR: Senator Hughes, you've got one question?

Senator HUGHES: I do. It comes to a concern that I have—and it was you, Dr McPhee, who made the point—with regard to the role that pharmacists could possibly play in rural and regional primary health. One of the complaints that we've heard as we've travelled around is about the strain that GPs were put under when they were delivering the vaccination program for COVID. We know that the RACGP opposed the introduction of pharmacists being allowed to deliver the vaccine. Obviously, when that was overturned and pharmacists were allowed to deliver the vaccine, that reduced some of the burden on GPs.

We've also seen a campaign by the RACGP to oppose allowing pharmacists to prolong scripts around the contraceptive pill. We just heard Dr Denness say that people are travelling for an hour and a half to see a rural GP. Isn't it now ridiculous, if a woman's been on a contraceptive pill, with a continuing prescription, that we would make them drive for an hour and a half to get an updated prescription for a contraceptive pill, when they would be able to get it from a rural pharmacist in their town? What is the continued basis for opposing pharmacists in providing some of these services whilst arguing, at the same time, that rural GPs are completely stretched? I noticed Dr Denness said that they can't take annual leave, which, I'm assuming, is because they run a small business—a lot of small-business owners can't take annual leave, because that's just how running a small family business works. Why not alleviate some of the pressure on regional and rural GPs by allowing pharmacists to deliver services in some instances? They can do the morning-after pill, which is stronger than a contraceptive pill. They do the flu vaccine. Why wasn't there support for them to deliver the COVID vaccine? It's got to be ideological or financial, so what's the objection to allowing pharmacists to support GPs in rural and regional areas?

Dr McPhee: Thank you, Senator. I really appreciate the question. I'd like to preface it by saying that I can't speak for the RACGP. As I've probably said, I'm a past president of the Australian College of Rural and Remote Medicine.

It would be awesome, if you had time, if I could take you out to my practice, which is just a hundred metres up the road, and show you what sits out in front of the car park, and that's a pharmacy. I'd like to say to you that I fully endorse your comments. We work very closely with our pharmacy colleagues. We have made a decision not to stock Novavax, and part of the reason is that the pharmacy is doing an awesome job looking after people by doing that.

I agree with you: I think, fundamentally, if someone is stable and stationary—as long as the GP is involved in their care and communicated with, which our pharmacists do very well—then I have no problem with it. We have had some innovation with COVID, of course, with our phone based consultations and our online consultations, so we can provide some of those services. But I do believe, where appropriate, that close cooperation and work with pharmacy is not a problem, and it should not be a barrier, because these are health professionals who are very good at their job. I do think, though, that we need to think about how we communicate and how we work together, and foster cooperation and collaboration, so that we are all working to the top of our scope or practice.

I guess I speak specifically around a trial around treating some 20 or 30 common medical conditions, such as hypertension and diabetes and whatnot. I want to say to you that the complexity of training that it requires to be a general practitioner now takes you at least 10 years. It would be disingenuous to suggest that somebody could do an online course for three months and do the same job. But I'm not suggesting in any way that pharmacists are not

highly professional people, and, in my circumstance, I work very closely with my colleagues and I have a very high regard for them. I would also say that the workforce challenges that they face are no less significant than our own. My local chief pharmacist is always struggling. She works extraordinary hours because she cannot get a pharmacist. We're sharing in a program—we've been very lucky to have the next centre for rural and remote health established here in Emerald, through James Cook University. One of the priorities for that will be the establishment of increased numbers of pharmacist trainees and pharmacist interns, because we need those clinicians. But they're no more than a phone call away—or, in my case, walk out the front door and have a conversation. So, I cannot speak for the RACGP, nor can I speak for a metropolitan point of view, because that is a completely different environment to the context in which I work, but I value and support my health professional colleagues.

CHAIR: Dr McPhee, if you've got the time in your very busy life, if you are willing to put some more detail or perhaps forward other submissions that you might have made, about your model of working more as teams instead of one system and what that would look like, we would really appreciate that.

Dr McPhee: Senator, I really thank you very much for coming to Emerald. I do have a plane to catch at 5 o'clock but, if you have some time, come and have a look at what we've established and what we're working with later on, if that's possible. And I would welcome the opportunity to put some more flesh to the bones. When I wrote my submission initially it was at a time where I was uncertain about how this whole inquiry would progress, and I was also very conscious that some of my comments were possibly sensitive. But I'd like to expand upon them and provide further information.

CHAIR: Thank you. Any further information that you could provide to us by the close of business on Friday 25 March would be appreciated, and we're going to be reporting to the Senate by 30 June.

COOKE, Mr Matthew, Chief Executive Officer, Gladstone Region Aboriginal and Islander Community Controlled Health Service Ltd trading as Nhulundu Health Service

KERR, Mrs Jennifer, Clinical Practice Manager, Gladstone Region Aboriginal and Islander Community Controlled Health Service Ltd trading as Nhulundu Health Service

MATTSON-FINGER, Ms Hayley, Manager Children, Youth and Families, Anglicare Central Queensland; Centre Manager, headspace Emerald

WEAZEL, Mr Joshua, Mayor, Woorabinda Aboriginal Shire Council [by video link]

[09:28]

CHAIR: I now welcome representatives from Woorabinda Aboriginal Shire Council, from headspace and from Nhulundu Health Service. Thank you for appearing before the committee today. Is there anything you'd like to add about the capacity in which you appear today?

Mr Cooke: I'm also chairman of the Queensland Aboriginal and Islander Health Council, the peak body for Aboriginal health in Queensland.

Mrs Kerr: We are an Aboriginal medical service, an ACCHO.

CHAIR: Thank you. I invite you each to make a brief opening statement—if you could keep it brief that would be really appreciated, because we are going to be short on time—and then the committee will ask you questions.

Ms Mattson-Finger: I come at this more from a consumer point of view, working with young people. There are the impacts the shortage of rural GPs has on young people being able to access services, whether it's for general or sexual health, including mental health and wellbeing, and the impacts that that has on being able to access service and delayed outcomes, and also GPs relocating and the impacts that has on the ED.

Mr Cooke: I am a Bailai man from Gladstone, Central Queensland. I acknowledge Aboriginal country out here in Emerald.

In my respective roles, I wish to raise and talk about the impact this workforce issue has on rural and general practice and that primary health care has on Aboriginal and Torres Strait Islander health. With the ongoing workforce challenges and the issues around funding methodology and models, it plays a huge role in impacting our ability to address health and wellbeing for Aboriginal and Torres Strait Islander people—including access to comprehensive primary healthcare services. Nonetheless, that is further compounded by issues shared by Dr McPhee this morning that also have impacts on our ACCHOs.

That workforce is not simply about the recruitment and retention of general practitioners and clinicians into our regions in rural and regional Queensland but also about the other broader challenges associated with the costs, and those costs being impacted by things like COVID, and also the fact that we are heavily reliant—even in Gladstone down the road with the high cost of locum GPs and agency fees, including registered nurses through agencies as well. An important issue to raise in relation to this is the fact that many of those doctors that choose to be locum GPs rather than permanent doctors within our practice quite often tell us their story about what they would say is a lack of a liveable community in Gladstone and Biloela, where we provide primary healthcare services, and the challenges around making our rural and regional cities attractive so they can stay there over the longer term and form a key part of providing health care to our community.

One other thing I'd like to mention in my opening statement is that the Indigenous Australians Health Program is the Australian government program run by the Department of Health. It is the Commonwealth budget which provides funding to the Aboriginal community controlled health services across Australia more broadly and here in the state of Queensland. There are challenges not only with regard to how the implementation of the Modified Monash Model works across rural and regional and remote communities but also with regard to the implementation of the Indigenous Australians Health Program and the funding methodology used by the Australian government. It too creates issues for our community controlled health services. One thing I've quite well pointed out over many years—I've been the previous chair of NACCHO and the previous chief executive of the state peak body, QAIHC, on which I now serve as chairman—is the fact that 141-plus of our ACCHOs across the country are seen as a larger service provider to our people for primary health care, yet we're funded with less than half the budget of the Indigenous Australians Health Program to deliver care to our people and communities. And if all levels of government, including the Australian government, have signed up to Closing the Gap by 2031 and we are recognised for playing a key part in terms of access to and delivery of care, then, even with workforce

challenges, surely there has to be a greater sum of those funds coming to the Aboriginal community controlled health sector to deliver that much-needed care.

Mr Weazel: I'll give a perspective in terms of my mayoral capacity in local government and in the context of an Indigenous community within Central Queensland. We are serviced primarily by Queensland Health. We don't have a community controlled health sector in our community, so it's that perspective that I'm happy to give a view on.

CHAIR: Thank you. I'll open with a few questions and then throw to my colleagues. I suppose my opening question to all of you is about the impact on your communities of problems with people being able to access GPs.

Ms Mattson-Finger: I think Dr McPhee really touched on it earlier—the waitlist for some of those doctors out at the Emerald superclinic. The wait is anywhere between nine and 12 weeks. I guess the impact, especially with young people who we see coming through headspace Emerald, is that we're dealing with a lot of mental health and wellbeing issues, and a lot of them are transitioning to then finding their own GP. And when we're looking at a delay of around three months to access mental health support, we then start to see a decline in their wellbeing and are not able to treat it when the issue first arises. As Dr McPhee mentioned, they do have on-the-day appointments, which at times can be challenging. We're really lucky at headspace Emerald in the sense that we have an MOU with the GP clinic, which allows us to at times get services for our younger people more quickly because of the mental health and wellbeing issues of our young people.

Then again, it's also putting the stretch on the ED; we're having to access that if we can't get on-the-day appointments, especially when we're dealing with mental health issues. We're also then finding that we're having to transport our young people outside of Emerald to access those supports further, which can be quite difficult for these young people, especially around that connection with community, as well as forming relationships with those GPs at quite a young age, especially if the mental health and wellbeing side is going to be ongoing in terms of seeking those supports.

Mr Cooke: Hayley captures it well in relation to that ongoing relationship. As with those Australians who live in urban metropolitan areas, we in rural, regional and remote Australia also want that continuity of care and relationship with our medical and health professionals. I think ultimately that is one of our biggest challenges around workforce and being able to attract and retain general practitioners, registered nurses and allied health professionals to our regions. That challenge alone presents an issue around giving continuity of care to our people in rural and regional areas, including Aboriginal and Torres Strait Islander Australians. With that there comes that challenge of not only access but also continuity of care. And when we're having such high numbers of locum GPs—I think we've had dozens of locum GPs over the past five years—we in Gladstone and Biloela alone have spent close to $4 million in locum fees to get them there. That's for part-time GP services. These are the challenges.

As Senator Chisholm noted, Gladstone is not that bad a place. I see his office down the road from our medical service. We, too, being an hour away from Brisbane, are still seen as not an attractive town and area to work. There are many things that compound that, but ultimately we see some solutions being brought by all levels of government with the recent advent of the University of Queensland and CQU with that partnership to bring a medical school to Rockhampton, Gladstone and outer rural areas, which is definitely welcomed. But the challenge is that it's going to take some time for that to materialise and provide immediate benefit to our people and communities. So, what do we do in the meantime? And with those increasing costs, not only locum fees but also agency fees and accommodation and travel that go with it, we alone, if we weren't a diversified business, wouldn't be financially viable. So I am absolutely minded with the pressures that private general practice and group general practice also face in trying to run a private small business with the challenges that come with recruiting and retaining a quality and capable primary healthcare workforce.

CHAIR: Do you think that it's going to be possible to make progress with closing the gap on health indicators unless we do something about access to primary healthcare practitioners?

Mr Cooke: That's a very important question. It's one that I quite often ask my colleagues and senior government ministers and bureaucrats: with the ongoing impacts of not being able to get a workforce, how do we meet those goals of Closing the Gap by 2031? The reality for us, I think, is in the recent reports from government around those measures and the lack of performance or the lack of achievement or attainment against those Closing the Gap measures. I certainly believe that this greatly impacts particularly rural, regional and remote communities. We are not capital cities and we do have that inherent issue of attracting and retaining a skilled workforce. The absence of that means that we're pressed. Our workers, our key registered nurses, our practice managers and our doctors—it's not just the GPs—are stretched in their ability to continually try and meet the health and wellbeing needs of our community.

CHAIR: Councillor Weazel, what impact on your community do difficulties with accessing GPs have?

Mr Weazel: Reflecting on our community, I think it's important to put the perspective out there that, in terms of when we look at our health services and our access to GPs, we may be the exception. I say that because we've had two long-serving GPs—one who's done a minimum of 10 years and the other three decades. So we've sustained and maintained due to local GPs being located on adjacent properties to Woorabinda. We've benefited from a locally based individual who has been able to service our community.

In terms of the goodwill and good intention that they display in serving our community, they go above and beyond the demands for that. We're still at the mercy of the demands and needs of the workforce to meet the demands and needs of our community. As I said, they extend themselves more, and it's hard to get locals in the service. Our doctors are working past that.

The other thing, which I think Matt touched on, is that a health service is more than just GPs; it's those allied health services and specialist health services. Definitely, Indigenous communities display a high chronic disease burden. We are fortunate to have access to allied health services and specialist services at the degree of service that has been made available to us. When we look at the perspective of us being under Queensland Health and not having a community controlled health sector, we've sat comfortably in our position of having these services, but we don't know any different.

I think the Closing the Gap strategy and those priority reforms talk about building a community controlled health sector. Indigenous communities want to control their destiny. Indigenous communities want to have capacity to provide solutions in their respective communities. I think that there's a lot of energy in that, but we're also dealing with issues of having appropriate accommodation for these health professionals to come and work in our Indigenous communities. So I guess we need that attraction and that package to get individuals here but also to upskill local capacity in our Indigenous workforce to drive the agenda of Indigenous health and work towards closing this gap.

CHAIR: Thank you. Senator Chisholm?

Senator CHISHOLM: Thanks for coming along. I'll start with Ms Mattson-Finger. I was interested in your testimony about how you are able to get people in to see a GP but you've got to pull a few strings and pull a few favours to make that happen. How much stress does that put the organisation under? I imagine you're making judgement calls on whether this case is more important than this person, and you can't do that for everyone.

Ms Mattson-Finger: Yes. Thank you for that question. I was also going to add that obviously headspace Emerald is new to our community. We opened on 4 January, so we're very new. But it's something that the community has been rallying behind and supporting for the last 3½ years. Part of the headspace model is to have a GP onsite and that's something that we're really struggling with because we've already got shortages within our community, let alone being able to employ a GP onsite. That's our model. The reality is young people come in, they're seen and then they're able to see the GP onsite. We don't have that. It may be a long time down the road before that can happen.

But back to your question, here in Emerald we're quite fortunate that we do have a strong relationship with Dr McPhee. But, yes, there are times where it becomes really challenging in and around looking at: is this an urgent appointment that we need to be able to get or is it an appointment that we can wait 12 weeks for? It is a judgement call, which puts pressure on to our staff, but it also puts pressure on to our young people. When a young person enters into headspace, wherever they are on their journey, it's where they will disclose information, and they don't. That can be a really hard judgement call, especially around sexual health side stuff too and making sure that we're able to respond as quickly as we can to get them seen by a GP. With the current processes that we have in play, and being a new service, at the moment we're able to fulfil the need from a GP base. But in six months time I don't know where headspace will be at in terms of—obviously we'll have more younger people engaging, but I think the demand will outweigh what the Emerald super clinic can support us with.

Senator CHISHOLM: In terms of making those judgement calls, I suppose the other risk with mental health is that you say: 'Well, this person may be able to wait a bit longer, but in the meantime their mental health may deteriorate—

Ms Mattson-Finger: That's right.

Senator CHISHOLM: which then makes the urgent need for care more necessary.

Ms Mattson-Finger: It does. Then it's also about—we also have a good relationship with CQHHS—working out whether or not they actually need to go through Queensland Health and receive that support for mental health too. But, again, the waitlist and the process can be quite lengthy. Then it's referring on to a GP anyway which is delayed. It definitely has its impacts. Being a new service, I would say it's manageable at the moment, but I do

have concerns around the next six to 12 months, as we increase and become more visible in the community, about being able to access GPs. Ideally we really need a GP onsite.

Senator CHISHOLM: Yes. When you match up Dr McPhee's testimony with yours it's a delicate balancing act.

Ms Mattson-Finger: It is.

Senator CHISHOLM: On the lack of a GP, could you talk us through how you're practically going about filling that? What incentives do you have access to try and attract someone?

Ms Mattson-Finger: There are not a lot of incentives through headspace national. Our model, in that we're working with the Emerald super clinic, will be that basically they provide us with a GP and then we do all the bulk-billing and administrative side for them. But in terms of where we're at at the moment, there are not a lot of incentives.

Senator CHISHOLM: Mr Cooke and Mrs Kerr, thanks for making the effort to be here in person, that's really appreciated. I'll just go back a bit. Within your organisation do you employ GPs directly? Is that the model? I suppose if you could give a sense of how you do that, how many you have and what has been the historical context of that?

Mr Cooke: Thank you, Senator. In relation to the Gladstone Region Aboriginal and Islander Community Controlled Health Service we've got a mix of locum contractor GPs and we've got our first permanent GP in Dr Sharon Muir. COVID in Melbourne gave us a benefit. She's a senior doctor who wanted to exit Melbourne, Victoria and come to Queensland. She saw it as a safer option to raise her young family. We were blessed in early January in relation to seeing Dr Muir come on full-time with our service. But again it's only a two-year contract. That's a pretty good thing to only get a two-year contract at the moment—due to cost as well. But it also is part of trying to stabilise that workforce. We've got two senior doctors that do a fortnightly rotation out of Brisbane. They are long-term doctors that've worked in the Aboriginal community controlled health sector as well. They have families and they have desires in life that are all well established down in Brisbane so we're only benefitting with that fortnightly cycle. But it is a least some level of continuity of care to at least have familiar faces returning on that cycle, as they rotate out each fortnight.

Senator CHISHOLM: How does that cover off on Biloela? Is there a permanent presence there or is that something, again, that people are—

Mr Cooke: It greatly impacts Biloela. Sadly, not being able to get those doctors out there regularly and frequently impacts our ability to give continuity of care to the Indigenous patients in Biloela. As Dr McPhee and others have expressed, you've got general practitioners who are doing rights to private practice and VMO with the hospitals and the like. They're stretched. Their ability to do comprehensive primary health care in relation to Indigenous Australians becomes compounded. The challenging thing for us is also not being able to give a good quality level of care to those people in outer rural areas, such as Biloela and banana shire.

Senator CHISHOLM: Thanks, Chair.

CHAIR: Thanks, Senator Chisholm. Senator McDonald, do you have some questions?

Senator McDONALD: I do, thank you. Thank you all for giving up your precious time to give evidence at this Senate inquiry. I want to turn to headspace, which I know in Townsville and other places is experiencing high demand and has long waitlists to get support. I just want to understand why I'm flooded with other organisations who are also looking for government funding to provide mental health care. Are we trying to stretch ourselves too thin across too many organisations? Can you give me some insight into what's happening there?

Ms Mattson-Finger: Obviously being in Emerald, being in a very rural setting, we haven't had a lot of services, so headspace would be the first funded service outside of CQHHS that focuses on mental health within the Emerald community in Central Highlands. I guess that's why there has been a big drive in and around bringing this service here. I would say that there are a lot more funded adult mental health services within the Central Highlands, but the reality is that they are all at capacity. We haven't even met the demand that is sitting there. We have been open for two months. We've had more than 100 contacts with young people already, and that's just from focusing on Emerald at the moment. I think in six to 12 months we will be running a waitlist and we will be at capacity. For Emerald solely it's around how these services can't work together to meet this demand. I think it's something we've done really well, and that speaks volumes with being able to have headspace Emerald here and the likes of CQ Rural Health and Anglicare, but, yes, we're going to reach capacity really quickly. I think we're actually underfunded and undersupported in being able to expand the current services we have.

Senator McDONALD: Again, how then do we have all these other providers bidding for service delivery in regional places? Perhaps this is more a case in North Queensland and north-west Queensland than in Central Queensland. I'm concerned when I hear stories about multiple providers in one area. There is not consistency of care and no sharing of case notes. Some providers come into town, do introductory meetings and then do teleconferences from Melbourne or somewhere else. Is that an adequate way to provide services? Is that better than nothing at all?

Ms Mattson-Finger: In the last couple of years we've seen services—funded, for instance, through the primary health networks—that have solely come from the likes of the sunny coast and have been providing telehealth or have come here and funded a stream that doesn't deliver on service. But I actually think that has changed in our community in the last three years. We've got the local service CQ Rural Health here that are funded through the PHN to provide mental health supports through them. We've also got Anglicare Central Queensland that has been in the community for over 35 years. They are providing the psychosocial funding, along with the mental health supports. Then, obviously, we have headspace, so I think that that's been a really big shift. Do I think telehealth works in a rural setting here in Emerald? No, I don't. I think that we need to have the people on the ground providing the services here. Both Matthew and Dr McPhee touched on this before: it's all around relationship building and being able to connect in the community. I guess telehealth creates a very clinical fill. For me and others who're focusing on young people, we know that the moment that we introduce quite a high clinical fill, we actually see a disengagement from access to service, which prolongs their engagement. Then we start to see a deterioration in their mental health.

Senator McDONALD: What you're saying is that long-term organisations in communities have those connections and there's the capacity to leverage on those connections, because it is complex when we're trying to bring additional people to a regional town. Then we've got a housing issue along with the cost of their travelling to get medical services or for them to have their own services. Again, I'm probably thinking of smaller communities than Emerald, but it's a complex issue to fund the provision of those services in Emerald. Is that right?

Ms Mattson-Finger: Yes, housing definitely is an issue. When we're bringing in services and not focusing on the services that have been here long term, we see a high turnover of those staff. For Central Highlands, Emerald is a big community, but in the scheme of things in Queensland it's not. It's around how we embed those people within our community so that they're here to stay. Instead of bringing in new services, it's about looking at the services that are here and have capacity, and building on those capacities because they're willing to stay, they know the community and they're embedded in the community. I think that that's key and that's something that's changed in our community over the last two or three years, maybe. We've been able to look at already funded services, headspace being one of them. When headspace was funded, it was funded as a satellite service, which meant that they were going to bring in a headspace from Rockhampton or Gladstone to oversee the services. That would have meant a service that's never worked within our community would have had to develop a model to fit our community because they didn't know it. We were lucky enough to be fully funded at headspace and a local service, being Anglicare Central Queensland, was able to run with headspace Emerald and to provide that service to the community that they've worked in for such a long time.

Senator McDONALD: Point well made. What about other smaller communities around you? Do they have to travel to Emerald to receive the services?

Ms Mattson-Finger: Yes.

Senator McDONALD: How far afield would you provide services?

Ms Mattson-Finger: Yes, headspace Emerald will provide services to all 13 communities within the Central Highlands within the next 12 to 18 months. We're already providing services within Blackwater, Springsure, Gemfields and Capella. But at the moment that requires the young person having to travel to Emerald or access services via telehealth. Being a new service, we need time to embed the model that we currently have because each headspace centre operates differently. But we will be providing outreach to all 13 Central Highlands Regional Council areas. For the likes of other mental health programs, I can speak on behalf of Anglicare Central Queensland. We travel as far as Rolleston, which is around two hours away, and that program services all of the Central Highlands. I guess the concern that we see is that a lot of programs reach capacity quite quickly, and the first thing to be impacted is outreach work. The cost of travelling and the impact that that has on the staff member, as well as fatigue and burnout over time, definitely need to be looked at in how we can support organisations to make sure that we are reaching out to all those smaller communities because they all require services and should be able to get the same access as people that live in Emerald.

Senator McDONALD: When I went to the Townsville domestic violence shelter and support, I asked about their biggest threat and the biggest challenge to their service delivery. I was waiting to hear that it was drugs or something related to drugs. But they said, no, the biggest issue was big overseas organisations, like Save the Children, being very good grant writers, coming in and winning the provision of service and then outsourcing services to some of the same organisations who were previously doing the work but taking a cut of the grant money. Is that something that you see as an issue in your sector?

Ms Mattson-Finger: Yes, it definitely has been an issue in, probably, the last four years. We've seen other services come in, but they can't employ staff because of the funding in and around getting people to relocate. You spoke before about accommodation costs, and being away from family has its own impacts. So, yes, then they were outsourcing to the people who were already here on the ground doing the work. I think it has changed slightly in maybe the last 12 to 18 months, but it's definitely something that we've seen, and it has impacts. A service is then overseen by another service, and if something doesn't go the way that it should it again falls on that local service. Then they've got their integrity in and around the relationship they have with their community, which can be impacted.

We did see that happen within this community around three years ago, and it had severe impacts on the young people and the people who were being supported. They were highly impacted in and around mental health. It posed a lot of risks for those young people accessing services. With the waiting time lines and other bits and pieces, we could have put young people's lives at risk. That was shifted. A local organisation now holds that funding, which we see as being a lot better.

Senator McDONALD: Thank you for that. Chair, I would like to put a pin in this conversation for the secretariat to take note. The prioritisation of grant funding going to local service delivery and people with the capacity to have people on the ground is something that we have had a learning on, by the sounds of it. This is not as bad a situation as it was four years ago, but we definitely want to have this written down as a recommendation going forward so that we don't forget it and have to reinvest at a later stage. I'll leave my questions there, thank you, Chair.

CHAIR: Mr Cooke, I want to come back to the issue of covering the costs. In your opening statement you said only half the costs of running your services are covered by the Indigenous health initiative. Can you expand on that and tell us what the current system is and where it's failing.

Mr Cooke: In relation to that statement, we're seeing broadly that less than half the funding is a statement nationally about the level of funding under the Australian government's Indigenous Australians Health Program.

CHAIR: When you say 'less than half the funding', what's less than half the funding?

Mr Cooke: About 400-and-something million dollars of the $1.6 billion or $1.8 billion per annum that's in that Indigenous Australians Health Program comes to the Aboriginal community controlled health sector, which is about 141 organisations nationally. That's where I draw great concern: seeing us, as one of the largest providers of primary health care to First Nations people, Indigenous people, receiving less than half the Commonwealth investment to do that crucial work. That has impacts for us on the ground in Gladstone, Biloela and the region. We see less than $1 million per annum out of that Indigenous Australians Health Program budget, for nearly 5,000 clients. More than half of them are Aboriginal or Torres Strait Islander Australians—

Mrs Kerr: Seventy-five per cent.

Mr Cooke: Seventy-five per cent of them, sorry—thanks, Jenny—are Indigenous. As such, it just doesn't reflect reality—what the true cost of delivering comprehensive primary health care in Gladstone and Biloela looks like. Reflecting broadly on it, it plays into the ability to attract, retain and afford the workforce and also into getting the model of care right. I think Dr McPhee and the James Cook University submission and others have talked about the model of care within communities being so important. It was in Hayley's comments as well in relation to mental health. It's a great investment to see that change come locally into headspace, but the reality is: what happens between therapeutic care and looking into acute mental health issues? How does the whole system wrap around and meet the needs of those people in community if we already have those great workforce challenges and infrastructure challenges in regional Queensland?

As it relates to Gladstone, we've currently just on a million dollars per annum for primary health care for our Indigenous Australians, and we have access to the Medicare Benefits Schedule under the 19(2) exemption, as with most Aboriginal community-controlled health services across the country. The issue is: if you fail to attract good commissions, you fail to get a good model of care in place, then you fail to get good use of the Medicare Benefits Schedule, and ultimately, when the cost of locum GPs sits between $1,600 and $1,900 a day, base, and then you add travel and accommodation and then 16 to 20 per cent for an agency fee, there is no way—with the

low sum of that grant funding out of the IAHP, supplemented with MBS—we can afford the cost of health service delivery. We run aged care. It was our core business. The old HACC program and community aged care program was our core business before we became a primary health care provider as an AMS, and, if the business wasn't diversified, we wouldn't have a financially viable option to deliver care across those communities. Sadly, as we reflect for Biloela, they too, as in our case, became the poor cousin even of Gladstone, as we try to get outer rural and outer regional service delivery.

CHAIR: So are you saying your aged-care services are basically subsidising your primary healthcare services?

Mr Cooke: Yes.

CHAIR: And I'm sure there's not a huge amount of money in your aged-care services, either!

Mr Cooke: I'm being very careful in how I respond to that, because the aged-care system, I'd argue, is not well funded, either.

CHAIR: Absolutely!

Mr Cooke: But the idea is: we were able to spread our costs across business activity. So it's not as if we're having big profits inside of aged care—that's certainly not the case. But we are able to spread our cost of operation across being a diversified human social-service provider. If that weren't the case, we certainly wouldn't be in the business of providing primary health care, because costs are increasing, year upon year, and, as I said, that impacts not only recruitment and retention but, ultimately, the model of care that we try and employ here in rural and regional Queensland.

CHAIR: So, basically, by doing that, you're managing to cover the costs by having shared costs. Are there other funding streams that are coming in to the health service?

Mr Cooke: It's a very good point about other funding streams. The challenge we have is that, in rural and regional Queensland, we can quite often be smaller populations dispersed across large geographical areas. Unfortunately, that doesn't bode too well for us, because Brisbane and Canberra, in looking at our funding submissions, see a low population in a large geographical area and sometimes don't take account of the fact that it's very expensive to travel across that large geographical area. So, as they see our submissions come in—and, as the other senator made mention of, we've hired big grant writers to write wonderful submissions—we have those complexities and challenges, as we look to other agencies like the National Indigenous Australians Agency at Commonwealth level. Even mainstream funding, through the Department of Health, becomes a challenge. At a state level it's further compounded as you try and get access to funded programs, either through Queensland Health or their regionally placed hospital and health services.

CHAIR: Talk me through how much you have to spend on locums, given that you haven't got the core practitioner workforce.

Mr Cooke: My colleague Jenny Kerr made a good point when we were driving over here. In the last five years, we've spent $3½ million on part-time locums for our services, and, if you look at the $5 million that we get across the same period, collectively, from the Commonwealth, we're spending three-quarters of it paying for just the locums.

CHAIR: Yes!

Mr Cooke: The other challenge we have is: What about the registered nurses? What about the Aboriginal health practitioners? What about the allied health specialists and the medical receptionists? All those people form part of that comprehensive primary healthcare mix, and they're barely, in all reality, getting paid an award base salary, or slightly above it; yet we have the cost of our general practitioners—as it has moved more towards this locum arrangement, or industry, as it has become—ballooning year upon year. So its impacts are wide-reaching. As I said, we certainly welcome seeing the medical school between UQ and CQU coming, regionally, but it's going to be years before we realise that benefit. There's a statement that around 70 per cent of clinicians trained regionally will stay or live regionally. We're certainly hoping and praying that that's the case as those students come through that new medical school—that it will help to ease some of the workforce pressure, and quality and continuity of care to our people and community.

CHAIR: Is that also looking at increasing the numbers of First Nations medical practitioners—GPs and nurses as well as other allied health? How are we going with that?

Mr Cooke: We've made strong comments about and given support to Central Queensland University and UQ accordingly, and even to Central Queensland Hospital and Health Service to look at it. I should declare that I'm also a hospital board member of the Central Queensland Hospital and Health Service. It's about making sure that

we have First Nations medical students looking at that pipeline and pathway. It's good to see submissions from other Aboriginal peak bodies contained within the report so far, even in terms of James Cook University. I think that's one of the first regional schools to come out of the capital cities and provide a school of medicine, so to speak. As such, again, it's building that pipeline and pathway so that they can bring First Nations students into those respective programs. Ultimately, the net benefit is that it's also a key part of bringing cultural capability into the overall healthcare system and architecture.

CHAIR: Do you feel that things are on the right track there, or are there still barriers to First Nations people doing their medical training?

Mr Cooke: It's definitely a step in the right direction but, again, everything comes down to a cost; investment must match that intent if we want to see more Indigenous people taking the option to study medicine and, hopefully, return to their communities. There needs to be the investment to match, and in my experience there has been investment by both sides of government respectively over the years. But it could certainly do with a lifeline to speed up the opportunity to use these regional schools, such as this one now with CQU and UQ in Central Queensland.

CHAIR: Where would you want to see more investment? Where are the gaps? Where would more investment bear fruit?

Mr Cooke: I think my opening statements about getting equity in the overall healthcare system for First Nations is paramount. But, firstly, it's about at least getting equity out of the Indigenous Australians Health Program, which is the main Australian government bucket of funds to provide primary health care. That certainly has to be a starting point. We can talk about all these things—a voice to parliament or voice to government, closing the gap or what have you—but government can start right now with better investment of that Indigenous Australians Health Program in those Aboriginal community controlled health services.

There have been many reports from the Australian National Audit Office and the Productivity Commission about self-determination and Aboriginal led models being those which achieve the best results and outcomes for our people and community. Sadly, even with those reports being delivered under respective departments from both sides of the parliament with the major parties, we're still not seeing a greater investment materialise. Rather, it's simply rebadging, CPI growth at best and small investments. We need to see equity for First Nations people in that $1.6 billion spend per annum under the IAHP.

CHAIR: There being no further questions, thank you all very much for your evidence today; it has been really useful to the committee. If you do think of something that you haven't said and which you would like to get to us, please get it to us by 25 March—that would be really appreciated. We'll report to the Senate by 30 June.

Thank you particularly to those who were here in person, who made the effort to come here. And thank you also for your time, Councillor Weazel.

Mr Cooke: Thank you for the opportunity.

BAKER, Mrs Lisa, Board Director, Services for Australian Rural and Remote Allied Health [by audio link]

GIUSEPPIN, Dr Marco, Chair, Council of Rural Doctors, Australian Medical Association

GROTH, Mr Allan, Director, Policy and Strategy, Services for Australian Rural and Remote Allied Health [by audio link]

MALONEY, Ms Catherine, Chief Executive Officer, Services for Australian Rural and Remote Allied Health [by audio link]

SAUL, Dr John, Tasmanian Vice President, Australian Medical Association [by audio link]

[10:13]

CHAIR: I now welcome representatives from the Australian Medical Association and Services for Australian Rural and Remote Allied Health. I now invite both organisations to make a brief opening statement if you'd like to do so. We'll ask you some questions after that.

Dr Giuseppin: Chair, with your indulgence, I do have some more verbose remarks. I'm very happy to have those tabled to the secretariat for inclusion on the record.

CHAIR: That would be great.

The opening statement read as follows—

Thank you for the opportunity to speak today. I acknowledge the traditional owners on the land on which we gather and pay my respects to elders past, present, and emerging. The AMA believes strongly in preserving the health and culture of our First Nations' peoples, many of whom live in Rural and Remote areas of Australia.

The AMA is the peak body for medical practitioners of all stripes in Australia. The AMA Council of Rural Doctors, of which I am the Chair, is the body that provides policy advice to the AMA Federal Council on issues pertaining to rural health. I am joined today by my colleague from Tasmania, Dr John Saul, a longstanding Rural General Practitioner and business owner, advocate, and a key member of our Council.

We are here today to discuss outer metropolitan, regional, and rural general practice issues. I will speak about this shortly but would like to begin with some remarks on General Practice itself and share some of my own experiences as they pertain to this hearing.

I am a Rural Generalist Anaesthetist and a Fellow of the Australian College of Rural and Remote Medicine (completed in 2020). Born in Brisbane, but a graduate of the University of Queensland's Rural Clinical School in Toowoomba, I trained initially in Rockhampton, not too far from here, and completed the entirety of my fellowship in rural and regional locations.

I have tried to find a rural and remote 'home' for the past 5 years, yet it seems my skills are not fully embraced anywhere. When I first started work as a GP in Chinchilla, our maternity service closed down. I am now working in a dream role where I am again told that my skills are deficient as I am "not a specialist", stifling any hopes of career progression. I have yet to find regular well supported work in procedural practice to combine with work in private practice. I need this as my income in private practice has never matched what I am paid on a public salary. Not as a registrar, or even as a privately billing GP.

I have since decided to move into medical leadership to learn more about what drives these decisions, because it is not safety and good governance. I am a GP and incredibly proud to be one. I am a rural generalist with skills in emergency care and anaesthesia. We have discussions around professionals working to the top of their scope, what I am telling you here is that rural GP's are seeing their own scope of practice narrow around them. This narrowed scope of practice is reflective of a Medicare that does not adequately reward GP's for maintaining skills essential for rural health care, as well as decisions made and standards set in metropolitan areas being applied to rural settings through a lens of what I call "geographic narcissism". In summary, we are applying urban concepts to rural medicine and expecting them to stick.

The reason I tell you this story is that it speaks to many of the arguments that the AMA has made about rural and remote health. This committee has asked "what can the government do?" - my hope today is that I can give you some ideas.

The Issues

Our first contention is clear. Whilst this inquiry speaks of outer metropolitan general practice, we believe firmly that the issues in outer metro areas are different and cannot be solved by repurposing incentives designed for rural areas.

There have been numerous failures in the outer metropolitan space, notably the demise of other medical practitioner programs including outer metropolitan OMPS programs that previously supported this workforce. The AMA initially supported the implementation of the More Doctors for Rural Australia Program (MDRAP) as a consolidation of these programs under the stronger rural health strategy, however over time it has become obvious that these programs have failed to deliver for rural Australia, whilst denying outer metropolitan areas access to a workforce they need.

We have a legion of doctors - offensively referred to as "non-VR" - who are able and willing to provide service and have been locked out of higher rebates in outer metropolitan areas leading to poor experiences for patients. It is high time we allow these people the opportunity to maintain their contribution to these communities.

We believe that the AMC and other federal stakeholders must insist on community based prevocational training to allow our young doctors a taste of general practice, and our outer metropolitan regions (as well as our rural and remote regions as a matter of fact) are an ideal place for these to occur. General Practice and Rural Generalist registrars nationally must have, as a minimum, their conditions protected by a single employer model as the hospital system currently provides a disincentive for those seeking to enter general practice training.

On rural health specifically (and I speak here about Modified Monash Category 3-7 locations), it has become clear that a rural general practice does not enjoy the economies of scale or benefits of a larger urban practice. My colleague Dr Saul will speak about this in more detail, but what I can tell you as a young doctor is that no GP business owner has advised me that starting a practice is in my best interests. It is further clear that the Medicare system does not adequately reward general practitioners for the time and skill they put into delivering a high standard of care to rural communities.

The final thing we must address is the role of GP's in our rural hospitals and in our hospital system in general. The system is broken and the blame game is strong. Some of this is within the culture of medicine itself, and we at the AMA acknowledge this and the need for us to role model the full scope of rural general practice and rural generalist medicine. We must take the medical profession with us on this journey.

Bureaucratic standards of care set in our cities are not applicable to the rural and remote context. As an example, we have very good quality evidence that rural maternity services are safe. Our current system of hyper specialisation and credential creep is crushing the spirits of GP's working in rural towns who wish to contribute to their hospitals. This may be in the interests of our cities, but it is leading rural GP's - particularly those with emergency and procedural skills - to leave our towns in droves and either retrain in other specialty fields or to work in urban general practice. More credentials do not equal a safe service. More compliance and CPD does not necessarily equal a safe service. This is ill informed and reflective of our hospital systems in metropolitan areas where the silo between primary care and hospital care is much stronger. The ability to work in a system without silos or barriers is one of the great joys of rural health and is a drawcard to rural general practice. The federal government has multiple funding and accreditation levers it may utilise to help bring this back towards a system that encourages young doctors to choose General Practice.

We need to end the geographic narcissism in our clinical governance systems, our hospital systems, and indeed within the medical profession itself, so that we value actual competence as opposed to fellowship. Our GP's have the skills, we should not require, for example, a Fellowship of the Australasian College of Emergency Medicine to work in a rural emergency department. This need for people to 'have the ticket' drives our rural GP's back into the city for further training, and we know that they are unlikely to leave once they are there. Maybe, just maybe if we fix this, I and those of my generation can realise the dream of being a rural generalist.

Significant people in my life often ask me "Why do you do this to yourself? It would be so much easier for you to be a GP in the city". I am probably not the only one who has heard this. My answer is simple. Our patients deserve better. When you are driving through Cunnamulla and have an accident, you deserve the best rural doctors at your bedside. When you are in Walgett, you deserve as good an access to your local GP as you enjoy in the city. We need to realise that the promise of quality healthcare in a time of uncertainty is fundamental to Australia, and it is more important than ever that we get this right. Let's end the blame game and bring the A game to our rural and remote communities.

Dr Giuseppin: Thank you for the opportunity to speak today. I would like to begin by highlighting a bit of my own experience and some of the issues that the AMA sees as key to ensuring the best outcomes for our patients, which I believe is the true focus of this inquiry. I am a rural generalist. I'm a GP with anaesthetic skills who was a pharmacist in a past life, so I'm very pleased to be appearing alongside Services for Australian Rural and Remote Allied Health today. I have worked throughout regional and rural Queensland and currently work for the Royal Flying Doctor Service, providing remote primary health and aeromedical retrieval services to both the Mount Isa and Charleville bases.

As a doctor of a particular generation, a newly qualified rural general practitioner, I feel that there are certainly a few elements to this inquiry that deserve attention. Much of the previous evidence has revolved around the level of remuneration and the ability of general practitioners to maintain a viable business model. I'm very grateful to be joined by Dr Saul, who has an incredible amount of experience in that area and can speak to that in more detail. In addition, I think we have a problem with our general practice training system. In essence, we have a system where our junior doctors face perverse incentives to continue with their careers in hospitals, often in quite metropolitan areas, at the expense of a career in general practice which can be quite rewarding professionally, even if it is not financially. I believe it is time that, as part of the solution, we consider our models of remuneration, particularly for general practice and rural general registrars, and how that may deliver a net benefit to our rural and remote communities.

The AMA maintains that outer metropolitan practice is quite different to rural and remote practice, and I'm thankful here to be in an area that under the Modified Monash Model is classified as a rural area. We believe that the solutions are different. As a result, the use of incentives that are tiered by the Modified Monash Model to address outer metropolitan issues is likely to be counterproductive for our most remote and vulnerable communities. A term I'm quite fond of is 'geographic narcissism'. It's the concept that, when the locus of

leadership is based in metropolitan areas, decisions are often made that are counterproductive to rural and remote health. We are seeing this in an increasing amount in our hospital systems throughout Australia. An emphasis on credentials, inflation of the need for credentials, which are often acquired in the city, further drives our young medical practitioners to seek out training opportunities in those settings, after which they're unlikely to return to rural and remote practice.

I believe that leadership is important and that how decisions are made regarding our leadership at a statewide level is critical to ensuring good integration of our rural GPs into our rural hospitals and a desiloing of primary and secondary care, which is so vital in these communities. We need to move beyond having the ticket and towards a competency based framework for our medical workforce. I believe this is all in the best interests of our patients. I believe good collaboration is in the best interests of our patients. This is because, when you're in a rural area, you deserve to have the best, most well-trained health practitioners by your side. We need to realise that the promise of quality health care in a time of uncertainty is fundamental in this country, and it's more important than ever that we end the blame game and bring our A game to these rural and remote communities.

CHAIR: Dr Saul, did you have some comments to add?

Dr Saul: I must confess, I'm at the other end of my career to Marco. I've been a GP for over half my life—35 years—and I've called myself a small-business owner for 32 of those years as a general practitioner owning his own business. It has been so deeply ingrained in the actual practice. I agree with Marco's comments. I work predominantly in outer-metropolitan practices, and as I'm getting older I doing more rural and remote medicine, and there is quite a significant difference. There are substantial business-model differences, and as a result, each has its own unique problems, and it's awfully hard to bundle the two together, especially from a business point of view.

I've certainly got some good examples of how we've struggled with grant-writing, with income, and with the fact that, especially with our rural communities in Tasmania, we survive on federal Medicare funding, state and federal government support programs, local council support and funding, and simple chook raffles and fundraisers. It's an odd way to work when you're trained purely as a doctor but have to put the business hat on. I'm happy to take any questions with regard to that side of it.

CHAIR: People from Services for Australian Rural and Remote Allied Health, do you have an opening statement?

Ms Maloney: Yes, and thank you for the opportunity to appear today. SARRAH acknowledges the Ngunawal, Wakka Wakka and the Gadigal people, from whose lands we join you today. We apologise that we can't be there in person. We acknowledge elders past and present, and any Aboriginal and Torres Strait Islander people who may be part of today's hearing. We also welcome the release this week of the 10-year National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan. Unlike previous plans, this has been codesigned with and led by Indigenous communities. We congratulate those involved, especially our colleagues in Indigenous Allied Health Australia.

SARRAH will support the plan to innovate and achieve greater equity in access and outcomes, including cultural safety and responsiveness. This is needed for Australia to genuinely claim to have a strong and universal healthcare system. This inquiry should have similar goals. SARRAH's submission notes our concerns that the terms of reference are narrow, notwithstanding the importance of general medical practice. Major stressors on our health system and the severity of health outcomes experienced in rural and remote Australia will not be addressed by narrow and fragmented activity. Beyond the roles of GPs there is a great deal involved in primary health care. The importance of services complexities, the shifting burden of disease, evolving practice and treatments and persistent high levels of unmet need is not adequately addressed in the reference to 'other related matters'.

SARRAH acknowledges the central role of medical practitioners in our health system. There are not enough GPs in Australia and far too few working outside of major cities. While we support better access to rural doctors, SARRAH argues that improving health outcomes for people living in rural and remote Australia also depends on other issues being acknowledged and acted on, such as improving rural training and practice supports for allied health professionals, which are minimal, and addressing allied health workforce and service shortages in rural and remote Australia, which are about twice as severe as those in the medical workforce.

The committee will be aware of the situation in rural and remote Australia—poorer access to treatment, higher levels of chronic disease, higher risk of avoidable hospitalisation, shorter average life spans and higher rates of disability. This evidence is not new. It is extensive and well known. Allowing the situation to continue is a choice—a choice to accept inequitable outcomes instead of taking the necessary actions. Others, including allied

health representatives, have raised these concerns. Importantly, the committee has also heard from senior medical representatives, such John Hall, the past president of the Rural Doctors Association of Australia, who said:

… it's not just about doctors. It's about access to doctors, nurses and allied health professionals as well—the whole multi-disciplinary team and significant access to care.

And the National Rural Health Commissioner, Ruth Stewart, an experienced GP obstetrician, said:

Doctors do their best work when they're part of a multidisciplinary team that's comprised of nurses and allied health practitioners.

If we as doctors work in a strong team, you don't need as many of us, for a start, because we're not doing stuff that other people can do better than we can, and we're providing better care for our patients.

We ask the committee to hear this testimony and help to ensure that everyone, wherever they live in Australia, can access quality primary health care when and where they need it. Allied health services are needed across the entire health system and for every age group. If someone has a stroke and needs help to speak, swallow, move or deal with stress and isolation, the care provided by physiotherapists, speech pathologists, dietitians, occupational therapists, psychologists and others can be critical to recovery and to the person's future quality of life. When a three-year-old child has a developmental issue that has serious implications for their future and needs attention now, their parents don't want to hear that the next available appointment is in 12 months' time. If someone has a serious accident, they want to know a paramedic is on the way. People want pharmacists to provide medications and tell them how to use them safely. A person with diabetes at risk of losing a leg is very interested in how a podiatrist can help and, if the person loses their leg, how prosthetists can help them retain as much mobility and independence as possible. When someone has an accident at work and needs rehab to keep their job, pay the bills and pay the mortgage, they understand what allied health therapies are about. In everyday situations, people who need this care want to know where and when they can see them and how much it will cost. In a universal health system, everyone should have primary and preventive health services they can access—plus, to look forward, links to more specialised services when they need them.

Enabling access to effective primary health care also makes economic and fiscal sense. It reduces demand for avoidable, invasive and costly downstream interventions. As well, it reduces human suffering while contributing profitably to tax and income transfer systems. It underpins sustainability. The RACGP has estimated system savings of almost $5 billion a year through a shift to better primary health care. One hospital admission avoided could fund dozens of preventive, high-quality, health-enabling services provided in a patient centred, coordinated way by a multidisciplinary team of skilled primary care professionals. Again, this is not new. There have been dozens of reports and plans, but too often they receive little or scant response or are ignored.

Our health system is very good in places, but there are serious gaps and structural problems that limit the potential impacts of primary health care. Those issues drive up demand and profit in other areas without delivering the health outcomes better targeted resources could. Whatever the result of the upcoming election, an incoming government will face these challenges. We need a better integrated, comprehensive and patient-centric health system than that which we have now. Thank you.

CHAIR: Thank you very much, Ms Maloney. I'll start where you finished off in your contribution there and in your submission with a question about the need to have patient-centred, coordinated primary health teams that are integrated and comprehensive. You say that this has been a recommendation from numerous inquiries. What actually has to change and happen to make that a reality?

Ms Maloney: There are a number of things that I can speak to from my experience as a physiotherapist involved for 30 years in working in rural townships. The first thing I'd say is that, in regard to the communications between local general practices and allied health services, allied health professionals have acted to put in place technical systems with similar levels of support that would help to better communications between practices. Things like practice management systems and having allied health professionals be able to access and provide input to the electronic patient records systems are things that would help the sharing of information so that the patient only has to tell their story once. The other things that could help are to reduce the out-of-pocket expenses that clients experience if they're accessing primary healthcare under the chronic disease management plan. The access to allied health services under the MBS is very limited and doesn't reflect the complex needs of people living with chronic disease. This is something that the AMA and RACGP have mentioned before. There could be better access to primary health care and savings made in preventable hospitalisations if there were better funding of primary health care services that included allied health intervention.

CHAIR: Thank you. We'll probably come back to that, but I'll just leave that there. Dr Giuseppin, there were a couple of statements that you made in your opening statement about the fact that we've got perverse incentives for

our medical practitioners to stay in hospitals. From your perspective, how would you change that system to stop that? Is it a matter of actually reducing the incentives to stay in hospitals or is it that we have to increase the incentives for GPs to actually come out of the hospitals and come out to the countryside where the people are?

Dr Giuseppin: Thanks, Senator; that's actually a wonderful question. I think it's more about increasing the incentives to match what is delivered in hospital settings. When you reflect on this issue, it's important to remember the point in their lives of the majority of our doctors when they are making the decision as to which career path they will pursue. Very often these decisions are made at critical junctures in these individuals' lives; times when they are deciding who they will marry, where they will settle down, whether they will start a family and whether they will need to perhaps access some of the incentives that they have built up during their time serving in the hospital system.

Currently our general practice registrars are paid in almost a hybrid billing-slash-employee model that is underpinned by an agreement called the National Terms and Conditions for the Employment of Registrars, which is an agreement that actually expired some time ago and has not been renewed due to ongoing conflict between general practice supervisors and registrars associations. What we see as the solution is essentially what we call a single employer model for our general practice registrars, where we can offer our training doctors in general practice a wage that is, if not identical, comparable to that which they can receive in the hospital and, in addition, allowing them access to the benefits that come with a salaried position. Obviously this generates a tremendous logistical challenge, particularly for small business practices that may have to fund some of these incentives. We—and by 'we' I mean the government—need to be looking at how we structure that model to best serve those individuals.

In the medical training survey last year, we saw amongst our prevocational doctors approximately 18 per cent are interested in a career in general practice, and probably about 50 per cent of those are interested in a rural and remote career, compared to about 30 to 40 per cent who expressed a desire to be hospital based surgeons. That is something that we need to change. Part of that is cultural, and I will grant that, but certainly the incentives and structures around general practice training are a key element of that reform.

CHAIR: You say the government would need to support that single payment model for GP practices. What would that look like?

Dr Giuseppin: That's a really good question. We already have some examples of that in action in rural generalist training, which is something near and dear to my heart. In areas such as Murrumbidgee, in southern New South Wales, we see a model where our rural generalist registrars are salaried by the state hospital system and supported by the government through a Medicare 19(2) exemption—that is my understanding—to allow those salaried registrars to bill Medicare. I'm not certain of the exact details of the arrangement in terms of the flow of funding, but that is one such example of a model that appears to be showing some early promise in delivering increased numbers of general practice trainees to rural areas.

CHAIR: Dr Saul, do you have any comments on the existing incentives for doctors to stay in city hospitals and how to change that?

Dr Saul: I go back too many years! I go back to a time in the late eighties in Townsville, where the standard item number, item 23, bulk-billed, was around $15. Now, in March 2022, it's $39.10. I know there a lot of other Medicare item numbers that have crept in, and it's not all about the one item number, but in reality in 1987 we were getting a lot more per consultation. From the point of view of traditional service medicine, we've effectively halved the Medicare rebate. Our calculations in rural practices in Tasmania are that to survive with our current pay rates—earlier today, Mr Cooke spoke about the high rates of locums—we need to have at least an extra $75,000 to $100,000 subsidy per year to fund a doctor, based on these dwindling Medicare rebates. Freezing the Medicare rebate, indexing off a low base—it's all contributed to the financial problems.

You mentioned disincentivising hospital doctors. Financially, rural general practices have been disincentivised for many a year. As my colleague Marco has said: if we can get any doctor who has experienced general practice in that early stage of their career, we've got a chance of keeping them. With any opportunity, program or support we can have to get young doctors into experienced general practice and to get medical students to experience general practice, we've got a chance of getting them into any practice—whether it be metropolitan, rural or remote. I fully support him in that area.

CHAIR: Can I ask you to expand on the figures you just mentioned—that you need a $75,000 to $100,000 subsidy. What's that for, and what sort of practice would you need that level of subsidy for? At the moment, if that's needed, where is it coming from?

Dr Saul: At the moment, the outreach practice at the Tasman Peninsula, about two hours out of Hobart, is one we manage. We finally did our cost of locums. I think Mr Cooke gave a hint of his locum fees; I certainly don't want to him to spread how much he's paying his locums to our guys, because it's above what we're paying! Paying [inaudible] averages about $1,400 a day. We're finding doctors just aren't billing high enough rates per day to cover the cost of reception, nurses, building costs and basic materials. As a result, we're running at a significant loss in a lot of these practices.

CHAIR: What size practices are they? How many GPs are in that practice?

Dr Saul: These are the one- to two-doctor practices. When I look at the models for five- to six-doctor rural practices, they probably survive a bit better. But our one- to two-doctor practices in Tasmania are potentially losing those sorts of dollars. Of four practices I know quite well—fortunately at the moment we are receiving substantial support from our local state government to help get the Nubeena practice back on track. Two other practices are receiving substantial support from the local council, who are currently charging ratepayers $90 per ratepayer for a medical levy to help subsidise the practices.

CHAIR: Which local government area is that?

Dr Saul: Glamorgan Spring Bay Council, on the east coast of Tasmania. The irony there is that there's a fantastic husband and wife running a traditional practice at one of those townships and it has received very little subsidy. These guys are in their early 50s. When you think about their succession planning—they have none. They're running a juniors-with-helpers model. It worries us all as to what's going to happen in that community when those guys want to ease back or retire.

CHAIR: You also talked in your opening statement about how, during your career, you've seen yourself as a small-business owner and you have big focus on fundraising. What sort of fundraising? What sort of other revenue streams have you found you've needed in order to stay afloat?

Dr Saul: Over the years we've had a crack at anything, and we've tied to adapt as much as we can. We were recipients of a Rudd government infrastructure grant. The interesting thing there, though, was that the grant was so complicated it cost us about $5,000 in consultancy fees and at least another $5,000 in time to put in our application. Then, because we were a small business, we got the money one year and we paid a substantial amount of tax the following year. Having said that, to do what we wanted to do we ended up spending four times the amount of the grant. We're still very thankful for the grant, getting 25 per cent of what we needed to expand our practice building and increase our doctor numbers. But we're just not set up to apply for these complicated grants. Our structures are such that it seems odd that we get given money one year and pay tax the following year. It would be great to simplify something like that.

CHAIR: Thanks, Dr Saul. Senator Hughes.

Senator HUGHES: I just want to continue with a theme that we've been talking about. We've seen campaigns, run by GP organisations, opposing pharmacists delivering the COVID vaccine. They've certainly had success in opposing pharmacists distributing the contraceptive pill without a new prescription, based on GPs opposition to this. Yet as we're going around the country we're hearing from rural and regional GPs in particular that they're overstretched and overworked. Wouldn't it be helpful, particularly in rural and regional areas, to encourage pharmacists to dispense the contraceptive pill, especially considering that they dispense the morning-after pill already, without a prescription? By allowing that to continue, that's one appointment you don't have to use to see a woman seeking an update on her contraceptive pill prescription, and encouraging pharmacists to deliver more vaccinations and immunisations, particularly as we head into flu season, would relieve the pressure on small GP clinics. What is the opposition? Is it financial? Is it ideological? What is the continual opposition, whether it's by the RACGP, the AMA or GP groups, to working more closely with the pharmacies, even if it is just in rural and regional areas, to help relieve that burden, particularly on services that they're more than qualified to deliver?

Dr Saul: You've made quite a few statements there, Senator.

Senator HUGHES: Yes, and I'm pretty much happy to stand by them all, as well.

Dr Saul: Ideologically, it is a GP position that we feel very comfortable doing that higher level of service. Saying that all pharmacists are more than qualified to do those services—I'm not sure how accurate that is. When I look at pharmacists, I put them into two categories. Shane, Ashok, Esther, Bianca and Greg—they're all our local pharmacists. They're all really passionate, caring people who we have really close relationships with. Like Dr McPhee, we have all the confidence in the world sharing our knowledge, our collective thinking and collaborative way with them. The assistance they gave to help us out with COVID vaccines—personally, I've seen some great work done by our local community pharmacists.

I find this a difficult space, and I'm not giving you a solution, or maybe an accurate answer, but a local community pharmacist relationship is fantastic; it's great to have it. It's great to be able to communicate closely with them, but I struggle with some of the supermarket pharmacies who might want to sell some evening primrose oil for the urinary tract infection that they want to diagnose, or who work the perfume aisles that you have to walk through to get to a dispensary. I just really value our community pharmacies so highly that I wonder whether all pharmacies are put through what you're asking.

Senator HUGHES: I assume all pharmacists have to do the same sort of university qualification, so they'd have exactly the same sorts of degree and qualifications regardless of where they work. I think we need to be mindful that we're not diminishing the personal rights and responsibilities of patients who are quite capable of walking through any pharmacy they want without purchasing a perfume or evening primrose oil if they're in there for a flu vaccine. So I think we have to be a little bit respectful of patients' rights and the ability of individuals to exercise their own judgement. I'm trying to find some solutions at the end of this inquiry, rather than a constant requirement for government intervention when solutions to reduce the burden are there, yet there is ideological opposition—as you just confirmed—to that occurring, and, I have a very strong suspicion, financial opposition to allowing pharmacists to do that. Anyway, I'm happy to leave it there, Chair.

CHAIR: Dr Giuseppin, do you want to comment on that question?

Dr Giuseppin: Yes. Thank you, Senator Hughes, for the question. As someone who has had a foot in both camps, I definitely understand your perspective. When you ask the question of ideology versus finance, the argument I would make is empirical, and the reasoning behind that is reflective of my experiences in rural and remote health. Certainly I would like to, I suppose, slay the sacred cow that the AMA opposes all pharmacists and other health practitioners working to the full scope of practise. I don't hold that to be true. Where we do hold concerns—and they are concerns that I believe are not to be dismissed—they are in two particular areas.

The first area is the fragmentation of care. Whilst it is correct that we can and should empower consumers to make good choices regarding how they access health care, when they access it and in what context; it is also important, and there is very strong empirical evidence, to support unfragmented care and continuity of care as being of tremendous benefit to patients. Certainly the proposals particularly around pharmacy that we have seen at this present point in time appear to encourage more silos than they break down. Whilst we're very open to collaborative models with our pharmacy colleagues, and I do believe there are areas in which they can contribute more significantly, it is important that we're mindful of—perhaps, a pun—the closed shop of the current community pharmacy model and how that actually can contribute to an increase in silos that is not in the best interests of our patients.

The second reason is, probably, overwhelmingly industrial. As somebody who certainly can't speak on behalf of any pharmacy organisation, I can speak on behalf of my colleagues who still practise. They're tired. They're burnt out. They're just as burnt out as every rural and remote GP, and their capacity at the coalface at this point in time to take on extra work faces very many similar issues that we're actually discussing here in the committee. So I think that, when we are thinking of solutions, it is very important that we support everybody to work to their full scope of practice, but we must do it in a sustainable way that ensures continuity of care and de-siloing. I am concerned that the current proposals don't reflect that.

Senator HUGHES: Thank you, Dr Giuseppin. Thank you, Chair.

CHAIR: Thanks, Senator Hughes. Senator Chisholm.

Senator CHISHOLM: Dr Giuseppin, you may have mentioned it, but I didn't hear where you're from.

Dr Giuseppin: I was born in Brisbane, but my current work is with the Flying Doctor Service in Mount Isa, delivering remote north-west of Queensland primary health care.

Senator CHISHOLM: So you cover the whole of the state then, I take it, in terms of the work you do?

Dr Giuseppin: Probably about one-quarter, yes.

Senator CHISHOLM: Very good. I'm just trying to get a sense of the impact of changes around Medicare levies—those sorts of impacts. What impacts have those changes had on the ability to keep doctors or to attract GPs to rural and remote areas?

Dr Giuseppin: When you say the Medicare levies, are you discussing the rebates or are you discussing—

Senator CHISHOLM: Yes, the rebates.

Dr Giuseppin: I believe my colleague Dr Saul mentioned earlier that it's the base in the indexation of rebates that generates a conflict which is quite difficult to resolve in rural general practice—the conflict between our want to provide accessible and affordable care and our ability to run a business. I believe that, perhaps contrary to the

running narrative, a lot of our rural general practitioners are incredibly dedicated to their communities and certainly would rather not be put in a situation where they have to charge significant out-of-pocket fees for patients to access quality care. However, at this point in time, what we're seeing is that the Medicare rebate for some time has not reflected the true cost of running a general practice business, even in the sense of being able to meet overheads and keep the lights on et cetera. With your indulgence, I might defer to Dr Saul for a bit more detail regarding that.

Dr Saul: As I said before and as I'm sure Mr Cooke would attest, the Medicare rebates are simply covering the wages costs of our doctors there. We've had some amazing recruitment challenges over the year. At the moment we're doing very well in the Tasman Peninsula area, for example, where we've got two really good doctors, but, to do that, we've had to house two Alsatians and two Jack Russells and find a wife a job with meaning and purpose. So recruitment comes in so many different ways and forms. You mentioned basic costs. Again, it's not just about the income for a lot of these doctors; they're dedicated, caring people. But it's very hard to overlook the fact that, unless there is a reasonable income or a competitive income, a lot of doctors just won't go to rural areas.

Senator CHISHOLM: Dr Saul, you mentioned earlier that one of the councils on the east coast of Tasmania was charging ratepayers a subsidy to keep a GP in town; is that correct?

Dr Saul: To help cover the costs, yes—councils in Tasmania are supporting general practices across the state. We get support from the Tasman Council and the Glamorgan Spring Bay Council. They run medical services in Triabunna and Bicheno. They do a fantastic job supporting as much as they possibly can. They're filling the gaps that the federal Medicare rebate is not keeping up with.

Senator CHISHOLM: The basic reason for that is that there's a lack of GPs in the area and they're just doing everything they can to support their local residents?

Dr Saul: Absolutely. They're doing a fantastic job and trying as hard as they can. I did mention dogs earlier. I believe our council, Tasman, does have a no dogs policy, Senator Chisholm—if you could please keep that a little bit quiet [inaudible] aren't making much mess, I must confess. We're just doing everything we can to just try and solve the Da Vinci code with some of these things. We're thinking laterally wherever we can. Allied health is a real problem. It's strong in some areas and weak in others. We do very well through state government funding of a great physio at Nubeena down on the Tasman Peninsula, but we can't get a podiatrist down into the area. We're struggling to achieve simple services for diabetics like podiatry at the moment. It's this inconsistency that's making us laterally think. A senator mentioned earlier the fragmentation of some services and the constant application for money to provide services. It's born out of the fact that our communities are getting so desperate, especially in the mental health space with headspace wanting money. Tasmania has a great service called RAW, Rural Alive and Well. To me, all these services are popping up because we're not providing adequate funding to keep one good service in place.

Senator CHISHOLM: Dr Giuseppin, putting on your AMA hat, do you think that the federal government are doing enough? Effectively we're hearing from communities that are crying out for more help, particularly in regional and rural Queensland. Do you think the government is doing enough and listening to bodies like yours to ensure that they're attracting the doctors that we need in rural and regional Australia?

Dr Giuseppin: No. The true answer is more complex. Certainly there is very good engagement, in the sense that we certainly have discussions that are frequently quite productive. The question is around whether this translates into action. It's when the time comes for the rubber to hit the road, so to speak, that we struggle to implement the solutions. A good example of this is in recent discussions around the implementation of the Primary Health Care 10 Year Plan, which is something that will have a national benefit, including a benefit to rural and remote Australians, which now appears to have had some of its funding brought into question. Certainly we had a lot of constructive engagement on the development of the plan, and the plan was very positive. It becomes a question of translating that to action. I certainly feel that, in many ways, the translation of engagement into action is where the problem lies.

Senator CHISHOLM: Thanks.

Senator McDONALD: I realise we're short on time, so I will try to be brief and perhaps if you wouldn't mind being reasonably direct in your answer so I can get through them. I want to acknowledge the comments that were made around the almost second-class allocation for young doctors who want to choose rural placements. The highest marks and the highest grades get allocated to the city doctors and programs. Even if you wanted to choose a rural career, the first message you get is that you are choosing the second-class option. Earlier in the session I asked about the number of overseas trained doctors that we use in Australia. We were importing 3,000 per year prior to COVID. I have been told that the reason why we weren't training more young Australians, particularly

from regional and rural places, was that the AMA didn't want to see more Australians trained in Australia. Is that a reasonable statement, or has the AMA's position changed?

Dr Giuseppin: Senator McDonald, would you be able to repeat your statements? Sorry, I didn't catch it on the phone.

Senator McDONALD: I'm so sorry. I wanted to ask whether the AMA has changed its position on limiting the number of students who are being trained as doctors in Australia, and that's why we were bringing so many doctors in from overseas; or has that position softened over the period of COVID?

Dr Giuseppin: In essence our position has never changed. Certainly we maintain that the current level of medical student training is sufficient to meet our needs. The problem that we have always had is around the distribution (a) of those medical school places and (b) of the doctors that then result from them. What we're seeing and what we support is innovation around how medical training is delivered, so we support innovation around end-to-end medical training. But the other side of this equation is that we have a significant number of junior doctors currently sitting in our hospital system for various reasons—and I'm happy to provide a bit more detail offline on those reasons—awaiting training in metropolitan based settings, and we need to look at how we actually attract. If we could attract probably even a third of those that are currently sitting in those positions into rural and regional general practice, we would not have anywhere near the problem that we have today.

In summary, our position has not changed; however, we believe that there are solutions that are based around how we distribute and allocate those medical school places to encourage Australian-trained doctors to adopt a rural and remote career. I hope that answers your question.

Senator McDONALD: Yes. We heard evidence earlier today about how in the 1980s there was a different view, but I'm pleased to hear that's the case. I'm a big proponent of seeing more medical schools open in regional places so that, instead of having young people end up in Brisbane, Sydney and Melbourne—where they spend the best part of 10 years with double degrees, meet a life partner and buy something in those cities but don't want to go to such far-flung places—we would see more of our regional kids, who know how fantastic it is to live in regional communities, being trained in Townsville, Cairns, Darwin and Rockhampton and then are more likely to stay and pursue a career regionally. Do you think that's a reasonable belief?

Dr Giuseppin: Yes, I do.

Senator McDONALD: Terrific; thank you. We've talked a lot about the rate of Medicare today. How do we address the fact that we have six-week waiting periods for appointments in Ingham and a nine- to 12-week waiting period in Emerald, and yet I can go to pretty much any practice in Brisbane and there are doctors who are sitting with empty books still receiving a similar Medicare payment. How does our Medicare system stay afloat under such overutilisation of cities? How do you find a balance going forward?

Dr Giuseppin: On that I might defer to Dr Saul, if he's available.

Dr Saul: This is a really difficult question, because there are many inner-city doctors who are doing very good medicine. Some might be more inclined to be outliers as far as their billing practices are concerned. There's no one answer to that question. We've mentioned financial concerns, but that's not the only answer. It's assisting those doctors through a gracious entry and [inaudible] exit when they go to rural practices. There are all sorts of psychosocial issues that we need to address—support for partners and families—when they go rural.

As a practice manager I'm certainly noticing that we're attracting doctors in the early stages of their careers and we're attracting doctors in the later stages of their careers. There are doctors moving back to towns for their kids' high schooling. A lot move back because their wife or partner goes into a career. Then when they are that little bit older they'll move to rural areas when they have a passion for it. We need to be working with these guys who have more capability and interest to go to those areas.

With COVID we've really struggled with recruitment because those older doctors, especially if they have a few health issues, just don't [inaudible] up anymore. So that's not helping us. Ironically, we too in Tassie have had some COVID benefits. We've managed to integrate one doctor who moved back to be with his parents in a rural area. We've got it in the [inaudible]. His wife has started a really good local business. We've some odd benefits from this. Provided we can keep the internet connection running well in a rural area, another doctor's husband can work from a remote area. We've seen some odd benefits in recruitment there. Again, I'm afraid there's not one answer. It's a complicated question.

Senator McDONALD: It is a complicated question. I pick up on your point that in Tasmania a number of the councils have provided support. The same thing is happening in Queensland. Rural councils provide housing or a subsidy to the hospital. A council I was speaking to the other day provides $60,000 a year to support salaries for a doctor. I think they do the same for teachers as well. You raise a good point about education. In Queensland it's

very difficult to have teachers teach STEM subjects west of Mackay. You're right; it is multifaceted to keep doctors and all sorts of professionals in regional places. This is a complex ecology. It's not a political issue; it is a geographical issue and an every-level-of-government issue that we're grappling with.

CHAIR: Senator McDonald, a final question.

Senator McDONALD: Regional people have been asking me why can't the provider numbers we provide to doctors be linked to a region, so linked to Springsure or Emerald? If that doctor wanted to leave, they would have to find somebody who is leaving a linked place somewhere else. That would restrict this constant flood of doctors towards the coast and would tie people to places. I can see some issues with that. What would you say about that to the regional communities that are so desperate?

Dr Giuseppin: There are two comments around that. The first is that in many ways that system does exist, particularly with regard to overseas trained doctors, through the Medicare moratorium and the current distribution priority areas system, which does to a certain degree prevent some of the I suppose percolation back into the city of doctors practising in rural areas. The second thing that I think is important to be mindful of with provider numbers is that I believe we underestimate how many doctors actually work for the state government system in roles where they're fully funded and don't have to rely on Medicare, so a resourceful practitioner who is looking to move closer to the coast would be able to find a way, in many ways, to get around geographic restrictions on Medicare provider numbers. I think we overall probably need to look at more carrot than stick when we're looking at our policy solutions to this problem.

Senator McDONALD: Thank you, Chair.

CHAIR: Thanks, Senator McDonald, and thank you very much everyone for your contributions today. It's been very useful for the committee. I don't think anyone's taken questions on notice, but if there is any further information you would like to provide the committee, if you could do that before 25 March, that would be really valuable. We'll be reporting to the Senate by 30 June. We will now suspend for a short break.

Proceedings suspended from 11:10 to 11:27

BRIGGS, Ms Kristy, Provisional Psychologist, Central Queensland Rural Division of General Practice Association Inc.

CORFIELD, Ms Sandra, Chief Executive Officer, Central Queensland Rural Division of General Practice Association Inc.

GALE, Ms Lauren, Director, Policy and Programs, Royal Flying Doctor Service of Australia [by audio link]

PURCELL, Ms Margo, Chair, Central Queensland Rural Division of General Practice Association Inc.

QUINLAN, Mr Frank, Executive Director, Royal Flying Doctor Service of Australia [by audio link]

MASEL, Dr Matt, President-Elect, Rural Doctors of Queensland [by audio link]

CHAIR: Welcome. Thank you for appearing before the committee today. I now ask each organisation to make a brief opening statement, if you'd like to do so, and then we'll ask you some questions.

Ms Purcell: Thank you very much for the invitation to be here today and to speak to the submission we have made. CQ Rural Health is the business name for the Central Queensland Division of General Practice, and Rural Health Management Services is our subsidiary company which operates a management and administration service to GPs in rural and regional Queensland. The services that we operate through Rural Health Management Services enable GP practices to remain in operation in rural and regional areas. We have practices in Ravenshoe, Herberton and Kingaroy.

I've only recently come to the chair, and I'm not a GP, so Sandra will deal with most of the operational matters. But it is clear in the work we have been doing that financial pressures as a result of the inability to attract GPs and the cost of attracting GPs to rural and regional Queensland have put organisations such as ours in a critical position. Traditionally our model has been to assist where a doctor is seeking to leave an area. We will step in and manage the practice and enable the doctor to leave and will continue to operate the practice until we have a doctor wishing to come in and take over.

But the cost of employing doctors has put critical pressure on our organisation. The objects of our organisation are to continue to offer health care. We have expanded into allied health, so we have mental health services, which have been an important part of our ability to offer projects for the PHN for such things as suicide prevention. Recent changes in funding for those project services have added to the increase in financial pressures for our organisation also.

The submission that's been made to the inquiry deals with the areas we particularly feel need reform. Also, we appreciate the difference between state and federal issues, which seem to be the total quagmire that is the delivery of health services everywhere. In the submission Sandra has elaborated further about the basis of our organisation and what we actually do, but we welcome the opportunity to be here to speak to the submission.

Ms S Corfield: Kristy is a local provisional psychologist on the ground, and we've asked Kristy to come to talk to you about some of the issues she sees.

Ms Briggs: Thank you for having me here today. I apologise if I sound nervous. I'm better in a one-on-one situation!

CHAIR: We're very friendly!

Ms Briggs: I've had the unique opportunity to live in Emerald. I studied in Emerald and now, through the university's kindness, I'm actually able to practise here. It's given me a good opportunity to experience some of the issues our clients are facing, personally and professionally. The biggest issue we get is the high turnover in GPs here in town. That leads to lengthy wait times. Sometimes you're looking at a minimum of two weeks and sometimes three months to get in to see your GP. That makes it really difficult for people who are in crisis. They're having to wait a lengthy time just to get in to see their GP to begin with, and that's if they've made the correct appointment.

If they need a mental healthcare plan, that's a separate appointment. There's then another lengthy wait time to get back into the GP, and then there's a referral process—that sort of thing. If we want medication reviews there is a lengthy wait time again.

The high turnover in staff means that a lot of my clients aren't actually able to see the same GP again, which means having to discuss their situation with someone new, having to expose themselves again to someone new. And I feel sorry for the GPs. They're under a lot of pressure. There are only a small number of them and they have to service such a large community. They don't have the time to give clients the care that they need. The downside

to that is that clients are walking away feeling that they haven't been heard. They're feeling that they've been dismissed, and they sometimes feel quite lost and abandoned. And the downside to that is that either they cut ties with services completely, and they go out into the community and their condition worsens, or they are forced to present to the emergency department, because that is the only avenue they have for services. That further increases the waiting times in those departments. It further increases the waiting time for mental health, when they are able to get there. That then fosters more of those feelings of loss and abandonment. They're discouraged and are more likely to disengage from services. Worst-case scenario: it could lead to suicide or harm to others.

CHAIR: Thank you, Ms Briggs. That was really powerful. And you didn't appear at all nervous!

Ms Briggs: I'm shaking. I tried to keep it down.

Ms S Corfield: I'd just like to summarise from our perspective of working as an organisation that originally was federally funded but is now an independent charity. We work with communities, with practitioners and with health and hospital services, and we're often the solutions broker when there is a point of crisis. Either that's been picking up the general practice or, in recent times, we've been doing some health planning and solution based planning in particular communities.

The biggest issue, which is the backbone of access to rural services, is a funding model whereby we've got Commonwealth money, state money and local councils putting in money but there's no actual, real plan for how those funds are to be managed locally in a community and what the expected outcomes and retention strategies are. It works where there's an informal relationship between the providers: between the HHS, between the local med super and general practice—if they're the same person it's even better. But if they're local GPs and there's PHN involvement in funding and the introduction of private practice services, that works by accident, not by intent.

What we have to do—from your position, as government leaders—is to start to manage the total investment in health care in each community, the sustainability plan in each community, and what the health outcomes are for that community. That data is available. You've got to dig deep to find it, but it's there. With the capacity when you pull all three of the players together, all three levels of government together, you can actually get fairly equitable results. If you need a new CT scanner, industry might build the building, private practice might put the scanner in there, Queensland Health might put the grounds in, and the Commonwealth will pay for the scans through Medicare. The solutions work when everybody works together, but current policy doesn't drive that as a way of performing. Each level of government just measures its own bits, so you get ivory towers and Canberra based bureaucrats that make policy that doesn't necessarily reflect what each community needs. If we're going to get different results, we have to think differently about how the planning happens and how the performance is measured.

CHAIR: Thank you, Ms Corfield.

Ms S Corfield: Sorry; on my soapbox!

CHAIR: No, don't apologise. It was a really useful perspective. Does the Royal Flying Doctor Service have an opening statement?

Mr Quinlan: Yes. With your permission, Chair, I might offer to just table the opening statement. I've got a few pages sitting in front of me that we'd glad to send to you separately, perhaps. If I could just draw a few highlights?

CHAIR: Yes, that would be great.

Mr Quinlan: Even though we didn't caucus, I think what I'm about to say follows very closely from the previous speakers. We have reflected a little on the approach that's been taken through the COVID crisis, which has been a real crisis and is going to be an ongoing crisis for rural and remote medicine. Our services have delivered as of today something like 75,000 vaccination services into remote communities where there simply aren't other services available. We've also used our logistical and clinical capabilities to deliver in excess of 100,000 doses of vaccine that have been delivered by others.

The approach that we've taken through the COVID crisis has, I think, a couple of very key characteristics. It's been built around a planning model. And by that I want to say: what we did right at the start was we clearly identified the need for a particular service—in this case, vaccinations; because we had the data, we could map where those populations are, where those people are; and we could work with Commonwealth government and state governments and local services on the ground to have a coordination discussion around who and how best to deliver those services. Now, it hasn't been perfect by any means, but a lot of it has actually gone pretty well.

And the challenge, I think, for us in delivering services into rural and remote in particular is that we often don't take that planning approach. We take a helicopter view instead of taking an on-the-ground view. And, ultimately, if we take an on-the-ground view, then we know where this population of people of live—we literally know their names and addresses—and we have a very good understanding based on the demographics of their likely health status and service requirements. What we are missing, I think, is an agreed definition of what we might call 'a reasonable standard of care'. So, even though we know where those people are, we don't say routinely, 'these people in this location are going to need this many blood tests for diabetes, this many forms of cancer screening, this many mental health check-ups and this many dental assessments and care', in the sort of atomised detail that I think is available to us to do. Without that detailed planning, then I think we are all to a certain extent fumbling around in the dark.

Once we have that need identified, and the agreed standard of services, then I think it goes to precisely the sorts of questions around funding reform that the previous speakers identified. Coordination between Commonwealth and state governments is essential and it costs money and no one is funded to do it. It actually costs people time and expertise to do that sort of coordination and to reach agreements, and to monitor a process; no-one is paid for that coordination effort, and therefore the funding system doesn't reward it. In addition to that, a lot of services that are provided in rural and remote locations in particular are provided under the umbrella of relatively short-term contracts, by which I mean contracts that may only extend for a few years. I don't have the data available, but I'm very interested in the question—and it may be available to this committee to ask: what percentage of health services, primary care services in particular—mental health, dental services—delivered in rural and remote Australia are delivered under the umbrella of short-term funding arrangements? Because I think that would tell us a lot about why it's so difficult to deliver those services.

Rightly, we should be looking at building up our GP workforce and we should be building up our rural and regional hospitals. But a lot of services, like ours, are going to be provided outside of the Medicare system and outside of traditional GP models of care. I think, if we're going to resolve some of these challenges, we need to think radically about not just who's providing the service but the models of care that are used and how we can deploy general practitioners, nurses and nurse practitioners, allied health professionals and others in ways that optimise their contribution to health outcomes that we know are still lagging, and lagging terribly, in rural and remote Australia.

I might say, to finish, these health outcomes are likely to continue to lag dramatically for a number of years because the interruptions to travel and the delivery of services into regional and remote communities have meant that many standard services, particularly dental services, and many preventative health services have been delayed or deferred. That's a backlog of need in the community, and that backlog will not be met by a simple return to normal and a return to business as usual. Overcoming that backlog will require particular remedial effort over the next few years to get people back even to the standard they were at beforehand. I might leave my comments there.

CHAIR: Thanks, Mr Quinlan. Dr Masel, do you have an opening statement?

Dr Masel: Yes, thanks very much for the opportunity. Our national body, the Rural Doctors Association of Australia, has made a submission. I thought I'd just use my opening statement to tell you all what I do to give you some idea of what questions I might have some answers for. I'm a GP in rural Queensland where I'm an owner of my own general practice. So, apart from being a doctor, I own a small business that provides rooms and services for other GPs, employs and trains new doctors and also employs 15 or so other nursing and administrative staff. I'm also a rural generalist, which means, in addition to that comprehensive general practice, in my own practice I provide components of other specialist care, such as obstetrics and emergency management, in our local hospital. I do that as a visiting medical officer contracted by our local hospital health service, so I'm paid on an hourly basis for that service.

I'm currently the president-elect, as you know, of the Rural Doctors Association of Queensland. I'm also the chair of the Rural GP Network within that. RDAQ is a member association representing rural doctors and the communities they serve. Our members work across Queensland and include general practitioners and rural generalists but also consultant specialists, doctors in training and medical students. That's just a bit about me. I'll leave it at that. I'm at your service.

CHAIR: Thank you. I'll start with a question to all of you. Ms Corfield and Ms Purcell, you talked about how we need to plan better and get all of those parts of the system at the federal, state and local levels working together. Does that look like we do actually need to have a complete comprehensive overhaul of how we manage primary health care in the country?

Ms S Corfield: Yes; that's the short answer. Matt's a great example of how things work very well when there are locally integrated services, good relationships locally and how you can solve problems effectively at a local

level. But not all communities have the luxury of that system being in place, having that good integration between general practice and the hospital system, and a good working relationship with their local council and good community ownership of those services. It can be for rural communities, it can be for Indigenous communities or it can even be for larger communities like Emerald where we are today. There needs to be that opportunity for doctors to work both in the hospital setting and in general practice. It's not easy being a small-business owner. Our organisation arose because one of our GP board members at the time said, 'Sandra, I think it's going to be the practice management that's as much the problem as the GP workforce crisis.' We've managed 19 different practices in different communities. We're currently managing eight practices. We come in, we build them up, we train the staff and we transition them to the doctor or the community—as was the case with the super clinic here in Emerald. That role was seen by the GP board at the time as something that was going to be essential.

CHAIR: Who pays for that service?

Ms S Corfield: We're a charity; we live off the smell of an oily rag! Some government funding would be lovely!

Ms Purcell: This is the first year that we have sought some block funding; we made a pre-budget submission. Traditionally, our successful practices have assisted us in maintaining practices in areas where we're struggling to employ or paying more than we would expect to pay for a GP; for example, we stepped in at Kingaroy. We've had COVID and so much difficulty in employing, and we've lost a lot of money. The objective is to maintain health services. We've hung in there and we've been able to provide services to over 10,000 people, but it's not sustainable unless we have some support. The submission we've made for funding is that we're ideally placed to assist in community controlled health care; if that model is able to be achieved, we feel that is an excellent model for rural and regional areas. The problem I see—and I'm not a doctor—is the cost to practice owners, or to us trying to manage a practice, or to those GPs trying to employ, is that the amount being paid through the state system makes it very difficult. Recruitment costs are excessive. The number of doctors you can recruit and the ability to get them into regional areas means we've got this conflict between the state and the GP practice.

Ms S Corfield: General practice is about economies of scale. If you have a 10-doctor practice, your margins are a lot better. For most rural communities it's a two-doctor practice, with, ideally, them also working at the hospital. The hospital income subsidises, in some cases. There needs to be a different way of looking at how rural general practice is funded. With the success of the AMS model, with some base funding going to establishing that practice and running some of the overheads, you then aren't playing catch-up all the time. If that was incorporated, perhaps with some planning as well, that would be good. We are working with Health Workforce Queensland on setting up some templates for primary care planning and integrated health plans. We're working with the PHN to do an integrated health plan for Gladstone. So that capacity is starting to come through, but it's the policy direction to make that an essential part of delivering health services—having that local integrated plan that looks at public, private and the NDIS and all the facets of health funded from a multitude of places.

CHAIR: And connects to that funding then being available. You are being a safety net, as a charity, to make sure those primary healthcare facilities are available to communities. We've heard of local governments in other areas that are putting money in, and the ratepayers are paying levies to make sure those health services are being provided.

Ms S Corfield: Health care is really important to the communities. If you give the communities a say in the health care that they need, they know the answers most of the time.

Ms Purcell: Could I just say one thing there, because I just want to make the point that we work with each of the HHSs, and we deal with PHN funding and delivery through projects. We work with each of the state HHSs, including Townsville and North West HHS, and we step in at their request where needed. So we do work with them, and I'm just complaining about the price they're paying their doctors. I didn't want to sound too negative, because that's a relationship that we foster. We try and work with all areas.

CHAIR: Mr Quinlan and Ms Gale, do you think that, in moving forward, there does need to be a complete overhaul in the way that we manage primary health services?

Mr Quinlan: I'd put that more cautiously, to be honest, because I think there have been many efforts or thoughts that have had a complete overhaul. I'm a believer in incremental change rather than revolutionary change. There's quite a bit of difference between the various services that are available on the ground. There are quite considerable differences between the services that are offered by state and territory governments. I certainly think, though, that we need to, in a coordinated way, invest much more in joining up the services that are available on the ground and in being clear about the gaps that exist, because, as I think I said in my introductory comments, we often take a helicopter view instead of a ground-level view, and at the ground-level view, it's a

finite population of people who need a finite range of services. I think we could do much more with clear statements about our expectation to meet those service needs. Using that as a basis, I think a lot of implications for services and funding flow out of that.

CHAIR: Thank you.

Ms Gale: Very briefly: when it comes to thinking about how we can do things better, having a greater focus on outcomes that we're achieving through our primary healthcare system should be a much stronger focus so that services can be designed based through providers in this area and so that individual communities are able to access the services they need to achieve better health outcomes in those rural and regional areas.

CHAIR: As Mr Quinlan said, there's a need for that agreed standard of care and services, and you commit to meet that.

Ms Gale: Exactly.

Ms S Corfield: Yes. Measuring health outcomes rather than services delivered is so important, and it doesn't happen now.

CHAIR: Ms Briggs, we've heard quite a bit of evidence about how it'd be better to have team approaches and GPs, with allied health services, operating together with the psychologist, for example. Does that happen in your work now, or how could that be improved?

Ms Briggs: It definitely does need some work because we do need to have that relationship with the GPs, especially when there is medication involved if it's a chronic issue and that sort of stuff. We need to be able to contact the GPs to have some of that face-to-face contact to keep that care from step one all the way through to the end. Sometimes, with the high staff turnover of GPs, we're not actually talking to the same GP. I had that happen this morning. I had to send a report to someone; it was the third GP for that client. I didn't actually know who to send that report to until I spoke to the client. They had gone to a third GP simply because someone had resigned or someone had too lengthy a wait time—that sort of stuff. It makes it really, really difficult on our end to ensure that there's a commitment to care and to really make sure that, when we do send the client back to the GP, they understand what the client's coming back for, understand their needs, hear them and give them that care.

CHAIR: It's hard to have a team based approach if you don't know who's in the team or the team keeps changing.

Ms Briggs: That's exactly right—or if a new team member comes in and they don't understand mental health. I understand it's not everybody's area. It's quite easy to torpedo my relationship with a client if the wrong thing gets said in the wrong context by someone else. The end result is, and has been shown to be, that they will disengage completely from all services. It's never a good outcome.

CHAIR: No.

Mr Quinlan: I'll just add to that, and I don't mean this in a mercenary sense by any means. I just want to re-emphasise that all that coordination takes time and therefore costs money. It costs time to have those conversations and it costs time to maintain the records that are required to underpin good communications in an integrated system like that. And it takes time to build people together. As we focus so much on activity based funding, on a transactional model of funding, then it's not easy for people to dedicate or allocate that time.

CHAIR: That's a really important point. Dr Masel, do you have any comments on how effectively that team based approach is working currently? What needs to happen to make it work better?

Dr Masel: That description of Kristy's experience is really worrying in that it isn't adequate, really. I think a team based approach starts with the continuity of a coordinator, and that's generally the GP. That continuity of care from a GP is critical and, in order to have that, you need to have enough doctors training to be GPs and to be GPs in rural areas in particular. I think that's where the support is needed.

Once you have that, obviously, you also then need training of allied health people, with encouragement and incentivisation to be in rural areas. There's not much point in having a GP who is trying to coordinate a team of care when there isn't a psychologist or other allied health.

CHAIR: From your perspective, what changes need to occur to encourage more GPs to practice in rural areas?

Dr Masel: It's happening already. I think we need to expand on the things that are working or, at least, to evaluate some of the stuff that's being done to find out which things are working and then expand those. I find my work incredibly fulfilling and rewarding; it doesn't pay as well as other specialities, but I love it and I know that it's appreciated. I'm constantly looking to recruit new doctors, but we have to compete with city specialist practices. I talk to young people, from high school to medical school through to new doctors and it's not just about

funding and increased incomes. If we are to get new doctors to us then we need to provide good funding, good training and a safe place to train and practice. That starts early on in careers.

One of the things that I think has worked really well is the Rural Junior Doctor Training Innovation Fund. We started that earlier with the PGPPP some years ago. In fact, a lot of our doctors started in that early training program in their first year or two out of university. They have stayed on and are now long-term GPs here. So, at a small scale, we can see that it works and, on a larger scale, I think the evidence is there that it works. That sort of prevocational exposure of young doctors to general practice and, in our case, especially to rural general practice, is very effective.

The numbers aren't enough; if we need a thousand new GPs each year then we're going to need to expose a significant number of thousands of junior doctors to general practice to get the message across that it's a career worth pursuing.

CHAIR: Yes.

Dr Masel: So that's an example of a program that I think is working very well.

CHAIR: You probably said this in your opening statement, but I missed it: where is your practice?

Dr Masel: Goondiwindi—I may not have said so. It's Goondiwindi in southern Queensland.

CHAIR: Thank you. Senator Chisholm?

Senator CHISHOLM: Thank you to the witnesses for coming along. You mentioned Kingaroy and I just want to get a sense of the geographic footprint which you operate in. I know your title is Central Queensland but I probably wouldn't have put Kingaroy in there.

Ms S Corfield: We started off as the Central Queensland Rural Division of General Practice in the 1990s. That's our business name and has continued. When the Commonwealth changed from divisions to Medicare locals, we were involved in infrastructure programs; we were managing general practices. We couldn't just abandon what we were doing, so the board said, 'Well, we'll hang around for another year and see whether there's any need for the organisation to stay on.' By then we were managing six general practices and doing a bit of project work for local government. The next year we were approached by a practice in Cloncurry to help there, and the board looked at that and said, 'Well, really the need for that practice management rescue or troubleshooting kind of services is across all of rural and remote Queensland.' So we extended our boundaries; we just didn't change our company name.

We do some local project work under Central Queensland Rural Health, and the subsidiary organisation, Rural Health Management Services, does a lot of the practice management. It originally was a for-profit company, but general practice doesn't make much profit, so it's now a charity as well. And we have the capacity to look at investment as a DGR investment for those communities, and we have used that in the past. We looked at that for mental health services here, when there's a funding failure.

So, we have options now to be able to help. We're currently doing some consultancy work in Torres and Cape towards accrediting their primary care service—going from an episodic model of care in the Cape to looking at some continuity of care and having patients see the same doctor all the time so they get those better outcomes, as Matt will say. And we were invited in in Kingaroy. Kingaroy's been hard, because it's in that difficult location where it's close to Brisbane but it's not close enough. And with the DPA changes now, there's not even that DPA advantage for Kingaroy; those doctors can go to the Sunshine Coast—and do. It's been a really rewarding process, but it has shown that there is an organisation that needs to be in place to do the doing.

Senator CHISHOLM: Yes. It sounds like you do a remarkable job. A challenge for Ms Purcell and the board might be a name change, at some stage! But I'll leave that to you guys. But seriously, it seems like you provide a remarkable service, such that if you're not doing it, who does do it? How hard is it to just keep your head above water? It sounds like with what you're doing you can't say no to people, given the need.

Ms S Corfield: Yes, it is a conversation had at every board meeting. But it is something that I think does make a difference in communities where we're able to establish services and they stay. We've worked in Central Queensland and have now established viable general practices—all through the North Burnett region. We've had a hand in managing all those practices, and they're now fully functional and have doctors in place. I think if you build the right business and have the training pipeline so that you have medical students coming through, you have junior doctors coming through and there are registrar training options and a good relationship with your tertiary hospital around experience, then rural general practice is really rewarding and it's a good place to raise families and for people to build a life.

I think that's the bit we need to look at—having that sustainable business to support the doctors who are coming through who want to do that mixed model of care, who want to be able to work in the local hospital and work in general practice. And some of them will want the business. That's the point of difference we have against the New South Wales model—the RARMS. It's a similar walk-in, walk-out model, only we let them keep it at the end if they want it. That, again, is that next level. As a practice management organisation, we can reach a certain degree of excellence, but we can't go all the way, whereas, if there's a GP in there who owns that business and is passionate about the business, you end up with the Matt Masels of the world, and they will take it to the next degree.

Ms Purcell: The reason we have made the pre-budget submission, and the reason we are here today, is that it's clear to the board that this strategy that we have had in place for many years is not sustainable under the current structures. Personally, I think the current structures are not sustainable; it's not just us. It is clear to us that if we are to continue to be able to offer services to other HHSs, such as health planning retrieving practices—which are alleviating the burden on the HHS, because we're keeping those people out of the hospital system by preventative health care—there's got to be a change in the way that we operate. That's why we are approaching the federal government for some block funding, but mainly because it looks clear that there's a recognition of the need to address community controlled health care and to identify what the community wants, which is absolutely the outcome that we are looking for.

As a board, it's not just the name that's worrying us; it's actually that we are at a critical point from the point of view of strategic planning. Fortunately, we now have doctors we have been able to employ in Kingaroy. The last few years have been particularly difficult. I'm sure I speak for the board in saying that health care in rural and remote Queensland is at a critical juncture, and the decisions that are coming in the next 12 months will very much be critical to our continued operation.

Senator CHISHOLM: Thanks for that. In one of your answers before, Ms Corfield—

Ms S Corfield: Somebody wanted to say something.

Dr Masel: I was just going to point out that, in an ideal world, we wouldn't need the incredible services of Sandra and Margo and their organisation, but we do. At our practice, we have the benefit of a pre-existing practice that we've stepped into and increased. With a service like that—one that supports the setting up and the management and all the rest, gets things going and then introduces the Rural Junior Doctor Training Innovation Fund pathway and the National Rural Generalist Pathway and gets people connected to all of the services that currently exist to encourage rural doctors to train in the bush, practise in the bush and stay in the bush—all of that then continues for the longer term. But it does start with the establishment of practices and also of integrated general practice and hospital services in rural towns, as Sandra was talking about.

Senator CHISHOLM: Thanks, Dr Masel. Ms Corfield, you mentioned in passing, in one of your answers before, the impact of the DPA changes. I was just wondering if you could expand on that. I might ask you to keep it as brief as possible; I'm running out of time. Sorry.

Ms S Corfield: I think DPA is a very blunt tool, I guess. It's not able to be tailored to particular communities. There's no real transparency about why DPA is awarded and why it's not, and you need DPA to import doctors. As much as I hate importing doctors—I think there are enough doctors trained in Australia; we just need to move them to the right place—we've had to do it for the first time ever. The allocation of DPA to those more urban areas and regional areas just means more doctors will be imported as well. There are other things that are tagged DPA. It really gives no rural advantage at all now because most of Australia is DPA; Ipswich is DPA. You can't compete, and there's no incentive for Australian trained doctors to come back other than having had a relationship with the practice. There's not a stick approach. It's a very difficult problem, and I don't think DPA is the only answer. I think there do need to be ways of making sure that some doctors go to rural and regional areas, but it's not necessarily only the overseas trained doctors that should be going to rural and remote areas.

Senator CHISHOLM: I have one question for the RFDS. The part of your submission that caught my attention was the long-term impacts of the disruption of delivery of regular health services during COVID-19. You said that, for example, RFDS research suggests that travel and associated restrictions in the RFDS footprint during the pandemic may be leading to unmanaged chronic disease. Could you expand on that and give some practical impacts that that is having in remote communities?

Mr Quinlan: Yes, certainly. I might say that we are just starting to see that data emerge, so some of this is based on our observations of what's happening rather than on our detailed analysis, which will no doubt follow. For instance, dental services in rural and remote communities are perhaps the most interrupted services. Because of the infection control requirements around COVID-19, many dental services were necessarily stopped as a

means of controlling the early spread of the virus. That means that communities that were already experiencing unmet demand for dental services are now even further behind. It also means that, as we come out of the crisis, dental services will return to those communities, but they are likely to be at much higher levels of acuity than we had seen previously.

Similarly, in our evacuation data—we provide evacuation from communities for people who are very ill, either due to illness or accident, to take them to tertiary hospitals—we're already seeing, we think, a trend that says that people that we're taking out of some of the communities that were locked down are coming out at higher levels of acuity than we would have expected prior to the pandemic. What we think that's about is in a way self-evident: where communities have had less preventive intervention, less early intervention, less management of chronic conditions like diabetes or heart disease then it's simple arithmetic to say that, as we come out of the crisis, those people will be experiencing even higher levels of illness than they might have otherwise. Our point is simply to say that a return to business as usual would do nothing to pick up the backlogs in services that have been delayed. Somewhat ironically, those lockdowns saved those communities from the spread of COVID early on, but nonetheless it's now our duty to catch up.

CHAIR: Thank you. I have one final question for the division of general practice. In terms of the amount of money that you're putting in to support practices and to help them to transition by finding new GPs, would you be able to provide the committee with some figures as to the level of resourcing that you have been providing for those practices?

Ms S Corfield: It depends on the practice at the time. I would budget at least $100,000 in the first year for every practice we take on. We have to have accumulated that amount of money to be able to invest in that next practice. In Kingaroy we're down about $300,000. There's nervous giggling in the hearing room. We've taken on the management of Hughenden as a temporary measure. That was a very well run practice. We've had to put in some IT infrastructure and will invest in some staff development and training there, but that's probably about $50,000.

So it depends on the practice, where it is and whether or not we recruit with HHS. If we're recruiting on our own, there are agency fees and recruitment costs. If we recruit with HHS, they cover some of those costs.

CHAIR: What size are these practices?

Ms S Corfield: They're mostly two-doctor practices, so they're quite small and just marginally viable at the best of times.

CHAIR: So you're sometimes recruiting for both GPs or just one?

Ms S Corfield: It is mostly both GPs.

CHAIR: Basically, they're in a situation where both GPs are going or gone.

Ms S Corfield: We don't get [inaudible] unless they're a rescue case.

CHAIR: And then you come in and need to put in at least $100,000 in order to recruit and before handover.

Ms Purcell: In Kingaroy the median age is higher. It's an older and disadvantaged demographic. The private practices in the area are not taking new patients. We're justifying Kingaroy by the number of patients we've been able to provide services for and the knowledge that they would have been exceedingly disadvantaged. We're now back on the recruitment trail there, so we are hoping to recruit.

CHAIR: Can you talk me through the Kingaroy example? There are other GP practices in Kingaroy, but they're operating with gap fees? Is that what's going on?

Ms S Corfield: Yes. We were approached by a local GP who wanted to exit but was aware that his patients would have nowhere to go. At the time, we had two GPs lined up who were able to come in. COVID got in the middle of it. There was a difficult landlord. There were a lot of stories there. But we do our research about where we go into. When we were looking at Kingaroy, we saw there were four other practices there. All of them had closed books. There are smaller communities that also had closed books. There was one practice in a neighbouring community that offered full bulk-billing. The majority of GP practices do offer mixed billing but don't publicise it too much, so vulnerable patients are looked after, but Kingaroy has a bit of a transient worker population. We talked to the local hospital, and their ED was experiencing 35,000 category 4 and 5 presentations that were strong GP presentations, so thy were effectively operating a two-GP practice out of the ED in Kingaroy—

CHAIR: at a massive cost.

Ms S Corfield: Yes. In an ideal world, there's a partnership between the hospital and the practice. Kingaroy is having trouble recruiting for their own staffing needs and are building a new hospital. We're still having

conversations about joint recruitment. We have one of the doctors who wants to do some ED work, so some VMO work or some shift SMO work, and they're very open to that. I think that, longer term, we need to look at co-recruitment and make sure that the VMO model, GP with special interest and rural generalist SMOs who also work in a general practice—all of those models—are available and that, from a state perspective, there's more creativity and partnership with local general practices in how they recruit and work across both sectors.

CHAIR: Thank you everyone for your evidence today. I don't know whether people took any questions on notice, but if you have any further information and you want to get information to us, please do so by the close of business on 25 March.

Ms S Corfield: I'll just leave this document with you. It has some information on our organisation.

CHAIR: Is it the wish of the committee to accept and table that document? There being no objection, it is so ordered. We will be reporting to the Senate by 30 June.

Ms S Corfield: Apologies if we took too much of the floor.

CHAIR: No. It was really terrific evidence. Thank you.

BAKER, Mrs Anne, Mayor, Isaac Regional Council [by audio link]

BURNETT, Mr Matt, Mayor, Gladstone Regional Council [by audio link]

REPINE, Mr Jonathan Blake, Chief Executive Officer, Central Highlands Community Services

[12:25]

CHAIR: I now welcome the mayor of Isaac Regional Council, the mayor of Gladstone Regional Council, both of whom are appearing via teleconference, and Mr Repine from Central Highlands Community Services, who is here with us in person. Thank you all for appearing before the committee today. Do any of you have any comments to make on the capacity in which you appear today?

Mr Repine: I appear in multiple capacities, the major one being as chief executive officer of the Central Highlands Community Services. I'm also a non-executive director with the Central West Hospital and Health Service and a non-executive director with Yumba Bimbi Support Services and I am a member of the ageing central highlands initiative.

CHAIR: Plenty of things! I now invite each of you to make a brief opening statement, if you'd like to do so, and then we'll ask you some questions. Mayor Baker, do you want to make an opening statement?

Mrs A Baker: Thank you very much for the opportunity. First, I acknowledge the Baradha Baranha people, the traditional owners of the land on which I'm standing today and from which I'm joining you through the phone. I pay my respects to their elders past, present and emerging. 'Wadda mooli', in Baradha Baranha language. It's a real privilege always to be able to present to a Senate committee, so I thank you.

I will just start by giving a bit of background on the Isaac region. We're regarded as the resources capital of Queensland. Isaac produces over 72 per cent of Queensland's metallurgical coal and 22 per cent of Queensland's thermal coal. Our community is made up of an extremely unique population mix, which consists of over 20,000 permanent residents and over 12,000 permanent nonresidents—they are our fly-in, drive-in, bus-in component—making up a total full-time equivalent population of over 33,000.

The rich deposits of metallurgical and thermal coal in the Bowen basin have helped feed power and build communities for generations. We're home to 22 operating metallurgical coalmines, nine operating thermal coalmines and 15 that are either in construction—and that includes the Galilee basin—in care and maintenance or in the advanced stages of other approvals. Over 60 per cent of the Isaac region's workforce is directly employed between mining, construction and manufacturing. The economic contribution is over $11 billion in gross regional product. And there's much more than mining. While mining is very prominent, Isaac is home to much more than mining; we have significant agriculture, significant gas and an explosion of renewable sector projects.

With a region that covers over 58,000 square kilometres, which is 25 times the size of the ACT, primary health services in this part of the world are critical to sustainability for all of our 17 communities and the powerhouse industries that function out of them. Through an advocacy lens, I will just give a bit of background that supports the submission that we have lodged. For many years there have been, in our view, critical shortages in medical, nursing and allied health services to this region, and this has been the case for an extraordinarily prolonged period of time.

The critical shortages are just exhausting and present unacceptable risks to our communities. There's an absolute need for increased resilience in clinical services, through planning for hospitals and for allied health services, to satisfy the demand that's generated by both components of residential, whether it's permanent resident or non-permanent. We're all people, and it's all a residential base in the Isaac region.

I've led many, many delegations, over a decade—I've been in my job for quite some time now—and this subject has been a high priority for us for the whole period of my tenure. I've been in front of premiers, I've been in front of deputy premiers and I've been in front of ministers for health and resources, with relevant departments. We've been involved with countless submissions, on behalf of Isaac, of the risk that we see in our region of not-fit-for-purpose health facilities and services, to highlight the inequity—most notably, around the health in the region.

The shortcomings of regional health services and the increasing community outrage are a core part of our advocacy, which is the point I'm trying to make. Obviously health is not a local government core business, but community is certainly our core business. The social impacts are certainly our core business, so that's been the fundamental platform for that. The current model that we see that's used to allocate medical professionals to rural and remote communities is absolutely inadequate. It uses outdated data to distribute resources, causing a mounting barrier that makes it just too hard for people in regional Australia to access basic health care.

In our submission, I would like to put on the record the absolute frustration for the Senate inquiry. We participated in 2015, so we are now seven years down the track from where there were firm recommendations to that particular Senate inquiry in relation to fly-in fly-out, long-distance commuting and the not-fit-for-purpose health services in this region.

I'll just close with the fact that we're one of Australia's biggest coalmining heartlands. We've moving into an enormously changing landscape, with renewable energies, and we are on that bus to continue our sustainability. We just can't do it unless we see some significant and fundamental change, yet what we are seeing is less and less on-the-ground, place based health support for our communities. It's simply not good enough. I hope that this inquiry and this committee can actually influence some practical change on the ground in these regions.

CHAIR: Thanks very much, Mayor Baker. We hope so too. Mayor Burnett?

Mr Burnett: Thank you, senators. I come to you from Gladstone, in Central Queensland. I'd like to acknowledge our traditional owners as well—the Gurang, the Gooreng Gooreng, the Baiali and the Taribelang Bunda people. Gladstone, for those who don't know, is the industrial capital of the state, if not one of the industrial capitals of the country, exporting many products through our amazing deepwater port—the most expandable in the Southern Hemisphere, by the way.

Today, I want to talk to you about the access to allied health professionals and GPs. In our region it's a real issue; it's really affecting the liveability of our 63,000 residents. We have other agencies that share our concerns. It's not just Gladstone Regional Council; it's not just the community members; it's other agencies as well. In 2019, the Central Queensland, Wide Bay, Sunshine Coast Primary Health Network conducted a health needs assessment of Gladstone. Findings highlighted several health concerns for the region, including low numbers of aged-care places for those over 65, high rates of death due to dementia and Alzheimer's, high age standardised rates per 100 of circulatory disease, high age standardised rates of death due to diabetes and an increased number of deaths by suicide. That's just some of those reports. As I continue on, the same needs assessment also identified gaps in antenatal health, child health, aged care, bulk-billing, chronic disease management services—along with general practice, dentistry and palliative care workforce gaps.

Central Queensland Rural Health has been commissioned to develop a health services plan for Gladstone. The draft plan has identified the following issues: mixed employment models are not available in Gladstone; there's a lack of student placements and graduate opportunities available; GPs are fatigued and burnt out, and I'm sure I heard that just before; at risk groups require access to affordable health services. The report goes on to identify immediate actions over the medium term of one to five years and a goal for each issue.

A survey has recently been conducted in the Gladstone region—between October 2021 and January 2021—by Health Workforce Queensland to gain an understanding of the community perception of health services. The results speak for themselves. Most participants are not happy with GP services in the region. Poor accessibility; cost, in particular the lack of bulk-billed services; long wait times; insufficient number and transient GPs were cited as the main reasons. Participants also struggle with booking a GP appointment, many reporting experiencing lengthy wait times even in times of acute illness. Accessing bulk-billing services was a prominent issue raised during the survey and it's something that I hear ever day as the mayor. The complete lack of bulk-billing services, limiting capacity of practices, and long wait times were all identified as factors increasing the difficulty of access. Many respondents reported that GPs has closed their books to new patients altogether.

Continuity of care is another major issue, particularly in relation to the lack of GPs and high turnover of GPs. There were many participants' comments that suggested there's a problem with individual service providers, including GPs, allied health, mental health specialists and the hospital. There are a limited number of specialists who visit the Gladstone Hospital. The cost of private specialists and the lack of private specialists contributed to these low scores. Respondents also shared specific concerns around psychology, speech pathology, social work, occupational therapy as allied health services with the biggest gaps. When surveyed on the Gladstone Hospital and whether it meets the needs of the community, specialist services, mental health services and children's surgical services scored the lowest, meaning that respondents believed these to be the services least meeting the community's need. There is the issue that services at the Gladstone Hospital are not meeting community needs. But that's not just at the hospital; that's in the health service in general.

The top five health workforces identified that need improvement were: specialist and surgeons, GPs, mental health practitioners, women's health and children's health practitioners, and allied health professionals. More than half the respondents, who included health professionals, believe there is a serious problem with medical services in the Gladstone region.

I'm advised that the Australian Medical Association has publicly stated we should have one GP per 1,000 people. I'd ask the senators to correct me if I'm wrong, but I'm advised that here in the Gladstone region we have about half of those numbers, which is just not good enough. Even if it's just above half or just below half we really need to increase the number of GPs. People are waiting weeks to get in and see their local GP. I'm really concerned that regional Queenslanders are missing out on vital medical services and that's particularly the case here in the Gladstone region. We currently have no bulk-billing surgeries in the city that I'm aware of, and that's certainly the case from the last time I spoke to GPs, which was only yesterday. We only have mixed billing surgeries, so that means you might be bulk-billed or you might not be bulk-billed. There are some examples of individual doctors across the region who do bulk-bill, but there are lengthy wait times to get in to see them—sometimes weeks.

To finish up, there's also a group of mums that connect with each other to seek support and information on how to access allied health professionals. They are advising me that some wait times in Gladstone can be up to one year. Senators, I hand back to you, but something needs to be done to address this issue. I'm so glad that a Senate inquiry is happening and you're hearing our concerns. Thank you.

CHAIR: Thanks very much, Mayor Burnett, for your opening statement. Mr Repine.

Mr Repine: Central Highlands Community Services have a number of interests within the community. We run a high-needs disability accommodation facility. A number of our clients have high-needs disabilities and are also NDIS participants. We are also the lead organisation in the Central Highlands social enterprise hub project. We formed an industry group called the Central Highlands Social Enterprise Alliance, bringing together a number of social enterprises in the region to look at solving other problems around health care—for example, giving our patients and communities access to health care by running a community transport project. Another is around access to healthy food and things like that. What we look at is: livability within the environment and region that we live in. We believe it's not just going to be throwing more GPs at the problem. Of course, that's one solution, but there are other solutions that we need to look at within the community, around livability factors, so we don't have GP turnover. When GPs who come here get to the point where they want to start or raise families, is there enough to keep them here?

Also, solving this issue would increase our clients' and participants' access to specialists, because if they can't get in to see a GP they can't be referred on to see specialists, so a child can't see a paediatrician. And specialists are very often outside of our region. Those extended wait periods to see the GP also slow down patients in seeing specialists. You're waiting several weeks or months, or even a year or longer—if you can get in at all. It's incredibly important, I believe. I've been talking with Dr Ewen McPhee, one of the healthcare providers in our area, and he mentioned that there's a 3,500-to-one patient-to-GP ratio, and sometimes a wait of up to 12 weeks just to see him. So it's incredibly important that we look at this issue and solve it. But again, we need to look at the community as a whole and see how we actually provide those livability factors, because it's not just financial incentives that are going to get GPs here.

CHAIR: Thank you all for your opening statements talking about the deficiencies in primary health care that you are experiencing in your regions and how it's impacting on your communities. For our two mayors: what have your councils done? We've heard of other councils that, because of the importance of having health services, have themselves been contributing financially. Have either of your councils taken that on?

Mr Burnett: I can jump in there, Annie, if that's alright. I've got two of my councillors representing us on that rural health forum that I was talking about before. There are a lot of conversations happening about how councils can get involved. We're certainly happy to take whatever responsibility we can to help address the issue, which is fundamentally a federal issue, and supported, obviously, with help from the states. Local council obviously isn't geared up or financially capable of managing most of it, but we certainly will do what we can. We can make buildings available. We can make staff available. And we can make, as I said, my councillors available to help provide feedback. Don't get me wrong: we do provide some health services, in terms of immunisation and things like that. But it's really getting the numbers of GPs up, to meet the community need, and, hopefully, those allied health professionals to match. That's where we are, from our council's point of view. We're part of the conversation and we're happy to be part of the solution.

CHAIR: Yes, and don't get me wrong, in terms of suggesting that it actually is something that local government should be doing; as a former councillor and mayor, I know how absolutely resource-strapped local governments are. Mayor Baker?

Mrs A Baker: We have actually donated bricks and mortar for a medical centre in Nebo. We've been part of a collaboration. I think initially it was funding from the federal government that started the actual construction of that. Then we bought into a partnership type of model. We now maintain that building. For a period of time we

were managing and still do bring medical services in. Just from memory, they come once a fortnight now from Sarina, one or two days a week. The actual modelling of that is similar to what Sandra was alluding to earlier. It's not sustainable. There's a bricks-and-mortar facility that council provides, and we help as much as we can in terms of management and advocating to get professionals in there. That's what we've done there.

We've also been very active in supporting the Clermont4Doctors concept. They've worked very hard and that's built from the ground up with the community in Clermont, not necessarily with bricks and mortar or funding cash components but more of a lobbying and advocacy role. I feel as though we've moved along with that. That's also directly with [inaudible] health and construction that they're trying to deliver. Our involvement, aside from the medical centre in Nebo, is always walking beside and trying to elevate the issue to support the inequity. We're in it; however, it's not really our role but we've got no choice. We've got a social conscience and a social obligation to the professionals, the allied health people, health in general, the residents and the businesses.

CHAIR: Thank you. Mayor Baker, you talked about how the health needs of fly-in, fly-out workers aren't being properly accounted for. Could you just expand on what you understand the current system to be in terms of assessment of need and how that's not accounting for FIFOs; and have you got any suggestions as to how it should change so that it is?

Mrs A Baker: It's more around the actual methodology of funding. Whenever there's an application put forward for funding, the general methodology used is based on permanent residents. When we've got such a high proportion of non-permanent residential people, there's no funding capability to support that extra 13,000 to 15,000 people a night. That's the key point. The nonresident people who come into regions who get sick or need services actually get them as much as everybody else whatever's on shift at the time. However, the reality of life is, as the local authority or the health sector, we're not funded for those 15,000 people. If we were to lodge a grant application to support Clermont4Doctors doctors it would be based on permanent residential places, and there's no methodology that is inclusive of the non-permanent residents. That was picked up in the 2015 Senate inquiry, and nothing's been changed to date.

Senator CHISHOLM: Thanks to the mayors and Mr Repine for being here today. I'll start with Mayor Baker: I just wanted to say what a fantastic submission your council has put in, and we can always expect that from your organisation. I was interested in the population issue that Senator Rice touched on. I think, across a wide range of issues, it is something that is often forgotten and not taken into account when governments are determining policy matters. I just want to get a sense of the impact that has on the community. Does it actually mean that sometimes local residents are the ones who miss out because there is that influx of people coming from outside the town for work?

Mrs A Baker: Absolutely. That is practically what happens on the ground. Generally, with our baseline community, it's a struggle to get an appointment with the doctor because of the supply of doctors. When you put the extra layer on top of your nonresident component, it triples that. There is an absolute direct impact because wherever we are—people, humans—in the country when you get sick you need to have the same services regardless of what your work practice is. To answer the question, Anthony, it is a direct impact.

Senator CHISHOLM: Mayor Burnett, I have a sense of the challenge in Gladstone, but I know your council represents areas outside of Gladstone. I want to get a sense of what it's like for those communities outside of Gladstone. Is there a doctor shortage, a GP shortage, in those places as well? Are those communities feeling the impact?

Mr Burnett: It goes right across Gladstone. The Gladstone region is just over 10,000 square kilometres. It includes Agnes Water; 1770; the Boyne Valley, which is Many Peaks, Builyan and Ubobo; and then up north to Mount Larcom and Ambrose. Obviously, the bigger population centres are Boyne, Tannum and Calliope, and there's certainly the same issue there. It's right across the region. As a councillor I represent all Central Queensland councils on the Local Government Association of Queensland, and we have a ROC, a regional organisation of councils. I hear the same thing from my fellow mayors. Nev Ferrier in Banana Shire says they've got issues in Moura. I know you're in the Central Highlands today. Kerry Hayes will tell you that there are similar issues in the Central Highlands, in Emerald and at Blackwater. Tony Williams tells me of the same issues in Gracemere. I'm glad you're having this Senate inquiry in Central Queensland, because, while I know that this is affecting the whole country, I'd be surprised if there's any place in the country that's affected more than we are. The issue is not just constrained to smaller communities; it's right across all of Central Queensland. So we just need to address it.

Senator CHISHOLM: Mr Repine, you wear a few hats. I thought it would be interesting if you could give us a sense of the type of effort that the community in an area like this has to put in to attract doctors and to keep them in town. How much of a focus is that for the local community?

Mr Repine: I think it's a massive focus, but I couldn't necessarily quantify to what extent. I know it's definitely a hot topic. Everybody tries to welcome in doctors as much as we can, work with the medical providers and things and try to accommodate as much as we can.

If I could just go back to your previous question to Mayor Burnett for a second, I'll give you a bit of lived experience. I lived out in Jundah, in the Barcoo Shire Council. It's a very remote area of 63,000 square kilometres with only 260 or so people. We were serviced by the RFDS for GP and medical services on a fortnightly basis. Living that remotely, I actually found that I was never necessarily disadvantaged from a medical side. I knew that once a fortnight the RFDS was going to be there. The RFDS doctor was going to be there, and I'd be able to see them if I needed to on the day. If anything happened in between their visits we were serviced by a primary health clinic that was staffed by a nurse. We could go in at nearly any time, they could get the RFDS up on telehealth almost immediately and we could be seen straight away.

Having relocated back to Emerald approximately two years ago, there have been times when I or a family member have been sick, and we didn't even bother ringing the GP, because we weren't going to get in. That kind of gives you an idea. Even though there are more of those livability factors here—there's a larger community here; there are more services here—getting to those services is more difficult. I found it quite interesting that the more remote I was, the easier it was to receive services.

Out there, I don't think it's a concern. Everybody's quite happy with it. We run the outback medical services there too, to provide GP services to our communities where we can. It is very much a community focus around keeping those services going. Here in Emerald I see the same thing in the Central Highlands as well. The community really supports this. Again, they try to make GPs welcome and work with the providers as much as possible in order to bring these people into the communities, to the extent of, if they have a partner or something like that, trying to find employment opportunities for the partner, making the children welcome in school and things like that. It's bringing them into the community, helping them feel part of the community in the hope of retaining them in the community.

Senator CHISHOLM: Mayor Burnett, what do you think needs to change? What can governments do to assist local communities like the one you represent to fix the healthcare crisis that they're facing in Gladstone?

Mr Burnett: I'm hoping that you get them here, from this Senate inquiry. From our point of view, we just need access to more support for our GP surgeries to attract GPs. Now, we did have the DPA. It was taken away from Gladstone and it was given back again. That was gone for a couple of years, and that set us back probably six years because we weren't able to have access to that. Those sorts of things—that's just the stroke of a pen—can completely change how GPs are attracted to local communities. And, obviously, it proved to be a bad decision because it's since been overturned, and I know that a similar thing has happened in Gracemere. But it's support to get those GPs here.

I see what is happening with universities, and that's a good step in the right direction. If you can train doctors and train nurses and train allied health professionals in the region, and if you get them from across the region in the first place, they're more likely to want to work there, and retire there, I guess, and go back and spend their time in general practice. That's the one of the things we're hearing from GPs is people are not wanting to go into general practice anymore. They see people getting burnt out and they see that you can spend another year or two at university and you can specialise in something else—rather than be a general practitioner, expect to work around the clock, and potentially have no back-up or no support, because there aren't enough people going into it. I don't think we're too late. We certainly have left it a long time, in terms of supporting universities in getting those future graduates trained. What I see now with the Central Queensland University and JCU is all good stuff, but that's going to take years to get results. But you've got to start somewhere, and I'm glad that that's happening now. Those are small examples.

I don't know if I've got enough time here, but I can say categorically that, at 5 o'clock in the afternoon when the GP is closed in Gladstone, people are making decisions about whether they go to the hospital—and potentially clog up the hospital with GP-type services, and potentially wait hours—or just don't seek medical advice. That's the reality in my community right now. Something needs to be addressed. It can be state and federal governments fighting over who is responsible for the hospital and who is responsible for the GPs, but the lack of GPs forces issues at the general hospital. That's a fact. I was on the Gladstone Health Community Council for years, and we saw an immediate change with the opening of the GP superclinic with after-hours GP services. But it's sort of gone back again, as the population has grown—and we want our population to grow, absolutely. We've got more industries coming to Gladstone right now—we've got hydrogen projects, we've got alumina refinery projects. These are projects that are going to attract thousands of people to our community, and if we don't have the health

services now, I don't know how we're going to manage it in the next five or 10 years if we don't address it sooner rather than later.

Mrs A Baker: Could I just add a last bit of information from Isaac. It's in relation to the Clermont4Doctors. In partnership with industry and federal government, they've actually got an offer currently on the table of half a million dollars on top of wages to attract doctors to the Clermont community, and they're still struggling, with that attraction. So, for mine, not everything is all about the funding as well. I'm pretty sure that the group of people prior to us coming on alluded to this: maybe the solution, or the vision, needs to be—and I'm certainly in no way anywhere near a professional in terms of health—the framework around compliant funding and planning and opportunities for the professionals to grow. So when Matt's talking about the training framework, training and offering the professionals, certainly, the financial incentive but opportunities to go outside of what their core focus may be, so they can then professionally grow. And, in my experience and what I've observed over the 36 years living in Central Queensland and watching old frameworks and old models, they certainly worked in that respect. I'm not suggesting for a minute that we go backwards. It's all about going forward. But, if we're looking through a solution lens, we need a little bit of old stuff blended with the new and the innovations to deliver a model that will sustain us going forward.

Mr Repine: Going back again to where Mayor Burnett mentioned CQU's program, I think that's a great initiative. It's definitely a step in the right direction, but I do question the effectiveness of that. It's going to be another decade, of course—and that's with any program—before we see some results. By their own media, they had about a thousand applicants for 40 places—20 in Bundaberg and 20 in Rockhampton. Out of those thousand, their own report said 170 were rural, regional and Indigenous. That's still 83 per cent that weren't. The media that came out earlier this year said that, for the 20 spots in Rockhampton, they promoted three that were from the Rockhampton region. That's still 15 per cent. Like I said, I haven't seen the breakdown of where the other 85 per cent were from. We're never going to solve the problem if only 17 per cent of applicants, and 15 per cent of the applicants actually getting in, are from the regions. We need to look at how we change the dynamics of that and get higher numbers of applicants in those programs that are focused on rural, regional and remote areas in order to keep them here. I don't know if that's even going to replace the number of retirements that we're looking at in the next decade or so.

Senator CHISHOLM: I have one final question to Mayor Baker. It was interesting what you said there about how the incentives can't be all financial in terms of attracting doctors to these regions. I think that was an interesting point you made. We want people to see going to base themselves in Clermont not as the end but as the beginning of an opportunity and to see that other opportunities will flow from this. What can governments do to help provide the training or the pathways so that having a stint in somewhere like Clermont is actually a stepping stone? Or they may want to be there long term, but they will have at least provided the community with a service whilst they're there, and it won't be as hard to attract someone to replace them if and when they do want to move on.

Mrs A Baker: Absolutely, and it doesn't have to be in Isaac. With the recent announcement for the training facility for rural practice in—from memory—the Central Highlands, there would a line of thinking around the satellites into that hub, for example, for training and professional development. It's the triple bottom line. It's livability, professionalism, professional growth. Of course there's got to be a financial component, but, if you go down and you talk in another lane about lifestyle and work-life balance—they can't be working 24 hours a day and then be diagnosing and prescribing appropriately. It's too risky. There is definitely a fundamental problem. We need to move to a solution. I feel like now, after all these years, the baseline facts and the need are well known. We should be close, in my view, to delivering a positive model to support regional and rural Australia. If we're not, we're in trouble.

Senator HUGHES: We were at hearings last week, I think, when we heard from a clinic based 10 minutes out of Melbourne that they wanted to have the same DPA status as rural centres when trying to attract doctors. Do you think that that's appropriate? If we were to see high-volume metropolitan areas receive the same ability to recruit as rural and regional areas, would that further impact on rural and regional communities? Anyone can take that.

Mr Repine: We're competing with those areas as well; if they're receiving the same incentives then where would you want to live? Obviously I want to live here, but those GPs are going to the metros. I saw that when I lived in Rockhampton. The GPs would go to Gracemere, which is five kilometres away, to do their remote service and they were getting the same incentives. It just doesn't pass the commonsense test and it doesn't pass the fairness test—

CHAIR: Can I clarify about the clinic in question? It was basically a community health service serving lower socioeconomic people in—

Senator HUGHES: Ten minutes from Melbourne—

CHAIR: where they—

Senator HUGHES: Senator Rice, I—

CHAIR: I just wanted to give some context—

Senator HUGHES: Senator Rice, we're talking about geography here. I made the point—

CHAIR: Those people aren't able to access other health services in the region—

Senator HUGHES: Senator Rice! I made the point last week in the hearing that people who actually live in rural and regional areas find it offensive that people who are 10 minutes from Melbourne want the same classification. I am asking mayors and people in rural and regional areas of need whether or not a clinic, regardless of the type of clinic, 10 minutes from Melbourne being given the same status would make it harder to recruit doctors in areas where they do not exist or are very limited.

Mr Repine: I believe it would; that's my opinion. I'll leave it to the mayors—

Senator HUGHES: Thank you. Do any of the mayors have a thought on that? Would you like to be competing with Footscray in Melbourne at the same time as Gladstone in Queensland?

Mrs A Baker: Absolutely not. It would definitely not be good.

Mr Burnett: I agree with that.

Senator HUGHES: Thank you for clarifying that point; we're in wholehearted agreement.

Mr Burnett: Any incentives that can bring GPs and allied health professionals to regional and rural Queensland would be welcome. If we're competing against Melbourne and Sydney then that's just going to make it near impossible.

Senator HUGHES: Thank you very much.

Mr Repine: I have a son who has autism and I have to go six hours for his treatment.

Senator HUGHES: We should talk. I'm just finishing up chairing the autism inquiry—

Mr Repine: Yes—

Senator HUGHES: We table next week. Thank you everyone.

CHAIR: There being no further questions, thank you all for your evidence today. We will report to the Senate by 30 June. I don't think you took any questions on notice, but if you have any further information you would like to give to us then please get it to us by close of business 25 March. We'd appreciate that.

Mr Repine: Thank you.

Proceedings suspended from 13:07 to 14:15

CORFIELD, Ms Genevieve, Club Member, Zonta Club of Biloela [by audio link]

ELLIOTT, Mrs Debbie, Chair, Moura MPHS Community Advisory Group [by audio link]

FREDERICKS, Mrs Angela, Club Member, Zonta Club of Biloela [by audio link]

ROWE, Ms Nancy, Secretary, Moura MPHS Community Advisory Group [by audio link]

CHAIR: I now welcome representatives from the Moura MPHS Community Advisory Group and the Zonta Club of Biloela. Thank you for appearing before the committee today. Do you have any comments to make on the capacity in which you appear?

Mrs Fredericks: As well as being a Zonta club member I'm an accredited mental health social worker.

Ms G Corfield: Legally my surname is Corfield, but I'm sometimes referred to socially as Ms Dippel.

CHAIR: We've got you as 'Dippel' on the list here but I thought you said 'Corfield'. If you're happy, I'll call you Ms Corfield.

I'll now ask each organisation to make a brief opening statement, if you'd like to do so. After that we will all ask you some questions. Would the Moura MPHS Community Advisory Group like to start?

Ms Rowe: To start off in terms of our community, our highest priority here in the community is retaining at least two permanent local GPs. Additionally, access to allied health, especially services, is also really important. How we're currently working to achieve this is that we're partnering with our regional hospital and health service. We also partner with federal and local government; with organisations like Health Consumers Queensland; and with industry, business and community. This ensures that the Moura community has a very strong voice in health services decision-making, planning and delivery for our area. We're looking at different funding models and ways to deliver services. Something that's really quite important to us is open communication and transparency. We've got a very active Facebook page with something like 2,600 followers, and we find that helps keep the community aware of services, how to access them, and any local issues. In particular, we've just had the recent situation with the doctor shortage here this week.

I particularly wanted to flag upfront, though, that we've got a couple of concerns with regard to some statements relevant to Moura in some submissions that have been submitted. It's really in regard to opportunities for health planning and management of health services. The statements are that there's no opportunity for health planning at the local level, that the disbandment of hospital boards has not been helpful, and that the hospital and health services are managed from a distance. I really want to flag right up front that that really does not reflect our on-ground experience.

In our submission we've listed a number of successful initiatives in Moura that we've been involved with or that the community's been involved with. We feel that there are learnings from there that we can take across, looking at accessing GP and allied health services especially. Some of those examples are the aged-care extension that we've recently secured, and that's something like $7½ million; a women's health clinic; the emergency landing site; the advocating for locum provision; and visiting dental services. A feature that I think would be very useful for us to take forward here, with the GP situation in particular, is the fact that all of these initiatives would be underpinned by local planning and very much by a whole-community approach. We really strongly believe in working with and trusting our government partners. The other thing is that the innovative and incentive funding from industry has been quite important.

In our submission we've got some specific suggestions in terms of facts, particularly with GPs—I think that's one we've all looked at. We suggested some sort of regional relief process for doctors across our region; sharing of resources between neighbouring centres; and looking at different funding models. So there are quite a few examples here in our area. The other thing, too, is looking at private practice and how they might find some of that locum time. That's a quick overview of the sorts of things in our submission.

CHAIR: Thanks very much, Ms Rowe. The Zonta Club of Biloela.

Mrs Fredericks: Thank you. In our submission we've been looking at the need for access to timely and affordable health care, and we've looked at the current systems where this is causing gaps in this happening.

Of the main things we would like to draw the committee's attention to, the first is the lack of practitioners, and that's both GPs and allied health on the ground. This is therefore resulting in long waiting periods, closed books or a complete absence of services altogether, which results in people either forgoing services, and therefore not accessing timely treatment or assessment, or spending substantial time and money travelling and accessing treatment, which often is not sustainable.

The second key issue is GPs being the gatekeepers for referrals to specialists and allied health providers. They are also often the only valid source allowed to complete forms for things such as Centrelink, NDIS or WorkCover. This creates a bottleneck and a barrier to timely and effective treatment, especially when there aren't those practitioners to get to.

The third thing we'd like to raise is the limitations within Medicare services—notably, the disparity between rebates and the cost of services for people in private or the number of people getting through to doctors; the telehealth incentives for rural outreach, which have currently been taken away throughout COVID, meaning that we've actually lost services travelling out here; and provider eligibility, which involves opening it up so that more people can actually be eligible for Medicare. In our submission we have supplied some more specific examples of the real-world impact of these issues and some possible solutions. We're happy to talk further to any of this and answer any questions.

CHAIR: Thanks very much, and thanks to both of you and both organisations for presenting to us. Clearly, you're both community organisations where you're doing an awful lot and are really, I think, good models for other communities to be emulating. Starting with Moura: clearly, you're really impressive with the level of coordination that you're doing, with your Facebook page and keeping people informed, and in bringing resources in, but you're still finding problems—I read in your submission—in actually recruiting and maintaining GPs. Do you want to talk a bit more about that and what that problem looks like?

Mrs Elliott: In terms of keeping our GPs: of the GPs who have recently left, one had been here for 12 years and another one had been here for 4½ years. That retention is, we believe, quite acceptable. Those doctors had had changes in their family circumstances; that needs to be something we can accept. We believe that if there were a pool of doctors who could fill the positions left vacant in the interim it would give recruitment a better chance. Currently CQHHS are in a recruitment process for the positions here; I believe they're moving along quite well. But if we had a situation where there was more readily available relief, that could take a lot of the pressure off that.

CHAIR: We've had quite a lot of evidence that clinics have been using locums and haven't been able to recruit, and the overwhelming cost of employing locums has been really prohibitive and has meant that many practices find it really difficult to survive—even with subsidies from various places to cover the cost of the locums. Would you see that as being an issue, with greater use of locums?

Mrs Elliott: I think that's something you need to plan for. With the situation here, in some instances the locums that come in simply work out of the hospital, not out of the surgery—they don't do the right-to-private-practice thing. I think that, from private practice, we may need a little more monetary support—not huge amounts, just two- and three-day things with locums where they look at taking on some of that expense. The expense in itself is large, but, the thing is, it also addresses a large problem. In terms of people feeling safe and well cared for in our community, having a locum here is a great help. I believe that we've got very good support with industry. If we were in a situation where there was a need for some help, it is probably likely that it would be forthcoming.

Ms Rowe: I'll just add to that. We have worked on lots of these other initiatives. We have worked on working with industry and business groups. In the past we have offered to provide incentives to the hospital and health service, if that would help with attracting short-term locums. That's something to explore. The community here is not opposed to doing something like putting in a monetary contribution. We're hoping the locum situation will be a very short-term thing until they can get through this recruitment process. It's just unfortunate in the circumstances, with COVID and all that; everyone is experiencing that right around the country. We think there are different ways to look at that funding. Like I say, the community is not backward in thinking about making those sorts of contributions.

Mrs Elliott: The other thing that has happened, to support the surgery in this instance, is Dr Vijay, who has just left, has come on in at the surgery and done some telehealth to cover scripts and any callbacks and things like that. That great relationship that we have with doctors when they're here is valuable in a situation like this. He was very generous in stepping up to help out with that.

CHAIR: That's really great. Have you found that telehealth has been important in overcoming the shortage of practitioners that you're facing? Has that been a strategy you've been using as well?

Mrs Elliott: We'd probably prefer not to do that because it's very nice to see someone on the ground, but this week, when we've been without a doctor, the nurses have been seeing patients and doing a telehealth link-up if necessary. In a real emergency we have used that successfully. We've used it with specialists, too, and it saves people travelling, which is wonderful. It definitely has its merits, but in an emergency that needs someone hands-on it's a fairly big ask of the nursing staff to take on that responsibility with the support of telehealth.

CHAIR: Have you had problems recruiting nursing staff as well?

Mrs Elliott: I don't think so. I believe the hospital is well staffed.

CHAIR: What do you think are the main barriers to recruiting practitioners to your community.

Ms Rowe: We meet a lot with management of CQHHS. We have discussions with them and get feedback about that. Oftentimes, one of the biggest areas is the whole accreditation process and the time that it takes to do that type of thing. Currently, feedback is that there are doctors who are looking at the position but because they're international it's going to take a period of months to get through the processes that they need to move through. We're obviously not involved with that side of things, but that's the feedback. I don't know whether that can be streamlined a little bit. That tends to be an issue.

I looked recently at Clermont, where there was a big investment into centres by the federal government to attract doctors to more remote places. A lot of effort was made by the community up there, supported by their big industry, to produce videos and that type of thing, which they could use with potential applicants.

Mrs Elliott: That's probably something—to have it so that, when you see a job offer and look at what's in Moura, what comes out is current and reliable information. Sometimes that can be an issue. Things are a bit stale in that section.

Ms Rowe: There are always ways you can update that, and that's the role community can play in putting forward that sort of process. We work with the GROW Rural program, where they bring around young student doctors and allied health people. We put a lot of effort into welcoming them into the community, and they have three-year programs where they return each year. We're putting investment in way before we're recruiting, and hopefully down the track that sort of process will help. But I think it's really important that the community gets up and helps with that promotion in welcoming people to the community.

CHAIR: To make sure your community is presenting its best face to the world.

Ms Rowe: Also, even with the applicants overseas, we were looking at doing some sort of Zoom with them as well, to introduce them to some of the people in the community beforehand. That type of thing, I think, could work.

CHAIR: Ms Fredericks, I was really interested in your comment about GPs being gatekeepers to other services and how, when people can't get appointments to GPs, they're blocked from other services. Do you have particular views of solutions to that and how it could change? Obviously getting more GPs would help that massively, but, in the absence of that, are there any other suggestions you have as to what could change?

Mrs Fredericks: What I'm personally finding, as an allied health professional, is that for mental health care plans, for instance, I have to have a referral from a GP, and at the end of six sessions they have to go back to the GP to get re-referred to me. I personally see this as a huge waste of time, honestly, for both me and the GPs, because I basically write the referral for the GP to send back to me. This is where, with our Medicare system, we need to acknowledge who has the expertise in the area to do the streamlining. If I keep with mental health, if it was a mental health nurse set up in a GP clinic who could purely just do that or if it is me personally, there is a Medicare item number that is around doing the mental health care plan, which is what GPs are charging it to. I feel like there are ways to take the load off GPs. At the same time, it's also continuity of care for the patients themselves.

Senator CHISHOLM: I had to duck out momentarily during the opening statements, so I apologise if I cover some ground that may have been covered already. I know both communities reasonably well, and I think that for someone like the Zonta club to be so concerned about this that they take time to make a submission and appear before us today really goes to the heart of why this is such a big problem in so many regional and remote communities. Could you give me a sense, from a Biloela point of view, of the impact the lack of GP services has in Biloela and on the families in the area?

Mrs Fredericks: In Biloela itself we're quite fortunate when it comes to GPs. We have quite a number of GPs. However, it is more the allied health and specialists we're struggling with here. We've got Ace Medical Centre, who have recently opened up as a bulk-billing practice. I see the difference here compared to Moura or Theodore, where people in this community can access bulk-billing services. That has had a huge impact on the low socioeconomic groups, who often leave medical conditions and medical issues, and then it becomes much more serious and then they come into the hospital system. I feel like that is something Biloela has actually done very well. It is more the allied health and specialist services we struggle with.

Senator CHISHOLM: What about, not so much in the health space but just in general, attracting people to come and live in Biloela or maybe attracting a local business to operate? Do you think that the lack of access to

some of the services is a barrier in general to a community like Biloela getting ahead and attracting a bit more economic diversity?

Ms G Corfield: It is 100 per cent a barrier. I've spoken to many people who either have moved or are leaving because of lack of access to some of these things or are thinking about moving and haven't. A lot of the time mineworkers come into our community and either they have families or they're having a family and so the lack of access to things like that is one of the factors that can lead them to transfer away. A lot of those people are really professional people who work to increase our services. We had a pathologist for a while and a psychiatrist for a while, but the lack of access to everything else meant that they left.

Senator CHANDLER: There's a bit of a flow-on effect, which means that if your health services aren't up to scratch then that impacts other elements of the community as well.

Mrs Fredericks: Absolutely, and even in terms of our schooling system people with children who require speech pathology or assessment often end up leaving the community, which is the flow-on effect. The lack of students in schools, the lack of teachers, the lack of services all flow on.

Senator CHANDLER: How has the Zonta club been raising these concerns? Are they something that you've discussed internally or are you a bit more forward facing on these concerns? How does it work within the organisation?

Ms G Corfield: It's something that we primarily have been discussing internally. But the difference would be that, if we found that there was something that we could to—like this, which we are doing—we do tend to do that, but it's just finding those opportunities for that advocacy.

Mrs Fredericks: That advocacy is also included. We have reached out to community programs in Gladstone and other areas to look at how we can use sponsorship to bring in things like training that can upskill people locally or to bring in services and then sponsor people to participate. We have been looking at some of those avenues also.

Senator CHANDLER: In relation to Moura, could you give me a sense of what the challenges are in your community?

Mrs Elliott: Currently, it's the recruitment of GPs to fill the vacant positions and the availability of locums to fill those positions in the interim. Otherwise, I think there is a fairly consistent recipe that is used here for people to access other services, and that's probably going to Rockhampton mostly. People are aware of the travel subsidy, which they make use of; I think it's an accepted thing. We also have the emergency landing site at the hospital and so, when there is a great need to move someone on quickly, that happens. We've recently been successful in getting the funding for aged care to be put on to the MPHS here, so that's now going to have 10 beds, which will meet a big need in the community.

Ms Rowe: To add to that, in Biloela we look to see how we can have different ways to get some of those services into the community. Like Deb was saying, people probably are prepared to travel to Rockhampton and places like that. With the heart bus that comes around now, we're looking at getting specialists on to that. We're particularly looking at paediatricians and maybe even neurologists, some of those sorts of specialists travelling with those mobile units. So the actual mobile units, I think are taking on a lot more importance. We are even looking at, say, specialists that might come to Biloela that we could try to get, if they have another night and they come across to Moura. We are looking at that type of thing and that sort of scheduling.

Mrs Elliott: Particularly things in the area of speech pathology and OTs. A trip to Rocky becomes an issue if you've got a child that needs those services and you have to take them out of school for the whole day. That's another thing our group are working on at the moment, trying to get some visiting OTs and speech pathology people coming in. Even in Rocky there's a backlog, and I think Biloela would be the same. We have a visiting dentist service that comes once a month. Them coming here once a month relieves some of the pressure on Biloela's public dentist.

Senator CHISHOLM: In regard to Moura, what other local organisations do you work with to advocate in this space or to try to solve some of these problems?

Mrs Elliott: The community advisory group was formed when the hospital was being built, when we went from our hospital closing and a new hospital being built, and there are representatives on our group. Basically, we try to work fairly directly with Central Queensland Hospital and Health Service, and we have very strong relationships with that group. We also work with Health Consumers Queensland. In terms of the women's health clinic, True Relationships and Reproductive Health deliver that, and that's through CheckUP. I did a lot with CheckUP to source help to have True come out here. The mines actually gave us $6,000 as an incentive, and in that way we were able to say to True, 'Well, you're going to make $6,000 and you'll be able to establish your

patients on top of that.' So that was a really good thing. We work with local government. The local councillor is part of our group. Also, the hospital auxiliary act as our fundraising group. The other thing is that, through the Facebook page, we keep the whole community involved by putting up a post when things are happening. People are able to comment or ask questions and we take the time to get back to them just to keep them updated so people aren't in the dark, going, 'Oh, I've heard that this is happening.' This is what we're doing to try to rectify it. I think it's very important to the community that they have that very transparent process where what the community advisory group knows they know.

Senator CHISHOLM: Yes.

Ms Rowe: To that I would just add that other state government services have to monitor that site as well. That keeps some of the service providers updated as well. But, as Deb said, the critical thing with it is keeping all of our community updated. Absolutely everyone in the community can get access to that information, or they know people that have got access to it. We work with a very broad group, so the engagement is really quite extensive.

Mrs Elliott: I'm going to have to pick up my grandsons from school and drop them home to their pa. If we're still on the line then, I'll be back, but Nancy is very competent to answer any questions.

Senator CHISHOLM: No worries. Best of luck and safe travels doing that. I was actually going to finish there, but I'll just finish with a comment. I think it's interesting in the sense that, for these communities, it isn't just the responsibility of the health professionals. I think we got a sense from Biloela and Moura of how much this is a community concern, impacting more than just health, and how they all pitch in to try and do what they can.

CHAIR: I also want to reflect on that and on the level of work that you're all putting in to maintain and improve the health of your community. Presumably all of the work that your community advisory group does and the work of the Zonta club in Biloela—you're all doing it on a volunteer basis?

Ms Rowe: Correct; it's all volunteer.

Mrs Fredericks: Yes. Zonta is volunteer, and Genevieve and I also work in the sector, so there is some crossover—many hats [inaudible].

CHAIR: You're doing a lot of work that, clearly, in other models, would need to be paid for. Ms Rowe, you talked about how you initially felt that there was a good level of cooperation between the different agencies and the different levels of government, but how much of that collaboration work is also people doing stuff on a volunteer basis, with the hours that are put into doing that not being paid for?

Ms Rowe: I didn't quite get your question. In terms of the advisory group? Are you talking about other people, other organisations, that we work with? I need to clarify the question.

CHAIR: You said that you felt that there was a good level of collaboration between the state and federal government, the hospital and the other agencies.

Ms Rowe: Yes.

CHAIR: In terms of the collaboration that's going on—and you might not know, in terms of the people that are doing that collaboration and taking time to meet together and talk together, whether it's in planning or in implementation—how much of that work is actually being paid for and how much is people and organisations doing it in their spare time, on top of all of the other things that they're doing?

Ms Rowe: Well, if we talk about the work that we do in the community advisory group, the sorts of groups we work with would mostly be service providers and organisations, so I guess that would be paid for—like all of the industry groups. Some of the businesspeople that come along and attend some of the meetings might be voluntary, but certainly the advisory group members are all volunteers. There's not a big number of us, but we're very passionate about what we're doing. I guess what's driving all of this, with the community advisory group, is the hospital here going to [inaudible]. We formed a reference group back then, and Deb actually chaired that reference group. For three months, we met weekly with government providers to negotiate an outcome to retain our hospital. There was big involvement from community through that. We had vigils and all sorts of things happening in the community itself, and there were up to 800 people at a meeting. There was a really big investment by the community there, and the community advisory group grew out of that. We've been very passionate about what we do, but, at the same time, the fact that the need has been so high, particularly with the hospital—it was such a huge thing to maintain in the community. We were only able to get two inpatient beds. Aged care was one thing we couldn't provide. So, in the last few years we've put a massive effort into that, and we've worked in what's probably just a small group. I've worked with the director of nursing here in Moura, another community person and a local government person to do all the applications, firstly, through the federal

process and then during the last few years with the state. So it takes a lot of time. I've actually worked in government before and I've just retired, so I probably have time on my hands! I do a fair bit of that sort of work.

CHAIR: Thank you for that work. I think it's really informative to know the level of work that does get put in on a voluntary basis by the community that is helping keep our health system afloat, particularly in rural areas.

Ms Rowe: It's a huge investment.

CHAIR: I have one final question for you, Ms Rowe, on the current recruitment process for GPs where you're struggling. Have the Rural Workforce Agencies been involved? What use have they been, if they have been useful?

Ms Rowe: I could not tell you. I know that in the past Deb has liaised with a number of those agencies about locum situations and things like that. They've been very helpful. But I couldn't tell you what's happened—I don't have access to that information.

CHAIR: No worries. That's fine. Mrs Fredericks, I have one question. You talked in your opening statement about the limitations of Medicare services. Do you want to expand on that?

Mrs Fredericks: There are a few things within that. The rise of Medicare rebates for practitioners compared to the cost of living hasn't been reviewed for quite some time—the cost to rent premises, particularly out in rural areas, the cost to actually travel to outreach clinics and those sorts of things. It ultimately leads practices to having to jam in more patients to cover costs, which then leads to burnout and actually losing practitioners. That's a big thing.

Another thing we've recently become aware of in our area is that the incentives for specialists to go to rural areas have been taken away in Medicare. What that equates to on the ground is people participating in telehealth for paediatrician appointments, which used to be bulk-billed and for which the specialist used to come to town on demand but it's no longer affordable for them to come here. That is a service that people are then going to have to start travelling to and paying for.

The final bit is around provider eligibility. In the case of mental health, I know the requirements for people, particularly in professions like social work or counselling, are such that counsellors are eligible for Medicare but, for social workers, the hoops that have to be jumped through to get that accreditation actually prevent them from getting it. This then means a lack of affordable services. Particularly with the current mental health crisis, there are a lot of highly trained individuals who could be filling these gaps; however, people aren't able to pay $100 to $200 for 10-plus sessions. So I think there are a few things that could be looked at there.

CHAIR: Yes. Thank you very much to all of you for your evidence to us today. If there is any further information you want to provide to us—I don't think you've taken any questions on notice—please get it to us by Friday 25 March. We are planning to report to the Senate by 30 June. Thank you.

BLOEMER, Mr Arjan, Chief Executive Officer, Central Highlands Development Corporation

DOWLING, Mr Peter, Manager, Business and Investment Attraction, Central Highlands Development Corporation

MOLHOEK, Dr David, Acting Director of Medical Services, Central Highlands, Central Queensland Hospital and Health Service

[14:59]

CHAIR: Welcome. Do you have any comments to make on the capacity in which you appear?

Dr Molhoek: I'm also the acting director of medical services for Emerald Hospital.

CHAIR: Thanks very much. Would each of your organisations like to make a brief opening statement? We'll then ask you some questions.

Mr Bloemer: I'm happy to make an opening statement. The Central Highlands Development Corporation is the lead economic development organisation for the Central Highlands. Where health comes into play in our organisation is in attracting workforce—for example, where we have organisations attracting talent and retaining talent, particularly attracting talent. We see it as a challenge for our health services. We have a very young demographic here—33 years old, on average—and there are a lot of families who are looking for health services, education and things like that. They base their decision to move to the Central Highlands, or not, on those elements as well. That's where we see a big challenge.

Is there anything to add from CHDC, Peter?

Mr Dowling: In the context of our workforce, we have a non-resident workforce that has impact on service provision across the region. We would have, I think, about 4,232 non-resident workers in our region—

CHAIR: Exactly?

Mr Dowling: Exactly. And that's gone up slightly from the high 3,000s. The indication is that that status quo will continue, in that sort of realm. Importantly, that means that the provision of services, both health and otherwise, is highly impacted. These workforces are in and out of our region, both drive-in drive-out and fly-in fly-out. Obviously we're quite a pragmatic region, and we need a workforce to service our industry and our business—and that's inclusive of our hospitals, our health providers and our allied health providers in the community. So it's an important one to note.

I think the other side to the equation, for any region, is the project development that's taking place. In the Central Highlands, we have more ongoing resource projects, so some new mines that are going through the prefeasibility stage and will bring a workforce in the construction phase of about 1,400 workers, with one particular project, and an operational phase that will bring about 1,200 workers, with that same project. That's one project, let alone other projects where there are existing operations and where they're expanding those operations or giving them an extended lifetime, which could be decades.

Again, that shows that the implication of workforce in our region is not just static. You might say that we have nearly 29,000 people—residents—but you've got to add on to that the non-residents, plus the impact of projects when they do come.

CHAIR: Thanks, Mr Dowling. Dr Molhoek?

Dr Molhoek: Thank you for the opportunity to address this inquiry into primary care within rural and remote Australia. It's an area that I'm very passionate about, so I'm glad to have the opportunity to speak here. I'd like to start by acknowledging the First Nations people of the land on which we meet—the Gayiri people—and elders past, present and emerging.

As I said, I attend here as the acting director of medical services to Emerald Hospital. My catchment includes Emerald; the Gemfields clinic, out to the west; Blackwater Hospital, to the east; Woorabinda, which is a community to the south-east, relatively; and Springsure hospital as well. I come here on behalf of the Central Queensland Hospital and Health Service, which includes Rockhampton and Gladstone and goes as far south as Theodore and those communities I've mentioned. Our population is about 220,000, so we have a reasonable chunk of the Queensland population, and we have a number of areas that are exclusively modified Monash 2 to 7, so we very much fit within the realms of this inquiry.

We have challenges. We see that within CQ there are 15 per cent more preventable presentations compared with other hospital health services, and, among the seven per cent First Nations people in our population, 16 per cent have those potentially preventable presentations. So, it's a real challenge.

I'd like to briefly address three issues: access, service, and impacts on the workforce. Access remains a real challenge within CQ. In regional communities like Rockhampton and Gladstone, patients can go through to GP clinics and sometimes utilise our EDs as a result of not being able to get through, or using them as an adjunct. We are very challenged within CQ with a limited access to bulk-billing clinics, as I'm sure you've heard throughout the day. There are none in Emerald, except in certain specific cases. There are significant wait times—two to six weeks. I think Ewen said this morning that it was up to three months for him, which is very challenging.

We operate multipurpose health services within the district. These are small facilities that, as you will have heard, have a medical officer who works as a medical superintendent with the right of private practice. They work between the hospital and the primary care setting. In instances where there's been market failure, and this has been the case in the Central Highlands—in Capella and in the Gemfields—we operate a primary care service from our multipurpose health centre. That's where we have a doctor who sits there three days a week in the Gemfields. That is a salaried, paid employee who sees patients as you would do in a normal primary care clinic. For the calendar year July 2020 to June 2021 we had 2,195 presentations at the Gemfields. In Capella, where there's a doctor one day per week, there were 641 presentations per year, and there's a nurse practitioner who has a [inaudible] practice; she sees 1,022 per year—so, trying to fill those gaps in the workforce.

Regarding service impacts: again, limited primary care does result in increased ED presentations across CQHHS. For the calendar year of 2021, the No. 2 diagnosis code for all the EDs within the 4-to-5 triage category was Z00, which is general examination and investigation of persons without a complaint or reported diagnosis. I'll elaborate briefly on what that means. This was 4,961 presentations for the calendar year, but the diagnosis code when people put the diagnosis through on the ED system includes diagnoses like scheduled follow-up examination, administration of medication, surgical dressings, blood collection—those diagnosis codes that would very much fall within the remit of primary care. This was our top diagnosis code for a lot of our rural hospitals—Baralaba, Biloela, Emerald, Blackwater, Mount Morgan, Woorabinda and Springsure. In Biloela, for example, last year, when they had approximately 7,000 presentations per year, up to 30 per cent of these presentations were within that diagnosis code: scheduled follow-up exam, 458; administration of medication, 260, or four per cent; dressings, 200, or three per cent; blood collection, 195; UTI, 105; and ankle sprain, 98. So, where patients can't come through to a GP, they will use the ED, and this is what we see in Emerald and across CQ.

Finally, to briefly touch on workforce, the rural generalist workforce model is what we use in Emerald Hospital in the Central Highlands. This consists of 27.35 FTE, of which 24.25 is occupied. Banana, which includes Moura, Biloela and Theodore, has 13 FTE, of which nine is occupied. These jobs are a combination of SMO positions and medical superintendent with right of private practice positions. At Emerald Hospital we have an SMO model. This aligns with other level 3 birthing facilities. These are facilities that have a scope of practice to provide birthing in rural communities. We employ rural generalist SMOs with an anaesthetic advanced skill, obstetric advanced skill, internal medicine, emergency et cetera. We employ staff as provisional fellows. This means they have done their core terms as a GP registrar. They can be as early as PGY4, and they are employed as a senior medical officer while they're completing their GP registrar training. This is common practice across Queensland Health. This is a very significant attraction measure for staff, when compared to the National Terms and Conditions for the Employment of Registrars award, the NTCER; it makes working within a public hospital role very attractive. Again, this is a common practice.

There has been a trend within Queensland Health by different facilities to employ people in a fractional capacity in rural areas; that's where they are offered a 0.5 to 0.75 FTE position. Staff are encouraged to consider that as a way to help supplement people working in a private primary-care capacity. This varies, depending on the community and as you progress through, but there is a requirement through ACRRM's curriculum to have six months within a community practice, so it allows them to fulfil that requirement as well as have exposure in that capacity.

In CQ we struggle with COVID, and, again, in accessing locums. I've been hearing, from some of the talks today, that locum access has been a huge challenge, and that's been an issue for us in the public sector as well. We rely on a lot of locums for our regular workforce, and I think it goes without saying that workforce is our No. 1 challenge within rural hospitals, and especially for me in my role as the director of medical services; trying to get the staff to fill the roster is what will make me grey!

I hope that I've been able to briefly address the terms of the inquiry, and I look forward to further questions.

CHAIR: Thank you, Dr Molhoek. That was really comprehensive. There was lots of information in that opening statement. If you've got it and you can table it, that would be great.

Dr Molhoek: Yes. Thank you.

CHAIR: Terrific. I'll start off with the Central Highlands Development Corporation. You opened by saying how having adequate health care was really critical to attracting and retaining the workforce. Could you just give us a few more examples or expand on that a bit, as to how you understand people are coming or not coming here on the basis of their ability to access health services.

Mr Bloemer: Yes. I think that it's overall—it's in every part of the industry, whether it's in hospitality, tourism, manufacturing, agriculture or resources. Attracting workforce is the No. 1 concern for businesses. When we talk to businesses about what's stopping them from growing and expanding, it's always the workforce. What we hear back is that, when they go out to market and try to attract people, they have to have a really compelling case to attract people who have a really good lifestyle on the coastal areas, to move to Emerald, and, when they come—particularly the families—they look at: 'How's the health situation? How are the health services provided? How's education? How are the sporting facilities? Is there a cinema? How are the restaurants?' et cetera. But, particularly for the young families, education and health care are essential. A lot of this is anecdotal, from conversations with those businesses—and we have about 3,400 businesses in the Central Highlands. When they have challenges and when people say, 'No, we're not coming,' health is always mentioned, and, 'There's the risk I can't get through.' And a lot of people do actually do their research. They try to find out: 'How are the schools? Are there private schools? Are there public schools? How do the public schools score?' They do the same with health: 'How long does it take to get an appointment?' When you hear anecdotally that it might take weeks to get in to your GP and you have young kids, then I can totally understand that you'd make the decision to not come to the Central Highlands and find a job elsewhere where you don't have those challenges.

Mr Dowling: To add to Arjan's point: as to getting a national context on vacancies in Australia, we do a lot of work with institutes like the Regional Australia Institute. They put out the marketplace survey work that indicates that there are over 70,000 vacancies in what they call regional Australia, which is everything outside the capital cities, essentially. So the challenge is this. We have a platform called CQ Job Link. We would average in excess of 200 jobs every month, for our region as well as our adjoining region, the Isaac regional shire. It just tells us that there are quite a lot of vacancies out in regional Australia in the broader context. We're getting less than zero per cent of those that are migrating away from large centres into rural or regional centres. We're getting a very, very, very miniscule percentage of that so that migration's not working for us in the domestic sense. Obviously, with the implications of COVID, the international market is not open to us other than some very specific access to Pacific workers for our horticultural sector, which is excellent. But, from a health perspective, that's a challenge for Dr Molhoek. We find it a challenge. The incentivisation of getting people to the region in the first place is an underlying theme behind all of our workforce.

Mr Bloemer: I want to add that even though the other conditions are excellent—incomes are rather high in the central highlands; the pay is really good—you can't put a dollar figure on your own health or the health of your family. That's where the challenge is.

CHAIR: What's your understanding of how the 4,232 nonresident workers are or aren't accounted for in the provision of health services?

Mr Dowling: That's something you'd have to dig deeper into. I don't have that data available. Some organisations will house their workforce in camp-style accommodation near the operations, if it's the resource sector. They're not all resource sector workers, by the way; they're right across our industry. But if they are resource based, some are in camp accommodation and may still access the local medical services. Other organisations will have, and at different times have trialled having, their own medical services provider at the camp or the accommodation village. It just depends on which model works. The challenge with those models is that sometimes a company can think that they're doing the right thing in providing the medical service, but then the local medical provider will get upset because they're losing the opportunity to have that service. Yet they can't service it. It's that business tension side of the equation.

There have been multiple opportunities to trial ways of doing it. Many years ago in Blackwater the mines had a coalition where they actually supported a second doctor within the state system. Then, after a period of about five years, from memory, they felt that that burden was too great and that the state was just relying on that happening and not looking at any incentivisation for raising the standard of service in that community. That's a challenge too: how much reliance do you put on industry versus state? Where are the partnership arrangements to make that service happen?

Senator HUGHES: We're aware of this as well because we're the federal government, not the states.

Mr Dowling: Absolutely.

Senator CHISHOLM: Then there's filling the short-term gap versus solving the long-term problem as well. There might be an immediate need that you can help with, but you don't want that to distract from the ability to solve this problem in the longer term.

Mr Dowling: Yes, depending on your model. If it's the current model, which seems to be a hub-and-spoke model, you're then putting more strain on the issue of accessibility, both within a region and beyond the region. If there are critical cases that go elsewhere, how do they get there? By the Royal Flying Doctor Service and, in our region, the RACQ Capricorn rescue service. Those organisations are continually seeking funding to be able to provide those services, so there are implications in that supply chain of service provision.

Mr Bloemer: And, like you mentioned, there's this large cohort of fly-in fly-out workers. The manager of McDonalds is a fly-in fly-out worker. My dentist is a fly-in fly-out worker. They're everywhere. They just live on the—

Senator CHISHOLM: It's not just the miners.

Mr Bloemer: No. Everyone has people who are fly-in fly-out. Mechanics—everyone.

Senator CHISHOLM: But with your dentist, you're seeing the same one. It's the same person flying in and out, isn't it? We've heard a lot about continuity of care.

Mr Bloemer: Not necessarily. My dentist has been here a year and a half, and I see him every six months—I'm a loyal visitor—but there are also dentists who fill the gaps. If one of the locals goes on holiday, they fly them in from the Sunshine Coast, I believe.

CHAIR: Dr Molhoek, there were a couple of statistics I didn't quite grab in your opening statement. One was about a 15 per cent increase in something.

Dr Molhoek: That is the 15 per cent higher rate of potentially preventable presentations to hospital.

CHAIR: What is that compared with?

Dr Molhoek: Compared to other hospital health services. It is Central Queensland compared to other districts.

CHAIR: Why is that the case? It's basically saying there is a higher health need here compared with elsewhere?

Dr Molhoek: Yes, correct. I don't think we can blame primary care as being the sole cause of that. It's multifactorial. There are obviously lifestyle factors. We know what impacts health.

CHAIR: And was it seven per cent First Nations communities in the region?

Dr Molhoek: The population of First Nations was seven per cent of CQ, and, of the increased presentation, 16 per cent were from First Nations, a factor that was almost double. They were overrepresented in that statistic.

CHAIR: We had some really good evidence from some Indigenous community representatives this morning about things that needed to change to improve healthcare and health outcomes for our First Nations communities. The next thing I want to go to is the limited access to bulk-billing clinics. In Emerald there aren't any bulk-billing clinics?

Dr Molhoek: Exclusively bulk-billing clinics, yes.

CHAIR: At our hearing last week, I asked the health department about what seemed to be limited access to bulk-billing clinics across a wide range of areas across Australia, and they said, 'Ninety per cent of all consultations are bulk-billed in Australia,' which just does not tally with the experience that people tell us. It certainly doesn't tally with my experience and that of my friends. Can you shine any light on that discrepancy?

Dr Molhoek: It is challenging. In my capacity, I won't profess to have a deep understanding in that space. I do believe that a number of the practices in our community bulk-bill concession card holders, for example, or bulk-bill children. I know that, when I worked as a private GP, I was a bit of a soft touch and would bulk-bill lots of people, because I was there because it was the community service thing to do. If there are multiple item numbers that are being bulk-billed, it maybe increases that rate, potentially, but again I won't profess to have an expertise in those numbers specifically.

CHAIR: It seemed to me that that needed a bit more unpacking, because the lack of access to bulk-billing is a huge equity issue. People are able to get health care and able to see a GP if they can afford to pay gap payment, but, if they can't, they are struggling.

Dr Molhoek: My personal bulk-billing rate was about 50 per cent, from memory, if that helps.

CHAIR: I want to go to the clinics that you operated at Gemfields and—I didn't catch the name of the other one.

Dr Molhoek: Capella.

CHAIR: How do they work financially?

Dr Molhoek: Great question. We employ an SMO from within our team of staff. That would be someone who is a salaried employee of Queensland Health. They are rostered to then go cover those clinics. They are paid their salary, based on hours worked, so there is no direct implication, no income, from the clinics. Those particular clinics are able to then bill Medicare for services. Those clinics are completely bulk-billing, so there is no charge to the patient in that capacity. They're accessible to residents of those communities exclusively, because we don't want to open a service in Gemfields and have people flocking across from Emerald. The need is in Gemfields. It's an isolated community. It's a very vulnerable community. We need to have a good service there. We have found that, by running that clinic, it has reduced our presentations to ED substantially, because there is a medical officer there to intervene, to prevent deterioration and to catch things early. So it has made a difference in our community having the services there.

CHAIR: Do the Medicare rebates that you get cover the cost of running that?

Dr Molhoek: No.

CHAIR: What's the shortfall?

Dr Molhoek: I'd have to get back to you on those numbers specifically.

CHAIR: One option that's been put to us has been having more clinics like that, but clearly they'd need to have more financial support from somewhere to enable them to run.

Dr Molhoek: Yes.

CHAIR: I want to go back to the massive 30 per cent of your hospital presentations being for things that should be seen by a GP or a primary health carer, which is extraordinary. We've previously received evidence—I think it was for this inquiry—about the overall cost to the government of people being seen in an emergency department compared with a GP. Can you walk us through what that extra cost overall to our health system is?

Dr Molhoek: Yes, of course. That number comes with the caveat that there will be some people who come through who maybe did have to come to a hospital, and that's appropriate, so that can't tease out the intricacies of those presentations. But that diagnosis is capturing things that are not particularly well funded and not of particularly high acuity. I feel that, for a rural ED, you arguably just have to do what you have to do, but in these contexts it could be managed in primary care.

With regard to the funding, I believe the cost of a category 5 presentation to a hospital is in the vicinity of $550 for a non-Medicare-eligible patient. I'd need to confirm that number definitively, but it's much more expensive when you factor in nursing staff, administration staff and medical officers. It doesn't stack up compared to what primary care can do. Having worked in both of those contexts, I can say that hospitals are much less efficient in managing those presentations in an ED context.

CHAIR: They're much less efficient, and the cost to the government overall is 10 times or more as much as if you were having a GP seeing that person, with the Medicare rebate being paid.

Dr Molhoek: Yes, completely.

CHAIR: So, even if we doubled the Medicare rebate, it would be incredibly cost-efficient compared with those people ending up at ED.

Dr Molhoek: Yes, completely.

CHAIR: This is my final question before I hand to my colleagues. You talked a bit about the registrar employment model that was operating here and how that is actually working quite well compared with other parts of the country. Can you just talk us through what the difference is and some of the characteristics of it that make it better?

Dr Molhoek: Yes, of course. As has been raised recurrently, I think having that single employer and having continuity of entitlements—including long-service leave, maternity leave, sick leave and conference leave—is attractive. I can speak specifically to what the offering is if that's helpful.

CHAIR: Yes.

Dr Molhoek: For a provisional fellow SMO, there is a base salary that has an attraction and retention bonus allocated to it, which is a loading of 45 per cent of salary. There's a 10 per cent rural incentive for Central Queensland on that one. There's a motor vehicle allowance of about $21,000. There is an inaccessibility allowance of about $21,000 for Emerald as well, and there is a professional development allowance of $20,500. The entitlements of that position include five weeks of annual leave, 3.6 weeks of professional development

leave, 10 days of sick leave—those are accrued—long-service leave accrual and parental leave—one week for a father and, I think, up to 14 weeks for a female staff member. That can be taken at half pay.

CHAIR: For these people that are getting these benefits, exactly what is their role?

Dr Molhoek: Recently we've employed some new staff—people who have done their internship, their JHO training and their advanced skill training. That was my journey from Rockhampton. I did my anaesthetic advanced skill. I then came out to Emerald Hospital as a provisional fellow and finished my registrar training here and at Emerald Medical Group over two years. I was employed as an SMO from the day that I set foot in Emerald Hospital, and that would be the case for many of the employees that we bring here as well. These include people who are our obstetric workforce, so they deliver babies. I was doing spinals, as my colleagues would be. We have people who have advanced emergency skills who staff the ED, people who have internal medicine ASTs who staff the ward and people who have mental health ASTs who support our mental health clinics. So working at a senior level, not as a registrar, is a step up. It is very attractive for people.

CHAIR: Are the SMOs who are staffing your clinics and providing those services on the same conditions?

Dr Molhoek: On that same package? Yes.

CHAIR: That would be very attractive, compared to trying to run a clinic as your own business in those communities if you were a GP.

Dr Molhoek: Arguably so, yes.

CHAIR: Thanks very much, Dr Molhoek. Senator Chisholm?

Senator CHISHOLM: I might start with you, Dr Molhoek. Some of your testimony was interesting, and he geographic reach that you have painted a bit of a story as well. What I was interested in, though, is that you gave us a current and a historical context. I wonder whether you have any future projections that say, 'Well, if this isn't fixed, it's going to get worse.' What will be the impact on your service.

Dr Molhoek: Yes, of course. Future workforce is an area that we are always thinking about and we ae trying to be proactive in that space. Looking forward, I look at communities like Blackwater, where we've struggled to attract permanent medical officers, and at how we can make that more attractive and more sustainable. I look at the model of employment that we offer there to ensure that that's going to work for people who are applying for those jobs. I think we have a good culture in Emerald. That has been attractive and we've used staff to then establish other facilities. I look west to other facilities and HHSs where there hasn't been a stable primary care service. Essentially, it has fallen over and then the health service has had to take over those primary care clinics and those primary care responsibilities and supplement that space. I think we're very lucky that, in some ways, we have a very strong primary care sector within Emerald. It has it's challenges, of course, but I think we have some GPs who are very committed to the community. As we move into the future, I worry about how we can continue to support that and continue to bring staff through to facilitate that. About seven of my staff are currently working in primary care as well as in their hospital appointments. We try very hard to ensure that we can keep supporting primary care where possible. They choose to do so in a private capacity, and that has worked very well so far. To be a well-rounded doctor I think you need to have experience in both of those spaces, so that works well. But, yes, I think the impact on primary care in the future is definitely a concern that worries me, particularly for some of the single-doctor towns where you have a med super with right of private practice. They've done it for 30 or 40 years. They've done it out of goodwill, and they'll be looking to retire soon.

Senator CHISHOLM: Are those seven staff you talk about spread geographically throughout the region that you're responsible for?

Dr Molhoek: I'm referring specifically only to Emerald Hospital. So, yes, those are staff who work in Emerald and they also cover primary care in a fractional capacity.

Senator CHISHOLM: So it's a constant battle for you to, with them, manage their time.

Dr Molhoek: Yes. Rostering is very challenging. Often there's on call with our positions. It's challenging to ensure that when they're working anaesthetic on call they're not being called in at 2 am for a caesar and then working in the clinic the next day. They don't like me very much when that happens!

Senator CHISHOLM: In terms of attracting new doctors, what levers have you got to pull? Are you constrained by your budget, and how does that work when they're doing private practice as well as working with your service?

Dr Molhoek: I'm very lucky that, in Emerald, I've been in this role now for nine months and I have 0.1 vacant FTE for the hospital. So we've been relatively successful here locally, and I think that's been due to a good culture. It's an interesting place to work. There's imaging. There's pathology on site. I think people have enjoyed

working in our team. What hasn't translated well is retention within primary care, and that's been a challenge. Sorry, what was your question?

Senator CHISHOLM: It was in terms of the levers that you have got to pull to encourage people to take up that slack.

Dr Molhoek: Reputation. Reputation has helped us immensely, as has, where I have facilities that struggle, using our positive reputation here to then have staff cover other facilities that have been a bit more challenged. That has been the model that has occurred in hospitals further south as well.

Senator CHISHOLM: In a way, it's not your direct responsibility as such. But if it's not fixed you feel the consequences of it, because they're going to turn up at your service. It's a bit of a chicken-and-egg scenario.

Dr Molhoek: Completely, yes. If primary care is stronger, the hospital does better. If primary care is struggling, we see it acutely.

Senator CHISHOLM: Is that the same for other services throughout the region as well?

Dr Molhoek: I would imagine so, yes.

Senator CHISHOLM: Thank you.

Senator HUGHES: I want to clarify a couple of points that have been made consistently. If you run a GP practice, who decides whether you bulk-bill or charge gap?

Dr Molhoek: It is at the discretion of the doctor.

Senator HUGHES: Does anyone in government tell you that you must charge gap?

Dr Molhoek: There would be a policy with each practice.

Senator HUGHES: So each doctor at each practice would determine whether or not they bulk-bill or charge gap?

Dr Molhoek: Correct.

Senator HUGHES: So bulk-billing not being available broadly in a town may purely be because of the decision of the doctor to charge more money?

Dr Molhoek: Essentially.

Senator HUGHES: Can I go to some of the stuff you were talking about, Mr Dowling, with regard to work you've done particularly with the state government. We're sitting here as representatives of the federal government. I know that generally people are either confused or over buck-passing, but hospital systems are run by state governments; we know that. And state governments take the lead when it comes to closing borders, which most people didn't know prior to the pandemic. All these things are at the discretion of a state government and are written into our Constitution. It's not for the federal government to come in and overarch. We're not a higher tier of government; we're a different tier but not a higher tier that can come over the top. What do you think are some federal levers available versus state levers available that have potentially not been enacted?

Mr Dowling: That's a very good question. There's an opportunity to investigate what those levers are or whether there's the ability to create new levers. You can look at taxation systems. You can look at other incentives that get people from an urban centre to a rural centre in Australia.

Senator HUGHES: So zonal taxation across the board?

Mr Dowling: It could be. There are previous policies that could be investigated and looked at; I know there's been a lot of work done over time. Bringing that forward, the federal government can certainly play a role in incentivising people to move to rural and remote communities in other ways. That's the challenge we face: there's an attraction within Emerald, which has got a wonderful reputation, but it can only do so much by itself. Then you have organisations like Queensland Health, who, as an organisation, are putting some very good incentives on the table to get people to the locality.

Senator HUGHES: Was that a 45 per cent loading, to come here on that salary?

Dr Molhoek: Yes.

Senator HUGHES: It's a pretty big loading!

Mr Dowling: Absolutely—so they're playing their part. We need to look at the federal government to play that part beyond that.

Senator HUGHES: We don't pay GPs, though; we have Medibank numbers.

Mr Dowling: No; I'm talking about liveability and bringing them to regions.

Senator HUGHES: But, again, the federal government isn't responsible for building amenities in a town; that would be a state or local council initiative. Federal governments don't come in and build cars or schools or—

Mr Dowling: It's not always about amenities. The taxation system and the zonal taxation initiatives—

Senator HUGHES: Outside of tax, what can we do?

Mr Dowling: I don't know; that's why I'm suggesting it requires investigation.

Senator HUGHES: We're trying to find out, but, at the moment, we're hearing about a lot of issues that are not within our purview. We're out here spending a lot of time talking to communities. We can do a great report in a couple of months time about all the issues that exist, but if it's not within our power to effect any of these changes, or it's not something that falls under the responsibility of the federal government, you, me and everybody else are wasting a whole lot of time. How do we put those levers together? What do they need to look like? Is it more medical schools in rural and regional areas? Is it making it easier for kids that grow up in rural and regional areas to access medical schools, whether it be through scholarships or easier access, because medical schools require very high academic achievement? Is it looking at provider number allocation? If there are only so many provider numbers available in Toorak or Brisbane but there are more provider numbers available here, how do we encourage allied health professionals—maybe you've got some thoughts, Dr Molhoek.

One of the things that I've been looking at is that some of the GP colleges and bodies are opposing pharmacists being able to re-dispense contraceptive pills. They're able to sell the morning-after pill, which is stronger, but they can't give out a contraceptive pill to someone who has been on the pill for many years and doesn't need to take up the time of a GP to get their script again. There was incredible pushback over pharmacists delivering the COVID vaccine, which, once we got it over the line for pharmacies to be able to do it, was incredibly successful and also relieved pressure on GPs. There seems to be a bit of professional jealousy and hoarding within the GP sector, not opening up to allied health and pharmacies but wanting to hold onto those Medicare numbers. We talk about reputation, culture and all those things. It's not stuff the government is going to fix, so what are the levers we should be looking at to boost this? I prefer to see a solution. I lived in Moree—the middle of nowhere. We had a base hospital.

Mr Dowling: One of the areas of importance for us would be that portability. We talk about a nation that is quite mobile, but the cost of moving from one location to another could be an area of consideration. Whether it's a federal-level consideration, I'm not sure. It's about thinking about how to get the person from point A to point B if they are interested in the job but the cost of moving is not within the purview of that organisation. How do we incentivise that opportunity? Some government levels do that; others don't. It's about looking outside the square, or the supply chain. What is that decision-making process for an individual or a family, and how do we support it? That crosses all levels of government, industry and business. It's about the getting together of those parties to better understand the process of decision-making to get an outcome, and then defining how we can all play our role in that process. I appreciate that the federal government has a level of responsibility, but I also say that some of that is about coming to the table with others to consider how we do it together.

Senator HUGHES: Dr Molhoek, how do we change that culture? How do we change that hoarding and not wanting to relinquish things? We talk about a team-based primary health approach. There are going to be things GPs are going to have to give up to have that team. There might be a Medicare number they can't charge for. How do we change that culture?

Dr Molhoek: It's a really challenging question. I wish I had the solutions for you. I'd be very rich, probably, if I could fix the challenges in rural health care. It's huge, and we need to collaboratively work to try to fix that. We try very hard in our community to engage with all of our GPs, allied health workers and pharmacy providers to ensure that we're providing a good service, but there are challenges.

Senator HUGHES: It's not going to be just one person's responsibility. It has been disappointing to hear, 'You need to fix it.' There's very little recognition or self-awareness when it comes to cultural challenges within the sector. We can pull every lever we like, but if those cultural changes don't come through it'll be all for nought.

CHAIR: I don't think any of you took questions on notice, but if there was any further information you would like to provide to us—

Mr Bloemer: If I can continue in the discussion, it's also important to know that you don't move just a health professional; they often have families. That is an additional challenge that we face. For example, if we want to bring a family, there is often a doctor with a partner who needs to find a job too. They can work from home, but connectivity is a big issue in our region. You can't work from everywhere. You need to be connected to the NBN, and that is an additional challenge. You might have the incentives for a doctor or healthcare professional, but the

partner, husband or wife says: 'I'm not coming because I can't work there. There's no job for me.' Not everyone wants to work in the mines.

CHAIR: Yes.

Mr Bloemer: That's an additional challenge. One of the other challenges that I see is that there is a lot of talk about regional Australia, but from my point of view there's 'regional' and there's 'regional'. When you talk about 'regional Australia', and you mean Wollongong, Geelong, the Sunshine Coast and the Gold Coast—

CHAIR: Bendigo compared with Emerald, yes.

Mr Bloemer: If you're in Emerald, that's not regional; that's just an outer suburb of Brisbane. I think that should be the difference, because you can promote working in a region but then you end up in the Sunshine Coast or in the Geelong hospital, and that is not the outcome that the rural areas are after.

CHAIR: Thank you. If you want to provide any further information to us, please get it to us by the close of business on 25 March. We'd appreciate any further stuff. Thank you for the evidence that you've presented to us today. It's been very useful.

Proceedings suspended from 15:45 to 16:00

BELLINGAN, Professor Michelle, Dean, School of Health, Medical and Applied Sciences, CQUniversity [by audio link]

CHEW, Dr Eleanor, Chair of Board, General Practice Training Queensland [by audio link]

CHRISTENSEN, Dr Mitchell, Senior Medical Officer, Emerald Hospital; and Graduate, James Cook University

FELTON-BUSCH, Associate Professor Catrina, Director, Murtupuni Centre for Rural and Remote Health, James Cook University [by audio link]

KNIGHT, Professor Sabina, Director, Central Queensland Centre for Rural and Remote Health, James Cook University

MAY, Ms Emma-Lee, Medical Student, James Cook University

MURRAY, Professor Richard, Deputy Vice Chancellor, Division of Tropical Health and Medicine, James Cook University

SADLER, Ms Kathie, Chief Executive Officer, General Practice Training Queensland [by audio link]

CHAIR: Welcome. Thank you for appearing before the committee today. Do you have any additional comments to make on the capacity in which you appear?

Prof. Knight: I have a remote RN nursing background.

Ms May: I'm a sixth-year JCU medical student.

Prof. Bellingan: I split my time between Rockhampton and Townsville.

CHAIR: Thank you. I am going to invite each organisation to make a brief opening statement—hopefully fairly brief! Professor Bellingan, I understand you would like to go first.

Prof. Bellingan: Maybe I can explain why I offered to go first. I didn't want to interrupt the flow of conversation with regard to the general practice training, because I was going to speak to the undergraduate piece. Having said that, I'm quite happy to go last as well—whichever you prefer.

CHAIR: No, go for it. You've started now!

Prof. Bellingan: I value this opportunity to provide some evidence at this hearing. The university offers numerous allied health degrees—nursing, midwifery and, more recently, a Bachelor of Medical Science, which we offer at both our Rockhampton and Bundaberg campuses. This pathway provides direct entry to the University of Queensland's MD qualification. The regional medical pathway—the partnership between the Central Queensland Hospital and Health Service, the Wide Bay Hospital and Health Service, the University of Queensland and ourselves—was developed to address ongoing medical workforce shortages in each region. I'll keep it brief, but that is my first point: I want to focus on the RMP. It's well known that CQ HHS and Wide Bay HHS have a very high reliance on locums and international medical graduates. The intent of the RMP is to deliver to these regions doctors who are, in essence, homegrown. We are very excited that our first intake commenced just last week. But, going forward, I want to say that support for Commonwealth-supported places for medical students studying at regional universities is an area that needs consideration, as does support funding for learning infrastructure and accommodation infrastructure at these sites. Our current experience shows that students and teaching staff are finding suitable accommodation difficult to source—particularly in our Bundaberg pathway, where the rental vacancy rate hovers around 0.4 per cent.

The next point, briefly, is to speak to clinical placements. At CQUniversity we offer up to 10,700 days of training experiences in the area you find yourself in today. These would be across nursing, midwifery and a host of other disciplines, including podiatry, speech and occupational therapy, sonography and paramedicine. A major obstacle for many of our students is the cost of that clinical placement, the bulk of that cost being accommodation. In Emerald, where you are today, for a student to stay in a single room in a caravan park costs $2,000 for a 20-day placement. That might not seem like a lot of money for some, but our university has a very high representation of lower SES students and also First Nations students. In fact, 95 of our First Nations students will be undertaking placements in this very area within the next couple of months, and they do find the placement costs prohibitive.

So I wanted to raise those two points, and I thank you for the opportunity.

CHAIR: Thanks very much, Professor Bellingan. Let's go to James Cook.

Prof. Murray: Thank you very much, Senator Rice. We have given evidence previously, at the first Canberra hearing, and I won't reprise that. We've provided a quite comprehensive written submission, which I really commend to you because there wouldn't be many that have quite distilled the set of complicated intersecting issues across programs in that level of detail. I think the opportunity today, for the group that we have here, is to look beyond the cold numbers and program design and titles and to get a sense of the lived experience. I'd therefore like to immediately fade to the background after I outline a couple of points, because I think that this is really the focus and maybe where some of the learning is.

As I introduce that, I think it's also really important—particularly when considering primary care and rural and remote health—to avoid discussion only of an average negative or difficulty. I think it's really useful to focus on those things that are working, where they are working, and seek to understand and expand upon success, rather than lay out a series of things and why they don't work, so I'd really invite that lens. I think trying to get a sense of the reason human beings make decisions and choose or not choose to do things that might be in the public interest is very important.

The three things I'll say that I think we would emphasise is that actually a lot of this is not going to get taken forward unless we can genuinely align the healthcare system to be one based upon comprehensive primary health care, and we are a long way away from that and indeed we're paying the price—not least the 45 per cent that the Commonwealth contributes to the cost of acute presentations in public hospitals. We're paying the price in terms of the health of people and the quality of care, and I think that that work is really critical. It's multiprofessional. It involves a reconsideration of financing systems, and we'd be happy to talk about that but I won't, obviously, at the moment.

The big thing then, of course, is workforce supply: no nurse-midwife, no pharmacist, no doctor, no allied health practitioner—no service. Workforce supply is absolutely critical. The big priority, particularly in the medical component, is to have sufficient numbers of domestic graduates who willingly pursue careers in rural areas, in regional areas, in general practice, in rural generalist medicine and also in regional consultant practice. That's a critical priority, and that's been our great strength at James Cook University—showing how deliberately aligning the pathways and the pipelines in a thoughtful way produces actual results. I really commend that to you.

The other thing that we can see as being really important is to look at the myriad of Commonwealth health workforce programs and some of the overlaps with state programs, which are often very siloed, very specific and not very outcome oriented and which are not aligned to a common objective. I think there is a wealth of good work that could go on into that area, and we've made plenty of suggestions about what some of the issues are there. Particularly in the context of the establishment of the Central Queensland Centre for Rural and Remote Health—we're very delighted about that, and we'll hear more from Sabina in a moment—I'd like to emphasise the idea of recruiting from an education and training facility that is in, with and for local communities. That is a critical strategy and is something we have considerable experience with—in all of the practicalities. I'm delighted to respond to the very pertinent questions from Senator Hughes: what can the Commonwealth do? I'm very happy to discuss that in more detail.

Prof. Knight: I too will be brief. I will speak on two things. The first is our Rural Health Multidisciplinary Training program, which is funded by the University Departments of Rural Health, in the Central Queensland Centre for Rural and Remote Health, and my colleague Catrina Felton-Busch will talk about the Murtupuni Centre for Rural and Remote Health. This very modest program has been very impactful in being able to influence the capacity of nursing, allied health, medical students and dental students to undertake placements in rural and remote areas, in that we are able to: secure and provide accommodation; provide some additional supervision; raise awareness in the community about health careers; and raise aspirations, with the students and graduates themselves mixing with their near peers in the communities. As Michelle referred to, many people who do go to James Cook University are first in family in any of the health careers. These are very important to us. We have just begun here, but we have 25 years of learning from north-west Queensland that we are eagerly applying here.

It is indeed true that the access to funds for infrastructure for student accommodation is critical. A very modest program rolled out this year will see a small increase across Australia for some University Departments of Rural Health to add to their stock in more remote settings. It is a very practical thing that can make quite a big difference.

I would now like to speak more broadly about professions other than medicine in primary care. We do not have a training program for small-rural-and-remote-area nurses in Australia that prepares them clinically to be able to work to the advanced standards that we require them to. Nor do we have the support systems in place. We know what works with training clinicians for these sorts of places. We've learnt a lot from medicine. We've learnt a lot

from rural generalist allied health and we, absolutely, need to be able to address this training. Wherever we have a population that has access to health care, whoever is working there needs to have the skillset and the supports to be able to provide the services. And the service that employs them needs to have access to the funds to keep the service going. The current funding mechanisms are inadequate and need to be reformed, but the training and support also needs to be reformed. This applies to Aboriginal and Torres Strait Islander health practitioners as well. It's a challenge, but we actually know how to go forward with that. I recommend that, and I'm happy to discuss that further if there is time this afternoon.

CHAIR: Thanks, Professor Knight.

Prof. Knight: My pleasure.

CHAIR: Ms May?

Ms May: I am currently in my final year of medicine at James Cook University. While I can't really speak to a lot of the issues that are being discussed, I thought I could add the perspective of a student who was brought up in a rural area and wants to return to a rural area in the future as a doctor.

Going back to the beginning, I was born in Alice Springs and raised there for most of my early childhood. My family then moved to Theodore in Queensland, which is about three hours inland of Rockhampton. I did high school at boarding school in Rockhampton. When I was in year 10, I did a work experience placement with Dr Bruce Chater in Theodore. I went into that not knowing if I really wanted to do medicine, but from the first day that I went home I knew that it was what I wanted to do. I'd say that was a big defining moment for me. From there I really dug in, worked hard throughout high school and got into medicine directly from there. I moved to Townsville for JCU.

The main reason that I chose JCU was, obviously, coming from a rural background, I know what it's like to live in a rural area. Having personal and professional experiences in the disparities that small towns have to face when it comes to health care really drove me to choose JCU. In fact, it was the only university I applied for. Obviously, going into medicine, we have a lot of opportunity to do rural placements, which is an absolute privilege. I've really enjoyed that about JCU because the rural placements that I've been on—I've spread myself between Longreach, Mossman, Mount Isa, Emerald and I'm going back to Mount Isa again after this—have given me the opportunity to experience a lot of different communities and to come to the same conclusion that, wherever you are, you feel like a part of the team, no matter what level of medical skill you're at.

I really like the sense of community that you get from working in a smaller hospital, and the patient groups that you meet in different places are always interesting as well. It's really nice to integrate yourself in the community. So, for that reason, after six years, I've definitely decided that I will be applying for the Rural Generalist Pathway in Queensland, and I'm about to submit that application. That's where I'm at.

I'm staying in James Cook University accommodation. Having our accommodation costs covered and funded is an incredible privilege that we get as medical students at JCU. It's a huge incentive, because if you did have to pay for your rural placement experience it might change the way that you view it.

CHAIR: Thanks, Ms May. Dr Christensen?

Dr Christensen: I might just speak off the cuff about my personal experience, as Emma-Lee did so well. I grew up in the Mackay region—a cane and grazing region—near Koumala. My grandfather, Jim Randell, was heavily involved in politics in the rural setting as well; he served as the MP for Mirani between 1980 and 1994. So I guess I grew up focussing on the importance of providing for rural populations. I did all my schooling in Mackay, ended up taking a gap year and travelling through Switzerland with Rotary, and then did the six years at JCU.

I might speak briefly about what I think some of the good things are about the JCU admission criteria. The interview process is very important because communication as a doctor is probably 70 to 80 per cent of the job. I think JCU does a very good job of choosing people from rural backgrounds, because although I love the work out here, it's very rewarding and I love the community, it is taxing. It's very hard, and you do make sacrifices out here. You don't know about those sacrifices unless you've come from a regional or rural area before. You may not know how to manage those quite so well. So that's probably one of the key points about admission to JCU. We see so many people come through Emerald that are from metropolitan areas and don't hang around. Even coming from a rural area myself, we still have worries about things like our daughters going through school: are they going to get a good education while they're out here compared to, say, at a grammar school in Brisbane or Ipswich?

My wife and I job share at Emerald Hospital. I'm a senior medical officer doing a subspecialty in anaesthetics; my wife is an SMO senior medical officer doing GP obstetrics. Like I said before, we've got three daughters. We

met in first year at JCU and we got married in our final semester of our university degrees. Our honeymoon was spent at Cooktown Hospital, working with Tash Coventry—

Senator HUGHES: The romance!

Dr Christensen: I think that was very similar to Emma-Lee's experience. The placements that JCU provided for us were incredible. Some of these people that you meet in the bush are just amazing. From there, I did my intern year at Logan Hospital. I did my advanced training in anaesthetics back at Mackay Hospital. We've been out at Emerald now for almost a decade. Like I said, we find it very rewarding albeit very fatiguing and hard work.

I thought it may be worth mentioning that I did start working as a GP at .75 when I was out here to begin with. That worked quite well in terms of family balance, but it became increasingly difficult in terms of income and also balancing what is an unrelenting job. It's just so hard to be a good GP. You've got community expectations, you're trying to supervise people, trying to keep your business afloat, trying to make money for yourself. When I was working .75 as a GP, although I was probably only seeing 15- or 20-minute patients at that point because I was quite junior, I was earning half the amount that I now earn working as an SMO at Emerald Hospital at .5, and I get things like long service leave, and I get sick leave, and I get rural retention payments, and I get my accommodation paid for me. The 44 per cent loading is a very big thing, but it keeps people out here.

Emerald Hospital is exceptional. Numerous times it has been named as a national leader in terms of its delivery of health care. I think what they do so well, and what Dave does so well, is incentivise being out here as a rural doctor. I don't think GP does that very well at the moment. To work in such a hard position that is unrelenting and doesn't pay quite as well, you have to be a very special person.

CHAIR: Thank you, Dr Christensen. Associate Professor Felton-Busch?

Prof. Felton-Busch: I'm currently the director of the Murtupuni Centre for Rural and Remote Health. In my lived experience I'm an Aboriginal woman from Mornington Island in the Gulf of Carpentaria, and it's kind of important to mention that because it's been my passion, working in the area I do in terms of Aboriginal and Torres Strait Islander health and the work we do at the Murtupuni Centre for Rural and Remote Health. My colleague Professor Knight has outlined the work of the UDRH and she referenced our centre, which has been going for 25 years. I've just recently become the director of the centre. One of my focus areas that I think will be really important is to try to address some of the long challenges we've had in trying to provide student placements and research and an evidence base so we could improve the workforce for the much-needed primary healthcare services in our remote communities.

The communities I'm talking about in particular are the communities on Mornington Island and in Normanton and Burketown—what we consider to be really remote communities. We've tried these things in the past. We do place students there, but we're limited in terms of student accommodation and we're sometimes limited in terms of supervision. The one thing we know about UDRH is that when we want to do student placements in whatever region, a great limiter is the availability of student accommodation. Once we build student accommodation—build it and they will come. We've attempted to do that on Mornington Island, for example. It has been a challenge because: (1) it's on an island, (2) it's an Aboriginal community that has native title issues, and (3) it's a community with ageing infrastructure. I mention these issues because they're the same kinds of issues other health services that deliver primary health care in those services struggle with. They struggle with having adequate accommodation for their clinicians and clinic space and things like that. I wanted to talk a little bit about that because that's a limiter on the work that we do. I didn't want to dwell too much on the issues.

I want to also talk about the times that we are able to go into the community. One concept we have is: 'service learning.' Our students will provide a service to the community. This is in the allied health space in particular. The thing about being able to have our students out in it is that the kids in those communities get to see health professionals and they can aspire to go to school and provide those services themselves back in the community. We have a mantra: you can't be what you can't see. So that's a really good way of raising the aspirations in that community.

I want to highlight the issues for the community because we need to think about what the models of community look like in those communities. While general practitioners are really important—and of course in parts of their services there are challenges on how we can get them into our communities and how we can support them getting to those communities that are relying on locum workforces and things like that are quite expensive. We need to meet the communities where they are and we need to have research and processes that think about: what are those priority needs in those communities and what is the shape of that primary healthcare workforce? What are the health professions that exist that may be developed to respond to those priority needs of those remote

communities? I've lived and raised my kids in rural and remote communities and it's one that really needs to be focused on. There needs to be effort put in to providing an evidence base that informs those models of care. I might stop there. I wanted to target the remote communities. Thank you.

CHAIR: Thanks very much, Associate Professor Felton-Busch. We'll now move to General Practice Training Queensland. Ms Sadler and Dr Chew, a brief opening statement if you wish.

Dr Chew: Thank you very much. Thank you for inviting us today. We're speaking from the lands of the Turrbal and Jagera people and we wish to pay our respects to the elders past, present and emerging. General Practice Training Queensland is one of nine RTOs, regional training organisations, delivering recruitment, placement, training, supervision and administrative services for GP registrars. There are two in Queensland. Our geographical footprint spans Brisbane north, Brisbane south, the Gold Coast, Darling Downs and West Moreton PHN districts. We support 433 training practices, including 104 rural practices and 27 Aboriginal medical services. We currently train 553 registrars, with 217 on the rural pathway, and we support 668 GP supervisors. GPTQ has always been oversubscribed for its training places, with 258 applicants for our 117 training positions this year. Our past rates are amongst the highest year on year.

Today we would like to raise our concern about the progress of transition of GP training from the RTOs to the two colleges, the RACGP and the ACRRM. We want to point out that the current RTO AGPT delivery system works. Our concern is that there appears to been no clear reason for this major structural reform, and without this there can be no clear way of determining its success in creating a better system. The transition process highlights to us that there is no clear understanding within either the department or the colleges about what RTOs have been doing for the past 20 years. We're also concerned that there is no avenue to transfer our insights, knowledge and experience to the new system. When RTOs have raised concerns about potential problems, we've been accused of obstructing the transition. Our involvement in the transition process has been restricted to a bureaucratic level in answering questions on forms. We have one RTO representative who has observer status on the transition committee, and that observer is not allowed to speak.

I would like to put on record that GPTQ has always been committed to ensuring that the transition progresses smoothly. Our key focus is for GP training to continue to produce quality general practitioners for our community. We believe in what we do and we want it to work. We are very fortunate to have with us today Kathie Sadler, who is the CEO of GPTQ but she's also the chair of the RTO network and is intimately aware of the issues relating to transition. Over to you, Kathie.

CHAIR: Please be brief, Ms Sadler.

Ms Sadler: I also want to make it clear that GPTQ is committed to an orderly and effective transition to college led training. We're committed to doing our best to hand over our centre of excellence to the colleges and other agencies. Over the last three days the network has met as a group and with each of the colleges. As a result, it has been very clear that there are a number of key factors that are going to be problematic with the transition by the end of this year. The first is IT integration, data transfer and integrity of that data. There are nine general practice training organisations, each with different IT platforms, some of which have languages that are no longer supported, and data. Another factor is staff: there is still no clear path for them to be employed by the colleges. A third factor is asset distribution: practices and supervisors are not yet being notified of what the options will be for them and the training regime next year. The final factor is registrars.

On registrars, I'd like to make the point that the national consistent payment system is supplemented by a flexible payment pool. However, there is no guidance or certainty as to how the flexible payment pool will be available to supplement the support of registrars in remote and difficult areas of need. It's not a question as to whether most practices will be better or worse off; the fact is that the vulnerable practices will be worse off, and they're the ones where we need to put our registrars. Centralised bureaucratic instruments will replace the highly localised, highly tailored approach that RTOs use to encourage registrars to work in challenging, rural, remote and outer metro areas. The RTOs work as matchmakers with practices to find the right individual for the community. This involves understanding what other incentives we can provide, such as knowledge about the amount of child care or other community services, or supplemented support for a person who needs to work remotely when they're in their training. This is built around our CRM system. We track potential applicants from the moment they attend one of our workshops, either at when they're at uni or when they are working within the hospital system, and work with them to make a decision about their career. We also take a systems approach to identifying registrars who may need extra support from supervisors and educators, which is provided as early as possible. Our data shows that selecting registrars only from the local community is not the sole answer. Our recruitment processes have led to 30 per cent of our rural registrars coming from urban areas.

We are well down the track of transition, but if we could turn back time we'd advise that the RTO system be retained. Instead of simply discarding them, adjust the KPIs to suit the desired policy outcomes and create consistency where needed. Creating more flexibility to deliver oversubscribed applicants to other areas would also have greatly improved things and provided more flexibility for the registrars, especially in forward areas. In our follow-up letter to the committee we will point out that we believe there's no standard approach to determining where community need for GPs lies. This is where we think the focus of reforms should be. The data from those heads-up tools only tells part of the story and not the complexity or idiosyncratic needs of the practices or communities. Only then can a pragmatic approach be developed to support practices in those areas while encouraging registrars to work there as well. Thank you.

CHAIR: Thanks very much, Ms Sadler. I'll ask one question to kick off and then hand over to my colleagues. On the things that we're doing well: if other medical schools were doing what James Cook is doing, and if we dealt with the issues like accommodation for student placements, do you think we would be able to provide enough GPs for rural and regional Australia, or are there other substantial changes that are also needed?

Prof. Murray: I'll have a quick crack at that. I would say absolutely. In a sense, it's not surprising that, if you select priority from a non-metropolitan background and they access their education and training outside of a major city, they have positive experiences in small rural towns and communities. Then there is an opportunity in a seamless way to transition to general practice training or rural generalist training without having to go back into a major city. There is absolutely evidence based international success, and we're the main example, the fully elaborated example, of that in Australia. Why wouldn't it work elsewhere is more what I would say. About 50 per cent of our graduates pursue general practice or rural generalist medicine as a career. That's a very different profile to the rest of the country. There are a variety of things, but I absolutely think that would work. It really is just applying those quite sensible evidence based elements to the pipeline.

I would also say though that part of the problem here is a failure to think through the whole thing as a system where human beings make choices and have alternatives. For instance, the mention of geographic provider numbers is always something that comes out but may add to, much like so called rural pathway training places in general practice, a sense that might turn people off the choice of general practice as a career when there are so many alternatives being offered in other branches of medicine, and often more readily available, perhaps with a different sort of status, opportunity and remuneration. In a sense, we have to acknowledge the functioning of the system as a whole in order to make this work.

On Kathie Sadler's point: I absolutely agree that, in a sense, the medical maxim 'first, do no harm' applies to the reform of general practice training. I am also alarmed. We're the only university involved in the general practice training arena directly, and with our colleagues in the south-east we cover 90 per cent of the geographic area of the state. We represent a model of joined up training. I think we could implement that a lot more effectively. It is very unusual to have 21 years of a program in operation without it ever having been reviewed for value or impact. I would think that it's very important that we take stock of this and other health workforce programs as a total package to find more clearly what the outcomes are that we wish to see and then undertake program design with that in mind, including how that might align to the Primary Health Care 10 Year Plan that's in development.

CHAIR: Thanks, Professor Murray. Professor Bellingan, did you want to add anything, from CQ uni's perspective, as to whether you think what you're now doing would, if emulated elsewhere in the country, enable us to be self-sufficient in rural and regional GPs?

Prof. Bellingan: Thank you for the opportunity. Certainly, James Cook has got a long track record of excellence in this area; what we are doing is slightly different, but it's for a tailored area. I think James Cook cover a very large area very well. We're focusing specifically on Rockhampton and Bundaberg, and we have the utmost faith that we are going to be successful with this approach.

I'd just like to reiterate the points I raised earlier. For the first three years, the Bachelor of Medical Science was us, but then there was the UQ MD component. I raised the point that, in terms of support for infrastructure and the Commonwealth-supported places—the redistribution of that pool—as Professor Murray said, if students are sourced locally and trained locally there's a much greater chance they'll stay there, but not if we have the bulk of our students training in metro. As I mentioned in the example about accommodation—it might have seemed I was harping on about it—it was very disappointing when we had rural students who lived in Bundaberg or surrounds who, because of the accommodation issue, chose to go to metro simply because they couldn't find a place to stay. I think that's most unfortunate because those young people could've been part of our future workforce. I absolutely think James Cook are the gold standard here, and we are doing something quite innovative for a select area, and I don't see why that can't work in other select areas.

CHAIR: Thank you. I'll hand the call to my colleague Senator Hughes.

Senator HUGHES: Thank you. I had some questions before: What do we think of? What do we do? What's state? What's federal? What's local? How do we actually get leavers that are going to do something, and what can the sector itself do to improve the culture to make it more attractive? Listening to what was being said, as to the attractiveness of the hospital situation, I thought: why don't we just get rid of private practice—just fund more GPs into hospitals some way or another and just get rid of private practice? And if you want to go into private practice, that's your choice, but we could look at solutions in rural areas—I'm not talking about everywhere—and having more GPs based out of a hospital who'd go under that system. Do it that way, because, if you're not having problems recruiting there but you can't keep them in private practice, and if we're going to start looking outside the box at different ways to do things, what's the point of private practice?

Prof. Knight: Perhaps I could comment just to begin. Not every rural community is the same; the populations in rural communities vary a lot. So if we take this—

Senator HUGHES: I know this—

Prof. Knight: in terms of the income, they will fluctuate a lot. Private practice has a role in a certain population threshold, but beyond that it doesn't. It never has and—

Senator HUGHES: But every single person who's come here, in front of us, at different locations, has been talking about private practice, lack of bulk billing, how it's so difficult—burnout, burnout, burnout. If we don't have population threshold to maintain it, then why have it?

Prof. Knight: Well generally we don't, and that's where you will see the state-led rural generalist model in Queensland Health and others. In the Territory and the Kimberley you'll see Aboriginal medical services that are funded to employ GPs. The challenge for being able to attract and retain GPs in those areas is the disparity in the way that they are funded and the salaries that they can offer.

Senator HUGHES: But that's coming from state governments.

Prof. Knight: No, that's coming from the federal government.

Senator HUGHES: They're getting Medicare rebates, but then—

Prof. Knight: No, the very remote areas are funded federally.

Senator HUGHES: Right; okay.

Prof. Knight: State is the default; you're right. However, we do have the impact of the ceiling on the Medicare rebates, which has a significant impact in small rural and remote areas and regional areas, where people may be asset rich and cash poor, depending on what's happening, like the impact of drought and other things. The costs of operating the practice are higher, and the economies of scale are different. So there are things the Commonwealth could do, but, as my colleague said, there is a whole system to examine. There are some practical things, and various previous reform reports have recommended several of those.

Senator HUGHES: So a medical practice is, in effect, a small business?

Prof. Knight: Yes.

Senator HUGHES: Other small businesses in rural and regional towns don't get this sort of support. I appreciate the different level around health care, but I don't think you're going to find much sympathy in a small rural town, where the highest earning salary person is the doctor and they're there saying, 'Give me some more money,' when you've got other struggling businesses in town who have the same scalable issues and who have the same staffing issues. They don't get a holiday either. If you've got a small family business you don't get a holiday. Some of these arguments, I've got to say, are falling very flat with me because any other business you run has exactly the same issues.

Prof. Knight: I couldn't agree more. But there—

Senator HUGHES: Can we move beyond the 'Woe is me' and towards what we can do to fix it?

Prof. Knight: I wasn't considering it as, 'Woe is me.' It's just that what it takes to be able to run within a private model in small populations—

Senator HUGHES: But that's what we've been hearing an awful lot of.

CHAIR: Can we let Professor Knight finish, please, Senator Hughes.

Senator HUGHES: I'd actually like to get some real information rather than cultural things.

Senator CHISHOLM: You're being disrespectful by interrupting them.

CHAIR: You are.

Senator CHISHOLM: Let them answer the question.

Dr Chew: Can I say something?

CHAIR: Yes.

Dr Chew: I am a GP, and there is a distinct difference to the services and value that a general practitioner adds in a rural community, as opposed to a hospital doctor. We have a large amount of evidence that supports the fact that care provided by a GP, in terms of the continuity of care provided to a patient, is much more beneficial to the patient and far more cost effective. With hospital practice, one gets episodic care, acute care—reactive care. With the GP, one gets holistic, comprehensive and continuing care. The outcome for the patient is far, far better with a regular GP than it would be with hospital care.

Senator HUGHES: We don't have continuity of care. We don't have access to GPs. Only today, we've heard multiple times that you can't get into your GP for two weeks or three months or 12 months. So we don't have any of those things.

Dr Chew: That goes back to what Richard was saying—

Senator HUGHES: I'm trying to find something we can put in this report that actually says we can do something here.

Prof. Murray: It's a great challenge. Do I suggest that we should shift comprehensive, team based primary care into a public hospital state system? I'd strongly recommend it. I think that there are all sorts of inefficiencies in the way in which public hospital systems work. They have their role, but I think comprehensive primary care needs to be much closer to communities. My colleague Sabina Knight is too modest. She was one of the commissioners examining the hospital reform a decade or so ago. I would say from both my own lived working experience as well as from studying all of this for a long time that probably the best examples of fully elaborated models of comprehensive primary care are Aboriginal community controlled health services run and owned by communities. They are run as small businesses but are accountable ultimately to the community, not to a distant—

Senator HUGHES: Bureaucrat?

Prof. Murray: political or bureaucratic process. The other thing I'd point out is that part of the problem is the funding system. I'm not advocating for provider number restrictions—I could elaborate on that—and I'm also not advocating for a boost in Medicare fees for service. In fact, in many ways, part of the problem is that we have a pay-by-the-turnstile system. When you have oversupply of workforce, the turnstile is moved faster and many more people are scooped up into it.

I think the whole world pretty much agrees that the way in which you fund primary care in distributed, devolved and community settings, including private practice, is blended payment. I think we're getting there with the national primary care plan consultations. You'll notice the three elements of that. There's voluntary patient enrolment, so there's a belonging to a practice—a contract, if you like, whether you come in the door or not—and a proactiveness, therefore, as Eleanor was saying, around accountability for individual family and community outcomes. That's along with payment for activity or service—Medicare, if you like—and a little bit of payment for hitting your numbers or targets or polity or whatever. The only argument is: what are the proportions? And even on that, most of the world agrees that it's probably about 50 to 45 to 5 or something like that. That's probably where we need to go, and it's going to be the only way we get out of this problem of the downside of a pay-for-activity model and move into something that's more sustainable.

I'd also highlight the point made earlier on that it's much more cost efficient. With an ageing population with increasing comorbidity and increasing complexity, relationship based health care, GPs and primary care teams, nurses, allied health and so on, Hospital in the Home, health care delivered in residential aged care and admission avoidance are the ways that we will help to hold back the costs of acute public hospitals. By allowing general practice to degrade and fail, all we're doing is tripling the costs and, indeed, losing opportunities to improve the life, dignity and health of the community—by allowing a primary care system to fail.

CHAIR: You have one more question, Senator Hughes.

Senator HUGHES: Thanks, Chair. We hear a lot that the JCU model and those sorts of things are having great success. Unfortunately, we're not seeing that around the country. There was a school opened only last week in Gosford, on the Central Coast in New South Wales. It bid through the University of Newcastle to continue to build up those kids that grow up in the Hunter region and the Central Coast with the opportunity to stay there if they're studying medicine. Do you think that there should be more requirements for rural and regional medical schools to grant more access and help facilitate entry into them for rural students?

Prof. Murray: I do. It's a complicated issue. I'll distil it to its basics. We currently produce around 3,000 domestic graduates a year from our medical schools, plus another 600-odd international students who graduate with Australian degrees, and many of them—in fact, most—stay on. But then we bring into the country another 2,000 to 3,000 a year to top up the bush, mostly. Those are my colleagues. They provide valuable service, and indeed many of our facilities in towns would close down without my international graduate colleagues. However, it does suggest that the system is not working. What happens, if you follow the data, is that many of those international medical graduate colleagues who stay will percolate into the cities, followed by a sort of rinse and repeat. This in a sense explains the paradox of increasing metropolitan supply, subspecialisation, supply led demand and cost escalation whilst shortage exists at the same time in the regions. You don't get a sense of that just by doing a headcount; you've got to look at the dynamics of it.

I think, absolutely, it's true that we need more domestic supply, but it needs to be applied in a smart way. So, absolutely, we need more into the regions, from, in, with and for regional communities, linked and accountable, and much more opportunity to train in primary care, aged care, rehabilitation and NDIS. All of these areas are missing, in a sense, from the student experience. And they should be joined up to a greater profiling experience in quality primary care of the sort that Dr Chew was talking about earlier on for learners at all stages—medical, nursing and allied health—so that we can move our training system away from large acute public hospitals, which really remain the dominant learning experience for most graduates.

Senator HUGHES: Yes. It seems that, once they go into hospitals, they don't leave.

Prof. Murray: That's the trouble.

CHAIR: Thanks, Professor Murray. I'm going to pass the call to Senator Chisholm, but I think we have got somebody who wants to contribute an answer to that question.

Dr Chew: Thank you. I certainly agree with Richard in that it needs to be a whole-of-system reform. The reason you can't get GPs out of the rural communities and the reason that you wait weeks to get an appointment to see a GP is that the system is the problem. We need to have a look at the funding, and we need to look at blended payments. We certainly need to look at peer based care, which Richard has said. I totally agree with all of that. I'm very glad that this Senate hearing is looking into those areas.

I would like to make the point that the rural and remote focus is very, very important, but I'd also like to just point out that the outer metropolitan regions are also among the fastest growing regions in the country, with many of these communities having significant health disadvantages. It really is vital that these communities in the outer metropolitan areas are not overshadowed by too narrow a focus on the rural issues. Both communities deserve the attention. We know that a report from Deloitte actually predicts a shortfall of 7,500 full-time GPs in the urban areas by 2030. So it is a whole-of-system and whole-of-country issue.

CHAIR: Thanks, Dr Chew. Senator Chisholm?

Senator CHISHOLM: I thank JCU and General Practice Training Queensland for your submissions. I might focus on Ms May and Dr Christensen whilst you're here—and thank you for giving up your time to be with us today. Ms May, I've got a sense of where you're at with your career. I was just wondering whether you could give me an insight into what the next five to 10 years might look like for you in terms of training, where you end up and what sort of process you go through in that time frame.

Ms May: At present, like I said, I'm about to apply for the Queensland Rural Generalist Pathway. What that entails is my internship, which is my next year. For that I am preferencing Mount Isa first, which is where I'll likely end up. From there I can't really say where I will end up, whether I will stay in Mount Isa or whether I'll return to the coastal area where I live now in Mackay. However, I can say that I want to continue with the rural generalist program.

The length of the program varies. You have a few years of GP training, hospital training and advanced skills training. My interest in advanced skills is pretty broad. I'm someone who does tend to take a liking to absolutely everything, which is perhaps why I'm choosing this pathway. My main interests are obstetrics and gynaecology, paediatrics and surgery, all of which are luckily offered by the rural generalist pathway. So, in five to 10 years, hopefully, I'll be in one of those areas.

Senator CHISHOLM: Just say you get accepted at Mount Isa, you would gain experience across a broad range of areas whilst you're at that hospital.

Ms May: For your internship there are certain rotations that you must complete: emergency department rotation, surgery and internal medicine—all of which Mount Isa has and to a very impressive degree. Your other rotations can be electives. The electives I want to focus on are obstetrics and gynaecology, and paediatrics. Luckily, Mount Isa also has both of those departments. I think the rural generalist pathway also benefits in that

they preference you to ensure that you get the rotations that you want for your internship; whereas, as a general intern, you don't always have those opportunities.

Prof. Murray: I'd just like to make an observation. At the moment in the current system it's the Queensland Rural Generalist Program; the education, training and feet on the ground is JCU again. There is a point of graduation, but there will be continuing engagement, including at the local level, such as in Mount Isa with staff based with Catrina Fenton-Busch at the Murtupuni Centre for Rural and Remote Health, and you therefore get the continuity, the relationship and walking the journey which I think is a great strength of the model. I just note that, because it may not be obvious.

Senator CHISHOLM: I was going to a similar point next. My observation on Mount Isa is that some people go there and never want to leave and become a bit addicted to the place, so it'll be interesting to see how you go there. What about you, Dr Christensen? You're a bit more advanced in your journey. Can help us get an understanding of what the training's been like and how you end up in a place like this?

Dr Christensen: It started from first year at JCU when we were shown rural experiences and that continued through the whole of training. When you get onto the ACRM pathway, you're immersed in that again, so it's very streamlined the whole way through to the rural generalist training at the end of your university degree.

To answer what I'm going to be doing in the future: I'm just going to continue out here. I feel like our family are well and truly entrenched here. We love the community. I feel a personal responsibility for all of these people in the community that I've now been in for a decade. I think I'll probably just continue it until such time as I can no longer do the on-calls anymore, it gets too stressful or something else comes up, like we feel the children's education is lacking or we need to move for family reasons or something like that.

Senator CHISHOLM: Dr Christensen, given you're a bit more advanced in your training, what message would you have to someone who's starting off and maybe thinking, 'Well, I'm a bit more attracted to the big city lights and the big smoke'? What message would you give to them about considering the advantages of practising in a rural or a regional location?

Dr Christensen: It makes you feel like a real doctor. You do everything. I could give you an example, without going into too much detail. On the last evening shift that I did, we had a full ED. I had a snakebite envenomation in bed 1, I have a perforated bowel in bed 2, I had a seizing two-month-old in bed 3, I had a trauma from a fall from two metres in bed 4 and I had a mental health patient in bed 5. Nothing beats the feeling of getting home from managing that and doing a good job of that and feeling like you are providing excellent care to the community.

Senator CHISHOLM: Thanks, Dr Christensen, for your service, and all the best as well. Thanks for giving up your busy time to come along today.

Dr Christensen: Sorry about the—

CHAIR: No. That was good. It's real. You were like a real doctor.

Senator CHISHOLM: As politicians, we're used to people faking that sort of stuff.

Prof. Knight: If I may, I will comment that we take very seriously the importance of engaging with children in the primary school years. Emma-Lee mentioned this. She went to boarding school in Rockhampton. Fortunately, it's a regional city, but the children who grow up in the very small communities such as the one where Catrina grew up—remote communities or the remote stations—go away to boarding school for the first year of high school, many of them to the south-east corner. They do six years at boarding school. If they then go to university in the south-east corner with their friends for the following six years, they're not coming back. So a big part of what we're engaged with is through the School of the Air and the parents of those children, asking them to be much more hands on with their children and in planning their future, because these kids are very autonomous.

CHAIR: You'll bring them back.

Prof. Knight: You're encouraging them to think about where they go. This has been very important to us.

CHAIR: Thank you all very much for your evidence today and for your submissions, and thank you to those online as well—Professor Bellingan, Ms Sadler, Dr Chew and Associate Professor Felton-Busch. You didn't quite get as much air time as those who were in the room, but we absolutely heard everything that you were saying and we really appreciated it all. I don't think any of you took questions on notice, but if you do want to provide any further evidence to us and you can get it to us by 25 March, that would be really appreciated. We are planning at the moment to report to the Senate by 30 June. That concludes today's hearing. On behalf of the committee, I'd like to thank everyone who has made submissions to the inquiry and has made representatives available today. I

thank broadcasting, Hansard and the secretariat staff for their assistance today. The committee now stands adjourned.

Committee adjourned at 17:02