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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Health funding

FRIDAY, 17 MARCH 2006

CABOOLTURE

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Friday, 17 March 2006

Members: Mr Somlyay *(Chair)*, Ms Hall *(Deputy Chair)*, Mr Cadman, Mrs Elliot, Mrs Elson, Mr Entsch, Mr Georganas, Mr Johnson, Ms King and Mr Vasta

Members in attendance: Mr Entsch, Mr Somlyay and Mr Vasta

Terms of reference for the inquiry:

To inquire into and report on:

How the Commonwealth government can take a leading role in improving the efficient and effective delivery of highest-quality health care to all Australians.

The Committee shall have reference to the unique characteristics of the Australian health system, particularly its strong mix of public and private funding and service delivery.

The Committee shall give particular consideration to:

a) examining the roles and responsibilities of the different levels of government (including local government) for health and related services;

b) simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals;

c) considering how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved;

d) how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government; and

e) while accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior's Private Health Insurance Rebates, and Lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.

WITNESSES

BRUYNIUS, Mrs Julie Anne, Manager, Community Development, Caboolture Shire Council 2

DAY, Ms Virginia, Manager, Centacare Bribie Community Options 2

DEVEREAUX, Councillor Lynette, Elected Representative, Residents Division 4, Caboolture Shire Council 2

FRAWLEY, Miss Jane Alison, Community Planning Coordinator, Caboolture Shire Council 2

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LEISHMAN, Mayor Joy, Caboolture Shire Council 2

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Committee met at 9.06 am

CHAIR (Mr Somlyay)—I declare open this public hearing of the House of Representatives Standing Committee on Health and Ageing inquiry into health funding. We are examining how the Australian government can take a leading role in improving the efficiency and quality of the health care system. Although Australia has one of the best health systems in the world, members of parliament are only too aware of the need for improvements. We all receive a steady stream of complaints from our constituents concerning the health system, often about private health insurance premiums, gap payments and of course public hospital waiting lists. We are in Caboolture as a response to the widespread community concern about the state of public hospitals in Queensland generally and here in particular. The committee is not looking for people to blame but wants to find solutions to help improve health services.

At today's public hearing we will hear from two local shires, Caboolture and Pine Rivers. We will also hear from a local medical centre and the company now running the emergency department of the Caboolture public hospital. Most importantly, from noon we are holding a community forum where anybody can come up and make a short statement to the committee in an informal way on any health issue that they feel is relevant to our terms of reference. This hearing is open to the public, and the transcript of what is said will be made available via the committee's website. If anybody would like further details about the transcript or the inquiries, the committee staff can help. On behalf of the committee, I would sincerely like to thank Mayor Joy Leishman and the Caboolture Shire Council for hosting this forum and for your hospitality—which we are enjoying and I am about to enjoy even more!

[9.08 am]

BRUYNIUS, Mrs Julie Anne, Manager, Community Development, Caboolture Shire Council

DEVEREAUX, Councillor Lynette, Elected Representative, Residents Division 4, Caboolture Shire Council

FRAWLEY, Miss Jane Alison, Community Planning Coordinator, Caboolture Shire Council

LEISHMAN, Mayor Joy, Caboolture Shire Council

DAY, Ms Virginia, Manager, Centacare Bribie Community Options

MINETTI, Mrs Christine Anne, Special Projects, Bribie Community Options

CHAIR—Welcome. Do you have any comments on the capacity in which you appear?

Mrs Minetti—I will be speaking on behalf of Virginia Day, who is the Manager of Bribie Community Options.

CHAIR—Mayor Leishman, I invite you to make an introductory statement to the committee.

Mayor Leishman—Thank you. The Caboolture Shire Council would like to formally welcome the chair and members of the parliamentary Standing Committee on Health and Ageing. The Caboolture Shire Council and the community appreciate the opportunity for input into the inquiry. Our shire has faced enormous growth in the last couple of years. Since 1990 the growth in the shire has been between 7.3 per cent and 8.6 per cent, so that is pretty extraordinary. I know that, when I go out into my community, almost every second person that I talk to has lived here for less than seven years. There are 130,000 people that live here today; 65,000 of those have come here in the last decade.

Council is currently ranked sixth in Queensland in terms of total dwelling approvals, and the latest PIFU population trends released in May 2005 have Caboolture as the fastest growing local government area in south-east Queensland for the year ending 2004. The growth pressure translates to increased demands, of course, on council and on every other level of government for social infrastructure, both built and service program and delivery. Demand has outstripped, and is still outstripping, supply of needed community facilities and services. In particular, the impact of an ageing community, both existing residents and people migrating here, has created enormous pressure in that sector.

On Bribie Island, 29 per cent of the population is aged 65 years and over—one of the highest percentages in Australia—compared to estimates for the nation that, by the year 2021, 18 per cent of most communities will be aged over 65 years. These are enormous numbers, and the impact they hold for this shire is evident. I should also explain that not only does the Bribie

Island community have a higher incidence of aged people but also, geographically, there is only one transport corridor, so there is an added layer of difficulty faced by the aged on Bribie Island. This population will need nurturing and support through a diversity of services and programs.

The demands on infrastructure and resources, including human resources, were highlighted by the recent ordeal of the closure of the Caboolture Hospital emergency department. I am sure everybody is aware of that incident, and our concern was very evident. Two months have now passed since the closure of that department, and the reopening date—it is certainly welcomed by the community—is 18 April. But there is enormous concern out there about the closure and the additional hardship that was faced by people who had to seek that level of medical service out of our shire, with the added impact on families of having to go to hospitals in Brisbane to support them.

Council is also facing a number of pressures around health and ageing, and key areas will be covered in our presentations today. I thank you for your time and I thank you again sincerely for bringing the inquiry to Caboolture shire. I now hand over to Julie Bruynius, the manager of the Caboolture Shire Council's community development unit.

CHAIR—Before you do, can I say that with these committee hearings, as we travel around the state or the country, we sometimes have smaller groups according to who can make it on any one day. It just so happens that today all three of us here are Queenslanders, so we have some knowledge of the Queensland system. Julie, please go ahead.

Mrs Bruynius—Thank you for your time today. What I would like to do is give you an overview of five key issues around health and ageing for Caboolture shire, some of which have been covered in council's submission, as well as additional information that we have gathered from the social sector. Other points will be covered in the remaining council presentations today. The five key issues I will cover are: funding for community facilities and programs; isolation and social needs; ageing with dignity; liveability and design and construction of the built environment for an ageing population; and the health professional workforce shortages.

On funding for community facilities and programs, there is rapid growth of and migration to the shire. An increasingly aged population brings a greater demand for community facilities and an increased need for social services. This is particularly evident with the increased number of aged care facilities being constructed in the shire and the sea-change migration to the coast. Increased funding options, state and federal, are needed for facility development, services and diverse program provision. Over the last five years council has experienced increased requests for capital funding from essential local services, who have either inadequate or no facilities to operate from but are still attempting to provide vital services. With limited funding sources for community facilities other than gaming funds, the community is suffering.

Even with a significant council contribution, sourcing the remaining funds for facility development is a major issue. For example, Caboolture Meals on Wheels has outgrown its current facility. Ninety-three per cent of its clients are over 60 years old and the number of meals delivered has increased from over 10,000 in 1984 to 41,270 in 2004, but it has had a negative response from external funding agencies, including Regional Partnerships. Narangba resource centre is in a similar situation. Council has allocated a major contribution, but there is limited

opportunity to source additional sufficient funds for this much-needed facility to deliver health and social services to a rapidly growing area in the shire.

There has been an increasing devolution of responsibility to local government for both facility and program provision. Program funds are available under a number of program areas, such as HACC funding, but it is generally limited in the amounts available and is generally restricted to health programs for those already suffering ill health. There are limited funds for respite care, preventative programs, social and recreational programs, community transport options and much-needed administration costs. Respite care funding in particular is not considered adequate to meet community need. There is also a recent trend for federal and state funding to go to larger services, who may sometimes have limited activity or networks in a local area. The small organisations already supplying those vital services could then have difficulty operating effectively. This could mean a loss of local experience and skills. It is vital that larger services, if funded, be required to collaborate with smaller local service providers to provide those programs.

I will now refer to isolation and social needs. Across the board, one of the major issues facing the wider aged community is social isolation and a lack of social and recreational opportunities. The multicultural and Indigenous communities both highlighted issues of social isolation and community disconnection. There are an increased number of people migrating to the shire, often due to lower housing costs, and this brings with it a community that is less connected and without the social and family networks in place. There has been an increased preference to provide in-the-home services, however this could also increase social isolation. A number of reports are that services are often contacted because the aged are seeking social interaction, rather than for a real support need. Aged services have also stated that there is a fear of accepting aged services in the home, because that may be seen as the first step to being put in a home. Funds are needed to integrate and connect the aged and socially isolated, and to provide social and recreational programs. This will in turn act as a preventative measure, as it is likely to decrease health issues as people continue ageing.

Within program funding there is a need for an increase in funds for community transport. The elderly find access to services difficult and costly. For example, there is a community transport service in the shire that does support social programs, but the funds for this are limited. Currently that service is funded to meet the transport needs of only five per cent of their client base in Caboolture and it is also prioritised for only those in poor health. Program and transport funding needs to be not just for the aged who are in poor health. The 'well' aged are often forgotten, and they need social opportunities also. Social and recreation programs may not be seen as vital to health service provision but can be a precursor to physical and mental health issues.

The third point is on ageing with dignity. The aged in our community need to be seen and promoted as important community contributors who are of value to the wider community. The feeling of being undervalued can contribute to health issues over time. There needs to be national promotion of the value and skills the aged can bring to the community. The aged often state that they no longer feel a valued part of the community, socially as well as in the workforce.

The fourth point is around liveability and improvements in the design and construction of the built environment. There is a need to improve the planning of urban and rural communities so that aged care services and facilities are located close to transport, supporting community infrastructure and adequate health services, both now and in the future. Design is an important issue for aged care facilities. In particular, it has been reported that there are a number of over-50s relocatable village complexes in the shire that do not have adequate access—for example, hand rails, steps and everyday mobility needs. Some local services are having to fund modifications to these facilities to cater for the aged and less mobile.

The final point concerns shortages in the health professional workforce and the need for adequate numbers of trained health professionals to cater for community needs. It has been noted that GPs in this region are also ageing, with over 90 per cent of Caboolture GPs being over 45 years old. The impact of the closure of the Caboolture Hospital emergency department was felt by all the community, but was, and is, particularly frightening for the aged and those in ill health. Council has a social infrastructure program under the Caboolture regional interagency, and a number of these issues will be included for further discussion and support across local services. This program led to an aged forum two years ago to discuss the ageing population, the increasing number of aged care facilities being constructed in the shire and the number of new aged residents coming to the shire and requiring services. A lot of the issues discussed at that forum have been and will be covered today and are still relevant.

In summary of the key points, there is a need for increased funding opportunities for vital community facilities and programs, including social programs and transport needs, and these programs should include the healthy aged; a national promotion of the positive contribution of the aged to the wider community; program funds to encourage connection and inclusion of the aged within communities; improvements in the planning and design of aged care facilities to make them more liveable, with access to necessary services; and an increased number of trained health professionals to meet the needs of an ageing and rapidly growing community. Thank you. I will now hand over to Jane Frawley, the Community Planning Coordinator from the Community Development Unit.

Miss Frawley—Today I am going to talk specifically about four key issues affecting aged communities in the Caboolture shire: aged care services and the provision of bed allocations for high care and low care; respite services; the introduction of a national accreditation and quality control system for the provision of aged care services; and, lastly, the need for better integrated planning between local and state government and between state and federal government to ensure that aged communities are well planned and have access to essential services. I will talk firstly about aged care services and bed allocations.

Currently the planning ratio to allocate aged care beds for communities is a federal government responsibility and is based on a ratio of 50 low-care beds and 40 high-care beds and 10 CAPS for every 1,000 people aged 70 and over. This ratio is applied on an annual basis. In a community that equates to 10 per cent of the ageing population being serviced through aged care bed provision. Annual planning mechanisms that allocate those beds to communities are difficult to integrate in a planning scheme sense because it is challenging to project that forward and integrate that into a land use planning mechanism to ensure that adequate land is provided and uptake of those beds continues.

The other difficulty with having an annual basis for bed allocation is that there is often quite a significant lag between when beds are allocated and when they become operational and those in the community can access those beds. This sometimes results in a severe waiting list for those services. In addition to this, servicing only 10 per cent of our ageing population may not be adequate to keep pace with the ageing demographic of our communities, so part of council's submission has asked the federal government to consider a review of the planning ratios for allocation of beds, as that would help us in planning for an ageing community.

The other concern that council has in relation to the planning ratio for aged care services is the fact that our community is experiencing rapid growth. We also have high-population transience rates, with lots of new people arriving and leaving in short periods of time. In addition, we have large numbers of culturally and linguistically diverse communities and Indigenous communities. Not all of these specific communities participate in the Australian census done every five years. This results in some hidden populations, which can also impact on what we understand is the demographic make-up of our community. Sometimes services can be faced with trying to deliver an appropriate number of allocated beds but having to service a community that is much larger than they knew it was. So there is a need to ensure that census data is accurate and up to date to ensure that our planning ratios meet the needs of our ageing community.

I will now talk specifically about respite services. Respite services for both carers and carees are fundamentally important to ageing communities. Ageing people need to be able to age in place and there is an increasing trend towards providing in-home services. Respite services provide an essential way for carers to get support within the community and outside their family network. Quite often in our community the 55-plus communities that are being built are taken up by interstate migrants who do not necessarily have strong networks within the community. So they are heavily reliant—not necessarily in their first years of residing in that community—as ageing increases, perhaps after 10 years in that community, on drawing on local services for their needs. The impacts of that are very significant. At the moment our services report that we have a waiting list of 12 months minimum for respite care. That leads us to the point that there is a strong need to increase the level of funding for respite services. Our services—and I think Chris Minetti is going to talk more about this—have reported that there would be strong community support and take-up of those services.

The second last point I want to talk about is the national accreditation and quality control system for aged care services. At the moment, many services in the area provide for the needs of the aged. They can access a range of funding programs, each of which have different eligibility requirements, like HACC and CAPS, and all of which have different reporting structures. This can place an incredible burden on some of our services, which struggle to communicate with clients to find out what their service needs are to match them to a program and then, on a monthly and quarterly basis, report on the number of people accessing those programs. With a multilayered approach to the different funding programs, this can result in very overstretched local services, which perhaps are so busy delivering the services that they struggle to actually meet those reporting requirements on a monthly basis. So there is a need to give them greater resources and more training and skills to be able to cope with the introduction of the national accreditation system.

The community has a desperate need to ensure that aged care is consistent and that our elderly residents are able to age with dignity and in services that are meeting their needs. These services

need some sort of control and some kind of national process to ensure that continuity of care is provided to our elderly community. Council has raised that as a key issue in its submission.

My last point concerns the need for better integrated planning for ageing communities. With national trends towards large populations in all communities being significantly older, there is a need to make sure, as Julie suggested, that the built urban form actually meets the changing needs of our demographics. We need to ensure at a local government level that the land we allocate for aged care services is in close proximity to essential services including transport and commercial and medical centres. The whole gamut of communities' needs need to be integrated.

What local government needs, though, is more support in order to make sure that our planning allocations actually receive market take-up. Whilst we are able to control what happens on a local level for our land, it is sometimes difficult to advocate that the private industry and developers ensure that an appropriate housing mix is delivered on the ground. We have an increasing trend towards 55-and-over communities. There is a need to make sure that these communities are located in the right place and are actually built to a standard that meets those residents' needs, not just in the shorter term but in the longer term as they age in place. To do that, we need the support of state and federal government to ensure that, for things that are outside of the purview of our control, like transport and health services, different state agencies and federal agencies work together to deliver better integrated communities on the ground. I will hand over to Christine Minetti, who is going to talk specifically about local service issues in the community.

Mrs Minetti—As I said previously, I will be presenting points on behalf of Virginia Day. Whilst Virginia is visually impaired, her brain and 16 years of experience are not. Virginia will be available for questions later on. As to the existing situation, as we said, we are currently dealing with a generation that has gone through the Great Depression and the Second World War. They want to leave an inheritance to their children and are mostly very grateful for any care service they receive. This generation has embraced the government's funded policy initiative of ageing in place.

However, one of the concerns associated with this generation has been ensuring that, whilst providing funding to keep these clients in the community and in their homes, they do not suffer from isolation, the side effects of which are numerous and debilitating. Bribie Community Options has had some success with a couple of initiatives for socialisation. Older single gentlemen living alone we found to be the hardest to get moving. The girls generally are happy to attend pamper mornings and outings. The blokes just prefer to sit at home and sit pat. So we organised a deep sea fishing trip for 10 of our aged blokes who we had concerns about. We had two carers, a skipper and deckies. We had a great day, resulting in some very engaged and enthusiastic blokes coming home from the fishing trip. This was funded from some community contributions and Bribie Community Options social support funding.

Another opportunity was a viewing of Christmas lights in an eight-seater bus with a driver and a carer. This also resulted in some couples enjoying a night out together that, due to their particular health issues, had not occurred for the last 15 years. The bottom line on this is that a safe and secure environment was established that included trained community carers and gave the clients enough of a feeling of security to participate in these outings. Specially targeted innovative initiatives need to be funded.

Continued education and support programs need to continue and expand, with particular attention being paid to the first signs of help need—domestic existence and garden maintenance. The attention to the first signs of need will quite often prevent a higher need service, such as falls management, later on. Carer respite and support programs need more funding now and into the future. This has been highlighted in the community now by higher respite requests and requests for more information on diabetes, continence education, dementia management and mental health issues.

Government funding bodies need to be made aware of the special service provision required for clients with mental health issues. This is a very specialised area of service. These people and their carers require a supply of workers specifically trained in this area. Normal community support services such as those provided through HACC do not have these specialist workers. They are therefore unable to provide appropriate services for these clients. Preventative measure funding currently needs increasing. This need for funding will continue, with a focus on lifestyle programs for healthy ageing. To make it affordable for the aged to be involved in programs such as water aerobics, a stepping-out program, Tai Chi classes and the University of the Third Age, programs need subsidies.

'Use it or lose it' still remains the constant in the ageing process, which leads to the government policy of encouraging us all to work longer. There are not enough Xs and Ys, who are looking for balance in their working lives, to support the baby boomers, so the baby boomers will be needing all the aforementioned programs. Employees will be looking for employers of choice to build into their work environment incentives to keep trained staff for longer. Exercise programs are a wise choice for employers and employees. As you are no doubt aware, many papers have been written on the benefits of fitness and flexibility at any age, in particular for white-collar workers. If time permitted, I could expand on this point with an example of the swimming program at my current place of employment.

Another issue I would like to touch on is the issue of duplication in reporting formats. This must be addressed sooner rather than later. I refer to the HACC, Veterans Home Care, CAP and EACH packages, and disability sector responsibilities, all of which have different reporting requirements and, like private enterprise, are looking to have a base quality assurance document with additions, if required, for the different services rather than completely separate documents which are both excessively time consuming and expensive to report on. It is not allowed for in the funding supplied for that particular service.

Quality assurance is important. Constant improvement is essential. Reporting on public funds is a governance responsibility. However, this could be done so much more simply with the use of a base quality assurance document. Let us contain this new evolving industry of quality assurance experts and implement a base quality assurance document. Neither community nor private enterprise can continue to afford this form of duplication.

Benchmarking for residential care beds should be under constant review. I think that has already been mentioned. I believe that the current figure is that 11 per cent of the population will need a residential bed. The average age currently requiring those beds is 83. This raises the next issue of the over-55s villages. This shire has seen a huge influx of applications. It is a very clear indication of future housing choices for the baby boomers, who want secure grounds, maintenance, socialisation and the convenient locationing of these facilities.

Remembering that the girls live longer than the boys and that one in four are divorcing, is the new look housing going to be for single housing? That is the new trend. However, the current generation is not yet at this point. The average age entering the over-55s villages is 74. They are independent initially but on the verge of needing some services. A lot of the newcomers to Queensland are without the family infrastructure to support them and some have interstate health service expectations. They are already comparing other states against Queensland. Services are not equitable across the states and they need to be.

One of the seven HACC principles—equity of access in the national services standards—talks about this. Why is my mother in Mount Isa not able to receive the same access to services as my friend's mother in Brisbane? Services should be the same—that is equity of access. We have found here in Caboolture shire that the community groups have had the opportunity to work with the council's planning department and were notified of an application for an over-55s village going through. They were then able to start the process of getting extra funding at the same time as the developer was going through the application and building stages. This process assisted in getting the supply and services on the ground in time for when the demand hits. This system could be expanded to include advice on building statistics and the demographics of the occupiers. Could this incorporate statistical information from real estate agents on the demographics of people taking up residency? This would give us a quicker snapshot than waiting for census information, and there would be more lead time for service infrastructure to be put into place.

Assisted transport has been piloted in this shire and has proven to be extremely successful, enabling the client to enjoy the socialisation of an outing as well as doing some shopping. They do not have to struggle home on public transport with parcels by themselves and then struggle into their houses with the same parcels. That was a very good pilot project.

There is infrastructure charging for mobile dental vans. With more over-55s villages, residential beds and the issues faced about dental care, with ageing baby boomers having their own teeth, I believe the need for fully equipped mobile units will be an essential resource in the future. Emerging higher and better quality services will be demanded in the future. I believe there is an opportunity for the school dental van concept to be expanded to service residential centres.

There are also independent living facilities, with the frail-aged already living in the wider community. Allied health services, such as podiatry, physiotherapy et cetera, could also be made mobile. Would the funding of community organisations to do this on a needs basis be some of the implementation answer that could be investigated?

The new situation is the baby boomer syndrome. We are a generation which has not been through a depression—although we did do 'the recession we had to have'. We have not been through a Second World War; however, we are the greediest, most selfish generation born to date. That is my generation.

CHAIR—And mine!

Mrs Minetti—We are already challenging services with the need for more information—the 'what ifs' and the 'why nots'. What is funded? What is not funded? What are the options? What

is the ACAT? What arrangements can be made for residential care? In home care, we want to know the whole lot, and we will not accept a brush-off. And this we are doing for our parents. Imagine the challenge we want for ourselves.

We will have much higher expectations of quality and quantity of services than the current generation. We will have the expectation that we can have what we want. We will know where to get it and, with the aid of the internet, we will probably know how to do it as well. Fortunately, we have also been the most innovative generation. We have a good understanding of user pays, and superannuation may be the saving grace of all of the baby boomers.

What are going to be the impacts of the stem cell research, DNA investigations, genome technology and plastic surgery? Will we be living to be 100, looking like 60-year-olds and living in over-45 villages? Terrifying. Is this the scary reality in the future or not?

I believe that, in consultation with government departments and our community representatives, the baby boomers will continue to drive innovation in the community for services and prioritise what the needs are and where they need to be. I ask that we continue to encourage and fund innovation for our future. Thank you for the time and the opportunity to present these points.

CHAIR—I must say that my own children say to me: ‘Dad, you’d better be very good to us, because we’re going to choose your nursing home.’

Mrs Minetti—That is exactly right. Remember those points!

CHAIR—Could you tell us a little bit about the shire itself? What sort of industry is here? What drives the economy with this massive growth rate you have? We know what infrastructure problems you have as a result, but, just for the record, could you tell us a bit about the local economy, Mayor?

Mayor Leishman—A wider snapshot initially is that Caboolture shire is about 1,200 square kilometres. We are the same size as Brisbane, just to put that in context. As we said earlier, we have a population of 130,000, and half of them have come here in the last decade. Sixty per cent of the people who work actually work outside the shire, so the great majority of people who are employed are employed outside the shire, generally to the south. A lot of them go into the northern suburbs of Brisbane and into Brisbane daily, and that of course has a great impact on the Bruce Highway, which we affectionately call ‘the car park’.

Locally, of course, the retail sector is quite large. Certainly we have major industries in and around the Narangba Industrial Estate. There is certainly large industry in the Corporate Park estate. They are of course service type industries, although there are a number of international and national industries throughout the shire. Certainly service to the aged is a component of business within the shire, with so many aged care facilities. In the other part, to the western part of the shire, there is also the largest prison in the southern hemisphere located in our shire. Of course, we do not talk about that in our tourism documents. But, talking about tourism, tourism is also a very good economic driver for the shire.

Generally, just to wrap that up, it is about people who choose to live here but have to go elsewhere for employment. Council actually has a policy in place now of what we call containment in trying to turn that around, but it is really about service industry, retail, the large industrial estates and certainly tourism.

Mr VASTA—Just following on from that, I remember that Miss Frawley spoke about a transient population. Is that something that the mayor just covered? Is that what you mean by the transient population?

Miss Frawley—South-east Queensland on the whole has quite a high population transiency, meaning that residents will move to an area, whether it is for work or for lifestyle, stay there for sometimes less than five years and then move on to another community, quite often within south-east Queensland. Caboolture has those rates, but the particular communities I was talking about are the culturally and linguistically diverse communities. We have strong populations of Samoans in Deception Bay and a high Indigenous population, and those communities are quite transient. They tend to move a lot.

The other key point about our population transiency is that we see a lot of intrastate movement. We have a lot of people from southern states like New South Wales and Victoria moving up here for the quality of life but they are not necessarily moving up here with any job opportunities in mind. It is more a case of once they get here they will find employment, which I think ties back to the mayor's point about Caboolture's concern around containment and finding opportunities for those people to keep them in their communities.

Mr ENTSCH—You raised the issue of a proliferation of over-55 villages and the need for governments to follow on and provide the necessary support infrastructure for those over-55 villages. I have to tell you that I have similar challenges in Cairns in that we also have an attractive climate, if you like, and we get a proliferation of people towards the end of their working life moving into that area for the lifestyle. We have similar challenges, and our community is a similar size to yours, too. Is there any planning mechanism through council that would encourage a developer to build in areas where there is already the start of the infrastructure needed for the future rather than in greenfield sites on the basis of 'build and they'll all come' in relation to other services?

Mayor Leishman—I will take that question. I know there are some answers to that. That is the great challenge for all planning documents in that the villages require greenfield sites. The greenfield sites are not really available in your more closely settled areas and it is in those areas—just look at Caboolture—that the services are that people need to access. Quite a number of the over-55 villages that have been built within our shire have been out in the other areas.

To put it in context, if you recall the statistic that was given, the average age of someone entering an over-55 village is 74. Within a couple of years, if not already, that person will not be driving. Caboolture shire is the same size as Brisbane—and I am sure you remember me saying that. We have 17 villages. We do not have a transport system like Brisbane, yet we have the same expectation to access our hospitals and other medical services, which are in the middle. We have some transport services, but they in no way meet the need of those people in the villages to access them.

The issue that you started with was the planning documents. Certainly there is some opportunity for those villages to go into areas where of course council would find it desirous; but, in the main, the land is not available because Caboolture is already closely settled. The density is already there. They are the great challenges.

The other issue is one that council has no control over. I can recall it from a couple of years ago when the villages started appearing. The villages are not all the same. Without identifying them, some are excellent and some just meet basic needs. When people go into a village they are quite able and the walls, say, of the toilets and bathrooms are made out of gyprock, and then all of a sudden something happens and people need to have rails put in. But when the building was originally built, the noggings behind the walls were not put in. It is an additional cost that is then met by government to make sure that all of those additional parts are put in.

We would say that, if you are building an over-55 village, you should build it in that way. Council does not have the ability to require the developer to do that. It is those subtle changes that seem quite miniscule at the beginning of a planning process that need to be put in place. A great variety of those requirements relating to pathways and lighting et cetera are covered by building regulations.

Mr ENTSCH—Who covers that?

Mrs Minetti—The building act, which comes under the state government.

Mr ENTSCH—Because one would think that that would be the most sensible thing to do: if the developers are going to look at doing something to target a specific group then they need to be looking at what that group is going to be like in 10 years time.

CHAIR—There must be national standards.

Mr ENTSCH—There must be a standard.

Mrs Minetti—It is not a standard, and it is something that was raised a couple of years ago when the new town plan was being done—getting them to change the building act—because the cost of putting a nogging in a wall at that point and making the doors slightly wider is absolutely minimal compared to retrofitting, which is what the HACC funding and Home Assist Secure money is used for, putting in ramps and things like that. Those sorts of things can be addressed at that stage. The thing is to get it into legislation, which it is not, and that does need to change. It is a very simple answer to what is very expensive to retrofit later.

CHAIR—I was on the inquiry a couple of years ago that looked at cost shifting by the state governments and federal governments onto local governments—which I think is enormously unfair. The Commonwealth has a responsibility for aged care and should pay for it. It should not put the burden on local authorities and therefore the ratepayer, just as the state government should not in areas which are their responsibility.

I must say, and I should have said this at the outset, that we have had no cooperation from the states with regard to this inquiry. We are looking at health funding and what the future of health funding should be, such as all the things that you have raised—the ageing population, the sea

change phenomenon and the massive growth rates we have here in the south-east corner of Queensland. But the state government will not cooperate with us because, they argue, 'You give us the money and we'll look after it; we'll do it.' That is the case with the public hospitals. The Commonwealth government, through the health care agreements, provides half the funding for the cost of public hospitals but has no right to ask the states, 'What are you doing with that money?'

The Commonwealth also provides all the GST revenue to the states. That means that about half of the state governments' expenditure is again Commonwealth money. So, in reality, the Commonwealth is funding three-quarters of the cost of public hospitals, with the state government having no level of accountability to the Commonwealth. In the renegotiation of the health care agreements in a couple of years time, the health minister has indicated that the Commonwealth will be looking much more closely at levels of accountability to the taxpayer and, by establishing national goals in health, requiring the states to achieve those national goals, which we do not do at present.

There is cost shifting and blame shifting between the Commonwealth and the states, and a number of us at the federal level—I think all of us—are sick of it. We are sick and tired of the blame game. The information that we have been given, not supported by empirical data but I suspect that it is accurate, is that only 20c in the health dollar gets through to the patient; the rest of it gets siphoned off to bureaucracy and other things. When Queensland gets $8 billion from the Commonwealth over five years for public hospitals, but only 20c in the dollar gets through to the patient, we see the Dr Patel situation arise and what happened at Caboolture Hospital, because of workforce shortages and other issues. But we cannot talk to the states about it, because they will not give evidence to this inquiry. That is our problem.

I would like to just turn to the problems in Caboolture. Of course, we were invited here by you, Mayor; and Mal Brough, who is the local federal member for this area, also encouraged the committee to come here as part of our taking evidence about what is wrong with the health system. Would you like to give us a briefing on what happened that resulted in the closure of the Caboolture Hospital emergency department? We did hear yesterday from the division of general practice that covers the area from Caboolture to North Lakes, and they may have a different view as to the role of emergency departments. Most general practitioners will say people should not go to emergency departments for things they can get from a general practice. Would you like to comment on that for this area?

Mayor Leishman—Certainly. I will once again put things in context. I have lived in Caboolture for 30 years. For the first 20 years I lived here we did not have a hospital, so the community of Caboolture—my family and all the other families—went to either Redcliffe hospital or services in Brisbane for all of our health needs. There was much lobbying for and a great need to have our own hospital. The Caboolture hospital was opened a little over a decade ago and was warmly received by this community. In the six years I have been mayor, and in the time before that, I only ever heard great praise for the care that was delivered at Caboolture hospital.

Shortly prior to Christmas just past, I was moving around the community, as one does, and was hearing that there was an intention to close the emergency department. To be quite frank, I did discount it. I did not think that anybody could possibly believe that they could close the

emergency department of a hospital. I did not know then but have since found out that Caboolture emergency was seeing some 38,000 patients a year. Shortly after New Year, I received information from people within the community who worked at Queensland Health that there was a probable closure of the Caboolture emergency department. Quite early in the New Year, I received a phone call from Monica O'Neill, who was the acting district manager. Monica is part of our multicultural external task force. She phoned me to say, 'Mayor, I just wanted to let you know that there is a high probability that the emergency department will be closing on 16 January.' I was quite devastated by this news, and she indicated to me that she would keep me informed. She also said that they were doing everything they could to keep it open.

On 6 January, which was a Friday morning, she phoned me and said, 'There is a meeting this afternoon of the medical, nursing, administration staff of the hospital. Will you attend it?' The discussions were to be around what was now being called the contingency plan for the closure. I explained to her that I would not be able to attend that meeting because a young lad had been killed here in a road accident on New Year's Eve and I had given an undertaking to his mum that I would be at the funeral. The acting district manager was quite insistent that the meeting would be going ahead and that she would very much value my presence in being there, so I made other arrangements. I also said to the acting district manager that morning that I thought it was imperative that the state member, Carryn Sullivan, be there, because I was a mayor and the state government had responsibility for the emergency department.

I set one other condition for attending the meeting, and that was that I was attending as mayor of this community and nothing that they would say to me would remain confidential because I would be taking notes at that meeting and coming out and addressing the media on what was being said—because at that time a lot people in the media were saying, 'It is not going to happen; it is not going to close,' yet I was getting this very clear information that it was. I attended the meeting on the afternoon of Friday, 6 January and spoke at length with the medical, nursing and administration staff. They were very clear that the emergency department would be closing on 16 January, and we talked at length about the sorts of processes they needed to put in place—patient transfers, movement of staff and how the community would be informed.

I did do a press conference after that meeting. I have to tell you that personally I was devastated that we could be in 2006 and have an emergency department close in this community. If you can feel the emotion now, that is how I felt on that day. On the Monday morning I rang the office of the Minister for Health and asked to see him urgently. I was told to put my request in writing, and I did so. I had a phone call about lunchtime. I met with Minister Robertson and the local member, Carryn Sullivan, on the Tuesday afternoon. We still had denial at that point that it was closing. I said to the minister, 'I think, Minister, you need to go out and talk to your own staff.' The minister came out here on the Thursday. He then announced the closure, which happened on the following Monday, 16 January.

I can tell you that every day since the day of that closure there has been a very sad story about people in this community who have been denied life-saving essential services and the hardship for their families. It has changed the way people think. We have a number of people who moved deliberately closer to the Caboolture Hospital because they had some sort of health problem and they knew they needed to live close to an emergency department. They have lived for the last two months in great fear. I have talked to many of those people. They are people who I do not

think have shed a tear in fear in their lives, but they have lived in fear now for two months. They have lived with the question of whether it is really going to be opened again.

I have talked to parents whose kids have been injured and who should have been able to get emergency treatment at the Caboolture Hospital. Not only did they have to go to Redcliffe or Brisbane but also they were unable to get an ambulance. I spoke to a family whose child injured themselves on Morayfield Road in such a way that they had to ring the ambulance. The ambulance have been fantastic through all of this, but they said: 'We're sorry, but we can't get someone there. It is actually better if you drive the child down yourself.' These are the stories that we have heard day after day without our emergency department.

This shire is 126 years old. I do not think that, in our history, we have had an issue as big as this one. We have not had an issue that has impacted on everybody's thinking process. For some it is a huge issue because of what has actually happened to them. The community of Bribie Island—this aged community that we talked about—have felt particularly vulnerable. There are many other instances, as I said. There has been a story a day. It has changed the way people think in this community. This community holds its breath 24/7 until that emergency department is reopened.

CHAIR—You have an undertaking that it will open on that day. I understand that a private contractor has been contracted—Aspen Medical—to provide that service on that day. Do you know how long the contract is for Aspen Medical to provide that service?

Mayor Leishman—Not last Tuesday but the Tuesday before, during a council meeting, I received a phone call from the Minister for Health, Minister Robertson. I was pleased with the news—I do not need to say that it was good news—that the emergency department would be reopening on 18 April. The minister advised me verbally that it would be Aspen Medical—a company which, I understand, has a head office in Canberra and which has done some work internationally—and that they had been contracted for 12 months to provide emergency services at Caboolture Hospital. I welcome that as good news. I do not have an issue with whether it is Queensland Health or Aspen Medical running our emergency department. If you are a mother with a child who needs a doctor, you want a doctor. I do not think there is much issue about who employs them. I took the minister at his word and welcomed the news that it would be a 12-month contract to work it out and that they would be working on post that.

CHAIR—It was—

Mayor Leishman—Can I finish, because it is an important point. There was a lot said in the closure of the emergency department about the shortage of doctors. The doctors that were working at Caboolture Hospital—most of them live in the shire—left because of many issues, but one of them was the denial of beds in the wards, this thing called access block. One of the things I talked to the minister about that day was whether that issue had been solved, that the emergency ward doctors did have enough access to beds in the wards. What happens is that they have to manage them far too long in emergency. The minister said that that issue had been addressed and that Aspen was actually not just employing the doctors in emergency department but would be responsible for the management of the emergency department.

Mr ENTSCH—Has there been a guarantee that the service will be continued after that 12-month contract? For example, Cairns is also a very high-need area in relation to medical services and expert staff. I am aware that one of our anaesthetists was taken from an area of very high need and brought down here to fulfil that need, along with one of our key senior nursing staff from the emergency ward, which has had an impact up there. What concerns me is that you have got a 12-month contract and you are poaching from other areas of high need. If you can be a little bit cynical, there will probably be an election in the next 12 months. You would have to be concerned that there is a guarantee. What were the guarantees that the service would continue after that 12-month period?

Mayor Leishman—There was no guarantee, nor did I seek it, because there is an expectation in communities that you should have life-saving essential services 24/7.

Mr ENTSCH—Absolutely.

CHAIR— Has the state government or the health minister indicated what happens after that interim arrangement? I take it this contract is an interim arrangement. We are taking evidence from Aspen today some time after 11, so we will ask them as well. We are looking at the long term. I am sure you are looking at the long term as well. This was an emergency procedure to meet an emergency situation. How long is this going to last?

Mayor Leishman—The advice from the minister on the day was that the contract was for 12 months and that that would be reviewed at the end of 12 months. As mayor, that is not a role for me to play. The Queensland government have the job of managing Queensland Health and in turn the emergency department of Caboolture Hospital.

Mr ENTSCH—I have another couple of quick questions. There was an issue raised in relation to quality assurance. Unfortunately, it is a reality. You would have heard of a recent instance I think in a Victorian nursing home. Every year there is an incident where quality assurance has to be tightened up. We are now looking at what I think are being called grey cards for staff. Again, it gets back to this demand, and rightfully so, for an appropriate level of care. The expectation for that level of care is getting greater and greater. Quality assurance is an aspect not so much of industry but is a necessity that is demanded by the people accessing the service.

Mrs Minetti—We do not have a problem with the fact that we need to do quality assurance. That is fine. What we are talking about is the reporting documentation for HACC funding. They have a separate QA document. Then you have Veterans Home Care, with a separate QA document. Then you have EACH packages and CAPS packages. They all have separate documentation. What we are saying is that you could have one base QA document and, if you need to have an addition for Veterans Home Care or for CAPS, you just put in an additional section rather than having seven-page documents that are very time consuming—

Ms Day—Forty-eight page documents—

Mrs Minetti—Sorry, they are 48-page documents that you have to fill out once a year and are not funded. That is not part of the funding that comes into the service.

Mr ENTSCH—Last Tuesday the minister, Mr Santoro, had a forum in relation to dealing with issues such as this. Did you have the opportunity of putting in a submission to that?

Ms Day—Not then, but we have communicated directly through Mal Brough on this issue.

Mr ENTSCH—I would encourage you to do that because there is a process that is happening there and an undertaking from the relevant minister that he will be looking at addressing a lot of these issues. A number of the things that were raised by your panel today actually fit hand in glove with the work that he is doing and the forum that was held last Tuesday. You made a comment that there is a low acceptance rate or a reluctance to accept the HACC program in the home. You made a comment that people feel that it is the next step before a nursing home, or something to that effect. I am interested in that.

Ms Day—With the older folk, the generation that we are dealing with now, their greatest fear is that they are going to be put in a home. They are forever saying to the children, ‘You’re not going to put me in a home.’ They still have the bogeyman concept of what residential care is all about. They have not got a concept of the elevated status that residential care offers them as an option these days. There is a great fear around being removed from the community and put in a home, and therefore they are reluctant to access HACC services. Their feeling is that if family members see that they need this support in their home they will be told by the family member, ‘Look, Mum, you’re getting past it. We think you’d better go in a home.’ That is forever their fear.

We are breaking it down through having constant forums and addressing the community and getting out there with them. The concept with having people in our HACC services, the base level services, is that, from that stage on, we monitor their care levels and escalate the care level as necessary. We introduced from the outset the concept that they need to be looking at residential as an option for respite for the carer component of the household, and getting the bogeyman concept away from the residentials. We have open days at Eden on Bribie and the Bribie retirement village and encourage the people, the community, to be involved there. They are involved in activity pursuits within the village complex, within the village life, and it is no longer the big bogeyman thing. We have tried to open it up that way by simply taking them out and having them actively participate in what goes on there and seeing that this is a really viable option, particularly for respite. Respite is, of course, a big issue because we do not have respite beds to access when people need them. Carer respite is a particularly heavy need in the community.

Mr ENTSCH—In relation to the number of respite beds that are available in this community, I am interested in the number of nursing homes you have, given the disproportionate number of aged you have in this community. For the record, how many nursing homes do you have here?

Miss Frawley—We have 17 nursing homes or retirement villages listed in the submission.

Mr ENTSCH—No, I am not talking about retirement villages. I am talking about nursing homes—aged care homes.

Miss Frawley—I think there are only seven.

Mr ENTSCH—Out of those, is there any provision for profoundly disabled young people? Do you have any idea how many beds are taken up by young people in nursing homes?

Ms Day—We have a very low incidence of that, which is good. The thing is, though, that the options for these people are not there. They are being cared for at home in a lot of cases.

Mr ENTSCH—I appreciate that, but I understand that through the last COAG there was specific recognition of the needs of profoundly disabled young people. I would encourage you, as a means of freeing up any beds in aged care, to do an audit of how many young people are taking up these beds and grab the opportunity to be able to get the appropriate accommodation for them. Get them out of the nursing homes; I think it is absolutely appalling.

CHAIR—We are finding that carers are ageing as well, and we have 75- or 80-year-olds caring for 45- or 50-year-old disabled dependants. This is why COAG is particularly looking at that issue.

Mr ENTSCH—That was my next question. What support accommodation do you have available in your shire for people with mental or physical disabilities who do not qualify for nursing homes? Unfortunately, a lot of young people have been dumped in nursing homes. A lot of these people, as Alex said, are not just 45 years old but can be up to 60 years old. They are mentally disabled. They are not violent, but they are very active. They are very dependent on a very aged mother—usually—because the father has passed away. There was an instance in my electorate of a woman coming in and suggesting that she was looking to euthanase the son because she was getting to a point where she felt she was going to go. I am wondering whether there is any support accommodation available in your community for mental—

Ms Day—We have limited access to accommodation. The focus seems to mainly be on respite, though, and not on residential provision, which creates a difficulty. We have a huge concern among our older carers about exactly what you mentioned. They want to know what is going to happen to their adult child when they are no longer here to care for them. We have looked at an innovative program to address that need using the concept of lifestyle education. Many of these people are, with support, able to live independently in the community if they are given the opportunity to have some lifestyle education.

We are currently communicating with the Endeavour Foundation, because it is their core business. Currently, council is supporting them to set up an activities facility in the middle of town. They will set up two purpose-built independent living units and run a six- to 12-month lifestyle education program there, which TAFE has already agreed to put in place. Then, with support from community workers, they will take the students through a process of budgeting, shopping, general home maintenance and whatever, and educate them to live independently.

We have looked at the exit strategies. We have already negotiated with the Department of Housing so that they can take the concept of these purpose-built units and locate them in the community. If the people are educated to live in those units, because they are relocatable—Glendale homes and Halley homes have been very interested to support the concept—they could be moved onto their family's property or into the community in other areas. If they are familiar with their environment and learn all of these skills, they can cope with minimal support.

Mr ENTSCH—The reason I raise that is because part of the action plan that is currently being developed by the state premiers, and which is due to come back in June, has a particularly focus on mental health and on looking at removing young people from aged care facilities. Given the challenge you have here, I would encourage your community to keep right on that one, because it does present opportunities, particularly in relation to infrastructure for support accommodation. That could be publicly funded infrastructure with a full-time carer living there and supporting a number of people. An alternative, which happens in Western Australia, is that individual families could buy a node within that accommodation—it becomes like a strata title unit. There are opportunities.

Mrs Minetti—That is an interesting comment, and it is something that we have looked at. We have started discussions with developments like the over-55s villages in terms of developing an exit strategy. The issue the Queensland department has is that, if you have more than four or five people within one house with one carer, you then start getting an institution type of thing happening. To make it viable to give these people an exist strategy with a Halley home or with an over-55s village—the node that you are talking about—requires there to be more than two of these in place. You need to have at least six. There needs to be a bit of a mind shift there from the state. It needs to accept that having more than four of these people in a cluster does not mean that it is an institution.

Mr ENTSCH—There will be an opportunity in June.

CHAIR—Unfortunately, we are half an hour over time in our very first session. We can raise more issues later on in the community forum. I would like to thank you, Mayor Leishman, for the evidence that you have given to us today. If there are other issues that arise, I invite you to send us more information in writing. If necessary, we might invite you to appear again. Thank you very much.

[10.21 am]

JENKINS, Mrs Pamela Catherine, Director, Lifestyle and Environment, Pine Rivers Shire Council

CHAIR—Welcome. Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. I read that out to all witnesses; it is not directed at you. I invite you to make a brief introductory statement before we go to questions.

Mrs Jenkins—I would like to thank you very much for the opportunity of coming here today. This will be brief. A lot of the discussion that has transpired already this morning relates directly to Pine Rivers Shire as well. We are neighbours with Caboolture and we carry the same profile to a large degree as a shire. We have similar population growth issues, the same ageing population issues and the same service delivery issues that Caboolture has already talked to you about. Rather than listening to me expand—bearing in mind the time—please take it that what has been said by Caboolture I most definitely support.

Pine Rivers made a submission back in May. The driver at that time was in relation to the funding for immunisation services. I think there is great value for the community in the immunisation program that is offered. It is a quality-of-life issue. It certainly assists in the health services area in being a preventative action, so from that perspective it is a very important service. The burden that Pine Rivers Shire Council is carrying at the moment is in the vicinity, from a dollar perspective, of $150,000 a year. This is just one very small service along with a number of services that we deliver.

Those relevant to this discussion are: respite and support services, the Community Assisted Transport Service, the Home Assist Secure Service, aged care respite and our Pine Rivers Disability Program. These services are highly valued by the community. The demand that we are facing now due to the growth in the population and also the ageing population is enormous. Issues for us are not only the solid infrastructure and the maintenance of those facilities to enable us to deliver the services in the first instance but also the attraction of skilled staff. We are not experiencing anything different to Caboolture, but, in relation to the immunisation program, we felt that this hearing was an opportunity to try and get some recognition of the service that is being delivered there.

CHAIR—Would you take us through your submission, particularly where you talk about the variations between the states in funding to local government?

Mrs Jenkins—There is a chart in it highlighting the difference in the funding. This is as of May last year. In South Australia, with the preschool program they receive $6 per child per immunisation.

CHAIR—Does the Commonwealth provide $3 of that?

Mrs Jenkins—Yes. Victoria receive $11 per child, New South Wales receive $6 per child, Tasmania receive $6 per child, WA receive $6 per child and Queensland receive $3 per child.

CHAIR—So Queensland gets Commonwealth money but there is no state money for immunisation?

Mrs Jenkins—Yes. This makes it a heavy burden for local government. It comes down to that aspect that there is very much a need in the community and I am quite sure that everybody in the community and everybody in every level of government values the immunisation program that exists. However, it is yet another burden on local government to deliver it.

CHAIR—I do not remember that being raised as an issue in the cost-shifting matter.

Mrs Jenkins—I do not actually remember it being raised.

CHAIR—It is plainly cost shifting to local government, expecting local government to pick this up. How much does it cost Pine Rivers shire to deliver this service given the $3 Commonwealth subsidy?

Mrs Jenkins—Given the subsidy, it is costing us $150,000 a year. That is the council's total contribution.

CHAIR—So you do not know how much it is per child? In South Australia it is $6, so obviously there is a dollar-for-dollar subsidy by South Australia.

Mrs Jenkins—That is what they are receiving, yes.

CHAIR—It is $11 in Victoria.

Mrs Jenkins—We are not getting any extra subsidy at all, so it is carried yet again.

CHAIR—I would be interested in knowing, if you could work it out and send it to us later, how much per child it costs Pine Rivers shire. It is costing the Commonwealth $3. How much is the shire putting in?

Mrs Jenkins—I am happy to do that.

CHAIR—Thank you, Mrs Jenkins. As for aged care, you heard earlier Jane, I think it was, saying that the formula determining the allocation of beds is based on the number of people aged over 70 per thousand of population. In my area on the Sunshine Coast, most people in nursing homes and aged care centres are over 80 and the plus-70 formula allocating beds disadvantages my area because we have people not going into nursing homes until they are 80. Do you have that same situation?

Mrs Jenkins—I am not aware of the actual statistics in terms of what is available. There is most definitely a lack of services for residential care for the elderly in Pine Rivers. The current situation with our population is that a very high percentage, something of the order of 80 per cent, are single in home dwellings, and we do have a large aged population. There is support for

those people to stay in their own homes, and I most definitely support the HACC programs in terms of maintaining people in their own homes. That is the aim of our services. Everything that we deliver, whether it by transport or whatever, is to prevent that ultimate residential care situation.

CHAIR—That is Commonwealth policy as well.

Mrs Jenkins—That is exactly right, and local government most definitely supports that philosophy. The difficulty comes in the delivery of those services and the demand for those services. You find that, with our community assisted transport program, at the moment we are delivering 67 per cent above the funded amount simply because of the demand—and, once again, it is highly valued by the community. We just cannot keep up with what is going on in the community in terms of the ageing population.

CHAIR—Pine Rivers is an outer metropolitan area. Do you find it difficult attracting GPs?

Mrs Jenkins—Yes, we have a shortage.

CHAIR—Where is your nearest hospital?

Mrs Jenkins—We would go to Brisbane, Redcliffe or Caboolture.

Mr ENTSCH—What was the impact of the closure of the emergency department of Caboolture on your shire?

Mrs Jenkins—I think it was along the same lines as what happened in Caboolture in terms of shock. Something that is very difficult to cope with for the aged community is that element of fear that exists in their lives, that if something does go wrong they do not have the ability or the access to care. They are dealing with that on a daily basis. It is not just when something actually goes wrong; it is that fear of something going wrong. They live with that fear and a lot of their communication is about that anticipated event that may happen. It may not have happened, but that fear is with them constantly.

Mr ENTSCH—You mentioned the shortage of GPs in your submission. Given that the submission was sent some time ago now, have there been any changes?

Mrs Jenkins—No. That is still the case. What is happening at the moment is that there is at the state level a proposal for an allied health group to be set up at North Lakes but operating more as an outreach service to a large degree.

CHAIR—Is North Lakes in Pine Rivers?

Mrs Jenkins—Yes, North Lakes is in Pine Rivers.

CHAIR—North Lakes is covered by the division of general practice that covers this area.

Mrs Jenkins—That is right, yes.

Mr ENTSCH—We met with them yesterday. Given the limited access to GPs, how do people in your region get around that? Do they just travel to other areas?

Mrs Jenkins—Yes. We probably would have stats if they were required for our community assisted transport, because a lot of that transport is for taking those people to doctors appointments, hospitals, a day hospital or some service of that sort. That could be either in the shire or out of the shire.

Mr VASTA—I want to ask about Meals on Wheels, because we heard there was a bit of a problem with the burden on Meals on Wheels. How is it in your area?

Mrs Jenkins—Pine Rivers shire does not actually deliver the Meals on Wheels service. We provide the service with a facility and our mayor is very proudly the sponsor of it, but we do not deliver that service directly. But there is certainly a demand on the service, yes.

Mr ENTSCH—I thought I saw you here when I mentioned mental health and young people, and I would strongly urge your shire to do the same thing as Caboolture. There is a window of opportunity here that we really cannot afford to waste. I will not go over that again, other than to suggest that you look at that very closely.

Mrs Jenkins—Most definitely. I would be happy to do that. May I just say that in coming here today I had also contacted the Local Government Association of Queensland and I spoke to both Greg Hallam and Desley Renton, who are pretty diligent workers for that organisation. They had wanted to come with me today, but due to previous arrangements and commitments and a shortage of staff—as with all of us—they were unable to attend.

CHAIR—You could tell Greg that we would be very happy to hear from him and to take a submission. Our terms of reference clearly mention local government, and we have not had much of a response from local government. We have not heard from the LGAQ, but we would encourage that. The first of the terms of reference is: 'examining the roles and responsibilities of the different levels of government (including local government) for health and related services'—who should handle what. We are really not interested in this blame game between the Commonwealth and the states anymore. We want to get the health services and deliver them in the most efficient way. We do not really care if the Commonwealth does it, if local government does it or if the states do it—we just want it done efficiently.

Mrs Jenkins—Don't we all!

CHAIR—We would like local government to have a say.

Mrs Jenkins—Can I say that in Greg's response he did highlight perhaps six points that are very important to the LGAQ, and that of course means they are of concern to all local government authorities in Queensland. He has, via Desley, given me those six dot points. Would it be reasonable for me to go back to the LGAQ and request further information relating to them?

CHAIR—Yes.

Mrs Jenkins—It is difficult for me to speak on their behalf with a one-sentence point, but I am quite sure that they have significant data they could put behind those issues. Would that be an acceptable practice?

CHAIR—That would be good, yes.

Mrs Jenkins—Wonderful. Thank you.

CHAIR—We pretty much covered everything in your area with Caboolture shire.

Mrs Jenkins—Yes, and I appreciate the discussion with Caboolture because, as I said, the same issues are reflected, but the responses were interesting to hear as well.

CHAIR—We will have a community forum a bit later on, so other issues might be raised. Thanks very much for giving us evidence and for opening the door to the Local Government Association of Queensland.

Proceedings suspended from 10.36 am to 10.56 am

TAIT, Mr Stuart Peter, Executive Chairman, Family Care Medical Services

CHAIR—Welcome. Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the parliament and that the giving of false or misleading evidence is a serious matter which may be regarded as a contempt of the parliament. I now invite you to make a brief introductory statement.

Mr Tait—Thank you very much for the opportunity to make a presentation to the committee today. I am going to talk a bit about health care services in the far north of Brisbane generally—how they need to be integrated, and the effects of the closure of the Caboolture Hospital emergency department—and give an overview of how things are travelling, from a public and a private perspective, here in Queensland. Family Care Medical Services is Australia's largest medical deputising service. We have two broad roles. We look after all the daytime general practitioners' patients in the night-time period by doing home visits and we also run co-located clinics here in south-east Queensland. We run the after-hours GP clinic at Caboolture, we run a co-located clinic at the Logan Public Hospital and we have another clinic at Caloundra. We see about 200,000 patients per annum, of whom we clinically consult a bit over 30,000 patients. We do approximately 80,000 home visits each year and we refer about 85,000 patients to next-day GP coverage. We work very closely with our subscribing general practitioners. Our clients, really, are GPs who support our service, and we look after their patients in the after-hours period.

I must compliment the GPs in this particular area. Throughout this crisis, the GPs have been fantastic in supporting their patient community. Throughout this crisis we have we have done our very best to keep our services open. We provide a full home visiting service to all of the community in the greater Caboolture area. Even though we have had significant medical workforce shortages we have been able to keep our clinic going throughout this problematical period.

Our model of combining home visits with clinic consultations has been supported extensively by the Commonwealth. I do not know if many people are aware that the Commonwealth government, over the last four years, through its round-the-clock Medicare program, has committed expenditure of over $450 million for improving access to after-hours services for patients in the broader Australian community. That has certainly allowed us to expand our services. Previously we did not look after the Sunshine Coast, but we now look after the area all the way south from Noosa. We cover all of Brisbane—the eastern suburbs and the western suburbs—Ipswich and all the way down past Logan to the Coomera River. Patients who are ill in the after-hours period can access our service by directly telephoning us. Alternatively, if they ring their GP and the GP's clinic is closed, the phone call is diverted through to our service. We then triage the call and the patient is either allocated a home visit or referred to one of our co-located clinics.

Clearly, the challenge for all health care systems in Queensland, whether they be public or private, is to provide the best possible service to the community. Accessibility is obviously a key factor, but there is also integration. There are various skills within both the public and private sectors which need to be properly directed. They need to be efficient and effective. Sadly, the integration that is occurring at the present time is not as clever as one might think. We know that

the Queensland Ambulance Service, for example, does about 12,000 patient contacts per year where the patients would be better off being home visited. Those current contacts involve an ambulance evacuation to an overcrowded emergency department. That is problematic for the state. The costs cascade to the state through the $800 per ambulance evacuation cost, and then you have the cost of the ED attendance. On top of that, you might have patients with young children or the elderly or others who might need a catheter changed. Those patients should not really be in an ED; they should be looked after in their residential environment, if at all possible. So of course there is great anguish in the community.

We are trying to work very closely with the state government to increase the integration of the Commonwealth and state systems. That has been a pretty hard road for us to hoe up to the present. I must say, though, that Stephen Robertson has been a pretty accessible minister. I regard him as honest and approachable, and I think he is aware of the integration issues that are confounding Queensland Health at the present time, especially during the acute doctor shortage that they have.

Clearly, the closure of the Caboolture emergency department is a substantial breach of trust between a government and a community. It is hard to imagine a service more essential in any community than an emergency department, especially one that is next door to one of the major arterial roads of Queensland. We have worked for many years now at Caboolture with a very good relationship with the public hospital. We support the emergency department there. GP patients that they might not be able to see will often come and see us because we have quicker response times, but it has been very difficult for us to cope with having the emergency department next door to us closed. We have had some patients with very serious illnesses come to see us, where they should really have gone to the emergency department, if it had been open.

Thankfully, the Queensland Ambulance Service have been absolutely brilliant in supporting our clinic and in supporting the GPs of Caboolture. I cannot speak too highly of the care and attention that they have paid to rapid responses from the Caboolture area to the nearby Redcliffe public hospital. We have had response times of two and three minutes for significant events that we otherwise would not have got. It is hard to imagine how you could provide a better service, and my thanks go out to the Queensland Ambulance Service for all the support that they have given us.

The reopening of the Caboolture emergency department is, of course, an essential feature of resolving this issue. Joy Leishman has been a very vocal supporter and campaigner on behalf of getting this problem fixed. I am aware that there are some questions around whether a private sector contractor should have been used in the short term. From our point of view, we do not mind how it is fixed, as long as it is fixed. We believe the fact that Aspen Medical has come in to support Queensland Health is a good thing. We certainly encourage the Queensland health department to work in close cooperation with Aspen Medical to make sure that their contract is a successful one. The committee has our assurances that we will do everything in our power to make sure that we support Aspen Medical all through this current contract.

It is not going to be an easy ask. The culture of Queensland Health is very public sector orientated. Each time someone from the private sector goes to meet them, it is like a meeting between someone from Mars and someone from Earth. We do struggle to explain how our services work in Queensland Health, and we have done for some time now, but Stephen

Robertson is working tirelessly to try and get us better access to and better understanding in the department. That is probably a good enough kick-off from where we are coming from, and you might like to ask me some questions.

CHAIR—I think it was an excellent kick-off. Was it a deliberate policy of your organisation to co-locate next to the hospital? I know that that is happening in a lot of places. The division of general practice that covers this area intimated to us yesterday that there are perhaps people going to the emergency department who should be going to GPs. Maybe that puts pressure on the emergency departments that should not be put on them.

Why did the emergency department close down? You might have been here when I was speaking before. As a committee, we have not had any communication with Queensland Health. They have refused to give evidence to this committee, so we are getting our information from second- and third-hand sources. Was it a staff shortage? What was the reason for the closure?

Mr Tait—Do you want the short or long answer?

CHAIR—Both.

Mr Tait—You need to go back to the Patel affair over two years ago now and the great trauma that that caused to the people of Bundaberg. We had in our midst in Queensland a surgeon who was unsupervised and was encouraged—

CHAIR—We had evidence from Tony Morris yesterday.

Mr Tait—to do operations that really were out of his core ability to do. Naturally, that caused huge ructions politically. One of the ways, politically, that health in general dealt with the Patel issue was to strengthen or to, in the words of the Premier, 'toughen up' all the medical registration criteria that applied to doctors in Queensland whether they be IMGs, international medical graduates, or Australian graduates. At the same time, though, that we were toughening up those controls on overseas trained doctors we were actually in the early stages of a doctors crisis. Medicine is a global profession. People can work in Britain one year, the United States the next and Canada the year after. They are a highly regarded profession easily able to move around the planet. and they do. Indeed if you speak to any group of Australian doctors and you ask them to put up their hands as to how many have been trained internationally it is very rare to find an Australian doctor who has not had UK experience or whatever the case might be—gone to South Africa.

What we did by toughening up the Queensland Medical Board standards is that in effect we crashed our medical recruitment programs in 2005 and 2006. If you take the Caboolture Hospital and go north, 40 per cent of all the doctors in Queensland Health are IMGs, international medical graduates. Queensland is hooked on overseas doctors and has been for two decades. Even if we train more Australian graduates there is no guarantee that those graduates will stay in Australia. They are global graduates. They will travel just as easily to other states of Australia and to other countries as they will stay here in Queensland. The shortage that we have here in Queensland in emergency departments in particular has meant that there are just insufficient doctors in the system to be able to move them around to cover the crisis that we had here at

Caboolture. The system is stretched so tight that there are no additional resources available to move doctors around. That is why this emergency department has closed down.

There is a report out shortly, which will be delivered to the health minister, from Professor Ken Donald. It is probably the most important report that Queensland Health will have seen in the last five years. The Davies report was important, so was the Forster report and so was Tony Morris's report, but this little document, which will slip in behind the scenes, is even more important because it is a restructuring of all the medical recruitment processes in Queensland to make them the most efficient and effective in Australia. Without the best processes and without the ability to get overseas trained doctors in, the closures we are seeing here at Caboolture will not be the last ones.

In a certain sense, in Queensland both the public and private systems are facing what I would call a 'perfect storm'. We have, at the present time, great stresses and strains in our system and we have all read about code reds and so forth at the hospitals. But everyone needs to be aware that this is at the lowest demand time of the year. We have bed closures and we have code reds when there is no demand. The demand period increases dramatically as we go towards the flu season in August. At the same time, we have significant numbers of UK doctors who are currently working in the emergency departments who will be going back for their exams.

These are significant issues which I am sure the Premier and Stephen Robertson are well aware of, and everyone is pedalling like mad to make sure that they are addressed in time. But we are in a very difficult situation. The problem here in Caboolture is not the end of it. This is the canary in the coalmine.

CHAIR—We heard evidence yesterday that there are about 1,700 foreign trained doctors in Queensland.

Mr Tait—In Caboolture and north, I understand it is 40 per cent.

CHAIR—That indicates that there is a shortage of 1,700 doctors in Queensland if there are 1,700 foreign trained doctors here.

Mr Tait—Not really. One of the problems that we all have is that we tend to focus on the crisis in the public health care system, but there is an equal and smaller scale crisis in the private health care system, especially in metropolitan fringe and remote and regional Australia.

CHAIR—I was getting to that. The Commonwealth has a system for recruiting overseas trained doctors for the private sector. The public sector recruits doctors for the public sector. Are we competing with each other? Is the Commonwealth competing with the states on the market for foreign trained doctors? Should we take a national approach to recruitment?

Mr Tait—I do not think the Commonwealth is competing with the states. In my experience, and I have quite a bit because I recruit a lot of doctors both internationally and nationally, the Commonwealth has been very supportive of the state recruitment programs. The Commonwealth has been trying for some time now to get national medical registrations and a few other things in place. I am actually not a great believer in having a national system. I think one of the strengths of a federation is that you get competition between the states, which encourages efficiency and

effectiveness. It could well be that if you have a national system where everybody agrees on a process, the process that they agree on is even worse than the one we currently have.

Mr ENTSCH—Obviously competition within the states has created one of the problems we are seeing in our public system at the moment. We are losing a lot of our trained professionals out of the state. We are seeing a significant drift and it is leaving large areas of our population exposed.

Mr Tait—Exactly. There are ways you can address that, though. Clearly the culture of an organisation is terribly important—if it is welcoming, if it is honest and open. Clearly pay rates are important. Queensland has gone a long way to redressing some of those issues. Doctors will come to places where they are well treated, where their clinical acumen is well regarded and where they are allowed to treat their patients unrestrained by draconian administrations and so forth. I think Queensland Health has a fair way to go, as Davies and Morris both suggested, in fixing up its culture. I know Stephen Robertson is dedicated to trying to do that. But you have thousands of employees. It is going to be hard work to turn it around. It is not going to happen overnight.

We are training more doctors now in Australia, and that is ramping up over the next five years. But there is no point in training more doctors if you cannot give them their postgraduate experience in the hospitals. The Royal Australasian College of Surgeons for a long time has been telling people that there are not the registrar positions in the public hospitals to be able to train the people that they want to train. I know that the College of Surgeons gets blamed all the time for supposedly trying to manipulate its market to restrict entry to others doctors. Nothing could be further from the truth. We know that the College of Surgeons is desperate to train another 150 surgeons, but there are no registrar positions left in the public hospitals.

Mr VASTA—What is the solution to training the next generation of doctors?

CHAIR—Should private hospitals take a role in training?

Mr Tait—I believe that the College of Surgeons has already put some proposals to the Commonwealth about how registrars could reside within private hospitals. That has already started at Greenslopes. It is a problem that somehow has to be addressed. It is a difficult one, because if you are private patient you hardly want to be operated on by a registrar. If you are paying all those private health fees, you do not exactly want the 2IC doing the operation. Nevertheless, there is so little elective operating going on now in public hospitals and so few registrar positions, if we do not open up the private sector to training positions it is hard to imagine how we are going to train sufficient staff for the needs of our community in the future, especially as it ages.

I would recommend to all of you that you listen to the College of Surgeons. My experience with them is that they are an extraordinarily knowledgeable group that are genuinely interested in training specialists in this country. I think there is a lot of wisdom there. If they are recommending, as I believe they are, that we start training registrars in private systems, I would be inclined to listen to that advice.

CHAIR—One of the problems that we have heard is that the Commonwealth is responsible for undergraduate training in university and the states are responsible for the training in hospitals. Dr Cartmill, on behalf of the VMOs in Queensland, yesterday suggested that the Commonwealth should take over its proper responsibility in training future doctors and be responsible for the funding of their entire training. Do you have a view on that?

Mr Tait—I think that view reflects the view of the College of Surgeons, and at first glance I would be supportive of it. I think what really counts here is what is going to work. Clearly things we have going at the moment are not working. Aspen Medical taking over the emergency department is something that will work straightaway. It might not be the ultimate response to this particular issue; clearly it would be best if Queensland Health had sufficient staff to staff their own EDs, but they do not. I think as public administrators and health administrators we need to come up with ideas that genuinely help the community. If this is going to help the community, train more surgeons and make more skilled doctors available to the community, I think we should do it.

CHAIR—A medical place made available today does not produce a doctor for nine or 10 years.

Mr Tait—In surgery it is 15 years.

CHAIR—Concerns have been expressed about this private contract. While we all think it is a good thing for the community that the emergency department will be open again, and open soon, with all the underlying problems that you have been talking about and that we have heard evidence about today what guarantee have we got that the emergency department will remain open after the contract? Will the contract continue after 12 months?

Mr Tait—Or will there be more contracts?

CHAIR—Or will there be more contracts?

Mr Tait—I think that is a question you need to put to the Premier and the health minister. A lot is going to depend on Ken Donald's report and the capacity of Queensland Health to quickly ramp up their recruitment of overseas trained doctors sufficient to staff the emergency departments during this August flu season. None of us really want to think about the effect that the first emergence of bird flu is going to have in Australia either.

Mr ENTSCH—Clearly the only way we are going to manage this into the immediate future is by drawing on the expertise of people trained overseas. We do not have the numbers here to be able to deal with the immediate problem. Of course the issue that we have there is being able to assess the competence of the individuals that are recruited, and we have seen this issue in Bundaberg. Do you have a view on how that can be better achieved?

Mr Tait—Yes, I do. Family Care Medical Services have been working very closely with the Medical Board of Queensland. We have a board of medical directors, including one of Australia's foremost training medical directors. When international medical graduates come into our service they go through a formal induction program, they are mentored and they are encouraged to do their AMC exams, if they have not, or to start their fellowship exams. We have

close supervision of all their patient reports. We provide to our IMG doctors really close support, supervision and mentoring for all the things that they do. Our experience with IMGs has been that they are outstanding doctors. We have done a million patient contacts now in five years. We have had not a single unresolved clinical issue in five years. If things were going badly and some of our IMGs were not doing their jobs well, we would have significant clinical issues to deal with. We do not have any.

I do think it is very difficult in rural and remote areas of Australia where many overseas trained doctors are left on their own in single clinics. They do need support—it is a hard thing to do. If you have a vacancy and you can get an international medical graduate into that vacancy then there is a difficult balancing act at a public policy level. What is the right thing to do? Is it better to have a doctor in there, with maybe less supervision than you would ideally want, or to leave that position vacant? That is a difficult decision for governments, whether state or federal, to have to make. We do not leave any of our doctors isolated. We really support them and encourage them to do their exams and get their fellowships. We are proud in Family Care that we graduate more people through the fellowship than any other practice in Queensland.

Mr ENTSCH—I suggest that there would have been a few patients in Bundaberg who would have preferred to have waited another three or four months so that Dr Patel could have worked under his peers to get an appropriate assessment before he was turned loose on the community. One of the things that has been suggested is that, rather than just accepting qualifications on face value, there should be a peer review process where they work—

Mr Tait—Undoubtedly.

Mr ENTSCH—and that may be one way in which—

Mr Tait—Almost certainly that will be the system that rolls out here in Queensland and elsewhere around Australia. And so it should.

Mr ENTSCH—You work out of both private and public settings. Your organisation works here with the private hospital—

Mr Tait—We are co-located in the Caboolture Private Hospital but our rooms are only 20 or 30 metres from the emergency department.

Mr ENTSCH—What about some of the other services that you have, in Brisbane, Logan and the Sunshine Coast?

Mr Tait—They are co-located inside the public hospitals.

Mr ENTSCH—So you have a similar arrangement with the public to that which you have with the private hospitals?

Mr Tait—Yes. And all our patients are bulk-billed in the clinics.

Mr VASTA—Was there anything that came out of the recent inquiry that you would like to see happen but that you do not think will actually happen?

Mr Tait—Which inquiry are you talking about? There have been a lot!

Mr VASTA—Yes, that is true; I take your point.

Mr Tait—We are all inquiried out!

Mr VASTA—That is right. I was referring to the Bundaberg Hospital inquiry.

Mr Tait—Clearly, Geoff Davies's most significant recommendations involve the culture of Queensland Health and the need to try and get health back on a more clinical footing, so that it is more patient focused rather than process focused. I think the other thing, which Peter Forster brought up—and I think the government is really just coming to grips with this now—is that when we reconstructed our major hospitals here in Queensland we built them smaller than previously thought necessary. At the time, we all believed that the smaller hospitals would be ideal because operating processes had changed—laparoscopic surgery had come in; people did not have to stay in hospital for as long as they did previously. However, at the same time that we built smaller hospitals we had rapid population growth—very infrequently under 2.5 per cent per annum—and an ageing population, which meant you had chronic health overtaking elective surgery and other things, so that we are now really significantly underresourced as far as beds are concerned.

I know that there is a lot of political debate about whether the problems in emergency departments are caused by the patients allegedly not being bulk-billed in GP practices and therefore going to EDs. We run co-located clinics. We are one of the biggest runners of co-located clinics in this country. We can assure you that that is not the problem. The problem in health care systems—not just in Queensland but elsewhere—is that there are not enough beds in the public hospitals to be able to move seriously ill patients from the ED into the main hospital. So those patients build up and they have to be looked after by the staff; it is extremely stressful. What tends to happen in the EDs is that what they call category 4 and 5 patients—but, in particular, the GP style category 5 patients—have to wait longer and longer. If you have a young child with an ear infection and you are waiting for four or five hours in an emergency department, it might not be absolutely urgent to look after that child but it is very stressful for the parents. Tensions build up; there have been assaults of nurses; it gets very, very uncomfortable. That is where our clinics can really help out. We do not do very much to help the volume problem in the EDs. That is the truth; we do not. But we do an awful lot to allow those GP style patients to go in and see a doctor, be looked after very quickly and get home again. That is where we help. The only way you are going to fix the problem of EDs in this state is to build more beds and to properly staff and fund them.

CHAIR—The 25 per cent increase in salaries for nurses and doctors recently announced by the Premier is going to help to retain doctors in the public system. It is going to cause problems for the private system in that the private system will somehow have to meet the wages of nurses in the private sector or lose many of them. Are the increasing salaries offered in the public sector going to have an impact on your organisation?

Mr Tait—Yes.

CHAIR—Do you expect to lose people possibly to emergency departments?

Mr Tait—No, I am going to pay my staff more! I have to. When the market moves, if you have very good staff that are very reliable and trustworthy and there are competitors who are prepared to pay higher rates, you have to either be prepared to pay them more or to lose them, and I am not going to lose my staff. I value my staff and I have worked very hard over many years to build up a great team. I am going to keep my team, I can tell you that.

CHAIR—What gives?

Mr Tait—What will give will be higher private health insurance premiums. The private hospitals are under huge cost pressures now because of these quite dramatic increases. They cannot absorb them and must somehow pass them on. Private hospitals are all under contracts with the health funds. The health funds of course are under pressure from their members to keep funds down and the tension between funds and the private hospitals is going to dramatically increase in Queensland.

There is a great irony there. If you look at the number of operations done in Queensland—just raw productivity, elective surgeries being done and so forth—the vast majority of the efficiencies and the throughput occurs in the private system, not in the public system. Yet the pay increases are occurring in the public system. That is going to play through the Queensland health economy for the next three to five years. It is going to have significant effects on private hospitals.

CHAIR—But if you bulk-bill you cannot pass on your costs to the patient, can you?

Mr Tait—No.

CHAIR—So you have to absorb it.

Mr Tait—Yes, but that does not apply. We were talking about private hospitals, not about primary health care. Private hospitals will have no choice but to pass on their increased cost because they cannot afford to lose their wonderful—

CHAIR—Primary health care cannot.

Mr Tait—Primary cannot, but the private hospitals will have to pass it on. They cannot afford to lose their fantastic theatre staff. They have teams as well which they rely on. All the private surgeons have teams that they have worked with for years—laparoscopic surgery teams and so forth—and they are not going to lose them to the public system no matter what so they will have to match the market. I would just like to finish off by emphasising the thing I raised first up: what really is going to aid our systems in the future is integration. We cannot continue having these enormous fights between the Commonwealth and states—

CHAIR—Hear! Hear!

Mr Tait—and emergency departments closing down and people not being looked after and ambulances on divert and not enough beds. We really have to start thinking about how we can work more cooperatively. Firstly, I would like to congratulate the Commonwealth—and not just the Commonwealth but the Liberal Party and also the Labor Party that have been very supportive of after hours as well. Both political parties have recognised in Australia that after

hours needs to be better looked after and improved. You have gone a long way to improving those systems. Some of the integrational projects that are important here in Queensland include integrating the new health call centre—whether it is state based or nationally based—with the primary health care system. There is no point having a free nurse triage service that takes patients away from daytime general practice and then encourages them to go to emergency departments or, alternatively, a health call centre that speaks to a patient late at night and cannot refer that patient to a home visit, if that is the best modality for them being treated.

We have new systems being developed here in Queensland presently which are completely unintegrated with the primary health care service. Similarly, with the Queensland Ambulance Service, we know that there are 12,000 patient contacts a year which really should be home visited or clinic consulted that are currently being evacuated via QAS to emergency departments. We can stop a lot of this nonsense and look after patients a lot better than we are currently. I encourage all levels of government to try and take the politics out of it a little bit and work in cooperation with each other. If we can look after patients better, that is what our objective should be.

CHAIR—Thank you very much for giving evidence before the committee.

[11.31 am]

KEYS, Mr Glenn, Managing Director, Aspen Medical Pty Ltd

CHAIR—Welcome. Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the parliament and that the giving of false or misleading evidence is a serious matter which may be regarded as a contempt of the parliament. Do you wish to make a brief introductory statement to the committee?

Mr Keys—Yes, thank you. We have been recently engaged by the Queensland government to assist with a project here in Caboolture. While we do a significant amount of work for the federal government and overseas governments, we are obviously not very well known in Caboolture. So I think it might be worth while to give a little bit of a background of our company and who we are. Aspen Medical is a wholly Australian owned company. We are based in Australia. We are headquartered in Canberra, but I would ask that no-one hold that against us!

CHAIR—So are we!

Mr Keys—We have our headquarters in Canberra and we have offices in Adelaide and Melbourne. We have overseas offices in the Pacific, particularly in Honiara in the Solomon Islands. We have offices in Indonesia, Singapore and England—which is located at the moment in Belfast in Northern Ireland.

We have three major business areas. The first of those is health care delivery. It is about being a complete solution provider in that area. We break that health care delivery into two key areas: operational health and project based health. Those terms may not be familiar, because we have made them up, so I will explain both of them.

Operational health deals with an increasing requirement to support operations be they military, paramilitary, government or mining operations in remote areas. Very often these will have a limited life, so the deployment may be for a number of months or a number of years—they are not ongoing forever—and they need someone to come in and work in a remote environment, sometimes in a difficult and operational environment, and provide first-world health care in those areas.

Project based health care is quite different in that it is normally based in a major centre or somewhere where first-world care is perhaps under higher levels of demand. It may be around removing a waiting list, similar to some projects that we have done—which I will explain—or it may be more in line with the project that we currently have at Caboolture.

We have two other business areas. The first of those is consulting, where we are normally engaged to provide innovative views in the delivery of those services. Again, that is part of the services that have been engaged for Caboolture. Finally, there is e-health, which is a bit of a well-flogged term. In our particular case e-health relates to the use of internet and services to provide remote area access to medical care under a product we have called Second Opinion, where we have formed an alliance with five of the largest hospitals in America, primarily

Massachusetts General, Duke, the Cleveland Clinic, Brigham and Women's and Harvard Medical School. We can access specialists from there for a second opinion and a revised treatment plan in a number of hours. We have another product where we use a web based tool to be able access specialists when there may only be a few of them in a remote area, as we are doing in the Solomon Islands.

We have a number of contracts, but I will stick to some of the key ones that may be relevant to the sort of work that we are doing here in Caboolture, and it may be of interest to the committee. We are currently the contractor providing all of the health services to the Solomon Islands for the Australian and coalition forces based there. There are a large number of people—and a growing number of people—over there helping reconstitute and reconstruct the Solomon Islands. It is a fantastic project to be engaged in, because it is working so well. Defence had provided all of the health services up there, but it needed to withdraw those services back to Australia to keep them available for international or national deployments—and they have since been deployed on things like Banda Aceh, Pakistan et cetera.

That was the first time that the Australian government had ever outsourced operational health overseas, and it was a particularly high-risk project. It went through a government tender process. We competed against companies with an international standing, and we won. What made it particularly challenging was that we had eight weeks to be fully operational in the Solomon Islands, which included the purchase of all the equipment; the recruitment of over 30 people; the purchase and relocation of the only mobile surgery in Australia; the establishment, commissioning and testing—and when Defence tests you, you are tested—of all of that equipment; and then being ready and operational to take over. We had from 22 April to midnight on 23 June, and we took over all services at 8 o'clock in the evening on 23 June, with a good four hours to spare.

That was initially an 18-month contract, with 16 six-month extensions. The contract was transitioned to the Federal Police, who then decided that they did not want to be reviewing the contract every six months. They market tested it last year, and we have now been extended out to June 2008. We have a growing demographic of people. We started out with about 800 military people. They were all fit and healthy, and if they got a twisted ankle they went home. We now have a much broader group. We have AFP personnel and government employees from PM&C, tax, the department of health et cetera up there reconstituting the government. A lot of those people are now bringing their families, so we are caring for children and people with chronic conditions. We also do a significant amount of community engagement with the support of local people and deal with emergencies and village health. That has required a constant and ongoing review of the delivery of those services.

Defence has recently outsourced its services in Puckapunyal. For those who have not been there, it is a large training site in Victoria. It is the largest training site in Defence. It is 58,000 hectares. It is probably the highest risk training site. It has tanks, armoured personnel carriers, artillery firing, a large amount of unexploded ordnance spread around and thousands upon thousands of visiting troops and cadets training there. The site was once again a high time of turnover. We had four and a half weeks to assume responsibility. We won that in another competitive tender, and we assumed responsibility on 27 May last year. We have been running that for just short of a year now. We are responsible for all of the services, including ancillary health, which is physiotherapy and dental. We have over 250 specialists under subcontract to us,

and we have been able to engage with the local health community, particularly Seymour hospital, such that we have been able to consolidate specialist appointments to bring more doctors to the rural regions. So far we have saved over 793 training days for Defence. They have not had to send people into metropolitan Melbourne. Instead, those people have been able to go to a local appointment in Seymour. That is a significant cost saving for Defence and also for the progress of the people.

In summary, we currently have 30 people in Northern Ireland working on waiting list surgery and on a urology project. We cleared 200 cataracts for them before Christmas. We were contracted to clear 400 urology patients. We are actually over 520 now. That project will finish surgery at the end of March, and we will finish post-op cover on 21 April this year. Some of those people on the waiting list for urology have been waiting since 1997, and some have been waiting for cataract surgery for over two years. There are also opportunities to do other work.

We have offices in Indonesia doing work for a number of the mining companies up there. We have recently been contracted by the Western Australian Department of Health to provide medical personnel in the event of a natural or man-made disaster, including fully credentialling those people before they land on the ground to be utilised as part of that support. We are also about to sign a contract with Dental Health Services Victoria to take over a number of areas that have high waiting lists for rural dental work, particularly school dental programs, and pick those up over the six to 12 months to clear those waiting lists as well. We are busy people.

CHAIR—You are very well equipped to handle any flak in Caboolture.

Mr Keys—I must admit that I have never done quite as much press coverage in the last four years as I have in the last two weeks. In Caboolture, we were approached for a tender, which we submitted. We signed the contract, as I am sure everyone is well aware, on Tuesday a week ago. We have started meeting with staff. We were having meetings today, and we will be pursuing the time lines that have been outlined in the press.

CHAIR—Where do you recruit your doctors from who go all over the world?

Mr Keys—It is an interesting mix. We recruit staff primarily from within Australia, but we also recruit staff from overseas that are of an Australian standard and credentialled in Australia. We have, for example, a New Zealand anaesthetist who has done significant work for us in different sites. We have English doctors. We have some South Africans. We have some Europeans, mainly Germans. Where do we recruit them from? To be honest, there is a burgeoning pool of people within the medical environment who are realising that perhaps they do not want to be in a GP practice or in a long-term surgery situation. Perhaps they have reached a career point and they are looking for something different, and there is the opportunity to go and work on a surgical team where there is a very clear outcome about what they will produce. Some of the patient surveys we have had back give very clear feedback to us and our staff that there is such a positive input to those people. We find that we are getting either people in the 35-minus group, who just before they settle down into a long-term career would like something different, or those people who are, say, 55 or 55-plus who are looking for a career change, still have a significant amount to give to the community and find a way to access that through what we deliver.

Mr ENTSCH—What services will you be providing at Caboolture Hospital—just the emergency services? How are your services going to be integrated into other services within the hospital?

Mr Keys—The answer to the first question is that we will be providing two elements of the services into the department. The first of those is a review and an ongoing re-engagement and revitalisation of the department. There is a lot of engagement with the medical, nursing and administration staff as part of that, so we are putting a project team in place to support that. We have a separate project team which is part of the recruitment. But I think it is important to realise that it is not just about finding people. This is really about developing a robust solution that will be able to transition on from there.

The second question regards how we are integrated in. We are only really just starting up now, but we will integrate with the department. The emergency department cannot live in a bubble. It has to integrate in so many ways with the rest of the hospital, and we cannot develop a robust solution unless it is integrated with that hospital. I think the first step we did for that was on the day that we signed the contract. We briefed the emergency department first, and then we held a forum with the remainder of the hospital staff to brief them on who we were, what we were doing and how we would integrate with them—and that it was vital that we had their engagement in what we were doing.

Mr ENTSCH—So it is fair to say, then, that there is the opportunity for Aspen Medical to have some sort of influence on the overall hospital management in that area?

Mr Keys—I would say that our engagement in that influence would be as part of one of the many players within the hospital. There are a range of departments within the hospital, and each has demands and priorities. For example, we were discussing with the staff whether we would be changing work flow, procedures and forms. We will only be doing that with their engagement and their approval, because there is no use in us issuing a new form or a new process if they are not fully engaged. So we will be acting as one of the team members within the hospital.

Mr VASTA—Do you think that you will be contracted after the 12 months?

Mr Keys—I have to say that my eye is firmly fixed on the ball right now, as is everybody else's, I am sure. We are always looking for new business. We are a business and it is our job to do that. But right now our job will entirely be to make this work. I think the very fact that we have been tendered by other companies and asked by other companies and other organisations to tender for business is based on our performance. We live and die by our performance.

Mr VASTA—Do you think that Queensland Health might poach some of your people and that you might risk losing some good staff afterwards?

Mr Keys—It is always a possibility. Our staff are an absolutely critical part of what we deliver—not just the staff who are on the ground but the staff who are in our headquarters and in our executive. We look after all of them and make every effort that we can to keep them.

CHAIR—Are you providing your own staff doctors or are you re-engaging people who have worked at Caboolture?

Mr Keys—We have already started talking to the doctors who were working at Caboolture. They have significant expertise. They have a commitment to that hospital that has been evident already with the services they have delivered within the resources they had available. That is not just the doctors but the nursing and administration staff as well. We would love to engage those existing staff, and are working closely to do it, but there are many holes in staffing levels that we need to fill with additional staff.

CHAIR—One of the problems that we have been told about is that there are not enough beds in the hospitals to take patients who have to be admitted from the ED. Are you going to strike that same problem? Have you talked to the hospital about that issue?

Mr Keys—I have to say that we have not spoken about that issue yet. Our main focus is to talk to the staff who are there. We have to get an enormous amount of information out to all of these people. We ran a workshop this morning to engage those people. We have not got to that level yet. To be honest, we have many steps before we get to that point. To be honest, I would not want to comment on bed levels outside the ED.

CHAIR—Let me say at the outset that we are very fortunate to have an organisation like yours ready to step in in a case like this where a real need is apparent. We would all share that view.

Mr ENTSCH—The staff who have left Caboolture have left for a range of reasons. One which has been regularly raised at this hearing is the difficulty in dealing with the culture of the bureaucracy within Queensland Health. They are having difficulty in retention of health professionals. If you were to re-engage these people, do you have the capacity to be able to build a firewall around them to protect them from the problems that caused them to leave in the first place?

Mr Keys—One of the first things is—and we have started this already in the few days we have been up and running—to clearly identify what a lot of problems are. There is an enormous amount of emotion out there—as I have found from the newspaper and radio interviews I have had to do in the last week and a bit. What we are trying to do is clear through a lot of emotion and get down to the facts about what the significant issues are. When we can put those on the board and identify what those points are, then we can address them and get there. Some of the issues we have heard about to date relate to structure. The fact is that we have an enormously committed body of professional people across Queensland Health, not just medical staff but the nursing and administrative staff who make it happen. They want to find the best way to deliver the care to their patients, be that in Caboolture or anywhere else in Queensland. Our job is to make that as physically easy—and, to be honest, as emotionally easy—for them as possible.

Mr ENTSCH—I would suggest that Caboolture is probably the tip of the iceberg and that there are a whole range of hospitals throughout regional and rural Queensland that are really facing similar challenges. Some of them are very close to the brink as we speak. What are your views on the potential for an organisation such as yours to be contracted to provide core hospital services on a wider basis across the state?

Mr Keys—To begin with, it is important to look at what we have been contracted to do. We have been contracted to look at the revisions to the ED and process and efficiencies—which will

come not just from us but from the doctors and all the other staff as well. However, there is also a real requirement to be able to flow those efficiencies, those changes and those benefits out to every other ED in Queensland. I have to say that there is an enormous potential for value for money out of the Queensland government for doing that. To be honest, none of it will be a secret; it will be for any other department hospital in Australia that would like to take those ideas as well.

So this project will have a natural flow-on effect out to hospitals, which will be able to expand on those—whether that is cultural, management, workflow, patient pathways or technology. They are across all those areas. How we flow them out will be the next critical step. Do I think that they should be outsourcing into other hospitals? I do not know. I think they all need to be viewed in a unique fashion that is particular to that hospital. What I do know is that there is a requirement for some support here. They have contracted us for a set period to do that and that is our plan.

Mr ENTSCH—One of the comments I would make is that it would appear from the evidence that has been given to this inquiry that there is a real challenge in dealing with the fact that the administrators within Queensland Health tend to override the decisions of the clinicians on a regular basis. Therein lies one of the problems. It will be interesting to see how are you are able to deal with that challenge. You are the provider of a health service—you are at the coalface—and your performance is going to be gauged by how you deal with that. You do not want any impediments from the administration side of things.

Mr Keys—We have done some fairly significant projects in the UK. The NHS is the third largest employer in the world, next to the Chinese army and the Indian railways. If ever there was a bureaucracy, it is in the NHS. Any organisation—be it government or large corporate—has a degree of bureaucracy that has to be managed. We work with Defence, the federal government and the NHS. There are Indonesian organisations that make our bureaucracy pale by comparison. We have been able to deal with them because, usually, at the base of everything, there is a desire to do good. I believe there is that in Queensland Health. To be honest, we have not seen anything but that to date.

Mr ENTSCH—You would employ a lot of professionals in your organisation. Are you a user of health professionals or are you a trainer? Do you train within your organisation or do you just pick the skills and utilise them?

Mr Keys—We do do training. In this project—and I am happy to discuss this in a bit more detail—training will take a much greater focus than it has in the past. We do our own training, particularly in operational areas, because it is absolutely critical to have the teams completely meshed together. We did significant training in the Solomons and had a whole range of training packages from individual training, to group training, to running a whole scenario of major exercise training. The great thing about training is that it makes people focus on what they are meant to do. It gives them a real focus for what they are meant to deliver. You start, to be honest, forgetting about what is being talked about around the water cooler or what is in the paper that day; you realise that you are there to provide care to patients. For us it is a fundamental component of what we do.

Caboolture is even more important, because it has a training requirement for emergency department doctors. We have already started discussions with the college and AMA about how we will not only gain that accreditation but move that on from there for the training, because I think it is a vital part of that sustainability not only for the hospital but for Queensland Health generally. It is also a very important component of what the senior doctors and the director see as a critical part of their job.

CHAIR—I do not think we have any more questions. You have covered the area quite well. We are very happy that the solution has been found. Obviously, from your international and Australian experience, your organisation has the skills to do this. We wish you well. We hope you can restructure the emergency department to work normally after the 12-month contract or do further contracting. Tony Morris QC did tell the committee yesterday that Mr Beattie should not have contracted out Caboolture; rather, he should have contracted out Queensland Health. In 12 months time I will ask you what your view of that is.

Mr ENTSCH—I think you will be living in a bubble between now and that 12-month assessment period.

Mr Keys—I have got more than enough to focus on at Caboolture, thank you very much.

CHAIR—Thank you very much for coming all this way and appearing before the committee. We truly appreciate it and I am sure the people of Caboolture appreciate it as well.

[12.05 pm]

CHAIR—Thank you very much indeed, Joy. These gift packs are a very unexpected pleasure. I again want to say how much we appreciate Caboolture Shire Council's hospitality and its cooperation with the committee staff in making preparations for today.

Mayor Leishman—We are delighted to have you.

CHAIR—Thank you to everybody who is here for the community forum. Don't be afraid to be critical of the federal government, the state government or even the local government, which I am sure you would not be. We want to hear, at the grassroots level, about what you feel the issues are in health. Our inquiry is really about how health funding can be used efficiently, because we believe that so much health funding is wasted. For the future of health in Australia, what do you want to see? Jeanette, I invite you to start.

Jeanette—I would like to thank Mal Brough, first of all, for this opportunity to speak today. I am a former nurse of the emergency department at Caboolture Hospital. Unfortunately, I do not have enough time today to talk at length about the issues, but before I touch on my specific matter I would like to answer a few questions that came up during the last speaker's contribution. Chair, you asked about the percentage of overseas doctors. In 1998, when I was still working at the Caboolture emergency department, 90 per cent—not 40 per cent—of all doctors in that unit were from overseas, young and inexperienced and needed to rely heavily on experienced registered nurses like me. The next question I wanted to answer was about culture. Warren, I think that was your question. I will touch on that very explicitly shortly, and I hope that will give you some answers that you can go away with to find some solutions. It is the biggest problem of all.

I am speaking here today, I hope, on behalf of all nurses of my generation who are leaving the profession in droves, and I will mention some of the reasons. Mr Vasta, you asked whether there was anything left over in the Davies royal commission. Yes. My issue especially is one of those that were not touched on. I have a letter from Commissioner Davies in which he apologised that my matter could not be addressed in the royal commission because Premier Beattie blocked Caboolture and Redcliffe being included in the terms of reference.

My matter is known well right to the top desk—Mr Beattie's office. It deals with serious harassment, intimidation and high-level senior staff of Queensland Health bullying staff who have integrity. It revolves around a three-month-old baby's care, which was severely compromised by serious harassment of an individual who was a senior registered nurse in the department that I was working with and who I had witnessed steal morphine. They are two key parts of this whole issue. I was instantly dismissed eight years ago without a factual reason or a right of reply. I am still fighting for natural justice to be applied and to be innocent until proven guilty, but the Queensland health department has taken it to new levels of putting a person who is telling the truth in a revolving door to cover up serious problems that were going on in that emergency department.

Again, it goes right to the Attorney-General of the Labor government, to the Premier himself, and to three consecutive health ministers who know about this issue. They have totally blocked every avenue I have taken for an investigation, right through to the Ombudsman, the CMC—the lot. The gentleman whom I believe I witnessed steal morphine was uncovered through my own investigations. He has a criminal record for stealing from Nambour Hospital before he started work at Caboolture, where he is still working today. They are just some of the specific issues.

The lengths that were taken by the then Director of Nursing, Helen Woollett, and the then District Manager, Dr Stephen Buckland, who has been disgraced in the Davies royal commission for lying, went to their writing together—although it was basically Helen Woollett—a fabricated two-page letter which totally destroyed my character and my credibility, especially as a professional, and not only stole my career from me but destroyed my life in ways that are not quantifiable. It comes down to the culture within Queensland Health of shooting the messenger.

There is one other very important component that I want to mention before I finish. I have a submission to give to the committee today. I am fully aware that you do not have the terms of reference to investigate my matter, but I really do hope that pressure can be brought to bear for an independent investigation to deal with it, because it comes back to the Queensland Nursing Council.

Another person whose name came up in the Davies royal commission and who was not totally sidelined was that of Jim O'Dempsey. He is a medical board EO. He was the EO of the Queensland Nursing Council that destroyed my career without a single factual incident to support their claims. The claims they are using—and this brings me to the major point of why I am here today—are from the Queensland Nursing Act 1992. If you want to retain really good, skilled nurses like me with 23 years experience—I was the only paediatric trained nurse in that unit at the time—the Queensland Nursing Act 1992 has to be rewritten.

At the moment, the Queensland Nursing Council have a document that is so incredibly vague that it is abused on a regular basis. I am not the only registered nurse with extensive experience who has been dealt with in this way. Two years before my incident, a registered nurse with very similar, extensive experience was removed from her workplace in the Gulf of Carpentaria. She was sedated at Jim O'Dempsey's direction and, without her knowledge, flown out of the community to Cairns Base Hospital, admitted and then scheduled in the psychiatric unit. She was discharged the next day when the director discovered that there was nothing wrong with her. It is the same inference and prejudice that I have had to battle, and it has stopped a full investigation of a factual matter. The Queensland Nursing Council are using a vague section on health in the act. I am presumed to have a health concern—in other words, I have a psychiatric problem because I have invented all of this.

There are many other registered nurses who have been dealt the same thing under the same banner, and we are just put in a revolving door and never, ever spoken to. I have never even been afforded a person-to-person interview with the Queensland Nursing Council. They have breached the Nursing Act 11 times in their resolve not to allow material that I have from Caboolture Hospital to be presented. Helen Woollett, the then Director of Nursing, hangs herself in her own letter. That is why the council have gone to extraordinary lengths to block any investigation. Her own material and hospital documentation, which I have secured under FOI, prove exactly what I am saying.

I will leave it at that today. I will put in my submission, and I hope that when you read the submission you will understand the extraordinary lengths that have been taken to keep me in a revolving door and silent. I thank you for the opportunity today to finally be heard.

CHAIR—Thank you. We will examine your submission, of course. It is proposed that the submission be accepted and made public. Do members have any objections? There being no objection, it is so ordered. As with all other submissions, it will be covered by parliamentary privilege. We cannot really discuss this case at the moment because we have not had time to study the submission, but we will. Who is next?

Val—I am a sole trader of a company called CLIMBS. Thank you for this opportunity. My company delivers a flexible service to parents, government organisations, non-government organisations, young people and children with severe and challenging autistic spectrum disorder, so children with autism. My issue today is the health of a lot of the parents who are the primary care givers for these young people—their mental health, the stress, their wellbeing and their physical wellbeing. Daily, parents ring me to give me stories of woe and their concerns about being the primary care givers for children with severe and challenging behaviours. One of their concerns is the availability of respite. We all know there are not enough respite centres and options out there for parents. Regarding availability, one of the parents I deal with had a child whose behaviour was very severe overnight. It went for over 12 hours. It was during the night that the person needed the respite. It was unavailable, even though they had some funding from the government.

Another issue is the quality of the staff training. I am used by a lot of government and non-government organisations to train their staff. Staff will openly say that they feel that they are unqualified, unable to cope and ‘scared’ of children with severe and challenging behaviours and ASD. They want to keep their jobs so they try very hard not to ever tip the bucket when working with those children. Therefore the quality of time and care, having regard to the respite for those children with ASD, is lessened.

Regarding the cost of respite, I have stats from my parents which show that, for 48 hours of care, it is dearer than a five-star hotel or motel. Yet they also have to pay for their food and take whatever staff—trained or untrained—they have. Then we have the natural respite for these parents. We have Education Queensland and our private schools. This is supposed to offer natural respite for these parents. I work a lot in the schools when I am contracted in. We have a lot of admin staff saying: ‘Please do not even bother bringing your child. There is no education able to be given because of their behaviour, because they have ASD.’ Anywhere from 9.30 am onwards, most of my parents try very hard not to answer the phone because they know it will be the school saying, ‘Come and get him.’

One child in particular has not been to school for nine months, and that is not including the school holidays over Christmas. We cannot get government transport to take this child to school. We cannot get taxis to take this child to school. We have attempted to get a specific bus driver and bus aide, who I have trained, as I am in that area of behaviour. The government said that they would get a single minibus just for this child, but that has not happened yet. His mum is a single mum. She has some intellectual impairment. She is a non-reader. She has three other children. Two of the others have attended special schools. She has this child who has massive seizures, has ASD and has severe and challenging behaviours at home every day. She has a small

package from a non-government organisation funded through DSQ and they have not been able to offer her respite because they cannot find the right person.

I have actual safety concerns for these sorts of families—things we talked about this morning, like euthanasia. A lot of young parents feel the social isolation. We find a lot of fathers, or one of the care givers, choose to leave the family. So we have isolation, not being able to go to the neighbour's 21st, their cousin's wedding et cetera. It is the isolation of not being able to go outside in case the neighbours hear all that yelling, ranting and raving and think that you must be a terrible mother and abusing your children.

There is guilt. I have parents who ring me up, saying: 'I need to take my child to the doctor, but I actually can't make that drive. I'm not walking in there for people to give me looks, "Oh, you've got a terrible child; why aren't you doing better at bringing him up?"' There is also a lack of understanding by the providers of generic services. Parents say to me: 'I go to the dentist with my child with autism. I ring them up and I talk to the secretary about it, and the child comes in and behaves oddly and they say, "Excuse me, can you just settle your child down?"' We are talking about behaviours that are inherent in and characteristic of autistic spectrum disorders; we are not talking about naughty behaviours. I would like to thank you for the opportunity to speak today. All I did was bring up concerns.

CHAIR—Thank you. For my part, I am patron of the Asperger's group up on the Sunshine Coast. Can I ask you: do these people organise themselves—do they have a group where they can share their experiences? Another difficult thing in this situation is where there are two or three kids in the family, because the pressure on the others is absolutely enormous. So people like me are not unaware of the situation. I am sure Warren has had similar experiences, and Ross as well. This is a problem right across Australia, and members of parliament do come into contact regularly with this issue. But I would encourage the formation of a group, for them to get together.

Mr ENTSCH—Is there an autism support group here to help lobby and so on?

Val—Throughout the state where I work there are lots of wonderful support groups. What I have found is that the parents of children with severe and challenging autism, not Asperger's, go along to the Asperger's groups and actually feel quite emotionally drained and negative when they leave. You have parents saying, 'I wish my child with Asperger's would just stop talking all the time, stop asking questions'—because that is a characteristic of Asperger's—and you have the parents of the children I work with saying, 'I would be rapt if my child even talked.'

We have a couple of support groups that I really encourage a lot; however, I find that the parents are honestly so exhausted that they do not go. And if they do, as soon as they get to the meeting the phone rings to ask them to come and get their child anyway. We try very hard. Natural meetings are better, but when they are timed and it is Tuesday at 10, we find we have a real problem getting people to come at that time and to put any energy into it.

CHAIR—Chris Pyne has carriage of this area. I had him up to my electorate to speak to my group some time ago. Have you tried to get someone up from the government, through Mal Brough, to talk about this?

Val—Not yet. This is my first hello, so no.

Mr ENTSCH—We would encourage you to do that. And, if you have any solutions relative to your own specific area, it is very important to put them up as well.

Val—How could I share those?

Mr ENTSCH—Initially, what I would suggest you do is give us a submission on it.

Val—Love to.

Mr ENTSCH—Alternatively, for a quicker solution, you should put it through to your local federal member, Mal Brough. I would also ask Mal if he could invite Chris Pyne, who has responsibility for the area of mental health, up here to talk with you and the parents. Probably the best way to have an impact is not to organise a meeting like this but to ask him to come around to some of the homes.

Val—I would be absolutely delighted to.

CHAIR—That is what I did with him when he came up to my electorate.

Mr ENTSCH—Sit down and have a yarn to him in a home situation. You mentioned a case there of a woman who has a disability herself, along with three of her four children. That would be a wonderful opportunity—to take him to the home and sit him there and say, 'Here's something we need to address.' That is the best way to do it.

Val—Thank you for that direction. Yes, I will carry it through.

Mr ENTSCH—I will be interested to see how you go.

Pam—Hello. I am the mother of a severely autistic child. He is 9½ years old. He is non-verbal and as yet not toilet trained. He requires 24 hours a day one-on-one care. He attends a special school. From time to time we receive respite. I would like to tell you a little bit more about the respite problems that we have which cause me a lot of stress and medical problems. As to the availability of respite, it depends on how much respite facility has been allocated for you to use. They have a committee made up of parents and other people who decide how much respite you need. The respite facility I am talking about is funded through Disability Services Queensland. They set up a committee to decide your need. Then you get an allocation.

Our allocation for 12 months was $4,000. This gives us a couple of nights of respite a year. For our son to go in at 10.30 in the morning on Saturday and go home at 4.30 in the afternoon on Sunday it costs us $525.68 out of our funding. That is for one night, plus there is food and pocket money on top of that. If my child wakes up before six in the morning or is not asleep by 10 at night we are charged an extra charge of somewhere in the vicinity of $29 per hour. It is charged by the minute. If you have a severely autistic child, you would know that for bedtime they do not go by the clock. We do have a program in place—a bedtime program—but the staff at the respite facility are untrained with severe and challenging autistic children. They do not

know how to put the programs in place. My child is usually awake at 11.30 at night so then we are charged extra on top of the $525 because he is still awake.

I want to know why people say they are trained in disability but they do not know how to look after autistic—not Asperger's, not high-functioning but autistic—children. Why aren't they trained? They are talking about doctors and nurses being trained. I have been to a doctor's surgery and he asked me, 'Why does that child rock?' Rocking is one of the characteristics of autism. This was a GP who did not know why my son rocked. I have had a dentist who did not know how to get my son to open his mouth. I had to show him how to do it. Why aren't they trained in autism? One in 166 births is an autistic child.

Mr ENTSCH—I have personal experience in relation to autism so I am very much aware of the challenges in dealing with a child like that—and the rewards, particularly as you start to see the progress, But I do not know the area et cetera. The two of you obviously work very closely together. I would be very interested to see you progress with it. Chris is very approachable. He will come up here. Mal can also, and we will encourage him to do that. They can help to put these programs together.

I am not too sure about this funding for respite. There has been a focus from the Australian government perspective on respite in the last few years. There has been an increasing budget in respite for carers in the last few years. You were talking about this $4,000 and the board that makes an assessment. They obviously do so without coming into your home. They say they will give you a particular amount of money. That clearly is nowhere near enough. It does not hurt, of course, for your child to experience other people as well. It is critical. It is respite for the child as well as for you. That is a point I think you need to make. There is some money that we allocate federally. The Australian government does not have agencies on the ground that allocate it. I do not know whether it is money that comes from the Australian government and goes through the state agencies to be distributed or whether it is state money.

We will keep right away from the state-federal duckshoving because we do not need that. What I would like you to do is to take the time and talk to Mal's office to get some specific details on the funding and what is available to you in your region, and get Chris to identify some sort of plan and make certain the distribution. Between the pair of you, you could do that. I would encourage you to do that and would be very interested to see how you go with it.

Pam—I will just quickly make a comment. If this is sorted out, it might stop some of the young disabled people from ending up in nursing homes.

Mr ENTSCH—That is absolutely right.

Pat—I worked in Queensland Health for 21 years. It is very curious how that department works. I worked in the laundry for all that time. To get its money, the laundry charged the wards for the number of sheets, pillowcases et cetera used in the day. It was a strange situation. I thought that a laundry would be given a monthly or yearly grant to do its work. Going back to about 1990, they put the efficiency blokes through and we lost about 11 staff out of about 60. It was never done to the clerks. While we were losing staff, the clerical department was growing. There seemed to be one reason why it was growing: the charges that worked through the system. I think it was really crazy. Another thing is: never become a whistleblower, because they will

give you the dirtiest job that they can find or they will shove you sideways with something. I think it still goes on, because there was a case the other day in the news. I am retired now, but I think it still goes on.

CHAIR—Whistleblowers Australia has made a submission to this committee.

Pat—It is still very hard to be a whistleblower.

Mr ENTSCH—That was the evidence and we have another case here. We had evidence yesterday from Whistleblowers Australia and I can assure you that the concerns regarding intimidation are still very real today. You also made reference to the loss of staff in the laundry. That is interesting because there has been a lot of concern particularly about the cutting back of medical staff in wards—even in emergency centres where they have shut beds rather than replace staff who have gone on leave or are sick. There have always been plenty of clerical staff available to ensure that they are always being replaced. There has never been an issue in relation to the bureaucracy. You said that your case was a few years ago. Clearly, the concerns that you had back then were being raised in our hearing yesterday.

Pat—There are lots of problems in this department. You never speak to a member of parliament; they will fry you. When the Goss government came into power, I knew one of the fellows who got elected, so I had a few words to him. The next thing was that they had the union representative in and grilled him. They thought it was the union rep who talked, but it was me. He had to threaten to sue them to get out of it.

Mr ENTSCH—That is the culture issue that has been referred to regularly. I appreciate your comments.

Lynette—I am employed by the Caboolture Shire Council. They are a very progressive council because they saw a need for what I do. I teach wheelchair ballroom dancing. I have been doing it for 15 years. I trained under the world founder, started in Victoria and introduced it across certain areas of that state. I came to Queensland in 1995 and we are currently running classes in 17 nursing homes. I go as far as Ipswich, the Sunshine Coast, down to the Gold Coast and to the northern suburbs of Brisbane. I am recognised by the world founder and am the only one allowed to train instructors for the whole of Australia. We have just had an instructor training course this week and, of the 10 people I trained, five were diversional therapists from nursing homes within the Caboolture Shire.

What I do is very positive. I have been listening to what everybody else has had to say and I want you to know that there is something very positive happening in aged care, and I would like to see it grow much further. I currently have invitations to go to Mackay City Council—they want me to go up there and establish it. I have already been up to Rockhampton and Bundaberg and I am going up to Maryborough City Council. I am going back to Victoria to train people and I am also going to the Gold Coast and other areas of the Sunshine Coast. What we need to do is to be able to fund a tour to train instructors right across the aged care industry because I am just one person. I currently have 47 instructors in Queensland, 28 in Victoria and five in New South Wales.

It is a recognised sport and will become a Paralympic sport in the near future. At Easter I am taking two couples to Boxmeer in the Netherlands to represent Australia at the 25th anniversary of wheelchair dancing. There are a lot of benefits for people who participate, especially in the nursing home sector, because this seems to be more about aged care, and we see that it enhances their quality of life. In the age bracket of people in nursing homes their earlier days revolved around the Saturday night social dance. I am also a saxophonist. I have been playing for 42 years and I take the saxophone in and we have a bit of jam session and we have a bit of a dance.

I have noticed the change in the residents who participate but also in the ones who just come to watch. The beauty of wheelchair dancing is your degree of disability does not bar you from being involved. I always say that any person with any disability in any wheelchair can dance, and then I am challenged to prove it. So far I have been able to enhance the lives of anybody, even people who are in day beds in nursing homes who can no longer sit in a wheelchair. I am often seen pushing a day bed, which is a recliner armchair. They are involved just as much as the young people that I teach who have very good wheelchair skills. The styles of dance we do are ballroom, Latin American, bush dancing, freestyle and I am going to introduce wheelchair tap dancing before the end of this year.

Mr ENTSCH—Did you say ‘tap dancing’?

Lynette—Yes, in wheelchairs.

Mr VASTA—You will have to introduce disco soon.

Lynette—I draw the line at lap dancing.

Mr ENTSCH—I thought for a moment there you said lap dancing. For the next generation, of course, it will be break dancing.

Lynette—The next generation are the ones who have to look after me in a nursing home and that frightens me. I establish a relationship with the residents. The diversional therapists tell me that the residents are so excited when they know it is wheelchair dancing day. Just recently they dressed up with hats and gloves because I have just recently remarried, and because I have a hyphenated name—I wanted to be Lady Gordon-Smith. So they turned up with hats and gloves and pearls on, and they said they had planned it for about a week.

The thing that it gives these people is dignity. I just love what I do. I do not come away from any nursing home without a lump in my throat. I have shed a lot of tears in that time, especially if I see someone who has had a stroke and cannot use an arm but finally starts to tap one finger in time to the music—that does a lot for me. It is not seen as therapy, but it has therapeutic benefits for the residents. I do a lot of work with respite centres and that involves people who live in the community.

We are currently organising the very first national competition for wheelchair dancesport, which will be held in Caboolture Shire. We are having an international competition next year. With that, we are having—for the first time in the world—the Nursing Home Challenge Cup. Those Sunshine Coast ones think they are coming down here to show us how to do it, but I have

news for them and it is all bad. Everybody has a love of music, whether you have a disability or not—it is just the style of music.

Mr ENTSCH—Have you put in a broader submission in relation to that? What sorts of resources do you need to be able to do what you are saying you would do?

Lynette—I have been teaching for 15 years and it has all been self-funded, out of my own pocket. Caboolture Shire has taken me on board, and I am the very first wheelchair dance coordinator in Australia who is actually paid to do what I do. But I want to do more than that. I want to be able to do regional tours of Queensland. I want to get out there. Country people—and I am a country girl—have a different attitude to music and to dance because that was a big part of their social life. I want to get out there and train instructors. That is what I would do. I am the only one allowed to train instructors in the whole of Australia. The world founder has recently asked me to include New Zealand in that. I am 56 in two weeks and I will train instructors until they take me out in a pine box, but I need help to achieve that.

Mr ENTSCH—How do you quantify that? Why do you say you need help?

Lynette—Everybody tells me I need help! I need the funding just to be able to do a tour.

Mr ENTSCH—I understand that, but have you given any consideration to what you need? Do you need $100? Do you need $1,000? Do you need $10,000? Do you need $100,000?

Lynette—No, I have not.

Mr ENTSCH—What you are doing is absolutely brilliant. I do not know about the Sunshine Coast but, up in our areas, I can tell you now that there will requests for lap dancing! That will be a challenge to learn that! It is a great story, but the first step in taking it to the next level is that you need quantify it. It is easy to say, ‘Yes, this is a great idea,’ but not do anything unless you put out the challenge for something to be done.

Lynette—The facts and the figures.

Mr ENTSCH—You can use Caboolture because the council has had the vision to put you on, as the first in Australia. You have given us a hell of a lot of insight into the positives. The first thing I suggest you do is somehow find a way of putting that together into a submission with a quantified amount that you require. This is the sort of stuff that goes straight through Mal to Santo.

Lynette—Mal came to a ball that I did on Bribie Island. I love doing debutante balls. The oldest debutante I have had was 104. He came to that and has been very supportive. I went to Poland last year and he supplied me with some things to take over there to present to the International Paralympic Committee for wheelchair dance.

Mr ENTSCH—You tell him that we have strongly encouraged you to—

Lynette—Knock on his door again?

Mr ENTSCH—But to do this as more of a national or a state-based initiative. I think it would be a great national initiative. Understand also that he does have some control over the purse strings.

Interjector—You need to do a budget.

Mr ENTSCH—That is right. You need to quantify the dollars.

Interjector—You need to look at what you spent in the couple of years before.

Mr ENTSCH—That is right. You have a great initiative there, and I would be preparing it for Santo but submitting it through Mal. I give you an assurance that we will ask him and will chase him up to see how he is going with it. I will certainly offering my very strong support in pushing it through.

CHAIR—It will have my support as well.

Mr ENTSCH—I suggest that what you are looking for, quite frankly, is peanuts compared to the outcomes that you are going to achieve.

Lynette—I will be a monkey if that is all it takes!

Mr ENTSCH—I'll be the organ grinder! Good on you.

Lynette—I see a lot of young people in nursing homes in my travels. I find they tend to withdraw and isolate themselves because they are quite angry that they are there in the first place. They get involved in wheelchair dancing. Lastly, on 11 April I am taking two couples to Boxmeer to represent Australia, and they are so proud that they are going to wear green and gold, which will be the first time in wheelchair dance sport. I just want that acknowledged.

CHAIR—Wonderful.

Mr ENTSCH—Well done. Please make sure you get that information.

CHAIR—Make sure you do that.

Eileen—Good afternoon. I am from Deception Bay. I am speaking today not on behalf of an organisation but as an individual in the community in which I live and have an interest. Thank you for the opportunity to speak. As one of the ageing members of the population, a community member of Caboolture Shire and one of the residents to which Mayor Leishman this morning referred to as having moved into this area in the last decade—therefore increasing the population of the shire—I can say to you that one of the considerations my husband and I made when we were deciding whether to settle in this area was the level of services that would be available to us when we retired and of course later in life when we may need to be looked after.

We looked at this area because we saw that the services and infrastructure available locally would give us the opportunity to perhaps stay in our own home in our old age if we needed to be taken care of. After much consideration and research on our part we came to the community of

Caboolture from Townsville, and this is where we are going to stay. What distresses me as an individual in the 21st century is that, with all the knowledge and information that is available, those whom I vote for and give my trust to have actually allowed the closure of a vital service in my community. It distresses me greatly. The government indicated that they would legislate to provide for me and my community. This they have not done with a vital service that I expect in my community.

We continue to read in the papers and hear on the news that inquiries are being made. We had one of these talkfests back in May 2005, almost a year ago. We are being told that more money is being provided. Is this really the answer to what is happening in the system? We do not hear about the resolution to the problem and in what manner issues are being addressed. They are talkfests. The chair stated earlier that cooperation from the state in providing evidence to the inquiry to gain an understanding is not forthcoming, that states are indicating, 'Just give us the money and we'll look after it.' It scares the living daylights out of me, everyone. It should scare you that 20c in every dollar is all that is being used to deliver the services on the ground. Where is the other 80c going? Even if that figure is not quite right, it still scares the life out of me and it should scare you.

I for one hope that your inquiry, Chair, makes a recommendation that the state be accountable to the federal government for the money that the government gives them. What I do not want to see is an erosion of that 20c in the dollar on the ground with another level of bureaucracy to make it accountable, where we have to fill in another goddamn piece of paper to get the money. Let us really look at the system. Further, I would like to encourage you to consider putting in place some mechanism that has organisations and people who receive grant funding to deliver essential services in the areas of ageing and health respite et cetera take a good look at what is being delivered in the communities and identify duplications and what could perhaps be integrated into a better use of funds. Perhaps they could even share infrastructure.

We all have a cause and believe that our cause is more important than someone else's, that we deliver a better service than someone else and that our cause should be better funded than or funded above someone else's. The reality is that we do not have enough money to go around and we never will. We are a country of 22 million people. Probably only 25 per cent of us in this whole country actually provide the dollars that fund these services. So God help me when I retire, and I am almost there. Whilst we all want to see our pet project receive funding, we need to be mindful of how we do this. How are we going to make it sustainable in the community? How are we going to continue the service when the funding is no longer an option?

Volunteering in Australia is at an all-time low. Why? Because we are ageing. We want a rest. The younger members of society do not have the time or the inclination to volunteer and pick up some of the work that we are doing at the moment in the community for our aged residents and the people who need support and respite. 'Expect all services to be paid for,' say the people of our younger generation, and why would they work for nothing? We have given them an opportunity to perhaps be a bit selfish and a bit greedy. Somehow, all these things interlink together.

I, as a member of Caboolture Shire, expect both state and federal government to provide me with access to essential services now. I do not want to hear about grandstanding on these issues;

I want solutions, real solutions that are sustainable into the future. I want these solutions to be reviewed and updated to keep pace with my ageing status.

Sometimes, as leaders, you need to make a decision. You need to be trusting in that decision and you need to support the outcome of what you are trying to achieve and stop being the politician who is looking for the vote—because, trust me, we as the voting public will support you each and every time if you live by that decision. The public are better informed and more active in participating in their communities these days than ever before, and we are no longer afraid to speak out. So, please, gentlemen, stop the talkfest. Let us get some real solutions to the problems in the system, which is what the Australian Business Excellence Framework and quality assurance are all about. Let the bottom man have a voice. Thank you for the opportunity to speak today; it is appreciated.

CHAIR—Thank you very much. I think you wrote our terms of reference, didn't you! That is exactly what we are looking at. You have done very well.

Beryl—There is a lot of truth in the last speaker's words. Coming from an organisation that delivers HACC services: there are a lot of gaps. We use volunteers and get our transport costs down to about 16c a trip. We do about 24,000 trips across this area. Our volunteer bases are ageing. To get staff trained to do those services under accreditation or a quality management system is very hard. I think we have competition from government, in that fees are not required for HACC services from government, whereas they are required for community services.

I can sympathise with the people wanting respite. I know that the Disability Services Queensland staff are unfunded. A support worker gets a very low wage, yet specifically has to cope with very high needs and challenging behaviour. Those areas are being looked at, but, as you know, all those things are very slow.

We run a post-school program that tries to do some of that respite. Our main area is challenging behaviours. When the panel sits to look at that respite dollar, I believe it does not look closely enough at what that family's need is. Then the services take up the dollar that is offered and try to cope with that. Most times, that dollar is issued on a group basis, where a child with Asperger's or another challenging behaviour may get a group situation where they need a one-to-one or sometimes two-to-two worker. So those areas are issues right across the services in HACC and in disabilities.

That are some areas that restrict the dollars we have available and they could be looked at. In the Caboolture area we have a lot of homes that are being built in retirement villages. I am not quite sure how this works, but the building authority service cannot check those homes because they do not have the authority to. Those homes go in without grab rails and without the Australian standard steps—without all those things that prevent falls. That is part of the well ageing. As you know, a lot of the health dollar is spent on falls—broken hips and other things like that. When we try to catch that at an early stage, we have in some cases 800 homes—that is one case here in Caboolture—to look at. Some of those homes have been passed for people aged 50 years and over, but the people who live in those homes are on average 75 years or older. We start from behind in a lot of cases.

It is the same with domestic assistance. When we come into homes to do just a maintenance cleaning—our workers do not do the high places—what we see are homes falling down around people. The worker comes in and does the maintenance areas, but who does the windows and the gutters? How does that happen? Because of the new ongoing needs assessment process, a person's level of care often needs to be quite high before we can go in. What we find are homes that are in very bad repair and in very bad need of cleaning. One home recently required a $4,000 clean before a worker could go in. After all, these homes in the community are our workers' workplaces, so we have to manage risk and safety before they go in. Some of these homes cannot be serviced without something happening to them first. The funding is just not there to make those homes serviceable before our workers go in. Those are some of the concerns.

A concern relating to the well ageing is about getting good social support services out there through HACC—services that will stop people using their doctor's surgery as the place to get their social support. I have said to one of the local doctors that it would probably be to their advantage to put a cafe in their surgery so people could talk together, as they book every fortnight and go there just to talk together.

They are some of my concerns in those areas. I see the HACC service as a subsidised service that just touch the edges of the need. It is never going to give us the well ageing. As you know, health and ageing go together, and well ageing is something we really need first. It should be the entry points of our services that we are looking at, not the end points of our services. Thank you.

Ron—I have a very brief comment. I would like to talk about the mental health system and how the police services are being used in that area. In most cases it is not appropriate for police to be dealing with some of the people who are in the mental health system. What we are finding is that they have to take those people to the emergency ward, which ties up that emergency ward. On top of that, it is a danger area for self-harm—there are a lot of instruments there that can be used in an incorrect way. We also see that if there is police involvement then down the line it can end up in injury or death. There has got to be a better system that can be used, by health, to take care of these people, instead of tying up police resources. Police can come in if there is a violent situation, but they are being used far too early. That is tying up police resources instead of enabling them to do the other things they need to do. I just wanted to raise that issue with you.

Mr ENTSCH—It is not just the fact that hospital beds are being taken up but the fact that wards are not equipped to deal with this issue. After the Richmond report they deinstitutionalised mental health. Unfortunately, that was seen not only as an opportunity to shut down the institutions but as a cost-saving measure, and there was no mechanism put in place to compensate for the closing of those institutions.

We now find that our institutions are in fact the prisons or the streets or, to a lesser degree, some of the hospitals, which will keep them as long as they have to and then turn them back to the streets. This has been acknowledged, and this is where a major focus had now come out of COAG. The action plan is due out at the end of May or early June, and it has been an area that we have been pushing very strongly. Dealing with this is something that both the Australian government and the states have to accept equal responsibility for, rather than duckshoving backwards and forwards. I can assure you that there is a very strong focus on it. Police are not equipped to be mental health carers, nor should they have to be, but neither are council

employees and other people in the streets who have to deal with these issues on a daily basis. Hopefully, out of this process we will start to see some serious initiative. I talk about support accommodation and other things; hopefully it will come out of there. It is timely that you raised it, but I can assure you that it has a very serious focus.

Ron—It is an extremely serious thing. We have people in the street who need help, and we acknowledge that fact, but they are left out there to their own devices. Take a handful of tablets and away you go. As you all know, if you have the flu you start the process and once you have had a couple of tablets and feel okay you just go off them, and that is what they do. It is not right to ask the police service or the other people that you are talking about—council workers and everybody else—to try to deal with them. But we have to be careful of what we do. We do not want to go back to the old days of locking everybody up, but there has to be a better regulated service and a provision of appropriate people to handle them, and not just police.

CHAIR—Every Tuesday morning when parliament sits, the coalition parties and the Labor Party have their meetings. I can assure you that a meeting does not go by where this issue is not raised in our party room and, I believe, in the Labor party room. It is a top-of-the-mind issue, particularly with the long-term effects that we are finding now of recreational drugs. I fear for where that is going to end up.

Ron—I am conscious of your time; I will mention just one more thing. You raised drugs and so forth. If you have a person with what you believe to be a mental problem that might have come about from a drug related incident earlier on, they will try and fob them straight off. They will not want to deal with them at all and say that it is just a drug issue. Those two things should be closely linked. A drug issue is a health issue as well, not a policing issue, and it should be dealt with that way.

Mr ENTSCH—That is already done. That is part of this strategy.

Ron—Thanks for your time.

Interjector—Can I ask a question?

CHAIR—Let us finish with the gentleman down the front.

Mr ENTSCH—There is one more person to speak and then we can answer the question. This gentleman has been very patient.

Witness 1—I have plenty of patience at my age, especially when I broke my leg last year. I died the year before in our local hospital. If you think that the emergency department is only six months old, I lay there at the end of March last year with a broken leg—the bone was broken right through and had split off in two splinters—from half past six until one o'clock when they decided they were going to shift me to Redcliffe, and I would not let them move me. I was still lying on my stretcher in agony. I said: 'Before you move me, you give me a pain injection.' I am an ex-army nurse. I only did three years back in the fifties as a Menzies broomstick warrior, as they used to call us, and I went into air-sea rescue after that for a couple of years. So they gave me a needle. Three days later at Redcliffe, they set my leg. I lay there with a needle in my spine

and watched them do it. I came out after four days because I was up and walking. I still limp a bit now and again, but I have cancer in that leg.

Some weeks ago I found that my grandniece and my nephew had both been cured of the same cancers that I have. Theirs were not as big as mine. Mine are up to 15 years old. One covers a shoulder and another one covers a shin but both of them are shrinking. The bone is showing on one and the skin is now coming back around it. But it has not been done by a doctor as such. It has been done by a doctor who resigned four years ago. He now uses nothing metal. The stuff that I take is all organic. I have used it even to take the cancers off my arms. I have got rid of so many of them.

I have worked in the sun all my life. My father and grandfather were Poms. Their skin burnt. My grandfather came here and went off to the First World War. My father was in the Army but he did not get over there. They had cancers. They used thistlemilk. I tried it but I could not find the right thistle. Now I have got it and I have it for tea in the morning. The doctor knew about it and he gave it to me. I have picked up so much that now nobody else except my doctor, who is on holidays at the moment, will look at the wounds.

I was turfed out of hospital but, first of all, in 2005 my own doctor, whom I nursed for six months in my own home, said to me—and my wife—'You might as well go home and die. There's nothing we can do for you.' I had been home no more than three days—and my wife had given up on me—when my wife got the Blue Nurses in. The Blue Nurses sent me to Redcliffe hospital and then I went on to the Royal. I went to several specialists. One said that he could fix me. Four months later I was thrown out of the hospital. They said to me, 'We can't fix you. You're all but 74.' I said, 'Yeah, but you can fix me. You're now burning them off.' 'Yeah,' they said, 'but it would take seven weeks and we can't put you in hospital for that long.' They found three little cancers in my lung when they went in. After an hour and a quarter, the sister and then the doctor—an English lady who was very nice—said to me, 'They're dormant.' So home I went.

Now I cannot get any care from the Blue Nurses, because I am using an oil—virgin palm oil, because it does not pull the skin off the wound on my leg every time I change the dressing every day. I change that myself but I cannot change the one on my shoulder. So now I am stuck without anybody to do it. My 50-year-old daughter who lives with me—the only one at the moment; I have five of them—is backward. She did not talk until she was three. Her first words to me—in the backyard of my house, which I was building at Clontarf—were 'mudder cat'. She opened her two hands and in them was a baby kitten, which we had for about 15 years.

I could tell you about my broken leg and my broken neck. I have gone through all of them and I have got up and walked. As for the cancers, I am now so strong again I am back on the steel weights. But what can I do? I cannot get help from the Commonwealth. I cannot get any extra money as a single pensioner. My daughter who is a pensioner is now a third-year chef and is trying very hard to finish. The people that she is working for respect her very much. They have made her manager of the back section.

CHAIR—Can I suggest to you that if someone in my electorate had your problem I would see them. Have you tried to see your local member?

Witness 1—I have worked for Mal at every election. I can count standing on my head looking backwards.

CHAIR—So why don’t you go and see Mal and see if—

Witness 1—I have rung him three times. What did the government say when they got in? They said to go home from hospital and stay there. So I have gone home and stayed there, and I have fought the cancers. I have had 16. You can see the marks on my legs where they have healed and on my arms. I had one cut out, but the rest have just fallen off.

CHAIR—Let me have a talk to you afterwards.

Witness 1—You will not get much sense out of it, I can tell you.

CHAIR—Let us have a go.

Witness 1—I am ex-chairman of productivity, New South Wales business, 1970.

Mr ENTSCH—Yes, sir, you had one more comment to make?

Witness 2—The problem is this business about mental health. I know in Caboolture that the police should be easily able to get into the mental health unit down here—it is open 24 hours a day. It is a beauty. They should not be taking them to the casualty unit; they should be taking them straight to mental health.

Mr ENTSCH—A lot of the problem, sir, is that a lot of people with mental health issues, some with quite severe mental health issues, are not being diagnosed and are being treated either as criminals or as antisocial and subsequently they are finding themselves in trouble. There is an incredible percentage of people in jails who should not be there, because of mental health issues.

Witness 2—Yes.

Mr ENTSCH—There are a lot of people living on the streets because nobody has recognised the problem or nobody wants to recognised the problem. A few who actually get picked up and identified with mental health issues and end up in the facility you are talking about are the lucky few, along with those with the long-suffering aged carers who are not prepared to let their kids go out on the streets and who continue to look after them in their own homes. There has been a chronic neglect of mental health patients right across the whole spectrum of governments since the Richmond report back in 1983, I think it was.

Witness 2—Yes, but surely if you could get them down there, a psychiatrist could have a look at them and say, in or out—‘You stay here,’ or ‘The police can deal with you’.

Mr ENTSCH—They are the lucky ones.

CHAIR—Sadly, the time has come when I have to close this public meeting. I would like to thank the Caboolture community for taking the time to come here to share your views and experiences with us. We know that your motivation for coming is the same as ours—to achieve a

better level of service in the health of ageing sphere. I can assure you that this committee has that aim as well. When we publish our report, we will make recommendations to government that we believe will achieve these things. You have been an integral part of our community consultation process. Again, thank you very much indeed.

Resolved (on motion by **Mr Vasta**):

That this committee authorises publication of evidence given before it at the public hearing today, including publication on the parliamentary database of the proof of transcript.

Committee adjourned at 1.13 pm