Special Commission of Inquiry into Healthcare Funding

Statement of Robyn Martin

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1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding as a witness. The statement is true to the best of my knowledge and belief.

A. INTRODUCTION

2. I am the Director of Aboriginal Health and Primary Partnerships (**AH&PP**), Mid North Coast Local Health District (**MNCLHD**), and am a former Registered Nurse. I have been the Director of AH&PP since this role was formed in MNCLHD in 2011. A copy of my curriculum vitae is exhibited (**MOH.0010.0590.0001**).

B. SCOPE OF STATEMENT

3. This statement addresses Issues 2, 9 and 11 referred to in the letter from the Special Commission of Inquiry into Healthcare Funding to the Crown Solicitor's Office dated 14 August 2024, so far as they relate to my role.

C. ROLE

4. In my role, I am responsible for the executive leadership of Aboriginal Health and the mainstream District-wide services of Oral Health and Health Promotion. I am also a member of the District Leadership Team.

5. I have a broad background in health service delivery as I commenced my career as a trainee Enrolled Nurse after finishing school in Bourke, NSW, and have been a senior officer, including Director, since 2002. I have worked in NSW Health for over 25 years.

6. In my time with NSW Health, I have had the opportunity to manage a range of mainstream services including capital works and asset management, Women's Health, Alcohol and Other Drugs (AOD), and Breast Screen that was brought in from the Non-Government Organisation environment.

7. Before my role was created in 2011, I was the Director of Aboriginal Health with North Coast Area Health Service (**NCAHS**) which covered an area from Tweed Heads to Port Macquarie. Aboriginal Health was not on the NCAHS Executive.

8. Prior to that, I was the Director of Aboriginal Health and Specialist Community Services with Mid North Coast Area Health Service (**MNCAHS**). The Chief Executive Officer (**CEO**) of MNCAHS at the time had a keen focus on Aboriginal and Torres Strait Islander health and took the approach that Aboriginal and Torres Strait Islander people needed to be at the table to make a difference to bring their voice to the Executive. MNCAHS was the first Area Health Service to move Aboriginal Health onto the Executive.

9. With the formation of the new MNCLHD in 2011, Aboriginal Health was again placed on the Executive, and was one of the first LHDs to place Aboriginal Health on the Executive structure.

D. FUNDING

10. Oral Health is an important clinical stream, which delivers critical services to our communities and is a high performing team which represents a large part of my portfolio. We have had a focus on strengthening Oral Health as a clinical stream to ensure the best possible services are available for the community. Directorate management of the budget ensures funds are allocated in the most appropriate way to meet service needs and allows for flexibility.

11. We have been able to fund service delivery, as well as increase access to limited specialty services which are designed to provide equitable access to specialised Oral Health services as close to the resident's home as possible. These services include Orthodontics, Oral Maxillofacial Surgery, Paediatric Dentistry, Oral Surgery and Prosthodontics.

12. There are also broader system considerations for NSW Health including exploring opportunities and innovative ways of delivering oral health services and attracting and retaining a sustainable workforce in rural areas. The Australian Government recently had an inquiry into the Provision of and Access to Dental Services in Australia "A system in decay: a review into dental services in Australia Final Report".

13. MNCLHD Oral Health has a small repairs and maintenance budget and so procurement and replacement of costly clinical items such as dental chairs, that cost around $52,000, can be difficult to purchase within that budget. However, through careful management of

our budget, and savings at different times, we have been able to plan our replacement program. During the year, subject to availability, we may be allocated additional funding by the Ministry of Health's Centre for Oral Health Strategy to address specific targets, equipment needs and/or Minor Capital Works.

14. MNCLHD Oral Health's budget is made up of funds from NSW Health amounting to approximately 80% of the budget, and Commonwealth contributions under the Federation Funding Agreement (**FFA**) for additional services to adult public dental patients which is approximately 20% of the budget. We manage within the budget allocated, to provide services in line with the Annual Service Level Agreement (**SLA**) with NSW Health, though we know demand for dental services is always greater than the budget allocation.

15. The Primary School Mobile Dental Program is funded by NSW Health to provide Oral Health services to children at primary schools with a level of disadvantage (Index of Community Socio-educational Advantage 1 & 2) and is based on their rurality and distance from fixed Clinical Dental Services. We also internally fund the "Spencer" Residential Aged Care Dental Van Program that visited the District's aged care facilities once a year so that aged and non-ambulant residents did not need to travel to our Dental Clinics. However, this initiative is currently on hold as we do not have the workforce to support it.

E. WORKFORCE CHALLENGES

16. The workforce shortages in MNCLHD have been challenging, and in Oral Health it has been difficult to assure service continuity. Whilst the Rural Health Workforce Incentive Scheme has been helpful, to a degree, we are often competing with the private sector who are able to offer more attractive remuneration and incentives.

17. MNCLHD's clinical workforce has experienced a change since the COVID 19 pandemic. Many staff and clinicians are reflecting on their ways of working, work life balance and are preferring more flexible working arrangements. This has led to long term and ongoing vacancies, for example, in the last six (6) months, the Hasting Macleay Clinical Network (**HMCN**), comprising of Port Macquarie and Kempsey have had one Dentist despite numerous attempts to recruit to Dental Officer positions. To help with service continuity in the HMCN, we float a Dentist from Coffs Clinical Network.

18. The District is experiencing difficulties filling positions across all clinical areas and therefore we need to be agile as a system. To ensure our community is able to access

services in a timely manner, we partner with our registered and approved providers under the NSW Oral Health Fee for Service Scheme (OHFFSS). Ideally, we want to provide services in house, however, during these times of workforce shortages we have extended our use of the OHFFSS where eligible patients receive a voucher to access urgent, general or denture treatment from a private dental practitioner registered under OHFFSS.

F. HEALTH PROMOTION

19. For Health Promotion within AH&PP, we are fortunate that we continue to be able to attract and retain a highly skilled team of professionals which is a mix of Registered Nurses, Teachers, Aboriginal Health Workers and Allied Health Clinicians.

20. MNCLHD's Health Promotion team work to create environments that support wellbeing, reduce inequitable differences in health status between groups, and enable Mid North Coast individuals and communities to make healthy choices. This includes delivering preventive health programs, collaborative partnerships and capacity building initiatives in community settings such as schools, early childhood services and health services to reduce lifestyle-related risk factors that can result in chronic disease and hospitalisations.

21. Health Promotion holds responsibility for the delivery of SLA Key Performance Indicators (**KPI**).

22. Health Promotion and preventative health strategies, including research, are our enablers for a healthier community into the future. It is how we assure our communities future health needs will become less reliant on emergency and chronic health care and alleviates the pressure on the health system. It has been my experience that this area is a quiet achiever and as such may not receive a high weighting when considering funding priorities within the context of other pressures in the system.

23. MNCLHD's Health Promotion team are also high performing and have a strong research focus, leading successful research partnerships with Universities and other Local Health Districts to deliver research outcomes eg Translational Research Grants (**TRGs**).

24. Population and preventive health research are essential for building the evidence-base to support emerging and future health needs of our communities. It is also an important professional development and staff retention strategy within Health Promotion, building the capacity and capability of our workforce to identify gaps in service knowledge and form the evidence in response to local need.

G. ABORIGINAL HEALTH

25. The Aboriginal Health Strategic Unit is a small high functioning strategic team that focuses on District-wide Aboriginal Health strategy, policy and performance, State and District led Aboriginal Health projects, targeted program management, planning and reporting, whole of government and other external partnerships.

26. The Unit advocates for Aboriginal Health and focuses the MNCLHD on meeting strategic directions and priorities for Aboriginal Health.

27. It has a strong emphasis on developing and maintaining partnerships and building the cultural capacity and competency of the MNCLHD.

28. The Unit monitors key Aboriginal Health performance deliverables, supports Aboriginal workforce strategies and develops our emerging Aboriginal leaders. Collaborating on District-wide initiatives and provides advice on Aboriginal Health strategies, programs and operations across the system.

H. ABORIGINAL & TORRES STRAIT ISLANDER WORKFORCE PLANS & STRATEGIES

29. I am proud of our Aboriginal Workforce and the work they do every day and particularly reflect on all their work during the COVID Pandemic when they stood up with our partners in the Aboriginal Controlled Sectors and Non-Government Organisations to support communities in troubled times.

30. Service delivery of Aboriginal Health is embedded within the Directorates who provide the direct patient care and where the budget sits, for example, Aboriginal Hospital Liaison Officers in the acute setting in the Clinical Networks, Mental Health and AOD, Population and Public Health, Community and Allied Health etc. It is particularly important to ensure that Aboriginal Health is not siloed. Having Senior Aboriginal staff in the service delivery Directorates is vital as these positions provide the cultural lens, voice and advocacy for services to Aboriginal communities.

31. Historically, NSW Health's Aboriginal Workforce target is 3% as a percentage of our total Workforce, and it is noted that the 2024/25 SLA has been updated to focus on 3.43% across salary bands.

32. In 2011, MNCLHD's Board set a stretch target commensurate with the percentage of our District's Aboriginal population. This currently sits at 8.2%. MNCLHD's Aboriginal Workforce currently sits at around 5.8%.

33. As Director of AH&PP, I work actively with the MNCLHD Leadership Team on strategies to increase our Aboriginal and Torres Strait Islander workforce, Aboriginal Workforce and other Aboriginal Health initiatives.

34. People and Culture lead the Aboriginal Workforce Development Committee that guides and supports Aboriginal Workforce development, and I am a member of this Committee.

35. Our Aboriginal Workforce Manager, within the People and Culture Directorate, has recently been recruited and I anticipate that we will be re-setting our internal frameworks within the context of our Aboriginal Workforce Composition Policy Directive which sets the key priority areas aiming to support the growth and development of the NSW Health workforce. A copy of PD2023_046 Aboriginal Workforce Composition is exhibited (**MOH.0010.0642.0001**).

36. We want to ensure our Aboriginal and Torres Strait Islander workforce is represented across the organisation at every level, including in senior positions, to ensure Aboriginal and Torres Strait Islander voices are embedded across the system.

37. An example of embedding Aboriginal voices and leadership is to ensure Senior Aboriginal Positions are as close as possible to the Leadership Team members. These include the Clinical Network Aboriginal Health Managers, Manager Aboriginal Workforce Development, Aboriginal Wellbeing & Violence Prevention Coordinator, Manager Aboriginal Health, Strategy, Policy and Performance, Aboriginal Program Manager, District Manager – Aboriginal Integrated Care Initiatives, Project Manager - Patient Reported Measures, Telehealth and Value Based Care Aboriginal Public Health Program Coordinator, Nurse Manager - Aboriginal Health Workforce and Strategy and Aboriginal Clinical Lead Mental Health and AOD.

38. Workforce initiatives in MNCLHD includes the Elsa Dixon program, which is a school-based program that commences in Year 11. Students work with the District one day a week up until Year 12 to provide them with career insight and a taste of working in health. School Based Trainees who do not pursue further education or other outside employment are offered casual employment within MNCLHD and, for some, the opportunity to move into permanent roles in our IT services and as an Aboriginal Liaison Officer. A number of Trainees have also gone on to complete Nursing and Allied Health Professions.

39. Another Workforce initiative is to increase the number of Aboriginal Health Worker Practitioners in identified areas of need. We currently have two (2) employed, but our current target is three (3), and we will continue to explore potential opportunities further.

40. MNCLHD participates in the NSW Health Aboriginal Nursing and Midwifery Cadetship Program. The aims of the program are to increase the representation of Aboriginal and Torres Strait Islander people working in the professions of registered Nursing and Midwifery across the NSW public sector and provide an opportunity for the LHD or Specialty Health Network to improve Aboriginal health through education and employment. At present there are six (6) cadets, three (3) in each Clinical Network.

41. MNCLHD has introduced culturally appropriate identification badges for Aboriginal and Torres Strait Islander staff who wish to identify as such on their badge. This helps patients and their families to identify Aboriginal and Torres Strait Islander staff visibly. Community members can also easily identify Aboriginal and Torres Strait Islander staff to assist with their health and wellbeing needs and is great way to have conversations about culture, appropriate services, programs and reconciliation whilst empowering staff to be proud of their culture.

42. The Aboriginal Health Staff Forum is also a workforce initiative, chaired by the Director of AH&PP and is a peak support and network for the Aboriginal staff and other staff working in Aboriginal Health programs. The Forum meets up to three (3) times per year and has a commitment to creating a space for active support of social, cultural and spiritual wellbeing of staff, to foster District-wide opportunities for learning, foster supportive links and constructive exchange of information and to maintain and encourage partnerships.

43. We also have the Aboriginal Health Leadership Collective which is about building strong leadership and resilience. It helps empower our staff in their development and emerging leaders to step into this space. This is why it is highly important to develop our Aboriginal and Torres Strait Islander workforce across the different layers of the system to open these doors. Sometimes leaders are in situations where you are trying to influence a change required and at times you may be that only voice on that subject. Resilience is integral in successful leadership.

44. The importance of resilience was certainly felt during the lead up to the recent Referendum, for example, there seemed to be some confusion by patients between the Referendum and NSW Health's normal processes around Policy Directive 2012_042

Aboriginal and Torres Strait Islander Origin – Recording of Information of Patients and Clients, and patients being asked if they identify as Aboriginal or Torres Strait Islander. A copy of this Policy Directive is exhibited (**MOH.0010.0643.0001**). It became apparent that this stress was being experienced by both Aboriginal and Non Aboriginal Staff who were required to ask the question of patients as some patients associated this question with the Referendum and advised staff they would be voting No.

45. There was also a heavy burden on our Aboriginal and Torres Strait Islander staff to have all the answers concerning the Referendum both at work and in community which increased the impact of the discussion for our staff. Resilience was a personal resource heavily relied upon.

46. The MNCLHD also delivers the Aboriginal Cultural Training - Respecting the Difference. (PD 2022_028). A copy of this Policy Directive is exhibited (**MOH.0010.0644.0001**). The purpose of this training is that it assists with increasing cultural competence and promote greater understanding of the process and protocol for delivering health services to Aboriginal people.

47. The MNCLHD was one of the first LHDs to implement a Board Subcommittee for Aboriginal Health, the Close the Gap Board Subcommittee. A recent re-set has emphasised the importance of bringing Aboriginal voices to the table with membership adjusted to 50% Aboriginal, and 50% Executive Leadership team members. The membership also includes an Aboriginal Governing Board member.

48. The MNCLHD is a formal partner of the Mid North Coast Aboriginal Health Accord 2024 - 2029 with Durri Aboriginal Medical Corporation, Galambila Aboriginal Health Service, Werin Aboriginal Corporation and Healthy North Coast Primary Health Network. The Accord is operationalised through the Mid North Coast Aboriginal Health Authority. A copy of the Accord and Guiding Principles of the Accord are exhibited (**MOH.0010.0640.0001**) and respectively (**MOH.0010.0641.0001**).

49. The draft NSW Aboriginal Health Governance, Shared Decision Making and Accountability Framework will, by way of example, further strengthen the Aboriginal voice and leadership, embed strong partnerships with the Community Controlled Health Services, and shared decision making. The Framework is expected to be released in September 2024.

50. Through the Acknowledgement of Country Plaques and Statement of Commitment Signs Project, MNCLHD has demonstrated a strong commitment to Closing the Gap for

Aboriginal people. The commitment from MNCLHD ensures recognition and respect for Aboriginal people, and a culturally responsive and respectful health system. Displaying Aboriginal Acknowledgement of Country and Statement of Commitment signage at each site demonstrates a commitment to Aboriginal people and acknowledges Aboriginal people as the traditional owners and custodians of the land. MNCLHD has completed Stage 1, being Statement of Commitment signage and is progressing Stage 2, the Acknowledgement of Country plaques.

51. Aboriginal Health Performance is monitored by the Close the Gap Board Subcommittee and the Leadership Team. A copy of MNCLHD's Aboriginal Health Performance Report is exhibited (**MOH.0010.0645.0001**).

52. MNCLHD has embedded PD 2017_034, the Aboriginal Heath Impact Statement (**AHIS**) as part of our planning processes. A copy of this Policy Directive is exhibited (**MOH.0010.0646.0001**). The purpose of the AHIS is to support NSW health organisations and staff to improve the health and wellbeing of Aboriginal people by systematically applying an Aboriginal lens to all policies, programs and strategies.

53. MNCLHD also embeds the Aboriginal Cultural Engagement Self–Assessment Tool (ACESAT). The ACESAT aims to identify ways of strengthening cultural engagement between staff and Aboriginal stakeholders by bringing a continuous quality improvement cycle to cultural engagement. It assists moving towards a health system where cultural differences and strengths are recognised and responded to in the governance, management and delivery of health services. It supports us to assess whether there has been a measured approach towards the delivery of culturally safe services for Aboriginal patients and clients. MNCLHD services are required to undertake annual audits and it is a tool that provides evidence during the accreditation process against the six specific Aboriginal Actions in the National Safety Quality Health Standards (NSQHS).

54. The Darrundaygirr darruyaygam maabu-daariwaygam Girrwaanbigundi - Improving the health and wellbeing of Aboriginal People, Aboriginal Health Strategic Framework 2024-2034 guides how we plan, implement and evaluate our actions to ensure they are culturally safe, appropriate and effective. The Framework uses the views and voices of our Aboriginal team members, partners and community to highlight why this Framework is so important and shares insights we all need to consider when undertaking our work to improve Aboriginal health and wellbeing. A copy of the Framework is exhibited (**MOH.0010.0648.0001**).

55. In summary, as a District, we can be very proud of how far we have come, whilst appreciating there is more to do. Change takes commitment, energy and sharing the decision making space with Aboriginal people. Every time we achieve something positive together, for example, increasing and developing our Aboriginal Workforce, improving Aboriginal program delivery, increasing the Aboriginal Voice across the System, Aboriginal Influence on Policy, valued community engagement and partnerships, improved health outcomes in key performance indicators, it is very impactful and makes real change to people's lives.

56. I am positive that MNCLHD's leadership will continue the journey in partnership with our staff, communities, partners and stakeholders.

Robyn Martin

05/09/2024

Date

Witness: Grigori Cheguelman

5/9/24

Date