Special Commission of Inquiry into Healthcare Funding

Witness Statement

Name: Damion Brown

Occupation: Chief Executive Officer – Tamworth Aboriginal Medical Service – Aboriginal Corporation

1. This statement sets out the evidence that I am prepared to give to the Special Commission of Inquiry into Healthcare Funding as a witness.
2. The statement is true to the best of my knowledge and belief.

A. Role

3. I am the Chief Executive Officer (**CEO**) of Tamworth Aboriginal Medical Service – Aboriginal Corporation (**TAMS-AC**). I have been in this role for three years, including a period during which I served as Acting CEO. In my role as the CEO, I meet regularly with the TAMS-AC Board of Directors.
4. I have worked in the health sector for over 27 years, including 20 years working within the Hunter New England Local Health District (**HNELHD**). During this time, I started as a Registered Nurse and worked as a Clinical Nurse Specialist in Acute Care in Intensive Care, High Dependency and Coronary Care units.
5. I also worked as the Health Service Manager and Acting Health Service Manager of 4 smaller Hospitals, and held roles in Clinical Governance, as Patient Safety Officer and Acting Area Patient Safety Manager. I was also a member of the state Clinical Excellence Commission's Root Cause Analysis Review Committee for several years.

B. Tamworth Aboriginal Medical Service – Aboriginal Corporation[1]

6. TAMS-AC is an Aboriginal Community Controlled Health Organisation (**ACCHO**) which provides comprehensive and culturally sensitive healthcare to people in Tamworth and

[1] https://www.tams.org.au/

surrounding regions. Our main clinic is in Tamworth, and we also have clinics in Nundle, Quirindi and Gunnedah.

7. We are a key medical provider in the region. In the 2023/ 2024 financial year, TAMS-AC had approximately 52,313 client contacts.

8. TAMS-AC runs a variety of different health and wellbeing programs. We employ nine doctors, and several registrars, who are supported by Registered Nurses and Aboriginal Health Practitioners. We have a drug and alcohol team, social and emotional wellbeing team and mental health team. TAMS-AC also has a roster of visiting specialists, including Ear Nose and Throat (ENT), cardiology, speech pathology, dietetics, paediatrics, and optometry specialists.

9. We also:

    a. operate a transport service for people in the Tamworth region so that they can access quality healthcare; and

    b. run a series of non-clinical programs, including meditation, art, and men's and women's groups.

C. Funding

10. TAMS-AC has approximately 29 different funded programs, from 9 different funding bodies. TAMS-AC's clinical services are mainly funded through the Commonwealth Government's Indigenous Australians' Health Programme (**IAHP**)and Medicare where eligible. Medicare funding supports most of our clinical service delivery, including General Practitioner, Nurses, Aboriginal Health Practitioners (AHPs) and administrative staff and helps keep the lights on and doors open. The remainder of our funding is program-specific and comes from a range of Commonwealth and State partnerships and grants, and some other bodies including Primary Health Network (PHN) and NSW Ministry of Health.

11. At present, our major funding source is the **IAHP**. We secured $3 million p.a. in IAHP funding and are currently funded through to 2026.
12. We receive some State government funding, from the Ministry of Health for its Centre for Population Health initiatives, oral health services and for the Towards Zero Suicides programme. Other funders include the National Indigenous Australians Agency**,** Hunter New England and Central Coast Primary Health Network (**HNECCPHN**) and the National Aboriginal Community Controlled Health Organisation **(NACCHO**)**.**
13. There is a high administrative burden on TAMS-AC resulting from the program-specific funding model that we operate under. For example, each funding provider has its own reporting requirements that TAMS-AC must comply with, including activity reporting and financial acquittals. Furthermore, each application for a new grant must be very specifically tailored which can be quite a time-consuming task. For example, the *Health Data Portal*, which is operated by the Australian Government Department of Health and Aged Care, is particularly archaic and during the reporting period, it regularly freezes and is unable to accept changes or data uploads. It is hard to navigate and get reports from, and functions poorly. That adds significantly to the burden of reporting requirements.
14. Sometimes it can be difficult to find a funding source for the changing needs of our community. For example, we have been operating a clinic in Gunnedah for two years. We have not been able to secure any funding for this location, despite writing to the State and Commonwealth Health Ministers asking for their support. There are no other Aboriginal health services in Gunnedah, and not enough GPs in the town generally, so we continue providing services to meet that need which TAMS-AC funds itself.
15. The Rural Doctors Network (RDN), Hunter New England and Central Coast Primary Health Network (HNECCPHN), NSW Health, Local Government, TAMS-AC and the

Community have collaborated numerous times about the significant lack of access to GP and Health care in Gunnedah. In 2021 the RDN was commissioned to review health service delivery in Gunnedah. The *"State of Play report"* on the current situation and a survey of the Gunnedah Shire Community, found "It is very apparent that the people of Gunnedah Shire have too few local GPs to meet their needs". The report also found that "there is a significant gap in culturally appropriate and safe services for the Aboriginal and Torres Strait Islander residents of the Shire given there is no Aboriginal Community Controlled Health service either in Gunnedah or providing outreach services into Gunnedah, this being a service that might reasonably be expected for a population of this size". Annexed hereto and marked "**A**" is a copy of the State of Play report dated 15 February 2021.

16. The Gunnedah clinic does accept some non-Aboriginal clients, but they generally have a Kinship relationship with an Aboriginal person or are significantly disadvantaged. We do not charge and patients to use our services. We use some of our Medicare revenue to prop up this Gunnedah service, including GP/ AHP and Administration wages and operational costs.

D. Workforce issues

17. TAMS-AC currently employs approximately 70 staff members, and we are in the process of recruiting more staff as our services expand. However, the organisation also faces staffing and workforce retention issues. We currently employ four full-time GPs across three clinics and the remaining three work part-time. Their services are stretched to cover a population of 7000 people. Our staff including GPs are paid a wage rather than a percentage of their billings.
18. Furthermore, doctors are coming to Tamworth to train for three to four years, but do not often stay in the area. In saying this, we have retained the last 2 GP Registrars, who have

stayed on as fellows. However, for the first time in many years, we have not had an allocation of GP Registrars through RACGP.

19. TAMS-AC is currently trying to establish a school-based training model. That model will be targeted beyond Assistants in Nursing (AIN) roles, which NSW Health is particularly good at doing. TAMS-AC has its first School Based Trainee in reception and will be doing a School Based Traineeship in 2025/2026 in accounting/ finance. We work well with the AES (Aboriginal Employment Strategy), who are experts in this field. The struggle is there is no readily available funding for these School Based Trainee initiatives. That contrasts with Government organisations, who can more easily access funding for these types of initiatives, for example, through the Peggy Hunter Memorial Foundation.[2]

E. Relationship with the Local Health District

20. TAMS-AC meets with the HNECCPHN and senior executives of the Hunter New England Local Health District (**HNELHD**) for quarterly meetings around healthcare delivery. We have also had several meetings with the HNELHD in the past regarding our partnership agreement, but these meetings could be more effective in making practical change. Currently, the practical decisions do not occur at that executive level. The actual practical changes are being made by people on the ground.

21. One long term positive result of the relationship with the HNELHD, however, has been that TAMS-AC has approximately ten medical/ nursing/ midwifery and allied health professionals visiting from the HNELHD. Some we are funded for and others we are not, some we pay for and some we do not. The unfunded ones are generally HNELHD staff just working in there HNELHD capacity inside our building. Some of the HNELHD

[2] https://www.health.gov.au/our-work/puggy-hunter-memorial-scholarship-scheme

services include: Mums and Bubs, Dietician, Speech Pathology, General Medicine, Respiratory and sleep, Psychiatry, Paediatrician, ENT and Diabetes Educator.

22. The visiting staff are pivotal to our organisation. Many of our patients will prefer to come to TAMS-AC for medical care, even when they could access the same service at the hospital. We have seen a lot of patients presenting at TAMS-AC, when they should have been seen by the Emergency Department. They tell us that they prefer to come to our organisation as they feel safer here, even in patients experiencing with chest pain. Health outcomes would be better if we could provide more Emergency Department like care at our Aboriginal Medical Service. TAMS-AC could provide Emergency Department like care if it was appropriately resourced, to specifically cover Triage 4 & 5 patients and beyond.
23. There are also limitations with the operation of community nursing and care operated by the HNELHD. In the past, community nursing has typically involved nurses providing care in the patient's home. There has been a transition away from home-based community nursing. Currently, the community nursing team in Tamworth operates in Tamworth Hospital for some of its services. This means that if a patient needs to get a wound dressed, they have to go to the hospital to make an appointment to see the community nurse. Furthermore, patients are often asked to go to their GP instead. GPs, however, are not funded for any wound dressing and these materials are quite expensive. Patients similarly are often unable to buy the material from a pharmacy as it is too costly. This means the system is predisposed to relying on the goodwill of GPs, but that goodwill can become unsustainable for financial reasons.
24. HNE Staff have the expertise for wound care and easily keep up to date. This is not the case in primary health.

25. I am also aware that patients are required to travel to hospital to receive care, including for an intravenous infusion (but not limited to) administered by the 'Hospital in the Home' Program. I believe this is inconsistent with the objective of the program, which is to provide care to the patient in their own home. As such, Aboriginal patients are not inclined to access community nursing services at the hospital. There has also been a huge disinvestment from community or in community-based immunisation programs, by the LHD. An example of this would be the opportunistic community drop in Immunisation clinic in West Tamworth, which stopped during the COVID 19 out break and never restarted.
26. Our clients also encounter issues with ongoing relationships with specialists from the hospital. Patients will see a specialist within the hospital and then have a follow up appointment at the doctor's rooms which will then be privately billed. In our area, most specialist appointments cost a minimum of $350 to $450. This is where Dr Rajesh Ishri, one of our GPs, will step in to liaise with the Rural Doctors' Network or the ITC program to arrange for them to subsidise specialists to visit TAMS-AC' facilities so that our clients can receive this care without the significant costs they would otherwise face.

F. Relationship with other organisations

27. In my experience, NACCHO works effectively with ACCHOs and other bodies to push for viable funding sources. They are also good at allocating money across the board nationally.
28. TAMS-AC also interacts with the Aboriginal Health and Medical Research Council (AHMRC).
29. TAMS-AC works closely with some of the ACCHOs within the area, including Armajun Health Service Aboriginal Corporation who have clinics in Armidale, Glen Innes, Inverell, Tenterfield and Tingha, and Pius X Aboriginal Corporation based in Moree. We also have

good working relationships with our coastal counterparts based in Coffs Harbour, Grafton, Ballina, and Port Macquarie.

Signed

Damion Brown

Date: 16/09/2024