Special Commission of Inquiry into Healthcare Funding

Joint Statement of Ashley Brown, Nathan Jones and Phillip Bannon

Name and Occupation: Ashley Brown, Director, Centre for Aboriginal Health, NSW Ministry of Health (**MoH**)

Name and Occupation: Phillip Bannon, Associate Director, Centre for Aboriginal Health, MoH

Name and Occupation: Nathan Jones, Director, Centre for Aboriginal Health, MoH

1. This statement accurately sets out the evidence that we would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding (**the Inquiry**) as witnesses and the views expressed are jointly held. The statement is true to the best of our knowledge and belief.

2. This statement is provided to assist the Inquiry as to the role of MoH in relation to Aboriginal health in New South Wales.

A. INTRODUCTION

3. The Centre for Aboriginal Health (**CAH**) is a branch reporting directly to the Secretary, NSW Health. CAH's role is to provide strategic advice and leadership for statewide Aboriginal health priorities to relevant Ministers, the Secretary and Deputy Secretaries to shape strategic actions and secure high-level Ministerial, executive and community commitment. CAH is responsible for driving and influencing strategic, system-wide progress and accountability structures to improve holistic Aboriginal health and wellbeing outcomes.

4. CAH supports and maintains the longstanding partnership arrangement between the Aboriginal Health and Medical Research Council of NSW (**AH&MRC**) and NSW Health, including significant relationship management and funding agreement functions between the Aboriginal Community Controlled Health Organisation (**ACCHO**) sector and NSW Health.

5. A copy of each of our curriculum vitae are exhibited (**MOH.0010.0743.0001**, Ashley Brown) (**MOH.0010.0744.0001**, Nathan Jones) (**MOH.0010.0745.0001**, Phillip Bannon).

6. The Director roles at CAH are responsible for leading, developing and coordinating initiatives that drive system change through our overarching priority setting mechanisms, including the recently released NSW Aboriginal Health Plan, 2024-2034, the NSW Aboriginal Health Governance, Shared Decision Making and Accountability Framework,

published September 2024, the NSW Health Transformation Agenda, and NSW Health's contribution to the National Partnership Agreement on Closing the Gap.

7. Specifically, the Director of Strategy, Reform and Transformation role, held by Ms Ashley Brown, is responsible for oversight of system transformation activities to support improvements in Aboriginal health governance and accountability; racism and cultural safety; supporting Stolen Generations Organisations and Survivors and overseeing the implementation of Closing the Gap for NSW Health.

8. The Director of Partnerships, Performance and Innovation role, held by Mr Nathan Jones, is responsible for development and implementation of the NSW Aboriginal Health Plan; providing policy advice; the NSW Aboriginal Health Partnership Agreement; funding and relationship management with the Aboriginal Community Controlled Health Sector and strengthening system performance for improvements in Aboriginal health outcomes through working closely with Local Health Districts (**LHD**s) and Specialty Health Networks (**SHN**s) to monitor and support performance against Aboriginal health key performance indicators (**KPI**s).

9. The Associate Director role, held by Mr Phillip Bannon, leads the Strategic Engagement and Relationships team in CAH and is the key point of contact and relationship manager with the ACHHO sector. The Associate Director builds and maintains strong working relationships with the Chief Executive Officers and senior management of ACCHOs as well as providing a reference point or navigator role into other MoH branches or policy areas. The Associate Director oversees 42 grant agreements with the ACCHO sector and monitors sector strength and development. The Associate Director promotes the role of ACCHOs across the MoH, highlights their strengths and outcomes in service delivery, and identifies opportunities for the ACCHO sector in future grant and funding programs. Working with other funding bodies such as the Commonwealth Department of Health, the Community Grants Hub and the National Indigenous Australians Agency (**NIAA**) the team monitors performance, reporting, governance and business improvement and support functions for the ACCHO sector.

10. Aboriginal healthcare is the responsibility of the entire NSW Health system. This means that all services provided by NSW Health are available to all Aboriginal people in NSW. In addition, Aboriginal people access health care via ACCHOs and other primary care providers.

B. NSW HEALTH ABORIGINAL HEALTH SERVICES

(i) Role of MoH

11. The MoH role in relation to Aboriginal health services in NSW is largely met through the activities of the CAH. Until 2023, CAH was a branch within the Division for Population and Public Health. In 2023, CAH moved to reporting directly to the Office of the Secretary.

12. CAH provides funding to a number of MoH branches to manage Aboriginal health programs ranging from Environmental Health; Nursing Cadetships; and the Aboriginal Population Health Training Initiative amongst others.

13. In addition to this, funding for Aboriginal health in program areas such as mental health, alcohol and other drugs; oral health and workforce initiatives are managed by the respective MoH branches. While this is important and ensures Aboriginal health is prioritised and embedded where content expertise exists, it can create some governance challenges in relation to alignment and accountability with the overarching priority setting for Aboriginal health which is set by the CAH.

14. One way CAH has responded to this challenge includes the establishment of the NSW Aboriginal Health Transformation Committee (**the Committee**) which is the peak committee for Aboriginal health within internal NSW Health structures. This committee is co-chaired by the Executive Director of CAH and the Secretary, NSW Health. Other Committee members include Senior Aboriginal Leaders, Deputy Secretaries and Chief Executives.

15. The Committee drives NSW Health statewide strategies aimed to result in improved health outcomes for Aboriginal people. The Committee has oversight of the progress of Aboriginal health programs and impact of reforms on the outcomes of Aboriginal people.

16. CAH also facilitates and supports relationships with Aboriginal health services and other MoH branches which is an area for further maturity. As part of the implementation of the Aboriginal Health Framework, the CAH is developing a monitoring and accountability matrix tool for the system, including the MoH.

17. CAH currently utilises a range of mechanisms to engage with and support LHDs, predominantly via the LHDs' Directors of Aboriginal Health and by providing strategic

direction, support and policy advice. To support this engagement CAH coordinates and is secretariat for the NSW Health LHD/SHN Aboriginal Health Directors Committee and the NSW Health Services and Pillars Aboriginal Health Directors Committee which brings the Aboriginal Health Directors from the LHDs, SHNs, Pillars and health services together quarterly.

18. In addition to its work with the Directors, CAH participates in the quarterly LHD performance meetings which provide an opportunity to engage with LHDs around their performance in meeting the Aboriginal health KPIs included in their service agreements. There is a need to strengthen CAH's ability to be more directive across the system where there are clear gaps in the delivery of health care to Aboriginal communities.

19. Since 2022 the Executive Director for CAH has been a member of the NSW Health Senior Executive Forum (**SEF**). SEF is a group of all the senior executives across NSW Health including the Secretary, Deputy Secretaries and Chief Executives of LHDs, Health Administration Corporation entities and Pillar Organisations.

20. Since 2022 the SEF has held an annual Aboriginal Health focused session led and coordinated by CAH. Aboriginal Health Directors are invited to attend the session with all NSW Health Executives. The purpose of this session is to engage the senior leadership of NSW Health in a focused discussion in partnership around Aboriginal Health priorities and determine transformational actions that will support improved access to services or health outcomes for Aboriginal communities. Actions from these sessions are included in updated versions of the Transformation Agenda.

(ii) NSW Aboriginal Health Plan 2024 – 2034

21. The *NSW Aboriginal Health Plan 2024 – 2034* (***the Aboriginal Health Plan****)* was finalised in August 2024. It was developed in partnership between the CAH and the AH&MRC and guided by an Aboriginal Health Plan Advisory Committee that comprised senior leaders from ACCHOs, LHDs and Aboriginal Community Controlled organisations.

22. The Aboriginal Health Plan has five Strategic Directions which are:

    a. Growing and supporting the Aboriginal health workforce,

b. Providing holistic, integrated and person-centred care,

c. Enhancing health promotion, prevention and early intervention,

d. Addressing the social, cultural, economic, political, commercial and planetary determinants of health, and

e. Strengthening monitoring, evaluation, research and knowledge translation.

23. The purpose of the Aboriginal Health Plan is twofold. Firstly, it is to focus on sharing power that comes from self-determination and influence, enabling Aboriginal people to make the decisions that impact their health and wellbeing. Secondly, to drive system change by guiding how health systems are planned, delivered and monitored, drive shared decision making, be culturally responsive and safe to achieve health equity and eliminate racism in all aspects of health care.

24. The Aboriginal Health Plan sets priority needs and actions, which consider all determinants of Aboriginal health and wellbeing to make NSW Health systems and structures accountable regarding equitable outcomes.

25. As a new plan, it sets various goals and work for the future. An implementation plan is currently being developed which will cover the period from July 2025 to July 2027. The implementation plan will focus on transformational initiatives within the MoH that aim to have a meaningful impact on Aboriginal Health outcomes. Similarly, a measurement framework is also under development that will track what impact implementation of the Aboriginal Health Plan is having on health outcomes. The framework will be finalised in line with the first implementation plan.

26. Implementation of the Aboriginal Health Plan will require NSW Health organisations to report against their high-level actions that can make a real difference and impact Aboriginal outcomes. The measurement and accountability framework will include a level of system-wide reporting that considers the health access and equity outcomes for Aboriginal people in both the public and community-controlled health sectors, as well as health outcomes reporting on key health and wellbeing indicators.

27. System reform may provide opportunities for the Aboriginal Health Plan to identify avenues for innovative and targeted health care funding to meet Aboriginal outcomes as the status quo approach is not working.

(iii) NSW Aboriginal Health Governance, Shared Decision Making and Accountability Framework

28. The CAH launched the NSW Aboriginal Health Governance, Shared Decision Making and Accountability Framework (**the Framework**) on 27 September 2024 at the Aboriginal Heath SEF. This Framework focuses on transforming NSW Health systems, structures and processes to enable shared decision making with Aboriginal people. The Aboriginal Health Framework is an enabling tool of the Aboriginal Health Plan.

29. The Framework aims to improve outcomes for Aboriginal people in NSW through:
    a. embedding and amplifying Aboriginal voices and leadership within NSW Health,
    b. strengthening the accountability between NSW Health and NSW Aboriginal communities, and
    c. building upon and strengthening partnerships between NSW Health and Aboriginal Community Controlled Organisations.

30. The Framework was developed in partnership with the AH&MRC and through an extensive consultation and co-design process over a three-year period with Aboriginal and non-Aboriginal people from across NSW.

31. The Framework will be accompanied by a robust 'NSW Aboriginal Health Governance and Accountability Maturity Matrix' and a 'NSW Health and Aboriginal Community Controlled Organisation Partnership Matrix'. These matrices are monitoring and accountability tools for the Framework that will enable all NSW Health services to assess their maturity in enacting the principles of the Framework and outline a maturity journey for how they can enact success.

(iv) Closing the Gap

32. CAH leads and coordinates the MoH's Closing the Gap response, under the Executive sponsorship of the Deputy Secretary Health System Strategy and Patient Experience.

33. To support implementation of the National Agreement on Closing the Gap, the NSW Implementation Plan for Closing the Gap sets out the NSW Government's strategies for

delivering progress against the National Agreement's socio-economic outcome areas and Priority Reforms.

34. Under the NSW Closing the Gap Implementation Plan and in partnership with the AH&MRC, NSW Health leads initiatives aimed to improve the health-led socio-economic outcomes: life expectancy, healthy birthweight, early childhood development and social and emotional wellbeing.

35. This includes three health initiatives funded under 2022-23 Closing the Gap Budget enhancements:
    a. Building on Aboriginal Communities Resilience (suicide prevention initiative) - $9.8 million over 3 years,
    b. Aboriginal Mental Health Models of Care Program Grants – $10.1 million over 4 years, and
    c. NSW Aboriginal Primary Care Cancer Pathways Program - $9.7 million over 4 years.

36. As part of accountability requirements, the CAH and the AH&MRC lead regular reporting via NSW Closing the Gap governance arrangements and the Annual Report to Parliament on the progress of health-led initiatives and the status of health-led targets.

(v) NSW Aboriginal Health Transformation Agenda

37. The NSW Aboriginal Health Transformation Agenda is a key strategic workplan for the NSW Health system that contributes towards 'Transforming Aboriginal Outcomes'. The Transformation Agenda supports the recently Aboriginal Health Plan's vision of system reform and identifies short to medium term transformative actions that have been co-created by NSW Aboriginal Health Directors and members of the SEF and is monitored through the Committee. These actions also align and respond to the Priority Reform Areas from the National Agreement of Closing the Gap, as well as the Reform Priorities, which are identified as focus areas in the Aboriginal Health Plan.

38. Key initiatives that the Transformation Agenda will focus on in 2025 include: strengthening the NSW Mental Health services for Aboriginal people, strengthening the NSW Health maternal and infant care system for Aboriginal women and focussing on Aboriginal leadership in all health services, amongst others.

(vi) NSW Health Aboriginal health services

39. Although all NSW Health services are available to Aboriginal people, access and equity to services can be challenging for Aboriginal people, due to geographical locations of services, racism and cultural safety.

40. Each LHD has dedicated resources to support the delivery of health services to Aboriginal communities, however there is significant variation across the system in terms of the range of dedicated services and the size of the Aboriginal Health Teams. LHDs with a clear commitment to Aboriginal Health will have larger teams and a wider range of services while less progressive organisations will have much smaller teams. Typically, LHDs will have dedicated Hospital Aboriginal Liaison Officers, Chronic Care, Population Health, Mental Health, Maternal and Child Family and Palliative Care programs however there is significant variation in size and scope. LHDs with well-established Aboriginal Health Services may also have other dedicated Aboriginal programs in Violence and Neglect, Drug Health, Youth Health, Oral Health and Sexual Health. There remains a significant need to enhance all LHD Aboriginal health services to manage demand and keep pace with health need in the community.

41. The MoH supports a number of statewide Aboriginal health promotion and prevention programs including the Get Healthy Service, Aboriginal Go4Fun and NSW Health Knockout Health Challenge. Further investment is required in culturally responsive preventative health initiatives given the significant disparity that remains in health outcomes for Aboriginal communities both in terms of chronic disease and mental health.

(vii) Service planning

42. Service planning typically happens at the LHD level, which can result in variable outcomes in terms of prioritisation of Aboriginal health and engagement with Aboriginal communities and stakeholders. CAH is responsible for system level planning, that is the Aboriginal Health Plan and the expectation is that it would inform the planning done within LHDs and other NSW Health entities. LHDs typically have their own Aboriginal Health Plans but these are not always current and there have been delays in updating. There remain challenges across the system in broader health service planning and the prioritisation of Aboriginal health in these processes and the engagement of Aboriginal stakeholders such as ACCHOs.

43. The Aboriginal Health Impact Statement published 29 September 2017, PD2017_034, is a tool used by NSW Health organisations to support service planning as well as incorporating the health needs and interests of Aboriginal people in the development of new and revised health policies, programs and strategies. Applying an 'Aboriginal health lens' to programs at an early stage aims to improve the health and wellbeing of Aboriginal people by ensuring the health needs of Aboriginal people are carefully considered. It also assists to identify opportunities to improve access to healthcare, achieve equity, develop effective partnerships and conduct meaningful consultations.

(viii) Capital planning and design

44. CAH has no role in capital planning and design at the local level, this process is led by Health Infrastructure (**HI**) and the LHDs. However, HI has done extensive work on ensuring there is a focus around engagement with Aboriginal communities. This engagement aims to support the embedding of Aboriginal themes in hospital redevelopment art strategies and the creation of dedicated spaces that support culturally responsive care. For example, recent hospital redevelopments at Liverpool and Campbelltown Hospitals have had extensive Aboriginal community engagement.

(ix) ACCHOs and Aboriginal Medical Services

45. In addition to the program and service delivery funding provided to ACCHOs, CAH has a central role in working closely with Boards and Senior management of ACCHOs and Aboriginal Medical Services (**AMS**s) across the state to support and promote the health needs and priorities of their communities. CAH provides a point of first reference for the sector overall to raise issues and to work collaboratively across NSW Health to enable change. The long-standing partnership agreement with the Peak Body representing ACCHOs, the AH&MRC, provides the overarching framework for how we work with the sector.

46. Local engagement from CAH staff with individual ACCHOs builds trust and relationships through regular site visits, meeting with key staff and community. Understanding unique diversities and challenges of each ACCHO and its communities is a strength of the partnership and collaboration that CAH has with the sector.

47. As to LHDs, where good partnerships exist, healthcare can be delivered through integrated models between LHDs and AMSs. Such models are the exception rather than the rule and is an area for improvement.

48. There are however examples of where this works well, such as South Western Sydney Local Health District and Tharawal Aboriginal Medical Service who have a well-established partnership model that enables integrated service models, collaborative population health initiatives, mechanisms to support service coordination, planning and engagement in LHD governance structures.

C. WORKFORCE

(i) Representation of Aboriginal people

49. Aboriginal people are under-represented in the NSW Health workforce. NSW Health data for FY23-24 indicates the Aboriginal workforce is 3.08% of the NSW Health total workforce (NSW Aboriginal population in 2021 was 4.2%). Of Aboriginal staff employed at NSW Health, the majority are in Nursing (30.77%), followed by Corporate services (24.9%), and just 3.72% are employed in Medical positions.

50. Aboriginal people make up 4.7% of total workforce on a Level 1 salary ($0-$55,000 per annum, the lowest pay grade), and just 0.97% of those on Level 7, the highest salary band. The majority of Aboriginal people employed by NSW Health are in the Level 2 salary range.

51. The regional NSW Aboriginal workforce is 4.59% (compared to the 2021 population of 7.9%), and the metropolitan workforce is 1.6% (compared to 1.9% population).

52. In relation to targets, NSW Health has adopted the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031 (**the National Aboriginal Workforce Plan**), including the target of 3.43% Aboriginal representation across all occupations and salary bands. The NSW Public Service Commission's Aboriginal Employment Strategy 2019-2025 is broadly reflective of the purpose and intent of the National Aboriginal Workforce Plan.

53. Achieving the overarching target of 3.43% across all roles (clinical and non-clinical) and all levels, inclusive of management and executive level roles, by 2031 will be staged

through incremental targets. NSW Health will achieve 3.43% Aboriginal and Torres Strait Islander workforce minimum representation by targets of:

a. 2025 - 3.10%,
b. 2028 - 3.30%, and
c. 2031 - 3.43%.

(ii) Aboriginal Health Practitioners, Aboriginal Health Workers

54. The Bureau of Health Information (**BHI**) report, *Aboriginal people's experience of hospital care* 2021, showed Aboriginal people supported by, or offered the support of, an Aboriginal Health Worker during their admitted and maternity stays gave significantly more positive ratings of care across a wide range of areas. This included overall ratings of care, communication and information provision, and feeling respected.

55. The workforce attached to Aboriginal health initiatives across the system includes Health Service Managers, Clinicians, Aboriginal Health Workers and Practitioners. In recent years there has been a focus on elevating the role of Aboriginal Health Directors to the Executive Leadership Teams within LHDs and while this strategy has been successful there is significant variation and gaps in the second tier of Aboriginal health leadership across the system, which impacts on capacity to deliver effective Aboriginal health programs.

56. Similarly, there is great variation in the Aboriginal Health Worker workforce across LHDs. Aboriginal Health Workers sit across a range of service and program areas including but not limited to Hospital, Community Health, Child and Family, Chronic Disease, Mental Health, Drug Health, Population Health, Health Promotion, Violence and Neglect, Cancer Services and Palliative Care.

57. NSW Health employed less than half the Aboriginal Health Practitioners it needed in the period July 2023 - December 2023 (number employed 29.6, target was 77). There is significant work required across the system to increase the uptake of Aboriginal Health Practitioners in a range of settings and ensure the positions are supported to utilise their full clinical scope of practice. Aboriginal Health Practitioners undertake training that is equivalent to an Enrolled Nurse however there remains a number of barriers across the system to effectively establish and support the roles, particularly in terms of scope of practice. A MoH led working group has been established to support the promulgation of Aboriginal Health Practitioner roles in both Aboriginal health and mainstream settings.

58. The NSW Health Aboriginal mental health workforce is a key area for Aboriginal health. Approximately 35 Aboriginal mental health trainees are currently employed in the LHD/SHNs in 2024. There are 15 Aboriginal Clinical Leaders or Aboriginal Mental Health District Coordinators in positions to support the trainees across LHDs. There are Aboriginal Mental Health Care Navigators and Peer Workers in LHDs and SHNs. There are limitations in identifying the numbers of the Aboriginal mental health workforce and this requires manual collection.

59. Aboriginal workforce is not led by the CAH and sits within the People Culture and Governance Division at MoH. There are longstanding issues to be resolved and prioritised in relation to Aboriginal Health Worker roles, the Award, and resolution of scope of practice for Aboriginal Health Practitioner roles. MoH-led working groups have been established to progress both of these issues. While this work is starting to be prioritised, an increased sense of urgency is required to enhance career pathways and entry points for Aboriginal people wishing to pursue a career in NSW Health. More effort is required to employ Aboriginal people across the system in a range of roles, professions and salary bands, not just identified roles.

60. There is a need to continue to grow the Aboriginal Health Worker workforce however the current Award remains an impediment in terms of remuneration and supporting career progression. Further work is required to create career pathways that support Aboriginal Health Workers to transition into leadership or clinical roles.

61. Hospital Aboriginal Liaison Officers (**ALO**) who are employed under the Aboriginal Health Worker Award play a pivotal role in supporting the cultural and psychosocial needs of Aboriginal patients and families. There are significant gaps in the ALO workforce particularly in terms of gender, and after hours and weekend coverage. As Aboriginal patient numbers have increased across the system there has not been a sufficient focus on growing the ALO workforce. There is a need to develop consistent ALO models across the system that take into account patient numbers and ensuring appropriate coverage, particularly in parts of the system where there is a high throughput of Aboriginal patients.

D. STATE FUNDING OF ABORIGINAL HEALTH CARE

62. The Commonwealth Department of Health through the Indigenous Australians Health Program (**IAHP**) provides the core grant funding required to establish and operate a primary care AMS. Without IAHP it is not viable to operate a comprehensive primary care AMS. NSW Health funding to most primary care ACCHOs makes up only a small percentage of their overall funding revenue. The NSW Health funding provided supplements and complements the Commonwealth funding in areas of population health and chronic conditions.

63. Other significant Commonwealth funding sources for ACCHO health programs include the NIAA, Primary Health Networks and the Rural Doctors Network.

64. Medicare (Medicare Benefits Schedule, **MBS**) claiming is also a revenue source in the funding model that ACCHOs operate within. Most ACCHOs are provided an exemption by the Commonwealth under section 19(2) of the *Health Insurance Act 1973 (Cth)*, which allows the organisation to retain MBS revenue and redistribute it across the organisation as a revenue source to support programs and service delivery.

65. MoH provides recurrent grant funding to ACCHOs through the Ministerial Approved Grant program (**MAG**) across the state. The majority of this MAG funding program is historical and has not been increased substantially over time apart from Consumer Price Index and the inclusion of a small number of new ACCHO providers. Advantages of this recurrent model are certainty of ongoing funding and sustainability. However, disadvantages are that the funding in some cases does not keep up with demographic shifts in the region, particularly population growth or emerging health priorities.

66. NSW Health also provides program funding to across Alcohol and Other Drugs, Mental Health, Child and Maternal Health and Oral Health. However not all ACCHOs receive funding for each program and which ACCHO receives funding for a particular program is a historical funding arrangement and it has not kept up with emerging need or demographic trends.

67. NSW Health does provide the funding for oral health service delivery in ACCHOs. This is one program area that is predominately the state's responsibility in NSW ACCHOs as the Commonwealth has no specific grant funding for dental. CAH and the Centre for Oral Health Strategy in the MoH are concerned by the level of unmet need for acute oral health care and the need for more preventative oral health care programs for Aboriginal

people. The barriers include costs and the lack of a Commonwealth safety net scheme such as Medicare. Poor access to timely oral health care can negatively affect overall health of Aboriginal people and contribute to overall chronic health conditions. CAH has proposed a New Policy Proposal (**NPP**) for next financial year to expand the number of ACCHOs with an oral health program to improve access for Aboriginal people.

68. To mobilise change and meet unmet need for Aboriginal people, community programs within NSW Health and with the Aboriginal Community Controlled Health sector need to be better coordinated, resourced, and proportionate with population and need. This would allow for more community led culturally responsive initiatives to be delivered as well as investment in culturally specific prevention and early intervention models of care.

69. In addition, there remains significant variation in LHD investment in Aboriginal health both in terms of their dedicated Aboriginal health teams, but in-kind resources allocated to support initiatives that improve access and outcomes for Aboriginal communities. LHDs with robust governance structures for Aboriginal health typically have larger resource bases but often these have developed historically and are not based on need or population.

E. OTHER CHALLENGES, WORK BEING DONE AND WORK TO BE DONE

(i) Unmet needs

70. The CAH identifies unmet need via monitoring data sources such as NSW Health Aboriginal Dashboard for LHDs and SHNs, population data, the Australian Institute of Health and Welfare, and qualitative evidence from visiting communities.

71. Strong accountability metrics and effective resource allocation are also needed to ensure that the healthcare needs of Aboriginal people are appropriately identified and addressed, especially since the largest populations of Aboriginal people in NSW are in LHDs with the largest general populations in NSW. Improving the health outcomes of these communities are some of the greatest opportunities to improve Aboriginal health.

72. Data is essential to both establishing and understanding unmet Aboriginal health needs, developing initiatives to address it and evaluating such initiatives. There are currently nine KPIs that relate to Aboriginal health and wellbeing in the NSW Health Service Agreements. These agreements are reviewed on an annual basis, with input from CAH.

Existing Aboriginal health KPIs and performance mechanisms are focused on health service activity, with a particular focus on hospitals.

73. There are currently no indicators that measure unmet health needs and health outcomes of people that do not attend NSW Health services. Such indicators are important to ensure access and equity of health services for Aboriginal people, and to enable health prevention and early intervention focuses, which reduce the burden of acute health needs.

74. Examples of current unmet needs are mental health, drug and alcohol, violence and neglect services, specialist outpatient clinics and pathways into surgery, transport, oral health, and small infrastructure projects.

75. There are significant gaps across the system overall in relation to mental health, drug and alcohol and violence and neglect services for Aboriginal communities. In particular the LHD Aboriginal Health workforce in Drug Health and Violence and Neglect Services is limited, despite the significant over representation of Aboriginal consumers. Across the ACCHO network there are currently only 18 family violence worker positions which is a relatively small workforce given the level of need.

76. Over representation of Aboriginal people in mental health services is an area of concern. The magnitude of mental health issues is well documented:

    a. *"Aboriginal and Torres Strait Islander people experience a higher rate of mental health issues than non-Indigenous Australians with deaths from suicide almost twice as high; hospitalisation rates for intentional self-harm 3 times as high; and a rate of high/very high psychological distress 2.4 times as high as for non-Indigenous Australians … While Indigenous Australians use some mental health services at higher rates than non-Indigenous Australians, it is difficult to assess whether this use is as high as the underlying need"* (Source: https://www.indigenoushpf.gov.au/measures/3-10-access-to-mental-health-services).

    b. In 2018–19, based on self-reported survey responses, *"an estimated 24% of First Nations people reported having a diagnosed mental health or behavioural condition and 3 in 10 (31%) First Nations adults reported 'high or very high' levels of psychological distress (ABS 2019)"* (Source:

https://www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing).

c. *"The leading causes of total disease burden among First Nations people in 2018 were mental health conditions and substance use disorders (23%), followed by injuries (12%) and cardiovascular diseases (10%)"* (Source: https://www.aihw.gov.au/mental-health/snapshots/first-nations-burden-of-disease#First-nations-burden).

77. Through the Committee, CAH is pursuing opportunities to address unmet need across the NSW Health system for Aboriginal people.

78. Access to specialist outpatient clinics and pathways into surgery for Aboriginal people also remains a significant gap across the health system particularly in terms of access to Ear, Nose and Throat (**ENT**) and Ophthalmology. Some LHDs have well developed pathways that are integrated with ACCHOs providing access to bulk billing specialist clinics and a direct pathway to surgery, and these models support equity and enable Aboriginal communities to access essential services particularly where there is a higher proportion of illness (such as otitis media). The challenge is these models are not consistent across the health system meaning there are significant gaps and variation, and the established models can be fragile and dependent on an individual Medical Specialist who has a commitment to improving Aboriginal health. There is a need to develop system wide pathway for priority specialties such as ENT and Ophthalmology.

79. Transport is a further unmet need and is discussed below.

80. Aboriginal people are more likely to face structural barriers when accessing oral healthcare, including the cost of dental services and a lack of cultural awareness from dental providers. As such, Aboriginal people are more likely to have untreated dental disease, are less likely to receive preventive dental care and are more likely to be hospitalised for dental conditions compared to the general population.

81. CAH is also pursuing opportunities to specifically expand ACCHO oral health services and support ACCHOs in their ongoing infrastructure and capital needs to enable them to continue to provide high quality clinical services. ACCHOs deliver high quality, primary health and have a demonstrated ability to deliver culturally safe and appropriate dental

care to Aboriginal communities across the state. As such, CAH has proposed through a NPP to increase funding, so it is equitably distributed, and to expand dental services to all primary care ACCHOs.

82. In relation to small infrastructure projects, ACCHOs should have self-determined, fit-for-purpose, sustainable and culturally safe facilities. These facilities require adequate clinical and multi-purpose service spaces to meet projected demand and industry standards. Many ACCHOS are operating out of rented or dated facilities that are either too small, costly or not fit for purpose. A recent evaluation of the MoH's Aboriginal Minor Capital Works program demonstrated the improved service delivery outcomes from capital investment but highlighted a significant unmet need. Therefore, in line with the recommendations of the evaluation CAH has proposed a NPP to create a Small Infrastructure Grants Program specifically for ACCHOs to address some of this unmet need.

(ii) Prescriptive nature of service provision and reporting requirements

83. There is a challenge regarding the prescriptive nature of services to be provided to Aboriginal communities and the funding for those services. Funding models are often very rigid in terms of services to be provided and KPIs measured, which does not permit flexibility in response to changing community needs.

84. NSW Health is attempting to address this through less rigid KPIs that are outcome-focussed, and avoiding withdrawal of services when there are challenges related to meeting KPIs. CAH has reduced the reporting burden on NSW ACCHOs by accepting the national KPIs they are already doing for the Commonwealth Department of Health and Aged Care. This resulted in a significant decrease to the reporting burden for primary care ACCHOs, it reduced duplication of staff time and resources.

85. CAH is planning further amendments to improve reporting requirements to be implemented in upcoming NSW Health agreements commencing 1 July 2025. In recognition of the rigidity of some government funding and reporting requirement on ACCHOs, particularly PHN or other Commonwealth agencies, more flexibility and scope to program delivery and reporting will be negotiated with the ACCHOs for the next funding agreement cycle with the CAH in July 2025.

(iii) Culturally specific models of care

86. There remain significant opportunities across the system to realign how mainstream services are delivered to meet the specific needs of Aboriginal patients and their families. Developing culturally specific models of care has been proven to have significant benefits in terms of engagement, patient experience and improved outcomes.

87. For example, a LHD maternity service that has a high proportion of Aboriginal births already has allocated resources that are supporting those families, however there is scope to quantify what those allocated resources are and redesign the service model so that is responsive to the needs of Aboriginal families. Similarly, there are many parts of the system where there is an overrepresentation of Aboriginal patients, yet the services continue to be delivered in models that don't meet or acknowledge the specific cultural needs.

(iv) Duplication of services

88. There is a challenge in the duplication of services, particularly in areas when an ACCHO and a non-government organisation (**NGO**) may be funded to provide the same service to the same community. Nevertheless, it is also important that patients have some ability to choose a service or service model that best suits their needs, and multiple models available fulfils this process.

(v) Delivery of services by non-Aboriginal NGOs

89. CAH has a key role in supporting and implementing Priority Reform Two of the National Agreement on Closing the Gap, which is building the community-controlled sector. An ACCHO should be the preferred service delivery provider for most programs or services that are primarily for Aboriginal people. Notwithstanding this, mainstream providers such as NGOs, GP clinics, private health providers and LHDs must be enabled to offer a culturally safe and responsive service option for Aboriginal clients who choose not to attend ACCHOs.

90. CAH has recently been working closely with other MoH branches to ensure that there is quarantined ACCHO grant funding opportunities across all new relevant programs. Through initiatives such as Towards Zero Suicides, The Special Commission of Inquiry into the Drug 'Ice' grants, and End of Life and Palliative care grants, CAH has worked with the MoH branches to ensure there are streams of funding specifically for ACCHOs.

91. CAH has also negotiated with MoH branches to enable direct grant allocations to ACCHOs in specific locations or where a specialised capability or service model is required. A recent initiative that can be used as an example for future models is the expansion of Isolated Patients Travel and Accommodation Scheme (**IPTAAS**) scheme in a pilot program to provide direct upfront funding to select ACCHOs to reduce the barriers for their clients in travelling to specialist services (discussed below).

(vi) Racism – interpersonal and/or systemic

92. Racism remains a significant challenge across the system both at the interpersonal and systemic levels. ACCHOs continue to advocate on behalf of their communities highlighting the impacts of racism and unconscious bias in clinical care, particularly in the hospital system. There have been a number of coronial inquests which have highlighted poor care provided to Aboriginal patients accessing care in rural hospitals and the influence of racism on the outcomes. Systemic racism remains a challenge across the system and is best evidenced by the continuing disparity in the KPIs related to service performance such as unplanned readmissions, discharge against medical advice and Emergency Department did not waits and left at own risk all of which remain higher for Aboriginal patients. Similarly patient experience survey undertaken by the BHI highlight a consistently lower proportion of Aboriginal patients that report they were "treated with respect and dignity at all times" during their hospital inpatient stay.

93. The Clinical Excellence Commission (**CEC**) is the data custodian of the IMS+ incident management system used by NSW Health organisations to understand and address clinical and organisational adverse events. The CEC has indicated that they intend to improve how incidents involving racism or bias are captured and reported.

94. At a system level, complaints about patient care are managed by Health Care Complaints Commission and the Health Professionals Councils Authority (**HPCA**). The CAH has recently supported the HPCA in the development of their Aboriginal Cultural Safety Strategy 2023-2024, which aims to improve the experience of Aboriginal people who interact with the NSW healthcare and regulatory systems.

95. There is a need for CAH to be able to support interventions where there are ongoing reports about racism and poorer quality care for Aboriginal patients and their families in hospitals and other health services.

96. The CAH is currently working on a number of initiatives that aims to address racism. This includes:

a. The development of a Racism and Accountability Framework to address and reduce racism in the NSW Health system. This will include:
   i. developing, implementing and/or reinforcing reporting mechanisms for patients and staff to ensure they are culturally safe, appropriate and timely;
   ii. developing accountability processes for incidents of racism; and
   iii. developing a monitoring framework to track and respond to incidents of interpersonal and structural racism.

b. The initial scoping on the development of a system-wide cultural safety audit tool, using validated methodologies, such as the Cultural Safety Survey Scale[1], which has already been used in some LHDs and is being investigated by the National Safety and Quality Health Service (**NSQHS**) for national implementation as part of accreditation processes or national Cultural Safety Standards.

c. The development of a NSW health statewide Incident Management Cultural Governance Council to assess the role of racism, discrimination, unconscious bias, lateral violence and lack of cultural safety in incidents and make recommendations to support culturally safe service delivery and organisational culture.

d. The CAH has also developed the Aboriginal Cultural Engagement Self-Assessment Tool which is an annual continuous quality improvement mechanism that allows LHDs and SHNs to quantify, monitor and improve the cultural and clinical safety of their facilities and services for Aboriginal patients. The Tool aligns with the six Aboriginal-specific actions from the NSQHS and provides evidence to inform LHD/SHN accreditation.

(vi) Support for service delivery – transport, accommodation

97. ACCHOs in regional and rural locations have long advocated for improved supports related to transport and accommodation to enable patients to access the care required.

[1] Elvidge E, Paradies Y, Aldrich R, Holder C. Cultural safety in hospitals: validating an empirical measurement tool to capture the Aboriginal patient experience. Aust Health Rev. 2020 Apr;44(2):205-211. doi: 10.1071/AH19227. PMID: 32213274.

98. While there have been some recent positive developments around improved access to the IPTAAS transport subsidy scheme, there are a range of barriers with access to general transport for Aboriginal patients particularly in regional and rural areas. This is well recognised, and the Regional Health Division are implementing recommendations relevant to this emanating from the Regional and Rural Health Inquiry. However, ACCHOs are often called on by other service providers and expected to be a taxi service at short notice to either collect people being discharged from hospital at short notice or expected to transport clients to appointments. ACCHOs are not specifically funded for transport programs by NSW Health or the Commonwealth. Often there will be an NGO funded for community transport in a regional town, but the ACCHO is still expected to manage the transport requirement of Aboriginal clients.

99. In 2024 a pilot program was launched working with regional ACCHOs to deliver the NSW Health IPTAAS program. This was in response to data indicating the underutilisation of IPTAAS by Aboriginal patients and feedback from the ACCHO sector about challenges of accessing the program.

100. While expansion of the IPTAAS program into ACCHOs should increase access to transport services and accommodation there are limitations to the program including criteria for eligibility. The program is also only a subsidy and does not cover full costs. Further investment in initiatives such as the IPTAAS pilot is required and more effective systems that support effective transfer of care from rural to metropolitan hospitals and back for patients and carers.

(vii) Other

101. There remains significant variation across the system in terms of how LHDs prioritise and deliver Aboriginal health services. This is best reflected in the significant disparities in governance, management and service structures for LHD Aboriginal health teams. Similarly, partnerships and relationships with LHDs and ACCHOs have significant variation across the system with some regions having well established collaborations that facilitate shared resources and integrated service models and others having no formal partnership or collaboration at all.

102. To address the significant variation across the system there is a need to strengthen the system management role of CAH and its ability to intervene where the system is not

meeting the needs of Aboriginal communities. For this to occur appropriate delegation for Aboriginal health should be considered.

Ashley Brown

10 December 2024

Witness: Louis Yuill

10 December 2024

Phillip Bannon

10 December 2024

Witness: Louis Yuill

10 December 2024

Nathan Jones

10 December 2024

Witness: Louis Yuill

10 December 2024