Special Commission of Inquiry into Healthcare Funding

Outline of Evidence of Justin Files

Name: Justin Files

Occupation: Board Member, and Co-Chair of Aboriginal Health and Workforce Committee, Far West Local Health District

1. This is an outline of evidence that it is anticipated that the witness will give to the Special Commission of Inquiry into Healthcare Funding.

2. I was born in Broken Hill and raised in Menindee. I am a custodian for my First Nations community, and belong to the largest kinship system along the Darling River from the Queensland border to the Victorian border.

My role

3. I have been a Board Member for the Far West Local Health District (**FWLHD**) for over 2 years. I am co-chair of the Board's Aboriginal Health and Workforce Committee.

4. My background includes approximately 20 years of experience in mainstream health and the Aboriginal community-controlled health service sector, including at the executive level at Maari Ma Health Aboriginal Corporation. I was also recently appointed as the Regional Manager, Murdi Paaki Region with NSW Aboriginal Affairs. This footprint is more than double that of FWLHD and includes parts of NSW from the Queensland to Victorian and South Australian borders across to the central west region of NSW.

5. By way of overview, the role of the Board is to ensure effective governance and that FWLHD's frameworks work efficiently and in pursuit of the best interests of patients and clients within the community. The FWLHD Board is made up of members with a mix of expertise and experience. On my part, I share 20 years' worth of insight into health services from a First Nations perspective in the Far West of NSW.

6. This outline of evidence therefore focuses on the areas which I am most passionate about and canvasses some of the main areas of work the Board is undertaking in respect of Aboriginal health and workforce.

Aboriginal Health and Workforce Committee

7. The purpose of the Aboriginal Health and Workforce Committee is to oversee and guide strategies to improve the cultural responsiveness for the First Nations population within FWLHD, and to increase and appropriately allocate the proportion of the First Nations workforce.

8. The Aboriginal Health and Workforce Committee meets monthly. Our primary sources for performance review includes: Aboriginal Health Action Plan (Framework), Aboriginal Population Health Report, Aboriginal Workforce Report, Aboriginal Health Report, Aboriginal Engagement Report, Reconciliation Action Plan, and presentations from each of the directorates scheduled on a rotation throughout the calendar year.

9. The data we receive is useful in highlighting areas where we can do better as a LHD. An example of data reviewed by the Aboriginal Health and Workforce Committee is the number of First Nations people discharging themselves against medical advice, or not waiting at the Emergency Department.

10. The role of the Committee, and myself as co-chair, is to oversee and guide the FWLHD Executive to review the narrative behind that number and the reasons. This includes the above example of why First Nations people are not waiting or leaving against medical advice, and translating that into a quality improvement process. Given my experience of working at an executive level in a health organisation, I am aware that many of my colleagues with decision-making roles have often left First Nations business up to those holding First Nations-identified positions. I see my role on the Board as evolving that thinking at an executive level in order to create more conversation and discussion about what the Executive can be doing as a whole.

11. One of the main functions of the Aboriginal Health and Workforce Committee is also to determine where value can be added within the Aboriginal workforce and how members of the workforce can best be distributed to support our relationship with the community. In my view, a number of objectives in Aboriginal Health and its workforce have been quite intangible. Within the last month or so, FWLHD People and Culture have set a tangible target in terms of Aboriginal employment of approximately 14% of the total staff population to equal the Indigenous Population ratio for our region. We currently have equivalent to 75 FTE in the FWLHD that identify as First Nations. To meet this target requires an additional 44 FTE staff members who identify as First Nations.

12. In addition to this target, the Committee has also received a breakdown of where First Nations people are sitting within the workforce. The breakdown is to help the committee to understand if First Nations staff hold positions within the organisation that have carriage of influence and responsibilities, from an organisational authority standpoint.

Partnerships

13. Relationships with partner organisations sit mostly within the Executive and their reports by the operational side of the LHD, and within the Aboriginal Health and Community Relations directorate. Nevertheless, I see it as part of my role as a Board member to ensure that appropriate governance structures are in place so that the Director of Aboriginal Health and Community Relations can work at an executive and strategic level rather than being too involved in operations.

14. The FWLHD Board regularly meets with the Aboriginal Community Controlled Health Organisation (**ACCHO**) Board. Recently our Chief Executive and the new Chief Executive of the ACCHO have improved the relationship and are working towards future collaboration. I have a good relationship with the ACCHO Chief Executive and have extended an invitation to him to attend our Committee meeting, after he was an apology to our March meeting.

15. I have encouraged the Executive to look at partnerships with different agencies in the community and Aboriginal Medical Services (**AMS**). For example, a suggested new practice has been discussed of sending members of the FWLHD workforce to the AMS morning meetings in order to work more closely in a partnership and provide continuity of care for our patients.

16. Although I have strong relationships with a number of members of the community and those working in health in the region due to my background, I am mindful of the Board's governance role and ensuring Board members do not overstep and engage with stakeholders in a manner more consistent with the role of the Executive. We frequently have discussions as a Board and with our Chair to ensure this.

Community Engagement

17. There are currently 8 Board members, 4 of which reside locally in Broken Hill, including myself. As a result, the Board has a close relationship with the community and an ear to the ground.

18. Each Board member is also responsible for and sits on a Local Health Council. I sit on the Wilcannia Local Health Council, which has the most prominent First Nations community in FWLHD.

19. In addition to the Local Health Council meetings there are a number of ‘gates' through which we, as local Board members, engage with the First Nations community. These include: the Native Title Group, the Aboriginal Land Council, community working parties, which are a local decision-making governance structure for the Murdi Paarki region, and our elders. In my experience, each of these groups and especially our elders feel very comfortable speaking to the Board.

Challenges and Opportunities

20. Because of the national spotlight on disparities in health outcomes for First Nations people, there has been a concerted effort to structure and implement models of care that have provided more integrated service provision within the ACCHO sector. By recognising the demand seen from First Nations participation within the health system, a concerted effort has to be focused on what works and what does not work. The result is more often an integrated model of care that can benefit the wider community. Although the ACCHO sector provides targeted services to First Nations communities, they also provide a full gamut of services to the wider population in these remote communities. By contrast, from an LHD perspective, there is an extent to which the medical services which we can provide are dictated by the fly in fly out workforce and what they are able to offer. The Committee is currently working with the Medical Director to map out services provided by medical specialists based on the needs of the FWLHD population rather than based on what the visiting service are able to provide.

21. FWLHD still operates largely in a siloed service approach and this is reflected in a cultural mindset. There is an increasing appreciation within the Executive and the Board that, given the size of the population, we can cross-fertilise knowledge and resources across our services.

22. Beyond tangible initiatives and metrics, I believe that there are other intangible ways of bringing a First Nations perspective to FWLHD. For example, for the past 2 years I have provided a Welcome to Country and an additional explanation at the beginning of each Board meeting. The Board has now progressed to each Board member taking turns to do an acknowledgement of country at each meeting. I see this as an opportunity for my colleagues on the Board to take ownership of the presence and value of First Nations people within the FWLHD footprint and do their own internal reflective practice when writing their own acknowledgements, which are all different and individualised. I have received informal feedback from my colleagues that this process provides valuable insight and understanding of the purpose behind an acknowledgement of country which they would not otherwise be aware.