

**Special Commission of Inquiry
into Healthcare Funding**

**Before: The Commissioner,
Mr Richard Beasley SC**

**At Dubbo RSL,
Cnr Brisbane Street & Wingewarra Street,
Dubbo, New South Wales**

Tuesday, 14 May 2024 at 10.01am

(Day 026)

Mr Ed Muston SC	(Senior Counsel Assisting)
Mr Ross Glover	(Counsel Assisting)
Dr Tamsin Waterhouse	(Counsel Assisting)
Mr Ian Fraser	(Counsel Assisting)

Also present:

**Mr Richard Cheney with Mr Hernan Pintos-Lopez for
NSW Health**

1 MR FRASER: I understand we're ready to start,
2 Commissioner.
3
4 THE COMMISSIONER: All right. And the witnesses are
5 Dr Chua and Dr Hoffman.
6
7 MR FRASER: That's correct, Commissioner, and they are on
8 the screen.
9
10 THE COMMISSIONER: Yes. Good morning.
11
12 <AI-VEE CHUA, sworn: [10.01am]
13
14 <REBEKAH HOFFMAN, affirmed: [10.01am]
15
16 MR FRASER: Dr Chua, could we start with you, please.
17 Could you please give your full name?
18
19 DR CHUA: Ai-Vee Chua.
20
21 MR FRASER: Your first name is A-I-V-E- E; is that
22 correct?
23
24 DR CHUA: That's correct.
25
26 MR FRASER: You are a general practitioner in Dubbo; is
27 that right?
28
29 DR CHUA: I am, yes.
30
31 MR FRASER: You are giving your evidence from your
32 practice here in Dubbo; is that correct?
33
34 DR CHUA: I'm actually currently in Orange. I live across
35 two towns, having my children schooled in Orange, but my
36 practice is in Dubbo.
37
38 MR FRASER: I will ask you some questions about that in a
39 moment. Thank you, Dr Chua.
40
41 Dr Hoffman, first of all, could you please give your
42 full name?
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44 DR HOFFMAN: Rebekah Isabel Hoffman.
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46 MR FRASER: You are a general practitioner; is that
47 correct?

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DR HOFFMAN: Yes.

MR FRASER: You're giving evidence - could you please tell us where you are giving evidence from?

DR HOFFMAN: I'm in Woollooware in Sydney.

MR FRASER: Dr Hoffman, you're appearing specifically in relation to your capacity and your role within the Royal Australian College of General Practitioners; is that correct?

DR HOFFMAN: That's correct. I'm the chair for New South Wales and ACT for the RACGP.

MR FRASER: Thank you very much. Primarily, the questions will be directed to Dr Chua, but if there is anything that we need to call on you for, Dr Hoffman, we will do so.

DR HOFFMAN: No problems, thank you.

THE COMMISSIONER: Also, Dr Hoffman, if there is any answer given by Dr Chua that you think you would like to expand on or give a clarification, please let us know.

DR HOFFMAN: Great, thank you.

<EXAMINATION OF DR CHUA BY MR FRASER:

MR FRASER: Q. If I could ask you firstly about your practice here in Dubbo. I understand you own a general practice; is that right?

A. That's correct. My husband is a fellow GP, and we established our practice in Dubbo in 2005, having come to the region first up in 2002 for a six-month placement as GP registrars. We recognised the extreme need for healthcare services, and particularly general practice services, in Dubbo, and ended up establishing our practice there.

THE COMMISSIONER: Sorry to say this to you, Dr Chua, would you mind keeping your voice up so we can hear it clearly?

THE WITNESS: I will speak a louder. I will adjust my audio, I think, at my end. Just give me a second. Is that

1 any better?

2

3 THE COMMISSIONER: That sounded clearer, thank you.

4

5 MR FRASER: Q. I think you said that you and your
6 husband took on the practice in 2005; is that correct?

7 A. We established our own practice in 2005. The surgery
8 that we were both working at just prior was actually
9 closing down due to practice owners, one of the practice
10 owners in particular, moving out of the region and we were
11 actually looking to relocate to the lovely Southern
12 Highlands, but due to the great need and the fact that the
13 practice that we were working at was servicing quite
14 a large percentage of the population, and a lot of
15 encouragement from the community, we did end up setting up
16 Dubbo Family Doctors from scratch, as very young GPs.

17

18 Q. I will just get that background and then I will come
19 back to some formalities. You had come first to Dubbo in
20 2002; is that correct?

21 A. That's right, yes.

22

23 Q. And is that as a registrar, GP registrar?

24 A. For a GP registrar placement at that time, which was
25 to go for six months only at that point in time.

26

27 Q. And following the end of that, was that the completion
28 of your training?

29 A. For myself, I had another six months of extended
30 skills training, which I undertook in paediatrics at Dubbo
31 Base Hospital, and during that period I had also worked at
32 what was called Lourdes Hospital at that time, with
33 training in geriatrics, rehabilitation medicine and
34 palliative care as well. It was at the end of that
35 training, and a little bit of travel later, that we
36 returned to Dubbo after a six-month holiday and to
37 a practice that was about to close down, and then
38 subsequently established Dubbo Family Doctors in March
39 2005.

40

41 Q. Doctor, so you established it with your husband, and
42 since that time, is it fair to say the practice has grown
43 to include a number of other doctors? Is that right?

44 A. It absolutely has. We started with four doctors to
45 begin with. We now have 13, and five nurses, plus a fairly
46 new casual nurse as well, and - we also provide rooms for
47 a dietician who comes to us once a week and a mental health

- 1 nurse who is with us a couple of days a week.
2
- 3 Q. So you employ - the practice employs the nurses; is
4 that right?
5 A. Correct, yes.
6
- 7 Q. And in terms of those allied health staff you have
8 referred to, the dietician and the mental health nurse, who
9 employs those staff?
10 A. They are there as contractors.
11
- 12 Q. And they rent the rooms from you within the practice?
13 A. Correct. Yes.
14
- 15 Q. Just so that we can get some idea, you have referred
16 to the practice that you and your husband had previously
17 worked at closing down and the significant need in the
18 community being really the primary factor for you and your
19 husband deciding to stay here in Dubbo.
20 A. (Witness nods).
21
- 22 Q. From your experience, what's the level of service for
23 GPs in Dubbo?
24 A. At this point in time?
25
- 26 Q. Yes, right now.
27 A. The demand far exceeds the supply, and, you know,
28 comparable to at that point in time in 2005, we have an
29 expanding population in Dubbo. We've got an ageing
30 population. If you have a look at the open book/closed
31 book situation in Dubbo general practices, at the moment
32 the majority of our practices exist on closed books. As
33 much as we'd love to service more of the community, there
34 are only so many appointments that are available each day,
35 and so most practices have elected to - once your waiting
36 time gets beyond four weeks or six weeks for a standard
37 consultation, you really need to look very hard at closing
38 your books in order to properly and adequately service the
39 population who already do come to see you for their GP
40 care.
41
- 42 Q. Can I ask about your practice? What's the current
43 position for your practice in relation to closed book
44 versus open book?
45 A. We've got closed books, and for the vast majority of
46 our existence we've had closed books. Each time that we
47 open our books, you know, we have - we get a sudden influx

1 and it's a very short period of time before we have to
2 close our books again.

3
4 We do, you know, still obviously continue to accept
5 new babies to families whom we look after already. We were
6 able to accept the care of family members but have had to
7 be really specific to say those family members need to
8 exist under the same roof, because otherwise the extended
9 family situation in Dubbo ends up being that you end up
10 seeing a fair bit of the town anyway.

11
12 We currently look after probably close to 20 per cent
13 of our town's population with our surgery, and bearing in
14 mind that we've got, you know, difficult access to GP
15 services in our surrounding towns as well, which does mean
16 that we do drain patients from those surrounding
17 communities too, so, you know, I look after patients who
18 come from as far as Nyngan and Lightning Ridge and Walgett,
19 because the access to GP services in those areas are even
20 more difficult than in Dubbo and, in particular, female GPs
21 are quite tricky to access.

22
23 THE COMMISSIONER: Q. The four- to six-week time period
24 for consultations that you mentioned, that's based on the
25 experience within your own practice and discussions you've
26 had with your GP colleagues at other practices?

27 A. Yes, that's right. Look, it's certainly the situation
28 at our own practice. It's the feedback that we get from
29 our hospital practitioners, our specialist, non-GP
30 specialist colleagues, and you are left in a situation -
31 and certainly my own patients having struggles to get in in
32 a timely way, in particular for the semi-urgent healthcare
33 needs. Most of our practices in town do structure our
34 appointment system to try to accommodate that as best as
35 possible. At our surgery, we run what's called an acute
36 appointment system, so for things that really need to be
37 seen that very day, you know, you've got infections or
38 acute pain or injuries, those things we do our best to fit
39 in.

40
41 We rely very heavily on our nurses to assist with
42 triaging. We've trained up a nurse practitioner who helps
43 to fill some of the gap in those more urgent care needs.
44 But we're fighting a battle. We're fighting a funding
45 battle, we're fighting a workforce battle. Medicare has
46 not supported us over the years, becoming increasingly
47 difficult to cope with the inflationary costs of running

1 a surgery. Much of that is staff costs, but it's all the
2 costs of consumables and utilities, which, when you are
3 looking after a population who are vulnerable in the first
4 place, we've got a higher socioeconomically deprived
5 population than the average in New South Wales; we've got
6 a First Nations population in Dubbo that's higher than the
7 average in New South Wales; we are the main providers at
8 our surgery for our main disability support services in
9 town. So those - and we probably look after the lion's
10 share of aged care facility residents from our practice.
11

12 So those populations are ones who, you know, we still
13 stubbornly bulk bill, even though that doesn't cover
14 anywhere near the cost of what it costs to deliver health
15 care to that population.
16

17 MR FRASER: Q. Doctor, if I can just ask you a few
18 things arising out of the answers you just gave. Firstly,
19 is your current wait time in that four- to six-week period
20 for standard consultations? Is that right?

21 A. For our established GPs, it is in that order. For our
22 registrars, our GP registrars who have just been with us
23 since February, their wait time is shorter, and we do our
24 best to structure that so that we've got a wait time of
25 a few days to a week for a standard consultation for our
26 younger doctors, newer doctors - I shouldn't say
27 necessarily younger, newer.
28

29 Q. How many registrars are at your practice currently?

30 A. We currently have two. In times gone past, we've been
31 capped at having 2.0 full time equivalent registrars
32 because of the need to distribute a scant workforce across
33 the whole Western New South Wales region. For next
34 semester, which begins in August, we were actually provided
35 a cap of 3.0 full time equivalent registrars. However, we
36 had a sum total of three applicants compared to our usual
37 15 or 20 applicants for those registrar positions, two of
38 which - and I offered a position to all three. Two
39 accepted the positions, but we will be short one full time
40 equivalent, because the third applicant has decided to work
41 elsewhere.
42

43 Q. So you are not able to utilise that additional
44 training place. In terms of those numbers of training
45 places, are those numbers as approved by the college?

46 A. That's correct, yes.
47

1 Q. Could I just ask you also, you referred to bulk
2 billing. Roughly, what proportion of your patients do you
3 bulk bill?

4 A. It's around a two-thirds/one-third mix. We certainly
5 intend to be a private billing practice in terms of
6 sustainability, but when we look at our two-thirds to
7 one-third ratio, that's because of our population in need
8 and who can't afford private services. We will also tend
9 to bulk bill those services that provide sufficient
10 remuneration - so chronic disease item numbers and health
11 assessment item numbers - and we do bulk bill routinely our
12 patients with intellectual disability, our aged care
13 facility residents.

14
15 Q. Just lastly, in terms of aged care facilities, do you
16 and your colleagues undertake GP visits into facilities
17 here in Dubbo?

18 A. Absolutely. At our practice we strongly believe that
19 general practice should be cradle to grave medicine, and
20 any of our patients who move into an aged care facility, we
21 will follow their care to the aged care facility.

22
23 There are also an expanding number of aged care
24 facilities in Dubbo over the years and a relocation of the
25 elderly from surrounding towns into the Dubbo aged care
26 facilities. That has meant that our GPs have taken on
27 quite a number of new patients as aged care facility
28 patients. The challenge there is that not all of the GP
29 practices in town do look after aged care facilities, and
30 it means to say that the ones at our practices that do end
31 up taking on an additional workload there.

32
33 Q. One thing I omitted to do earlier was just to confirm,
34 you prepared an outline of evidence; is that right?

35 A. Yes.

36

37 Q. And do you have a copy there with you, in case we need
38 to refer to it?

39 A. I do. Yes.

40

41 Q. Thank you, doctor. For the record, that's
42 [SCI.0009.0093.0001]. I think it is anticipated that that
43 will be added to the bulk tender later. Doctor, can I just
44 ask you for completeness, you are working today at a clinic
45 in Orange?

46 A. No. So when I'm in Orange, which is half of the week,
47 I do HealthPathways writing, which is Western New South

1 Wales HealthPathways writing, I spend a portion of my time
2 doing the administrative work and the business management
3 behind our surgery, and I spend a portion of my time doing
4 telehealth visits as required.

5
6 Q. Now, you have referred to HealthPathways. Can you
7 please tell us a little about what HealthPathways is?

8 A. Yes, sure. In brief, it's a set of localised
9 guidelines and referral information for GPs, primarily
10 aimed at GPs. HealthPathways exists across Australia,
11 every region in Australia and New Zealand, and increasingly
12 across the UK. Western HealthPathways is a fairly new
13 venture in that NSW Health funded us a small pot of funding
14 to get the COVID pathways up and running at the beginning
15 of the pandemic, and subsequently our PHN has picked up the
16 funding to deliver a kick-start version of HealthPathways
17 in Western New South Wales across the wider breadth of
18 conditions.

19
20 Q. Firstly, does that cover both the full area of the
21 Western New South Wales PHN?

22 A. It does, yes. So it covers both Western and Far West
23 local health footprints.

24
25 Q. You hold a position of senior clinical editor, is that
26 correct, in relation to Western New South Wales
27 HealthPathways?

28 A. That's correct, yes.

29
30 Q. And is that a funded position?

31 A. It's funded by our primary health network, yes. In
32 other regions, the local health district, for example,
33 Hunter-New England, as I understand it, is the predominant
34 funder of HealthPathways in their region, which actually
35 makes a lot of sense, because a lot of the intention for
36 HealthPathways is to provide clarity for general practices
37 as to what are the referral pathways, what are the services
38 that they can refer to within their own region, what are
39 the inclusion criteria and exclusion criteria for accessing
40 particular services in the hospital outpatients
41 departments.

42
43 So the idea being - and, you know, it has certainly
44 panned out in reality and in the evaluations - that it does
45 reduce the unnecessary hospital presentations, referrals to
46 ED, and unnecessary referrals to outpatients or incomplete,
47 inadequate referrals to outpatients.

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Q. Is the local health district involved in any way in HealthPathways within the Western New South Wales area, or I should say either local health district, because there are two.

A. Neither Far West or Western health district took up the invitation of providing part funding for Western New South Wales HealthPathways. It is a challenge for our HealthPathways coordinator to obtain the information, in fact, from our local health district services in a timely manner so that we can populate our HealthPathways pages with the up-to-date and correct information. We hope to make a change to that over time, but it is a challenge at present.

Q. That coordinator you referred to, is that another general practitioner holding a part-time salaried role, or is that someone within the PHN?

A. No, that's a PHN funded HealthPathways coordinator role. So our clinical editors are all GPs in background. Our HealthPathways coordinator, she is actually of paramedic and nursing background, but the HealthPathways coordinator roles are basically people who have knowledge of the health system but don't have to be clinically based in background.

Q. In terms of the challenges you described, I may have to direct it to the PHN, but you referred to a challenge in actually obtaining the raw information from the local health district?

A. Yes.

Q. Or districts?

A. Yes, and that's because there is probably not that buy-in from the top level of the hierarchy that penetrates all the way down. There's a - you know, there is support in principle. However, it hasn't really filtered down to all of the departments and certainly when there is no funding contribution, there is not that - there is not necessarily that push for that information and that support to filter through all the levels of the hierarchy.

Q. You hold a number of other positions. I think you are the Western New South Wales representative on the RACGP faculty Council; is that right?

A. That's correct.

1 Q. And the North West New South Wales representative on
2 the AMA, Australian Medical Association, New South Wales
3 council?

4 A. That's correct.

5

6 Q. Lastly - I want to ask you a bit about this - you are
7 the chair of the NSW primary health network Western
8 Clinical Advisory Council; is that right?

9 A. Yes.

10

11 Q. Can you just give us a little detail about what the
12 clinical advisory council of the PHN does?

13 A. Yes. Part of the remit of primary health networks,
14 when they were set up, was that they needed to have GP-led
15 clinical advisory councils and also elements, I think, of
16 community council. So in our PHN we have a Far West and
17 a Western clinical advisory council; we have a Far West and
18 a Western community council; and we have an Aboriginal
19 council as well.

20

21 I have held the role of chair of our Western clinical
22 advisory council since the inception of our PHN. It has
23 a mix of different primary health care providers. Our
24 clinical advisory council really has not had as important
25 or useful a role as it could have within our PHN. It has
26 fluctuated over time, depending on the leadership of the
27 PHN, which has changed quite a bit over the years, and
28 there is not necessarily the recognition that people - of
29 people working at the coalface being able to provide
30 information about the gaps and needs in the local
31 communities, not necessarily that acknowledgment that we
32 know the evidence base behind solutions, and we do have
33 a new CEO, our PHN just very recently, and possibly that
34 might change. I hope it will.

35

36 Q. Something you touch on in your outline is the role of
37 GPs in health needs assessment. I think you describe it in
38 the outline as "limited".

39 A. Yes, that's right. I'm aware our primary health
40 network has to do a tick-a-box exercise each period of time
41 to say that they have performed a needs assessment for the
42 region, and our local health districts undertake a similar
43 exercise with needs assessments. I don't feel that those
44 could be as accurate and thorough as they could be. You
45 know, there is only so much information that you can get
46 from mortality statistics and hospital presentations and
47 admissions data. What nobody has visibility of is the

1 waiting times to get into a public service, the lack of
2 certain programs in our region and the impacts that that
3 has on our communities. In all our needs assessments, I've
4 never seen, you know, the fact that we don't have easily
5 accessible or timely access to, for example, falls
6 prevention programs in our region, but oh, my goodness, how
7 many hip fractures could we save if we actually managed to
8 have that preventative aspect of care in falls prevention
9 programs being available?

10
11 We don't have information on how many patients we
12 actually send to Sydney and to see private non-GP
13 specialists, because we don't have access to them locally.
14 So in Dubbo right now, our cardiology outpatients has got
15 closed books unless patients have been admitted to
16 hospital. So it's a waiting game until someone becomes
17 sick enough that they end up in hospital in order to be
18 able to get on to a cardiology outpatients closed books.

19
20 Paediatrics is down too. We're down to two
21 paediatricians in town, and the rest are locum services
22 that come and help out. But that was at a loss of three
23 paediatricians to our town fairly recently. Canberra was
24 able to offer fewer on-call hours, or close to no on-call
25 hours, and a higher pay rate.

26
27 We have basically no access to chronic pain services.
28 I have to send my patients to Orange, but the waiting list
29 there is two to three years at best. So there is no real
30 option there. My patients with chronic pain tend to be in
31 that demographic who really struggle to be able to afford
32 private services, and certainly can't afford to take time
33 out to travel to Sydney to see a private service there. So
34 those are some examples of how that access to care really
35 makes a difference to what we can or can't do with our
36 patient care out here.

37
38 Q. Just in terms of that information about waiting times
39 within general practice and waiting times for referrals to
40 specialist services as you have given a bit of an overview
41 of just then, just to understand or to clarify, it is the
42 case that neither the PHN or the local health district have
43 sought any information from your practice about that kind
44 of data?

45 A. No. Certainly not our practice. No.

46
47 Q. I think you said earlier that your practice services

1 approximately 20 per cent of the Dubbo population.

2 A. (Witness nods).

3

4 Q. Just in terms of the other GP practices, are they
5 generally of your size, or are they generally smaller than
6 yours?

7 A. There is one other practice, Dubbo Medical and Allied
8 Health Group, that are that sizeable, and I'm guessing
9 would service around the same number of populations that we
10 do. The other practices are smaller in size.

11

12 Q. And in terms of that concept of such information being
13 sought from GP practices, perhaps particularly larger ones
14 like your practice and the other practice you have just
15 referred to, is that something that you have had the
16 opportunity to raise, at least within the PHN, given you
17 hold a role there?

18 A. Yes, absolutely. I have lost count of how many times
19 I've raised the suggestion of monitoring waiting times so
20 that we can have a metric to work with. You know, things
21 like third available appointments, something we could
22 easily work with in general practice. But a similar
23 situation could happen in the outpatients departments in
24 the hospital, you know, we could absolutely monitor the
25 waiting times there. And the suggestion has been put
26 through to both the PHN and local health district over the
27 years, not to be taken up by anybody. It comes down to
28 funding as well.

29

30 Q. Just to unpack that a little, you said it comes down
31 to funding and no-one's interested in taking it up, but do
32 you mean funding in terms of funding for gathering the data
33 or analysing the data, that kind of funding?

34 A. Yes. It's administrative time. Not needing to fund
35 general practice to do that. I think that would be -
36 should be an expected part of one of the many things we do,
37 but, you know, it would be feasible to set up
38 a user-friendly online reporting system to be able to input
39 that data, but you need the funding to have somebody set
40 that up in the first place. But one would think, once it's
41 established and systems are put into place for that
42 collection of that data and the reporting of that data, it
43 should be a low cost exercise.

44

45 Q. You gave us an overview of the current position for
46 referral to outpatient services. Just in terms of your
47 experience here in Dubbo, which is now about 20 years -

1 I think that's right, isn't it, Dr Chua?

2 A. (Witness nods).

3

4 Q. Is that a situation, in terms of outpatient services,
5 that has remained similar, or is it worsening, or even
6 improving?

7 A. I think it is worsening, yes. When I first came to
8 Dubbo, we only had two physicians and a few surgeons. We
9 only had two general physicians servicing Dubbo and the
10 surrounds, and it never felt too difficult to be able to
11 get our patients in to those outpatient services at that
12 point in time.

13

14 I think what has changed over the years is that we do
15 have an ageing population with increasing complexity of
16 health conditions. There is increasing complexity of
17 treatments that can and should be provided for the various
18 health conditions. But we also tend to have a greater
19 amount of sub-specialisation, and along with that comes the
20 sub-specialised metro-trained doctors who have been used to
21 seeing patients - bringing patients back for reviews fairly
22 regularly, and I'm going to contrast that to the days of
23 Dr Hammill and Dr Canalese, who were the two physicians in
24 town, and they would see outpatients, but write back with
25 a very helpful list of recommendations of what needed to be
26 done, and for GPs to pick up those investigations and
27 coordinate their treatment, and only to refer back to the
28 outpatient service if we had concerns that the care wasn't
29 progressing as it needed to.

30

31 In our current climate, probably the medicolegal
32 climate, as well as the training climate, our
33 sub-specialists will tend to see a patient and bring them
34 back for review in three months or six months or 12 months.
35 It does create a service block to new patients getting in,
36 and some of that might be necessary, you know, particularly
37 when we're looking at our lack of continuity of GPs in some
38 of our smaller and more remote towns, but for our
39 longstanding GPs who can provide continuity of care, it
40 would be an advantage for our non-GP specialists to hand
41 over a schedule of care to the GPs and work more closely in
42 collaboration.

43

44 Q. Thank you. Just to go back to the voice of GPs within
45 the area and perhaps in terms of planning, I think you
46 raised two possibilities in your outline - either a general
47 practitioner advisory council to advise the PHN and LHD, or

1 an inclusion of GPs within local health district clinical
2 councils?

3 A. Yes. I think in the ideal world, we would have better
4 connectivity across both our primary care and secondary
5 care sector in terms of health service planning and
6 delivery. We would have better connectivity in
7 collaboration between our administrators of the
8 organisations and the actual clinical workforce at the
9 coalface, and that combination then to form a robust,
10 accurate needs assessment for our region, and then to be
11 able to prioritise the needs and plan the services in
12 alignment across the primary and secondary care sector, to
13 fulfil the needs of our population.

14
15 As part of that, in our current stage - status, I
16 should say - GPs are left out of that needs assessment, the
17 planning part of the service delivery and implementation,
18 but if you look at, you know, most of our population is
19 seeing a GP at least once, if not multiple times a year, we
20 should have a better idea of what the needs are and what
21 the gaps in services are.

22
23 So currently, our primary health network - and it also
24 happens in a lot of other areas of the country - are often
25 brought in to represent the voice of general practitioners
26 and to - you know, with the thought that also that
27 potentially we've got some governance over general
28 practice.

29
30 As we know, that's not the situation. Western NSW
31 Primary Health Network do struggle to engage with general
32 practitioners across the footprint. They certainly can't
33 represent the voice of GPs. Our RACGP members and our
34 ACCRM members are in a better - are better placed to do
35 that, and certainly, you know, should have the opportunity
36 to provide direct feedback and assistance for our local
37 health district and PHN. Even better would be to have
38 a wider group of GPs and not just one or two
39 representatives. So, you know, a wider group of GPs in the
40 form of the GP advisory council, and I struggle to recall
41 which other region does this particularly well, but I think
42 it's Hunter-New England and the Central Coast area who do
43 actually have a GP advisory council feeding directly into
44 the local health district, and not using the PHN as the
45 voice of general practice.

46
47 Q. I would just like to ask you now some questions about

1 the other end of system management, which is the funding of
2 projects, pilot projects in particular. I think you have
3 offered some comment in relation to the nature of those -
4 the funding of pilot projects.

5 A. (Witness nods). Yes. So I think - I'm just trying to
6 think back. From about 2007, I've been involved at various
7 levels with different projects, both from, in those days as
8 a division of general practice, then Medicare local and
9 then the primary health network, but also from a local
10 health district perspective and a little bit in more recent
11 times at the Ministry of Health perspective.

12
13 You know, the funding for those projects is often
14 quite short-lived, and certainly when we're looking at PHN
15 commissioning work, the funding for that is extremely
16 short-lived, anywhere from one year to three years, and
17 I actually struggle to think of a project that extended its
18 funding to five years or beyond. But when we're looking at
19 one to three years short-term funding, it means that
20 a substantial amount of time and funds is necessarily
21 committed to the planning phase for those projects, and it
22 often means that the actual service delivery phase of the
23 project might be restricted to 12 months or 15 months or
24 18 months.

25
26 The additional challenge with that then is that, you
27 know, who would apply for a job, a clinical job, that is
28 only funded for another 12 months or 15 months or
29 18 months? Most people would not pick up and relocate to
30 Western New South Wales to take up a job that's only
31 short-term in nature. And so the solution around that, we
32 would need to look at pilot project funding to have an
33 adequate amount of time in the delivery phase,
34 implementation phase of the projects and not consider that
35 the planning phase is part of the whole project timeline.

36
37 Q. I think you give an example of a current project
38 relating to the ADHD and behavioural management virtual
39 service?

40 A. Yes. Our paediatric services currently, and certainly
41 from a Dubbo perspective, but I'm also aware because I sit
42 on a steering committee for the ADHD and behavioural
43 management project - both Orange and Bathurst also have
44 very protracted waiting times for children to be assessed
45 for the possibility of ADHD, and so, you know, if you are
46 two years along and you finally get your diagnosis of ADHD
47 by that time, you might be in year two or three in school,

1 at which time you have missed out on two or three potential
2 years of treatment, and our Western New South Wales
3 children already start, you know - a better start
4 assessment, they are already behind the eight ball, and you
5 look at the cohort of kids who are delayed in the diagnosis
6 with ADHD, it means another cohort of kids who get further
7 and further behind in their learning.

8
9 So the ADHD and behavioural project, the idea behind
10 that is to try to get around that difficulty with access by
11 setting up a virtual multidisciplinary team to be able to
12 provide that initial assessment and diagnosis and then
13 potentially GP shared care in order that these young people
14 can get their ongoing care for ADHD and behavioural issues.

15
16 At the moment, we've only got 14 or 15 months left of
17 funding, but we've only managed to recruit half
18 a multidisciplinary team and only just kick started with
19 servicing some of the kids just in the last couple of
20 months.

21
22 Q. Just to come back to workforce issues, and you have
23 spoken about referral to specialists and the difficulties
24 there, can I just ask you firstly - and you also touched on
25 the fact that your registrars' positions, although great,
26 you have been able to secure a third place, unfortunately
27 you are not going to be able to fill that third place.
28 Just firstly, is that difficulty in filling your registrar
29 places a new phenomenon? You said that you usually get 15
30 or so applicants for your two or so places.

31 A. It is for our surgery. It's not a new phenomenon for
32 most other surgeries in our region. So we've been
33 fortunate as being one of the surgeries which has a good
34 reputation for registrar training and so it hasn't been as
35 much of an issue until recently.

36
37 I think you are going to hear from Dr Ian Spencer on
38 Thursday, and it will be worthwhile getting his viewpoint
39 on his access to registrars at this point in time.

40
41 We have a significant reduction of numbers of doctors
42 who are keen to take on general practice training, and then
43 if you look at the Western New South Wales part of that,
44 the GP registrars are much more inclined to take up
45 training positions in metro regions rather than venture
46 across to Western New South Wales.

1 We have a tradition in our area of tending to have the
2 registrars who score lower on the entry scores to registrar
3 training, but, you know, we really do need the workforce
4 there, and also, you know, our region is full of GPs who
5 are here precisely to service the population, and despite
6 the pull from elsewhere, want to be able to provide
7 continuity of care across to the next generation of
8 registrars.

9
10 MR FRASER: I will ask you another question about that in
11 a moment, but I think Dr Hoffman might have something to
12 add in relation to this particular issue. Dr Hoffman?

13
14 DR HOFFMAN: Thank you. I was hoping to add to this
15 issue, and that's this year, with the RACGP, we actually
16 have - our number of registrars across Australia, we've got
17 full numbers, so we filled all of our training places, but
18 what we have noticed is that Victoria's offered an
19 increased incentive for their registrars, which is funded
20 by their state government, so what Victoria's done is
21 they've offered a grant funding of \$40,000 to each
22 registrar coming in, and that then means that there is no
23 loss of income when moving from the hospital year to the
24 general practice training year.

25
26 So as a result, Victoria has surpassed their registrar
27 numbers, to the point that they have filled all of their
28 metro, all of their regional, all of their rural places,
29 and they have still got an increased number of training
30 positions that they have amassed above. So they are
31 actually now sending their registrars to the Northern
32 Territory and to South West Queensland, because they've got
33 too many that have wanted to take up this grant funding.

34
35 But as a result, what we're seeing is the registrar
36 numbers who may have been allocated to Far West New South
37 Wales or to Far North Queensland, have instead opted to
38 apply and take up positions in Victoria instead.

39
40 MR FRASER: That's useful Dr Hoffman. Just to clarify, is
41 this the first year of that incentive?

42
43 DR HOFFMAN: It is, yes.

44
45 MR FRASER: It is the first year you have observed that
46 phenomenon. Is Victoria the only state to offer an
47 incentive of that nature, to your knowledge?

1
2 DR HOFFMAN: It is, yes.

3
4 MR FRASER: I think the next witness will be commenting on
5 that a little, commissioner, as well. Thank you,
6 Dr Hoffman. That's very useful.

7
8 Q. Dr Chua, putting the incentive to one side, that
9 obviously wasn't a factor for you when you were making your
10 decisions about training as a GP and where you were doing
11 that training. Can I just ask you - and this is a topical
12 issue, I think there was an article this morning about GPs
13 undertaking GP training - for you, what attracted you to
14 being a GP?

15 A. I had a fantastic experience in medical school with
16 a GP practice in Gloucester, and so that was the
17 inspiration to be in general practice.

18
19 In those days, there was a fixed need at University of
20 Sydney to have a GP placement in rural regions as well as
21 metro. That no longer exists, but we certainly had a -
22 yes, it was a fixed commitment by Sydney Uni to send us to
23 experience rural life and rural general practice back then.
24 I had also undertaken a term up in Gove, in the Northern
25 Territory, and was similarly inspired by rural general
26 practice there. And then - yes. So that was the main
27 reason for choosing to go into general practice in the
28 first place, and then my registrar terms - which we, my
29 husband and I elected to do in rural GP, our registrar
30 terms in Grafton and then Dubbo solidified our intentions
31 to provide a service.

32
33 But I think, you know, we've got - in this day and
34 age, we have got an older cohort of medical graduates who
35 often have already established their roots somewhere,
36 tending to be in Sydney, if we're talking New South Wales -
37 with partners who have also established their roots, and
38 potentially also children who have established their roots
39 in Sydney, and that makes it a greater challenge for people
40 to relocate to the rural regions. But cost is also a part
41 of that decision-making process, which I think - we were
42 probably, yes, our intentions were a little bit different,
43 my husband and myself, back in our early 20s.

44
45 Q. Other than an incentive, as Dr Hoffman has referred
46 to, do you have any other thoughts on what might attract
47 people to GP practice, and particularly rural and regional?

1 A. Yes, look, our evidence is fairly clear. When we look
2 at - in lots of studies that have been done around
3 recruitment and retention of doctors to country areas,
4 number 1, if you grab a child who has grown up in the rural
5 environment, they are certainly much more likely to return
6 to the country to work as a doctor down the track. Number
7 2, their exposure in medical school, and as junior
8 doctors - what we lost for our junior doctor training is
9 the PGPPP program, which had an impact on having rural GPs,
10 you know, doctors choosing to become rural GPs and staying
11 in the regions.

12
13 Certainly incentivising GP registrars so that they've
14 got an ability to meet the costs in relocation to rural
15 area would make a difference. And so those are the things
16 that our university rural clinical schools can do to make
17 a difference, ensure that there are placements for their
18 medical students in rural general practice.

19
20 Administrative health could make a difference in terms
21 of placing junior doctors out in general practice, and -
22 yes, from a wider perspective in the funding of GP
23 registrars. And we need to do this as a matter of urgency
24 before our experienced and capable GPs in the rural areas
25 retire and can no longer pass on the skill set that they
26 have, which is I think quite unique to rural regions.

27
28 Q. I think that's something you refer to in your outline,
29 that there are a number of your colleagues in the area who
30 are - and I don't just mean Dubbo, the wider area - at or
31 past the usual retirement age and are perhaps continuing
32 because there is no-one to take on the practice?

33 A. Absolutely. Our PHN did a study about five years ago
34 now, and published that, to say that - as the small towns
35 workforce report, which is that the projection was that 41
36 of our towns would be without a GP over the ensuing 10
37 years. Now, we are five years along that journey and there
38 has certainly been closure of practices, particularly in
39 these last few years. COVID had an impact. Right now,
40 things like payroll tax issues are having an impact, and
41 general burnout, I think, and fatigue, it would be fair to
42 say, is contributing to some of that.

43
44 But there are some stalwarts of general practice in
45 our region who are well and truly past the retirement age,
46 who stubbornly continue to practise in town, because if
47 they don't, the community or, their friends, their

1 families, will be without a GP, and so they are electing to
2 continue to work and are hoping for some sort of solution
3 in the foreseeable future.
4

5 I'm not near retirement age. I feel like I've aged 20
6 years during the course of the pandemic and the extra
7 workload that occurred with that from a - you know,
8 external to our practice as well as internal to our
9 practice level and, you know, four years ago we had to
10 think very hard about whether we would leave Dubbo because
11 of the situation of our children's schooling, and so right
12 now we're in this challenging situation of going back and
13 forth, both my husband and I, across two towns because we
14 want our children to have access to good schooling but be
15 with them, but also, we are very aware that if we close our
16 practice in Dubbo, that's a substantial percentage of the
17 population without a GP practice to access.
18

19 So this is the situation. We are relying on the
20 goodwill of a group of GPs who are a bit beyond expiry
21 date, but that's - it's a brittle situation. And I don't
22 know how many years that's going to last for. Without
23 something in place in the very near future, I think we'll
24 find ourselves in a very dire situation in Western
25 New South Wales.
26

27 Q. Just one last area I wanted to ask you about, which
28 relates in part to the viability - financial viability,
29 that is - of general practice. You made some comments
30 earlier about the Medicare system not assisting or evolving
31 to assist general practice. Firstly, you make some
32 comments in your outline about, firstly, a reduction in
33 real terms, in terms of item changes, in relation, for
34 example, to ECG tests, but I assume that's an example?
35 A. Yes.
36

37 Q. So the current rebate to the GP of \$17.25, I think, is
38 the example you give, which doesn't come anywhere near the
39 cost of your time and that of the practice nurse who would
40 be involved in that.
41 A. (Witness nods).
42

43 Q. How big of a reduction did those changes in 2020
44 impose?

45 A. If memory serves me correctly, specific to the ECG
46 item number and Bek, if you remember, you might help me out
47 with this - I think it was around halved, and so, you know,

1 you need to do an ECG. If someone comes in with chest
2 pain, we would absolutely do an ECG and not just park it
3 and wait for the ambulance service to arrive. We do a lot
4 of pre-hospital, pre-operation ECGs on behalf of our
5 hospitals, in particular our private hospital.
6

7 So, you know, we have no choice with those things. An
8 ECG is one of many things. We will have no choice but to
9 charge a private fee for that, and it's a continuous fight
10 with the messages coming through from our health minister
11 about bulk billing. Well, we would love to bulk bill, but
12 only if the Medicare rebates actually cover the cost of
13 provision of those services. We have a very needy
14 population. We would absolutely love to bulk bill everyone
15 for every service. But the Medicare remuneration or
16 reimbursement absolutely doesn't cover for most of the item
17 numbers that are there.
18

19 On top of the Medicare rebate freeze that happened for
20 those seven years, even when the freeze was suspended, we
21 just still don't have an increase in Medicare rebates that
22 keeps up with inflation. I pay all the bills, have always
23 paid all the bills at our surgery, and the percentage
24 increase of the costs that happen with medical consumables,
25 you know, take something as a delivery of liquid nitrogen,
26 there is a fuel levy that is added to that these days. All
27 the costs have gone up, and staff award wages continue to
28 climb, and the only way that we can actually manage to
29 recruit and retain nursing and admin staff is if we try at
30 least to meet what the local health district might pay
31 a nursing workforce and administrative workforce, and they
32 can afford to do that much better than we do in general
33 practice. But there are many things we can do in general
34 practice if we did receive direct funding.
35

36 I'm going to use urgent care and after hours as one,
37 as another example. Currently, Medicare rebates for after
38 hours services only kick in at 6pm - sorry, 8pm. Our
39 nursing award wages, if they are doing what is called an
40 afternoon shift, so anything that concludes after 6pm, for
41 that whole shift we need to pay them time and a half. The
42 maths is simple. We can't afford to do that.
43

44 Meanwhile, we've got additional funding announced, as
45 I understand it yesterday, to even more urgent care centres
46 across the country, and that is an issue, in particularly
47 the rural areas. Where is our GP workforce going to go?

1 You know, there is not great remuneration in general
2 practice, because it all depends on what the GPs choose to
3 bill. But if you work in an urgent care centre and have
4 a lovely hourly rate that is going to be significantly
5 higher, or if you work in a local health district, or as
6 a locum rate, that is easily two or three times what one
7 would make in general practice.

8
9 You know, part of the urgent care centre issues is
10 that they are going to pull GPs away from provision of
11 proper GP care, but the other big problem is that it is
12 fragmenting care even more. So the continuity of care that
13 we know the evidence is extremely strong for, the
14 continuity of care that tells us it is the one thing that
15 makes a difference to people's outcomes with their health
16 conditions, including their mortality, but also makes
17 a difference to hospital presentations and admissions, that
18 is going to whittle away the more that that kind of care is
19 fragmented into urgent care centres in other settings.

20
21 Who is going to be left behind to do the preventative
22 care and ensure that cancer screening is captured
23 opportunistically or child growth and development is
24 assessed and fostered appropriately? It's a bleak outlook
25 when increased fragmentation is happening from a government
26 perspective as time goes on.

27
28 Q. In terms of addressing that, doctor, from your
29 perspective, given I think you said the
30 two-thirds/one-third split in terms of your patient cohort
31 and bulk billing, is the only option that you see
32 a revision of the MBS system, or are there other options?

33 A. The revision of the MBS system would make a huge
34 change. Perhaps private health insurers being able to
35 contribute for payment of doctor and primary care nurse
36 services would make a difference. Direct funding of
37 general practices instead of funding primary health
38 networks as commissioning bodies would make a difference.

39
40 Q. Thank you.

41 A. I'm sure there are more and I'm sure Bek would add to
42 that, and I would be happy to think further and come back
43 to you on that as well with additional ideas around that.

44
45 MR FRASER: Doctor, if you have any further thoughts, feel
46 free to send those through.

1 THE WITNESS: Thank you.

2

3 MR FRASER: Those are the questions I had for this
4 witness.

5

6 THE COMMISSIONER: I just have a couple of questions.

7

8 Q. Dr Chua, don't worry about the transcript reference,
9 but at page 2686 at about line 9, for those following, you
10 talked about losing the PGPPP program, which I think is -
11 is that the Prevocational General Practice Placements
12 Program?

13 A. That's correct.

14

15 Q. I think that ended in about 2014. Does that sound
16 right?

17 A. That sounds about right.

18

19 Q. Firstly, can I just ask you, did you have any junior
20 medical officers in your practice as a result of
21 a placement through that program?

22 A. We didn't at our practice but there were other
23 practices in the region who did accommodate PGPPP
24 placements.

25

26 Q. And can you just tell me, what was the nature of that
27 program? It offered a placement for junior medical
28 officers in general practices, did it? It funded that?

29 A. That's right. So as one of the terms within the
30 hospital rotations, to actually step out of the hospital
31 and do one of those terms in a general practice
32 environment, which is generally 10 weeks or so in general
33 practice.

34

35 I undertook a version of that in my younger days as
36 a resident medical officer based at Hornsby Hospital, I had
37 the privilege of undertaking a placement with Hornsby
38 general practice unit, and that was another significant
39 factor in ensuring that I did enter GP training.

40

41 Q. I don't know the answer to this, so this is a question
42 for both of you, depending on whether either of you know.
43 What was the reason for the cessation of that program? Do
44 either of you know?

45

46 DR HOFFMAN: At the time there were some concerns around
47 the insurance and the ability of the local health district

1 to ensure the community-run general practice trainees or
2 the junior doctors rotating into this space. Since, with
3 the single employer model, that has all been worked out and
4 the local health districts are able to rotate their junior
5 doctors into community general practice again.

6
7 THE COMMISSIONER: So that's, in effect, being replaced by
8 another means?

9
10 DR HOFFMAN: Another but very different. So the single
11 employer model, they are registrars on the GP training
12 pathways, so they have already decided that they want to be
13 general practitioners. The PGPPP gives the junior doctors,
14 when they are deciding what specialty training they want to
15 go into, the opportunity to experience what good community
16 general practice is.

17
18 THE COMMISSIONER: So you lose that aspect of someone
19 actually getting experience before they have made the
20 decision?

21
22 DR HOFFMAN: Absolutely.

23
24 THE COMMISSIONER: And do you consider that valuable?

25
26 DR HOFFMAN: Absolutely. It is valuable, whether they
27 choose general practice or not. If they decide to be
28 a cardiologist, an orthopaedic surgeon, a rehab physician,
29 knowing what community general practice and good community
30 general practice does is vital.

31
32 MR FRASER: If I can just clarify, Dr Chua, was it under
33 that program that you undertook that placement in
34 Gloucester that you referred to which gave you that
35 insight, or was that something, a different part?

36
37 DR CHUA: That was an even earlier part of the training
38 journey, which is as a medical student.

39
40 MR FRASER: But, similarly, you would agree that having
41 that insight into good general practice is, for you, what
42 made you want to do it, effectively?

43
44 DR CHUA: Very much so. Very much so, and the breadth and
45 variety, particularly that rural general practice provided.
46 The additional situation that happened back then, which is
47 no longer permissible, you know, the medical students were

1 able to stay in the homes of the rural GPs, and so you got
2 a 24/7 perspective of what being a rural GP looked like,
3 which included being called out to relocate shoulders and
4 popping in to be able to give anaesthetics to a patient or
5 perform an appendicectomy at all different times of the
6 day. That was the inspiration. We need to bring back some
7 of those experiences.

8
9 THE COMMISSIONER: Again for both of you, since the PGPPP
10 was cancelled, has there been any representations by your
11 college or any others that you know of to revive it or
12 something like it?

13
14 DR HOFFMAN: So ACT are currently looking at a model and,
15 well, they are currently in an election year, so they are
16 currently looking at a model this year and hoping to start
17 that next year. They are the only state or territory that
18 are currently having conversations in this space. Most are
19 having conversations in the single employer model space,
20 but again, that's missing that cohort of junior doctors in
21 the hospitals, in their decision years where they decide
22 who and what they want to be.

23
24 THE COMMISSIONER: All right. I think I know the answer
25 to this, but both of you, can you give me your opinion as
26 to whether you think this was a worthwhile program and why?

27
28 DR CHUA: I will let you go first, Bek?

29
30 DR HOFFMAN: I think absolutely it's a worthwhile program,
31 and like I have just described, it's worthwhile regardless
32 what specialty training program you end up undertaking, but
33 as a junior doctor being able to experience proper general
34 practice, proper community-led multidisciplinary care, you
35 don't otherwise get an appreciation and understanding of
36 what it is that we do for our patients.

37
38 THE COMMISSIONER: Do you want to add anything?

39
40 DR CHUA: I will second that. In the medical student
41 years and junior doctor years, the vast majority of that is
42 spent in the hospital setting, and so what comes through in
43 the hospital setting, you see the patients who generally
44 haven't had great continuity of care with general practice,
45 who generally haven't had a good handle on their chronic
46 disease management. Unfortunately, our hospital young
47 doctors tend to get a skewed perspective, then, of general

1 practice. Unfortunately - you know, we've got a large
2 number of GPs in the country, and things will improve as
3 time goes on now that, to be able to be a GP and obtain
4 your Medicare entitlements as a GP, you need to currently
5 be in a training program or have completed a training
6 program. But that wasn't the case in years gone past, and
7 so there is a breadth in abilities of current GPs in the
8 country, and certainly in rural areas.

9
10 And so you see these medical students and junior
11 doctors who get a skewed perspective that general practice
12 is not so great. But as Bek says, if we're able to place
13 our medical students and junior doctors, especially in the
14 formative years of their decision-making process, in good
15 general practice, it is a whole different world, and we see
16 that all the time in our practice. Our feedback that we
17 consistently get from our medical student placements is
18 that, "I didn't realise that this was possible in general
19 practice. I didn't realise that you were able to look
20 after so many different things and the complexity, and
21 babies right up to the elderly, and the different types of
22 medicine and procedural medicine that you do." We want our
23 junior doctors to be able to experience that.

24
25 THE COMMISSIONER: All right. Thank you. Can I ask you
26 a different question, and for those looking at the
27 transcript, it's page 2688, from about line 36. This again
28 is a question for both of you, but Dr Chua, you mentioned
29 urgent care clinics. I just want to understand, if you
30 could both, with some precision if you can, indicate to me
31 what concerns you have about urgent care clinics and their
32 impact on general practice and/or primary care. I will
33 give you some context for that. My understanding - we were
34 only having a discussion about this this morning - about
35 urgent care clinics is they are not really being set up to
36 provide primary care, I don't think they can. They are, as
37 I understand it - and I'm happy to be corrected - to take
38 some pressure off emergency departments.

39
40 What precisely are the concerns you have about urgent
41 care clinics and extra urgent care clinics perhaps being
42 funded in the budget coming down tonight, in terms of its
43 impact on general practice/primary care? Either of you can
44 go first.

45
46 DR HOFFMAN: I'm very happy to go first. I guess I have
47 two main concerns, and the first one is the siloing of an

1 aspect of clinical care away from primary care, and the
2 second one is the cost. So I will talk to the first one
3 first. So the first one, ideally, this urgent care model,
4 these lacerations, bruising, bleeding, missed script,
5 fracture management - all of this is in the remit of good
6 general practice care. If they are able to see their usual
7 GP, we know their brothers, their sisters, we know that
8 they don't want to sit in emergency because they've got
9 a sick cat at home and that's what's stopping them from
10 going in.

11
12 I've got a patient who I was talking to - I've got
13 a doctor who I was talking to in Canberra where they went
14 to the urgent care centre with a boil on their leg and
15 completely missed that the boil was due to their
16 uncontrolled diabetes, and so by only managing the boil -
17 and they managed the boil well, well enough, but they
18 didn't look at the patient holistically. They didn't look
19 at the cause of the boil, which is what general practice
20 does, what general practice does really well.

21
22 The second component is the cost. These are hugely
23 expensive, ambitious things to set up. The average cost -
24 and it is all anecdotal, we don't actually have the
25 published numbers - is about \$150 to \$200 per service, so
26 per visit, and when we're funding general practice at
27 somewhere between 45 to 85, depending on the incentive
28 payment, you are almost three times as much cost for being
29 seen at the urgent care centre versus being seen at the GP
30 who knows you and knows your family.

31
32 So it's really both aspects. It's what are the
33 outcomes; what are they trying to achieve; and could the
34 money be spent better elsewhere, and I would argue against
35 the model of urgent care centre for both.

36
37 THE COMMISSIONER: Don't think I'm putting a position to
38 you that is absolutely factual, but do urgent care clinics
39 have a role to play if they were set up in an area where
40 there weren't a lot of GPs and they took pressure off an
41 emergency department, or is that just not consistent with
42 what's happening?

43
44 DR HOFFMAN: Look, I think as you will find out as you go
45 through, one GP town is one GP town, and every GP in every
46 town will need something slightly different. I think where
47 there is already a GP, if you were offering them funding

1 for a nurse practitioner, an extra doctor, at the same
2 level that you were already funding the urgent care centre,
3 they would - well, in my very biased opinion, they would
4 probably give you better health outcomes.

5
6 THE COMMISSIONER: I think you were going in this
7 direction. What I was going to ask you is: here is an
8 opportunity for you: rather than spending the money on
9 urgent care clinics, how, in your view, would the
10 government better spend that money? This is of course the
11 Commonwealth Government, but you go ahead.

12
13 DR HOFFMAN: Wagga has got a model where instead of
14 funding the urgent care centre to provide the service, they
15 are funding the GP to provide the service. So they've got
16 the same number of services to be delivered, but they are
17 delivered through the patient's usual point of care
18 instead.

19
20 I would love to see that model expanded and I would
21 really like to see the evaluation of how that looks like
22 because I think that will be successful. Patients like
23 accessing their GP. What they like about the urgent care
24 centre is that it's free. If that funding meant that there
25 was a better cost incentive for those urgent items to be
26 seen in general practice, then we would be able to
27 subsidise to that same level.

28
29 What the GP needs is the nurse practitioner to triage
30 the calls when they come in, to say, "Is this something
31 that needs to be seen today?" "Yes, it's a laceration."
32 "Great. Come in. I will see it. I will fix it." GPs are
33 taught in fracture management, they are taught in simple
34 lacerations. We can manage gastro and foreign bodies in
35 eyes and all the things that urgent care centres are set up
36 for, and we can do it where they already have all of the
37 background knowledge about the key relationships, when
38 you've got the relationship with your local Aboriginal and
39 Torres Strait Islander Elders, with your LGBTQI diverse
40 populations. We are already in those communities and often
41 have been working there for 20-plus years.

42
43 THE COMMISSIONER: I don't know the answer to this, and if
44 you don't know, please say so, but I'm just wondering
45 whether your college has any information on this: has
46 there been any formal evaluation, or even do you know
47 anything anecdotally about whether patients that are going

1 to urgent care clinics are really going seeking what needs
2 to be really primary care attention, rather than going for
3 something that might be the sort of acute condition you
4 would go to an emergency department for and be triaged at
5 that sort of level?
6

7 DR HOFFMAN: There is anecdotal evidence but,
8 unfortunately, what the college is calling for at the
9 moment is a proper evaluation of these services.
10 Particularly in the ACT, they've got some of the longest
11 running UCCs, or urgent walk-in centres, and the last
12 published evidence-based evaluation of them is more than
13 a decade ago, and we actually don't have data on what the
14 spend is, what their outcome is, anecdotally, how often
15 they get seen there and then get cycled into emergency or
16 back to their GP anyway.
17

18 THE COMMISSIONER: What are you hearing anecdotally?
19

20 DR HOFFMAN: So anecdotally I'm hearing it is a split of
21 three. So a third are managed at the UCC and managed well,
22 and they've got really great outcomes, a third are sent
23 back to the GP, and a third are sent on to ED. Ai-Vee, did
24 you want to add any more?
25

26 DR CHUA: I just wanted to add that special element of
27 general practice, which is the opportunistic care we
28 provide, and it is going to take some years to unfold, but
29 the more that care is diverted to urgent care, the less
30 opportunistic care that GPs can provide.
31

32 THE COMMISSIONER: Q. Can I just ask you what you mean
33 by "opportunistic care"? Is that the example of the
34 patient with the boil that actually should be treated for
35 the chronic condition?

36 A. The chronic disease? There is that element of chronic
37 disease, but if I get a patient, look, I will show you
38 a few examples. So if I have a child come in for
39 a respiratory tract infection, what will I do? I will take
40 the child's height and the weight, have a little bit of
41 a chat with the parent about nutrition and physical
42 activity whilst they are there. You know, the wider, the
43 whole - look after the whole patient. Also get a sense to
44 see how mum and dad are coping with the new baby. Those
45 things, because I do - generally in Dubbo, we still do
46 manage to look after the whole family. So it is that
47 continuity of care, holistic care.

1
2 Take the older patient who may have a urinary tract
3 infection. Whilst they are there, I say - I will have
4 a look to see whether they have had their cervical
5 screening done or their mammogram, or their faecal occult
6 blood testing, do they their need bone density testing,
7 where are they at for their immunisations. Even if don't
8 do those things exactly on those days, I can provide them
9 with the forms, or I can ensure that they are booked in to
10 come back another day that I can sort out the rest of that
11 preventible health. Urgent care centres, it is not in
12 their remit to do that, and it wouldn't an expectation.
13 But those are the things that miss out.

14
15 The person who presents with a need for repeat
16 prescription, a repeat prescription is never just a repeat
17 prescription. If they come in for a repeat prescription
18 for the - let's take a really common, you know, their blood
19 pressure medication - what am I actually evaluating and why
20 are they using the blood pressure medication? Is the dose
21 the correct dose for them at this point in time? What else
22 is going on around the cardiovascular health and do I need
23 to give them some advice about their cholesterol and
24 smoking and alcohol whilst they are there?

25
26 It's that bigger picture opportunistic medicine that
27 is part and parcel of regular good general practice. We
28 miss those opportunities, and we won't know about it until
29 five or 10 years' time when we see those missed
30 opportunities present to the emergency department as
31 a heart attack or a stroke or needing an amputation.

32
33 MR FRASER: Commissioner, if I might just ask a couple of
34 questions arising?

35
36 THE COMMISSIONER: Thank you for that. Did anything come
37 out of that?

38
39 MR FRASER: Just two matters.

40
41 Q. Firstly, related, discussions about urgent care
42 clinics and GPs, obviously there will be instances,
43 particularly with shortages of GPs in some areas, where the
44 patients may not have a GP - you would agree with that as
45 a proposition. If they don't have - is it possible that
46 urgent care clinics, to an extent, may be masking the
47 problem of a shortage of GPs?

1 A. Masking and exacerbating, yes. It is a vicious cycle,
2 isn't it.

3

4 Q. What do you mean by exacerbating in that context,
5 doctor? How?

6 A. If the funding is diverted elsewhere, that means that
7 it's an increasing struggle for that GP in that area to be
8 able to have the practice, a viable practice. It also
9 means there is a greater attraction for those GPs to go and
10 work in an urgent care centre or work in the local health
11 district.

12

13 I love general practice. I absolutely love my
14 patients. But it is hard work and every now and then you
15 wonder whether, gosh, it would be just easier to just tie
16 things up in a "I will fix that boil", "I will lance it,
17 give some antibiotics, see you later." As compared to the
18 complexity of opportunistic care, mental health, the wider
19 complexities of the family situation, aged care. It is
20 hard work.

21

22 THE COMMISSIONER: I reckon you would get bored if you
23 just lanced the boil, doctor.

24

25 DR CHUA: Maybe I would. I probably would. Yes.

26

27 MR FRASER: Can I just - both of you, can I just ask you,
28 and this is just the last matter from me, Dr Chua referred
29 to the study five years ago, I think, of the RACGP, the
30 projected 41 towns being without a GP in the coming
31 10 years?

32

33 DR CHUA: That was a Western New South Wales primary
34 health network study.

35

36 MR FRASER: Yes, sorry, that's a PHN through the Western
37 health area. Can I just get both of your thoughts in
38 relation to those places where that has eventuated, ie, the
39 GP practice is no more, what are your thoughts in relation
40 to a salaried model for GPs to take up in those areas to
41 cover those towns?

42

43 DR CHUA: Look, Bek raised, you know, when you have seen
44 one town, you have seen one town, and when you have seen
45 one GP practice, you have seen one GP practice, and I think
46 it may potentially be a solution for some towns and some GP
47 practices. And maybe not for others. If I take my

1 personal situation, I would love to be on a salary, because
2 that would give me the wriggle room. You know, there is
3 population health that can be delivered when you are not
4 tied to being funded based on your one-on-one interaction
5 with the patient. There is wider care that can be - what's
6 an example? Every time I talk to a residential aged care
7 facility nurse about my patient, if I don't see my patient
8 on video or talk directly to my patient on the phone, which
9 quite frequently I don't if they have dementia and they
10 don't - you know, they can't give me any useful information
11 on history - and time restrictions wise across my day,
12 I very frequently just do have that communication with the
13 aged care facility nurse. There is no Medicare rebate
14 associated with that. That is a purely volunteer job that
15 I do, and that means that a lot of GPs don't want to do
16 that sort of work.

17

18 If I am looking at the population health - for
19 example, right now, you know, I am desperately trying to
20 increase our influenza vaccination rate at our surgery, but
21 there is times that I spend looking at our health data and
22 pushing out recalls and reminders to my patients that there
23 is no Medicare rebate for. So if somebody would give me an
24 hourly rate to do those - that patient care that doesn't
25 require - that isn't funded by the one-on-one interaction
26 with the patient, I would be a very happy person to take
27 that up.

28

29 MR FRASER: Dr Hoffman, do you have anything to add to
30 that?

31

32 DR HOFFMAN: No, I'm happy with what Ai-Vee said.

33

34 MR FRASER: Commissioner, those are the questions I had.

35

36 THE COMMISSIONER: Mr Cheney, do you have any questions?

37

38 MR CHENEY: Just a couple of things for Dr Chua, if I may.

39

40 THE COMMISSIONER: Yes, go ahead.

41

42 **<EXAMINATION OF DR CHUA BY MR CHENEY:**

43

44 MR CHENEY: Q. In your outline you lament what you
45 describe as the lack of true primary care representation
46 within the Western health collaboration. Do you recall
47 making that observation?

- 1 A. (Witness nods).
2
3 Q. That collaboration is a formal arrangement, is it not,
4 between the chief executives of Far West and Western
5 New South Wales LHDs and the Western Primary Health Network
6 and the Rural Doctors Network; is that right?
7 A. It is. It is. My understanding is that that was
8 designed to cross the bridge between primary care and
9 secondary care sectors.
10
11 Q. By providing a forum that would facilitate
12 communication between those representative organisations?
13 A. (Witness nods).
14
15 Q. Is that so?
16 A. That's the intention. That's my understanding.
17 However - because the primary health --
18
19 Q. And given your former role as a primary health network
20 board member --
21 A. (Witness shakes head).
22
23 Q. Sorry, are you shaking your head there?
24 A. No, I've never been a PHN board member.
25
26 Q. I'm sorry.
27 A. It would be fantastic if we had more local GPs on our
28 PHN board.
29
30 Q. I see. You are chair of the Western New South Wales
31 Primary Health Network's Western Clinical Advisory Council;
32 is that right?
33 A. Correct.
34
35 Q. In that role, would it be your expectation that the
36 chief executive of the PHN would be in a position to
37 advocate the position of primary caregivers in the Western
38 health collaboration forum?
39 A. They are in a position to do so, but our two chief
40 executives who have been in that role, in times gone past,
41 have not advocated for that.
42
43 Q. I'm sorry, the two previous chief executives did not
44 advocate the primary caregivers' position? Is that --
45 A. Correct.
46
47 THE COMMISSIONER: Q. What do you mean? Can I just ask

1 you to expand on "haven't advocated the primary caregivers'
2 position" - what do you mean precisely by that.
3 Because that was the question coming through from your
4 room. I guess, in my words, those would not necessarily be
5 the words that I use, but the phrasing from my perspective
6 would be because the PHNs not just in our region but in
7 general across the country are often thought to represent
8 the voice of GPs and they can't, because they, you know,
9 don't - they aren't GPs; there is very little in terms of -
10 in fact, usually zero staff who are working in a clinical
11 capacity as well as working within a PHN.
12

13 And certainly our chief executives we've had with our
14 PHN did not come from a clinical background. So they
15 couldn't be the voice, the direct voice of our clinicians,
16 nor general practice in our region.
17

18 I'm going to give an example. Look, our diabetes
19 collaborative commissioning project in Western New South
20 Wales initially was intended - there was an intention to
21 have two clinicians sitting at the governance level, in
22 addition to the chief executives of those four
23 organisations. There was supposed to be a First Nations
24 representative, a GP representative, a hospital clinician
25 representative, and patient representative. That never
26 eventuated. That patient-centred commissioning team ended
27 up just being the chief executives.
28

29 Q. Do you know why?

30 A. There was never the opportunity to find out why that
31 didn't pan out.
32

33 MR CHENEY: Q. In any event, Dr Chua, one of the
34 solutions that you proposed to enhance the representation
35 of primary caregivers in the collaboration is the inclusion
36 of GPs in the LHD clinical councils; is that right?

37 A. That would be an option.
38

39 Q. And I think you point to Hunter-New England LHD as an
40 example of a district where that has occurred?

41 A. I'm aware that - looking online, I'm aware that they
42 had advertised for two GP representative positions on their
43 district, the local health district clinical council. At
44 one stage early in the pandemic when the chairs of our PHN
45 clinical advisory councils attempted to come together to
46 nut through some issues and solutions across our state,
47 there was at least one who talked about the fact that they

1 had a GP council that fed back to their local health
2 district directly. So there was - it was a larger group of
3 GPs and not just GPs sitting on a clinical council, but
4 a larger group of GPs providing consultation to the local
5 health district chief executive and the next level of
6 executives as required.

7
8 Q. But just to direct your attention to paragraph 7(b) of
9 your outline, you refer to inclusion of general
10 practitioners in LHD clinical councils as a solution to the
11 problem. You had in mind that GPs would sit on the
12 clinical councils; is that right?

13 A. That's one option for a solution to increase that
14 connectivity with general practice.

15
16 Q. Does that not in fact occur with the Western New South
17 Wales District Clinical Council - that is, a GP, at least
18 one GP sits on the council?

19 A. I'm not aware that our Western LHD clinical council
20 has any GPs on it at present.

21
22 Q. Do you know or know of Dr Robin Williams, a GP from
23 MoLong?

24 A. Yes, yes.

25
26 Q. You understand he operates the multi-GP practice at
27 MoLong?

28 A. Yes.

29
30 Q. Do you understand he is a member of the district
31 clinical council within the Western NSW LHD?

32 A. I was aware that he chaired the district clinical
33 council previously, but I had thought that he was no longer
34 part of the district clinical council. He does chair our
35 PHN board.

36
37 Q. But if it were the fact that he presently sits on the
38 council, that would give you some comfort, would it not, on
39 the question of the amount of input that your body is
40 receiving?

41 A. That would give me a little comfort. Robin is an
42 excellent person, yes, and would advocate strongly. Look,
43 you know, we've got 110 general practices across the
44 Western New South Wales PHN footprint. Not exactly sure
45 what proportion of that is within the Western LHD footprint
46 but I would assume that's a vast majority of those 110 or
47 so. We have towns of varying sizes. We've got very

1 different populations across our 440,000 square kilometre
2 footprint. So it does give me comfort that Robin sits as
3 one GP on that group. I think we would need - to really
4 maximise the input provided by general practice, we would
5 be looking for a GP wider council.
6

7 Q. Just one last matter, Dr Chua. You, as we discussed,
8 sit as the chair of the clinical advisory council with the
9 Western New South Wales primary health network; is that
10 right?

11 A. Yes. That's right.
12

13 Q. Given that role and your experience, long experience,
14 as a rural GP, do you have a view about how the PHNs might
15 work more collaboratively with the LHDs to improve things
16 generally in the primary care space?

17 A. Yes, look, the proposal has been put forward several
18 times for an alliance in the region, modelled off the
19 Canterbury alliance in New Zealand, and unfortunately that
20 has not - that has never managed to take off. But the
21 concept behind that would be to have, as I alluded to
22 before, primary care and secondary care organisations work
23 together on a targeted needs assessment, align the service
24 delivery and, you know, we do have a federal/state divide
25 in funding that makes that particularly challenging, but if
26 locally we were able to identify our priority issues and
27 have aligned service delivery strategies to overcome those
28 priority issues, that would make a big difference.
29

30 So that would require an independent body to be set
31 up, which draws from both PHN, local health districts, but
32 also critically important to then also pull in your health
33 care providers, general practitioners included, that can
34 feed in to that role of contributing to evidence-based
35 service delivery - evidence-based solutions, contributing
36 to implementation of initiatives that are then developed by
37 such an alliance. Yes.
38

39 So what would I see - that would be the ideal
40 solution. And there are whiffs of that sort of model,
41 again, Hunter-New England, Central Coast, South West Sydney
42 have done work on things, I think more so the acute care
43 situation. Different areas of the state have collaborated
44 well with good impact on that.
45

46 Look, you know, we have really good people in Western
47 New South Wales who have made that attempt to do that, but

1 have forgotten the element of clinician involvement and it
2 never has gained enough traction for it to penetrate right
3 down all the hierarchies of all the organisations involved.
4

5 Q. I think you said earlier that your practice, at least,
6 deals with roughly 20 per cent of the patients in - was it
7 in Dubbo?

8 A. In Dubbo.
9

10 Q. Would there be some benefit, do you think, if the LHD
11 was able to work directly with larger practices such as
12 yours rather than having to deal with the primary health
13 care networks?

14 A. Very much so. Absolutely. Yes. During the COVID
15 pandemic where we - you know, there were so many challenges
16 in the pandemic, but some really good things that happened.
17 The Western New South Wales COVID group was one of those.
18 So I was part of that group who met up each week or
19 fortnight, or each month, depending on how terrible the
20 concern was around that point in time. We had the CCIC,
21 COVID care in the community clinicians as part of that
22 group. We had some administrators where there was
23 involvement of the emergency department physicians. It was
24 very much a clinically-driven group and it was a bottom-up
25 approach rather than a top-down approach. So what we saw
26 as the needs, you know, we put in our suggested solutions
27 and worked across the different sectors to make things
28 happen.
29

30 We haven't seen --
31

32 THE COMMISSIONER: Q. Sorry, can I just ask you, you
33 enthusiastically embraced the proposition Mr Cheney put to
34 you of there being a benefit if the LHD was able to work
35 directly with larger practices such as yours. What do
36 you - in embracing that enthusiastically, what encompasses
37 "working directly with the LHD"?

38 A. Oh, my goodness, the things that we could do. Look,
39 there are simple things like access to pathology and
40 radiology. Take a Friday afternoon and you are needing to
41 have - if someone comes in with atypical chest pain, and
42 you think, "Oh, look, in order to keep them safe, I really
43 need to have that opportunity to do pathology and radiology
44 on them now and I need to know the answer within half an
45 hour or thereabouts."
46

47 Right now, the pathway to make that happen is not

1 available in the community. I can't request the pathology
2 and radiology department to open up for my patient. I have
3 to send them through to ED in order for that to happen.
4

5 Another example, I have a fair amount of experience in
6 paediatrics and certainly have had a paediatric registrar
7 position at the hospital in days gone by, and I can see
8 a six-monther with bronchiolitis and know that they need to
9 be admitted and, ideally, I should be able to just work
10 directly with the LHD, phone the paediatrician on call and
11 say "This is the situation with this child. Here is my
12 assessment. Here is what I think needs to be done,
13 including that they need an admission." Right now, the
14 processes don't allow that to happen. Right now, I have to
15 send that child through to the emergency department where
16 they will get assessed by, typically, the emergency
17 department junior doctor, who then consults with the
18 experienced doctor in the emergency department. Then
19 they've got to call the registrar, paediatric registrar for
20 them to assess the patient, who then needs to talk to the
21 paediatric consultant to confirm that admission is
22 possible.
23

24 There is a lot of health dollar saving we could do if
25 practices could work directly with the LHD on things like
26 that.
27

28 THE COMMISSIONER: Dr Hoffman, did you want to add
29 anything to that answer?
30

31 DR HOFFMAN: I did. I just wanted to cycle back to
32 something that Dr Ai-Vee said earlier, which is the
33 utilisation of the outpatient clinics to see stable
34 patients, that if the stable patients were able to be
35 returned to their GP for stable diabetes, stable
36 osteoporosis, stable heart failure, then they wouldn't need
37 to be seen by their specialist outpatient clinics and they
38 would be able to take on new patients, which would
39 drastically reduce the wait time into those outpatient
40 clinics.
41

42 MR CHENEY: Nothing further.
43

44 DR CHUA: Another thing that would facilitate that direct
45 collaboration would in fact be continuity of patient
46 records. We aren't able, in general practice, to see
47 hospital records. We have to wait for discharge summaries

1 to come through, which may or may not come through, with
2 the information that may or may not be there. You know, if
3 we had a chance to share information both ways, that would
4 directly - yes, it would greatly enhance an ability to
5 provide collaborative care and shared care.
6

7 THE COMMISSIONER: You used the expression "we have to
8 wait for discharge summaries to come through, which may or
9 may not come through". How should I understand that? Does
10 that mean that a discharge summary is provided to your
11 patient when they leave the hospital but they forget it; or
12 does it mean they don't always get, in a timely way,
13 a discharge summary; or another alternative, does it mean
14 the discharge summary is provided to them and they give it
15 to you but it's not very helpful for some reason?
16

17 DR CHUA: In most situations, and I know Dubbo Health
18 Service have done a lot of work on this over the years - in
19 most situations, the discharge summary comes through. In
20 most situations it comes through in a timely manner before
21 the patient ends up seeing us in an appointment in general
22 practice. Not always, but, you know, that's - 100 per cent
23 is hard to come by.
24

25 But there are some situations where it's policy or
26 protocol where it doesn't happen. So a recent concern of
27 my GPs has been when somebody has died in hospital, one of
28 our patients has died in hospital, we don't get a discharge
29 summary to inform us that patient is now deceased. But we
30 see the family members and we still have existing recalls
31 that we end up sending to that patient, which is hugely
32 distressing to their family members.
33

34 In terms of content of discharge summaries, look, it's
35 usually the intern, you know, the most junior of the
36 doctors in the team, who writes the discharge summary, and
37 if those interns are great interns, they absolutely
38 understand what has happened for that patient in hospital
39 and the rationale for the treatment going forward. But
40 sometimes you do get a discharge summary which doesn't have
41 a lot of useful content, and our patients are often none
42 the wiser. Our patients often turn up to us and say "What
43 exactly am I supposed to be taking with my medication?
44 What exactly happened to me in hospital? I don't
45 understand. I wasn't feeling well. I couldn't understand
46 what they were trying to tell me," as happens in outpatient
47 departments as well. There is something in our knowledge

1 of our patients' health literacy that makes it much easier
2 for us to communicate with them at a level which they
3 understand.

4
5 THE COMMISSIONER: Did anything arise out of any of that?
6

7 MR CHENEY: No, Commissioner.
8

9 THE COMMISSIONER: Mr Fraser, is there anything?
10

11 MR FRASER: No, Commissioner. If Dr Chua could be
12 excused.

13
14 I note the next witness has been waiting.

15
16 THE COMMISSIONER: We will have a break. We will have to.
17

18 MR FRASER: I think for the stenographer, if for no-one
19 else.

20
21 THE COMMISSIONER: Yes. So Dr Hoffman is staying?
22

23 MR FRASER: Yes.
24

25 THE COMMISSIONER: Dr Chua is done. Dr Chua, thank you
26 very much for your time. We're very grateful. You are
27 excused.

28
29 **<THE WITNESS WITHDREW**

30
31 THE COMMISSIONER: Dr Hoffman, we're just going to have
32 a break until 10 past 12.

33
34 DR HOFFMAN: Thank you.

35
36 THE COMMISSIONER: We'll adjourn until 10 past 12.
37

38 **SHORT ADJOURNMENT**

39
40 THE COMMISSIONER: Commissioner, I believe we're ready to
41 commence, if you are?

42
43 THE COMMISSIONER: Absolutely. We've now got Dr Hoffman
44 but with Dr MacIsaac.

45
46 MR FRASER: Yes, that's correct.
47

1 THE COMMISSIONER: Dr MacIsaac, can you hear me?

2

3 DR MacISAAC: I can, yes.

4

5 <MARY BETH MacISAAC, sworn: [12.10pm]

6

7 <EXAMINATION BY MR FRASER:

8

9 MR FRASER: Just to confirm, Dr Hoffman, to the extent she
10 is required, is on her former oath.

11

12 DR HOFFMAN: Thank you.

13

14 MR FRASER: Q. Dr MacIsaac, could you give your full
15 name, please.

16 A. Sure, it's Mary Elizabeth MacIsaac. I am commonly
17 known and practice under "Mary Beth".

18

19 Q. You are giving evidence today from your rooms in the
20 Coomealla Health Aboriginal Corporation?

21 A. In Dareton, yes.

22

23 Q. And that's in Dareton?

24 A. Yes.

25

26 Q. And Dareton's a town in the Far West Local Health
27 District; is that right?

28 A. Correct, yes.

29

30 Q. And just in terms of basic geography, that's at the
31 southern part, or very southern part, of the local health
32 district, not far from the Victorian border; is that
33 correct?

34 A. Correct, yes. So it's the very south-west corner of
35 New South Wales, near there, yes.

36

37 Q. Just to give it a very basic orientation, how far is
38 it to Broken Hill by car?

39 A. It would be - it takes just under three hours to drive
40 to Broken Hill. It's a little under 300 kilometres,
41 I think, perhaps about 270 kilometres. But I would have to
42 look it up to be sure. It's about a three-hour car
43 journey.

44

45 Q. In terms of larger towns or regional centres, is the
46 closest regional centre Mildura?

47 A. Correct, yes, that's about 20 minutes away by car.

- 1
2 Q. And for those of us not overtly familiar with that
3 part of the country, Mildura is in Victoria; that's
4 correct, isn't it?
5 A. Yes, correct, yes.
6
7 Q. I will take you to some detail in a moment, but,
8 doctor, you have prepared an outline in relation to your
9 evidence; is that right?
10 A. Yes.
11
12 Q. Just for the record, [SCI.0009.0092.0001]. Doctor, is
13 everything in that outline correct as far as you have
14 ascertained; is that right?
15 A. Yes.
16
17 MR FRASER: That will be added to the bulk tender in due
18 course.
19
20 Q. Doctor, firstly, you hold a salaried general
21 practitioner position at the Coomealla Health Aboriginal
22 Corporation; is that right?
23 A. Yes.
24
25 Q. And in terms of your position, how many days a week do
26 you work at Coomealla?
27 A. Two.
28
29 Q. And in terms of that organisation, what other medical
30 staff are there at the practice?
31 A. Do you mean doctors, by "medical staff".
32
33 Q. Firstly, doctors?
34 A. Yes, we have a senior GP registrar - actually, two
35 senior GP registrars, one who works five days a week and
36 one who works four days per week, and we occasionally get
37 prevocational doctors from the Mildura Base Public
38 Hospital. It's a PGY2, postgraduate year 2 position, and
39 they would be two days a week, just the days that I am
40 there.
41
42 Q. So you would - when you do have prevocational doctors,
43 you are the supervisor; is that right?
44 A. Yes, I'm the supervisor for the prevocational doctors
45 and as well one of the registrars, so I continue to
46 supervise my registrar when I'm across at the base hospital
47 as well.

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Q. And the other registrar, are they supervised by someone else?

A. The other registrar is under the remote vocational training scheme, I'm hoping I got the wording of that right, the RVTs, and I'm not their direct supervisor but I'm not aware of who their direct supervisor is.

Q. In terms of staffing there at Coomealla, there are also some allied health staff; is that right?

A. Yes, yes.

Q. What type of staff operate there at Coomealla?

A. So we have a dietician, who I believe is here five days per week; we have a women's health nursing, who does cervical cancer screening. That is, I believe, a day a week or a day a fortnight, I'm not entirely sure. We have a diabetes educator one day per week. We have a podiatrist one day per week. We have visiting services from audiology, both adult and child audiology. We have a social emotional wellbeing worker, so various programs that are run. So, for example, we have a mums and bubs group for women and children that meet in a kind of social support circle. And I think there's someone I'm forgetting. It will come to me. But yes, we have a number of allied staff that work here. Aboriginal health workers. Oh my goodness, that was what I was forgetting, and nursing.

Q. How many nurses?

A. We are supposed to have a nurse here every day. It doesn't always work out that that's the case. There is no nurse here today.

Q. And in terms of those staff, are they employed or are they employed by other organisations using the rooms there at Coomealla, or is it a mix?

A. It's a mix. So I believe that the visiting audiologist is employed by another organisation. I can't - I think it might be called Happy Hearing, or something like that. I'm not sure who employs the women's health nurse. I think that might also be another employer but I'm not entirely sure. But yes, I'm not entirely - I'm an employed salaried GP, so I'm not entirely aware of the financial arrangements for the clinic.

Q. Certainly. Now, in terms of yourself, you also hold

1 a position over in Mildura; is that right?
2 A. Yes. Yes.
3
4 Q. Is that the director of medical education at the
5 Mildura base hospital?
6 A. Yes. Mildura Base Public Hospital, correct.
7
8 Q. Do you work in that position for the balance of your
9 time, three days a week?
10 A. Yes, the three days a week.
11
12 Q. That's a staff specialist --
13 A. Yes, position.
14
15 Q. -- level position?
16 A. Yes.
17
18 Q. Just in terms of your positions, you are also the Far
19 West representative for the Royal Australian College of
20 GPs; is that right?
21 A. Yes, that's correct.
22
23 Q. And the chair of the Far West Clinical Council of the
24 Western New South Wales Primary Health Network; is that
25 right?
26 A. Correct.
27
28 Q. Thank you. Now, you have been there in Dareton for
29 how long?
30 A. I started in late January 2023. So a year and
31 approximately four months or so.
32
33 Q. And a similar time at Mildura; is that right?
34 A. I started in Mildura in February 2023, so similar.
35 Yes.
36
37 Q. And prior to that, you have said in your outline that
38 you were a senior medical officer in primary care for the
39 rural flying doctor service?
40 A. It should have said Royal Flying Doctor Service.
41 Sorry, that's incorrect. It should say Royal Flying Doctor
42 Service.
43
44 Q. Of course. Thank you. It is perhaps why I stumbled
45 over it. The Royal Flying Doctor Service based in Broken
46 Hill; is that right?
47 A. Yes, yes.

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Q. Could you just briefly tell us the nature of that position? What work you were doing in that position?

A. Yes. So I worked clinically two days per week, so it was a 0.4 clinical position. I did most of my clinical work at the Clive Bishop Medical Centre in Broken Hill, although I did occasional clinical work in the clinics that are covered, so there are - there was at that time 17 clinics across the Far West and southern Queensland, northern South Australia, that were covered by the Royal Flying Doctor Service, so occasionally, particularly if staff were away, would fill in for clinics.

Goodness, there was a lot of work that I did in that position, I'm not sure how much detail you would like, but I supervised a number of GP registrars; I was clinical lead for the Far West, the immunisation program that the Royal Flying Doctor Service provided for the COVID immunisation efforts. I also had oversight of the respiratory clinic that the RFDS had. I provided clinical support to the nursing staff in the chronic disease programs.

I did some research, collaborated with the Broken Hill University Department of Rural Health on some initiatives, and on other initiatives collaborated with the Far West Local Health District in some initiatives as well, particularly around COVID.

Q. Thank you. I believe you were there about three years; is that right?

A. It was from July 2020 to January 2023.

Q. Now, in your outline, just in terms of coming to the Far West, as you did, you were previously in practice in the Sydney region; is that right?

A. Yes, in South Eastern Sydney. I worked at North West Medical Practice in Gympie, which is in the Sydney Sutherland shire, for eight years before moving to the Far West. Before that I worked for two years at Yarrawarra Medical Practice or medical clinic. I can't remember. It was years ago. But I worked there for two years after I moved to Australia.

Q. And both of those were as a GP?

A. As a GP, yes.

Q. You are originally qualified in Canada; is that right?

1 A. Yes.

2

3 Q. And you undertook your GP training in Canada; is that
4 correct?

5 A. I did. Yes. And I worked for two years in a rural
6 hospital in Canada before I - post fellowship, before
7 I moved to Australia.

8

9 Q. I will ask you a few questions about that. Firstly -
10 and it may be different in Canada - what was it that
11 attracted you to general practice?

12 A. What attracted me to general practice? It was
13 actually rural medicine that attracted me to general
14 practice. I did a rural rotation as a medical student and
15 it was a very unlikely thing to decide after that rotation,
16 what I wanted to do. I went to a rural hospital where
17 there were only two doctors and that meant they were on
18 call, one and two, and they provided all of the services
19 for the community, and they were very, very busy and my
20 accommodation was in a room underneath the stairs in the
21 hospital that didn't have any windows, and I ate every
22 night in the hospital cafeteria, which was by that point
23 empty, and the hospital cafeteria staff had kindly left
24 a meal out, which would get colder as time went on.

25

26 So that's where I ate in the evenings by myself. But
27 despite that, I could see the passion that the two doctors
28 had for their communities and I could see how much having
29 those two doctors there meant to those communities. So
30 while I was there, I was meant to undertake a bit of
31 a project and I thought, well, we will ask the patients
32 about all of the services they were lacking and all of the
33 things that they didn't have, and I couldn't actually get
34 the patients to say anything other than how happy and
35 grateful that they were that they had the services that
36 they had and how much it meant to them to have those two
37 doctors there, and I could really see from then the
38 relationship that general practice has with patients and
39 with the community as a whole.

40

41 And so despite those two doctors telling me
42 I shouldn't do general practice actively, because they
43 didn't have lives, it is indeed the career path that
44 I chose, and I chose to do a rural/regional program because
45 I felt that that is where I would learn the skills that
46 would help me to serve a rural community.

47

1 Q. And that rural and regional program you referred to,
2 was that part of your training in Canada? That was
3 a training path?

4 A. Yes. I did the family medicine program at Dalhousie
5 University. I trained in Fredericton, New Brunswick. At
6 that point, it had a population of about 80,000. Then from
7 Fredericton we had, like, a rural rotation from there as
8 well.

9

10 Q. I would just like to ask you now, you came to
11 Australia and worked in Sydney initially. You describe in
12 your outline there being restrictions as an international
13 medical graduate.

14 A. Yes.

15

16 Q. That effectively delayed your ability to become rural
17 or to relocate?

18 A. Yes, so the effect that - so I was under what is
19 commonly known as a 10-year moratorium, which restricts my
20 ability to access a Medicare provider number, and I knew
21 that when I got the provider numbers that I did in Sydney,
22 so the one for Yarrawarra and the one for Gympie, that
23 I was very lucky to get those two provider numbers. I also
24 knew that my ability to get another provider number in
25 Sydney would be extremely limited and that if I left where
26 I was practising, I would be asked to relinquish that
27 provider number and I would not be able to move back into
28 an urban area because of the closing of the geographic
29 locations that were available to me.

30

31 So I did not want to take a risk to move to a rural
32 area, even though I undertook some rural locums and my
33 husband was always very interested in moving to a rural
34 area - I didn't want to do so until I knew that I had the
35 ability, if it didn't work out, that I could move back any
36 time I wanted.

37

38 Q. And that 10-year moratorium you refer to, that's by
39 virtue of operation of, without going into the detail,
40 Commonwealth legislation and rules; is that right?

41 A. Yes, I think the - I think it was under something
42 called the 19AB exemption or something along those lines.
43 I can't tell you the legislation specifically, I just knew
44 where I was allowed to apply for a provider number or not.
45 And so my moratorium expired in August of 2020 and that is
46 when I started practising in Broken Hill.

47

1 Q. You have said that, putting aside the moratorium, you
2 would not have been able to relocate except for the fact
3 that your husband was also relocating here. Could you just
4 expand on that?

5 A. Well, family support is of course important, so it is
6 very hard to move to a rural area if your spouse is not
7 going to have work in that rural area. So it was actually
8 my husband that got the job in Broken Hill first and then
9 I - I mean the job with the - the Royal Flying Doctor
10 Service job came up and I thought that would be quite
11 interesting, and so I moved as well. There wasn't really
12 a drawcard or incentive, though, for me to leave suburban
13 Sydney and move to western New South Wales. I think I got
14 some of my relocation costs reimbursed by the - the
15 majority were reimbursed by my husband's job but I could
16 have had them reimbursed by the Royal Flying Doctor
17 Service. There wasn't anything to sort of incentivise
18 a move.

19
20 Q. I see. So really your interest and family relocation
21 ability is what facilitated --

22 A. The move, yes.

23
24 Q. Can I just ask you now about your experience of
25 general practice, both - some of these questions
26 effectively go into both your roles, your current role in
27 Dareton and your previous role in Broken Hill.

28 A. Mmm-hmm.

29
30 Q. You have made some comments in your outline about some
31 of the challenges in relation to your practice as a GP,
32 given your patient cohort.

33 A. Yes.

34
35 Q. Some significant numbers with various social and
36 economic disadvantages?

37 A. Yes.

38
39 Q. Low levels of health literacy.

40 A. (Witness nods).

41
42 Q. I think at one point you refer to multi morbidities?

43 A. Yes. So multiple health conditions that the patient
44 experiences, both mental health and physical health
45 conditions, and sometimes also issues with substance abuse,
46 drug and alcohol and - yes, the difficulty of navigating.
47 Because guidelines tend to be written for specific single

1 diseases, so they are not written for the patient who has
2 diabetes, mental health issues, overlapping substance abuse
3 issues, might be also experiencing domestic violence.
4 I can't follow an algorithm and figure out where to manage
5 that patient or how to manage that patient because it
6 doesn't follow a neat, simple kind of pathway.

7
8 Q. Related to that, presumably, is access for your
9 patients to specialist care when referred by yourself?

10 A. Yes. There have been numerous challenges with trying
11 to access, in particular, mental health and psychiatric
12 care for our patients.

13
14 Q. If we could just focus on that, firstly - and this is
15 in relation to your current role there in Dareton at
16 Coomealla. What are your referral pathways for patients in
17 relation to that currently?

18 A. So the referral pathway is to an organisation called
19 Buronga HealthOne, which has a psychiatrist that I believe
20 supports them. That psychiatrist I understand is in Broken
21 Hill.

22
23 Q. What's your experience with wait times for such
24 referrals?

25 A. So I've had numerous referrals rejected, so they
26 refuse to see the patient altogether, and I've had others
27 with serious mental illness that waited months to even have
28 the referral accepted that the patient actually was given
29 an appointment time. So I think I mentioned in my
30 affidavit, I did have a patient with schizophrenia that
31 I felt was - I was uncertain as to which of her symptoms
32 were schizophrenia and which were some other illness. It
33 was very difficult for me to know how to adjust her
34 medications, and that particular patient - and that patient
35 has low literacy levels and intellectual challenges and has
36 support workers, and despite the efforts of myself, the
37 support workers and the practice, that was five months to
38 get that patient in to get a phone call to have an
39 appointment booked.

40
41 Q. Presumably there are - well, I will ask you, are there
42 any psychiatrists there in Dareton?

43 A. No, no, there are not. There are psychiatrists -
44 I suppose this is a conflict of interest, so I will declare
45 that, but there are psychiatrists at the base hospital, the
46 Mildura Base Hospital where I work, and in a moment of
47 frustration, I said to them "You have so many psychiatrists

1 here, can you not send anyone out to Dareton?" And they
2 said "We would love to, but we're not allowed", and I said
3 "Why are you not allowed?" They said "Because Broken Hill
4 holds the funding and they won't release it." I don't know
5 how true that is, that is what I was told, but that's the
6 reason why they can't drive 20 minutes down the road to see
7 my patient who is far more complex than I - I can manage
8 a lot in general practice, I really can. I really have to
9 a lot of days, but I cannot adjust medications for
10 a patient whom I, you know - has a diagnosis of
11 schizophrenia and I do believe has that. I can't adjust
12 their medications if I don't really know what's going on.
13 That's just too difficult for me to do.

14
15 Q. It needs specialist input, from a psychiatrist?

16 A. They do, yes.

17

18 Q. Just in terms of access to other specialties, is it
19 the case - I think you have said in your outline that there
20 are other specialties that you are able to effectively
21 refer to specialists based in Mildura?

22 A. Yes. So we're able to access nephrology services in
23 Mildura; we're able to access cardiology services. I don't
24 believe that cardiology services are via the base hospital,
25 but they will provide low cost services for our patients,
26 which is really appreciated, private specialists. We can
27 access paediatric services, which is wonderful, obstetrics
28 and gynaecology services, so there are a few services that
29 we can refer across the border.

30

31 Q. And other than cardiology, which you specifically
32 mentioned, as not being in the hospital, are those other
33 specialist services based at Mildura hospital?

34 A. They are based at the hospital and via the Mildura
35 Base Hospital specialist clinic, yes.

36

37 Q. And as far as you understand, there is no funding
38 issue in that regard?

39 A. Not as far as I understand. I don't know exactly how
40 the funding arrangements work, but as far as I understand,
41 there is no funding issue, and our patients are actually -
42 if surgery is required, they are able to access surgery at
43 the base hospital as well.

44

45 Q. As a public patient; is that right?

46 A. As a public patient, yes.

47

1 Q. I just want to ask you now about some issues in
2 relation to - you make comments in relation to the
3 importance of continuity of care?

4 A. Mmm.

5

6 Q. Firstly, there at Coomealla you have described
7 a number of other allied health disciplines that are either
8 based there day-to-day or some days per week, or
9 periodically. I think you have referred to the various
10 disciplines there as working together as
11 a multidisciplinary team?

12 A. Yes.

13

14 Q. What are the benefits that you see from that?

15 A. There are so many. From a patient perspective, what
16 that means is that everyone is on the same page, and the
17 patient doesn't get conflicting information as to what they
18 are meant to do to access their care. So just today, the
19 diabetes educator that's here a day a week came to me and
20 said "Look, I have noticed a patient is on this particular
21 medication and it's not PBS subsidised". I said "No, it is
22 not, it doesn't fall under the PBS subsidy scheme", and
23 discussed what the reasons for that were. She said "Okay,
24 I will have a look at the patient's care, I will see if
25 there is another medication that we can actually suggest".
26 So because we're under the same roof, we get to have
27 conversations about our patients.

28

29 Additionally, when she finishes seeing the patient
30 today, I will be able to go into the patient's notes and
31 actually access what she has written and suggested and
32 I can seamlessly follow on her care. When providers are
33 located outside of the general practice, it can be very
34 difficult - I won't say impossible, but very, very
35 difficult - to track down letters, information, kind of
36 what has been written. So it just saves a lot of time for
37 me as a GP, which means that I get to spend more time with
38 patients and less time tracking down letters and guessing
39 what date they might have been seen and which particular
40 provider they might have seen and how long ago, and all of
41 that sort of stuff, and is there a letter available or not.
42 Waiting for things to be faxed and sent. So it saves a lot
43 of my time, which means that I can focus my time on the
44 patient.

45

46 Q. And in terms of those external practitioners, perhaps
47 if we can deal with places such as the hospital, whether it

1 be Broken Hill or Mildura or urgent care centres, which you
2 refer to --

3 A. Mmm.

4

5 Q. -- public services, put it that way --

6 A. Yes.

7

8 Q. -- what's your experience in getting information -
9 being provided routinely with information from those
10 services, such as discharge summaries?

11 A. Discharge summaries? So the Broken Hill Base
12 Hospital, when I was there, it was very, very difficult to
13 access discharge summaries. I actually - knowing that
14 I was going to be speaking to this Inquiry, I rang our
15 practice manager that I used to work with in the Royal
16 Flying Doctor Service to say was it still the case that
17 they are expending a lot of effort in trying to track down
18 discharge summaries. It is indeed the case.

19

20 So, for example, when a patient accessed the virtual
21 emergency service - I'm not sure of the name, but at the
22 Broken Hill Base Hospital - we would just get a kind of
23 letter back that said "This patient accessed the virtual
24 service. Please see the My Health Record", which isn't
25 handing over care. As a GP, I want a service to hand over
26 care to me so that I can then use that information to carry
27 on the care of the patient. When I receive something like
28 that, that's not handing over care, that's just telling me
29 that the patient accessed a service.

30

31 And then, having to go into the My Health Record means
32 that I need the patient's consent to do so. I can't just
33 access a patient's My Health Record at any time. I need to
34 ask them if that's okay. And in many cases, it means that
35 I need to have the patient with me to access the My Health
36 Record, and on a number of occasions, when I looked at the
37 My Health Record, there was, indeed, nothing there. So
38 I don't know how - I don't know if a letter was not
39 written, I don't know if it didn't make its way to the My
40 Health Record, but I can tell you that there wasn't
41 a letter in there.

42

43 So rather than having that process, it would be much
44 better for the care of the patient if the service was to
45 tell me exactly why the patient had accessed the service,
46 what had happened, and what I needed to know to carry out
47 the patient's care, and then I can make a decision as to

1 how urgently that patient needs to be seen in follow-up, if
2 any tests need to be done or followed up on other actions.
3 I can do those things and I can save both myself and the
4 patient time and potentially health, if it's something that
5 I urgently need to follow up on, by just having the right
6 information at the right time.

7
8 Q. In terms of your experience, either in Broken Hill or
9 there in Dareton, does that ever happen?

10 A. That I get handover of care in an adequate sense?

11
12 Q. Yes.

13 A. I can tell you that the Mildura Base Public Hospital
14 handover of care has gotten better since I started working
15 there, because if I get inadequate handover of care I will
16 find the person who wrote the discharge summary and ask
17 them to clarify exactly what they meant and, then, because
18 I've done that, they will then do a better job of the
19 discharge summary the next time. So it's gotten better but
20 it's not through perhaps - I would attribute that to just
21 my own efforts to go and advise the person that they hadn't
22 handed over care and what was it they were trying to tell
23 me.

24
25 Q. Your role in relation to - as the director of medical
26 education there may also be an incentive to people to make
27 sure you get those summaries, I suppose.

28 A. Yes.

29
30 Q. You've referred in your outline to urgent care
31 centres, or the urgent care clinic, and that it can
32 sometimes take time to piece together what the presenting
33 issue was. Just in terms of Dareton, where is the nearest
34 urgent care clinic?

35 A. Mildura, Sunraysia community health has an urgent care
36 clinic.

37
38 Q. Is it the same issue, that provision of information on
39 proper handover of care, is that what you are referring to,
40 or is there something additional in relation to urgent care
41 clinics?

42 A. Yes. So there is issues with adequate handover of
43 care. It can be difficult at times to know exactly what
44 the patient presented with and what is actually going on.
45 The urgent care centre is staffed by a nurse practitioner
46 and I don't know that there is any additional oversight.
47 So I don't know how well the letters are actually being

1 kind of reviewed for their adequacy and appropriateness as
2 a handover of care instrument. And so sometimes they are
3 quite vague. I'm not really sure what happened and I will
4 then have to recall the patient, bring them in and find out
5 what actually happened in the encounter. So really that's
6 doubling up on care because I haven't received something
7 that would tell me whether or not I needed to see the
8 patient, so I need to recall the patient and see the
9 patient and find out what the issue was, is it still an
10 issue, what do I need to do. So it hasn't saved me or the
11 patient any time. It's created a lot of work for both of
12 us.

13

14 Q. I just want to ask you now about the financial
15 viability issues that you have dealt with in your outline.
16 You are currently salaried - that's correct - for your time
17 at Coomealla?

18 A. Yes.

19

20 Q. And the organisation recoups money from Medicare for
21 services you provide; is that right?

22 A. That's correct, yes.

23

24 Q. You have given a comment that even with - well, even
25 with, whilst recent increases in Medicare rebates have
26 assisted general practice to an extent, your wage isn't
27 covered by the Medicare billings; is that correct?

28 A. No, it's not.

29

30 Q. Just firstly, in terms of the proportion, do you know
31 what proportion of your salary is covered by the billings?
32 You may not.

33 A. It would be hard to give an approximate number.
34 I would just have to think about my sort of salary for the
35 year and what actually was recouped from Medicare. I - if
36 I was to give a rough estimate, I would say that about
37 50 per cent of my salary is covered by Medicare billings,
38 just having seen my billings from a six-month period
39 from August to February. Yes, that was about 50 per cent
40 of the income that I made for that time period.

41

42 Q. So Coomealla has to then cover the balance of your
43 salary from its other funding sources?

44 A. Yes.

45

46 Q. Was that a similar experience in your time with the
47 Royal Flying Doctors?

1 A. I can't tell you percentages, but I can tell you that
2 my billings didn't cover what I would have earned in the
3 day.

4
5 Q. One of the things you note is the lack of incentive,
6 to summaries it, in the Medicare billing system, in terms
7 of sort of comprehensive consultations?

8 A. Yes.

9
10 Q. That is your observation?

11 A. Yes. Yes. So my patient population - I can't see
12 a patient in six minutes here. I have to take an account,
13 their living circumstances, their financial circumstances,
14 their literacy levels, because I can't just hand them
15 a patient handout and ask them to walk away. Some can't
16 read the patient handout. I have to figure out if I'm
17 going to follow them up, do they need transport to actually
18 get back to the clinic. If I'm recommending fresh fruit
19 and vegetables, do they have access to fresh fruit and
20 vegetables, because many of my patients do not. I have to
21 come up with some sort of alternative suggestion that does
22 not involve that because they can't access or afford those
23 things.

24
25 So for me to make actual sensible and practical
26 recommendations that will support my patient's health, it
27 takes a long time for me to get a history from the patient,
28 understand what their current circumstances are, take into
29 account all of those factors, come up with a simple
30 workable action plan and then make arrangements for
31 follow-up, and unfortunately, the Medicare rebate peaks at
32 about six minutes of time spent per patient, and then
33 subsequently goes down, the longer that you spend with
34 a patient.

35
36 So if I'm spending the amount of time that I spend
37 with my patients here, which is up to an hour to really
38 ensure that I've adequately managed the problems at hand
39 for today and had a plan to safely follow them up, the
40 Medicare system just does not incentivise that in any way.

41
42 Q. And when you say it goes down, it's not the actual
43 amount that goes down, it's the effective amount per time,
44 or period of time?

45 A. It is the amount per minutes. So between 6 minutes
46 and 20 minutes, the Medicare rebate, if that is what the
47 clinic is accessing, is exactly the same. It's also

1 exactly the same between minute 21 and minute 39, but it's
2 actually less per minute, the longer that you spend with
3 the patient. I'm sure Rebekah would have graphs or the
4 college would have graphs explaining how that works.

5
6 DR HOFFMAN: I'm just going to jump in for 30 seconds to
7 say, and the rebate is even lower when you are looking at
8 mental health or antenatal care. So, comparatively, our
9 physical item numbers are at a higher - highest when it is
10 a six-minute solo physical item. It's lower for complex
11 mental health, it's lower for antenatal, it's lower for
12 anything that is going to take more than six minutes per
13 visit.

14
15 MR FRASER: Thank you. That's useful, Dr Hoffman.

16
17 Q. I just want to ask about one other area, and I note,
18 Dr MacIsaac, I'm told you have patients at 1; is that
19 correct?

20 A. I do, and I'm the only doctor here today.

21
22 Q. We did keep you waiting, and we are appreciative.
23 Just in terms of some comments you have made in relation to
24 workforce, and we've covered your personal situation and
25 the lack of incentives there, you are involved with
26 students or prevocational doctors through your other role
27 at Mildura hospital?

28 A. Yes.

29
30 Q. And we've already heard briefly from Dr Hoffman in the
31 last session about the existence of the new Victorian grant
32 program for prevocational doctors in general practice.

33 A. Yes.

34
35 Q. Which we understand is up to \$40,000 per year per
36 registrar. Do you have any observations from your dealings
37 with those junior medical people over in Mildura in
38 relation to that?

39 A. Yes. Well, they are very interested in general
40 practice now. They are very interested and I'm aware of at
41 least one, but there may be more prevocational doctor, that
42 has taken up that offer. It's wonderful for Victoria.
43 When you are just across the border in New South Wales,
44 it's very tricky, because if that GP registrar then decides
45 that they are going to undertake training in New South
46 Wales, I don't know how the Victorian government would see
47 that. So it's a bit tricky.

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Q. I understand. There was one other question I just wanted to firm up. Often for rural and regional areas there are options that are explored in relation to telehealth.

A. Mmm.

Q. You make some comments. In terms of Dareton where you are right now, you make some observations that there are some technical barriers to that?

A. Yes, there are. So our internet speed in Dareton is extremely slow. I'm very pleased today to have had an uninterrupted conversation with you, where my internet has not dropped out and where the videolink didn't freeze and where the audio kept going. But that is not the case most days in Dareton. We have frequent internet interruptions and connection speeds are extremely slow. Mobile phone coverage is extremely limited, so my own mobile phone, when I'm in the clinic, if someone rings me - and keeping in mind that might be a specialist from the hospital - I have to leave my consult room, walk outside to the back alley and hold my phone up to hear my phone, otherwise that person can't hear me, I can't hear them. It's a very difficult conversation.

And so telehealth is quite often seen as the solution to a multitude of problems, and telehealth works in some instances where you have connection speed, infrastructure to support telehealth, computers, phones that work, all those sorts of things. In Dareton, that's very difficult with these very slow internet speeds, phone access, all those sorts of things. So if, for example, a specialist was trying to ring a patient on their mobile phone to say "Oh, I can't get through to you on the videolink", the patient's going to have to go outside, because the phone doesn't work indoors.

So it just is very limited. And many of our patients don't have computers, they don't know how to access the internet, they can't actually access those things that would serve them well with telehealth, if that was the case.

MR FRASER: Thank you. Those are the questions I had for Dr MacIsaac. I think there is a little bit of time.

THE COMMISSIONER: Q. Can I just ask you a couple of

1 questions, doctor? In paragraph 10 of your statement,
2 where you talk about, in the second sentence, if a patient
3 attends an urgent care clinic --

4 A. Mmm.

5

6 Q. -- based on the last sentence, I assume you are
7 referring to a patient who is - you are their usual GP but
8 for some reason they've gone to an urgent care clinic.

9 A. Yes.

10

11 Q. Where would the urgent care clinic they would
12 typically go to be?

13 A. It is in Mildura, Sunraysia Community Health Services,
14 Mildura.

15

16 Q. And, typically, why would they go to that urgent care
17 clinic? Would it be because you are not open at the time,
18 or what are the reasons that you have some patients that
19 are going to the urgent care clinic?

20 A. I'm not always certain why patients will choose an
21 urgent care clinic. I'm told that some patients think that
22 it's very straightforward - like if they have
23 a straightforward problem like they need a certificate for
24 something, a certificate for time off work, they are aware
25 that they can go to the urgent care centre and get
26 a certificate for time off work, so a very straightforward
27 problem. So some will access it for those reasons.

28

29 Otherwise I'm not entirely aware of why they are being
30 accessed. We do have urgent on-the-day appointment
31 availability here at CHAC. It's been an absolute blessing
32 that no-one has come and knocked on the door because
33 someone's here with chest pain or something similar,
34 because we do get patients of fairly high acuity at times
35 that access our urgent on-the-day appointment service. So
36 I'm not entirely sure why they're going to the urgent care
37 centre. Someone told me that it's just a quick way to get
38 a certificate.

39

40 Q. A quick way - oh, to get a certificate. Okay.

41 A. Yes, so certified for time off work or --

42

43 THE COMMISSIONER: Did anything emerge out of that?

44

45 MR FRASER: No.

46

47 Q. Just two matters, just to confirm. In Dareton, are

1 there any other GP services in Dareton itself?

2 A. Not in Dareton itself that I'm aware of, no.

3

4 Q. And can I ask, the service there, do you provide GP
5 services to non-First Nations patients as well as First
6 Nations?

7 A. We do. We do. Because we're the only service in
8 town, and often - so, one, because we're the only service
9 in town, and often Aboriginal patients are married to
10 non-Aboriginal patients, so are actually seeing the spouse
11 of one of our patients, rather than having that spouse
12 access a service elsewhere.

13

14 Q. And just in terms of wait times, other than urgent
15 appointments which you keep several aside for such matters,
16 for what you might call a routine appointment, what's the
17 wait time on average?

18 A. At the moment I think it's about two weeks or so. It
19 fluctuates depending on who is away. So right now I have
20 a registrar away and that might mean that wait times expand
21 a bit, and then when she comes back they might get a bit
22 shorter.

23

24 MR FRASER: Thank you. Those are the questions I had,
25 Commissioner.

26

27 THE COMMISSIONER: Mr Cheney, do you have any questions?

28

29 MR CHENEY: No, Commissioner.

30

31 THE COMMISSIONER: Thank you both very much for your time.
32 We are very grateful. You are excused.

33

34 THE WITNESS: Thank you.

35

36 <THE WITNESS WITHDREW

37

38 THE COMMISSIONER: We adjourn until 2 o'clock?

39

40 MR MUSTON: If I can just have a moment, Commissioner.
41 I think we have managed to compress the two groups into
42 one, and I'm just eager to avoid a situation where icourts
43 and those behind me are having to rush around to rearrange
44 the room in less time than is optimal, so I think if we
45 start a little bit after 2, we will comfortably finish --

46

47 THE COMMISSIONER: Someone is shaking their head. Why

1 don't you just find out?

2

3 MR MUSTON: 2 o'clock is fine.

4

5 THE COMMISSIONER: All right. We will adjourn until
6 2 o'clock.

7

8 **LUNCHEON ADJOURNMENT**

9

10 THE COMMISSIONER: Are we all here now? Welcome.
11 Thank you for coming. My name's Richard Beasley, as the
12 note says. I'm the Commissioner for this Inquiry. Again,
13 thank you for coming. We really appreciate it and we're
14 looking forward to hearing your views and, Grace, if you
15 would like to do an acknowledgment?

16

17 MS GORDON: Good afternoon everyone. My name's Grace
18 Gordon, I'm a proud Ngemba woman from out of Brewarrina.
19 I thank you for giving us an invitation to be able to come
20 and speak today. I would, first of all - under our
21 protocols we don't go to anyone else's Country unless we
22 recognise Country that we're on, so I would like to pay my
23 respects to the Wiradjuri people, the Tubbagah Nation of
24 this Dubbo region and pay my respects to their Elders past
25 and present and to thank them for allowing us to come on
26 Country to be able to participate in today's proceedings.
27 Thank you.

28

29 THE COMMISSIONER: Thank you. All right. Before we do
30 anything formal, I have introduced myself, I think you have
31 all met Ed and Ross and some other members of the Inquiry
32 team. You may not have met the other two gentlemen down
33 there, they can introduce themselves, for NSW Health.

34

35 MR CHENEY: I'm Richard Cheney, one of the barristers for
36 NSW Health.

37

38 MR PINTOS-LOPEZ: I'm Hernan Pintos-Lopez and I'm the other
39 barrister for NSW Health.

40

41 THE COMMISSIONER: The way we would like to proceed - Ed
42 will ask a question of someone to kick things off, but if
43 any of you at any stage want to say something in addition
44 to what the speaker has just said, or if a clarification or
45 something important occurs to you, I want you to feel free
46 to have your say. I want you to feel free to ask
47 questions, even of each other.

1 community that you come from.

2

3 MS GORDON: My name is Grace Gordon. I'm a proud Ngemba
4 woman from Brewarrina. I'm currently the independent
5 chairperson of the Murdi Paaki Regional Assembly and -
6 that's me.

7

8 MS McHUGHES: Doreen McHughes, proud Ngemba woman from
9 Ngemba Country. Chairperson of the Ngemba Community
10 Working Party and advocating for my people for over 35
11 years at the tables, without any success at the moment, I
12 might add, but we're here and we're still trying and
13 I can't wait for the conversation to start.

14

15 MS HAMPTON: Denise Hampton. I'm a proud Nyiimpaa
16 Paakantji person. I am here today representing Broken
17 Hill's community working party, so I live at Broken Hill.
18 Again, like similar to what Doreen is saying, you know,
19 we've got this opportunity to hopefully progress things
20 through for us, because we, as Aboriginal people, we're not
21 happy with how some of the things are progressing and they
22 could be improved in a lot of the areas. So I'm passionate
23 about those things and have been involved for a number of
24 years - I think 16 years of age, so a long, long time.
25 That's me.

26

27 MS SHILLINGSWORTH: Millie Shillingsworth, chairperson of
28 the Enngonia working party, I'm a proud Budjiti Murrawari
29 woman.

30

31 MR MASON: Carl Mason from Collarenebri, CWP chairperson,
32 proud Gamilaroi man from Collarenebri, and yeah, I'm here
33 to see how we go, too.

34

35 MR COBB: Allan Cobb, chairperson of the Lightning Ridge
36 Community Working Party. I was born in Brewarrina. I'm
37 a proud Murrawari man and I've been representing my
38 community, or the Lightning Ridge community, for some time.
39 I've lost the time there, but there's plenty of it.
40 Thank you.

41

42 MR KNIGHT: Anthony Knight. Proud Barkindji Kunya man
43 originally from Bourke but reside in Weilmoringle.
44 Chairperson for the working party.

45

46 THE COMMISSIONER: Thank you. I might just ask icourts,
47 would it be easier if we just left the microphones on?

1 Will it cause any feedback, or do we need to keep turning
2 them on and off?

3

4 COURT OPERATOR: We will turn them on.

5

6 THE COMMISSIONER: Is that all right. It might make it
7 easier so we don't have to keep pushing buttons. Ed?

8

9 MR MUSTON: I might start with you, Grace. Just give us a
10 little bit of an explanation of the background to the
11 assembly and the respect - how the respective roles that
12 each of these people have worked into it.

13

14 MS GORDON: The community working parties started way back
15 in the early 2000s. It was actually at the time that ATSIIC
16 was being abolished, so the community saw a need to have
17 another voice for our people to be able to speak out about
18 the issues and things that were affecting us locally. So
19 there was consultations that were happening across the
20 region, and the region is covered from Broken Hill right
21 down to Collarenebri and Gulargambone, and there are
22 16 other communities in between.

23

24 Each of the communities elected their own Community
25 Working Party chairperson to be the one to be able to step
26 up and take the issues to the table of the Murdi Paaki
27 Regional Assembly. We've been in operation for 20 years,
28 and sometimes we just feel like we are repeating ourselves
29 over and over to try to work out better ways of doing
30 business and working in collaboration with other services
31 when they are willing to do so to be able to alleviate
32 a lot of the problems and things that we have across our
33 communities, especially in relation to service delivery, to
34 ensure that we start to see things change across our
35 communities and that our people are really benefiting from
36 a lot of the funding and things that are coming to our
37 region for better outcomes for our lives.

38

39 MR MUSTON: So the assembly is a gathering of the chairs
40 of each of the community working parties.

41

42 MS GORDON: Yes.

43

44 MR MUSTON: Who else is on the assembly?

45

46 MS GORDON: Each of the community working parties chair is
47 representative at the Murdi Paaki Regional Assembly. We

1 have quarterly meetings and at those meetings we invite
2 heads of the agencies to come out to our table and if there
3 are issues and things that we need to discuss, we discuss
4 them with them in a face-to-face manner and we try to work
5 out solutions of better ways of them doing business with us
6 and us being able to do business with those and being like
7 the spokespersons for each of the communities.

8
9 MR MUSTON: Roughly how many people are members of each of
10 the community working parties?

11
12 MS GORDON: At any of the Murdi Paaki regional assemblies
13 meetings we probably have up to maybe 50 or 60 people over
14 the couple of days that we have our meetings. In the
15 community - the community working parties at the community
16 level, they are open to any First Nations peoples that are
17 in the community to be able to attend, but also other
18 services and things that are in the community, if they
19 would like to come along to our meetings as well so that we
20 can work out and try and work together on some of the
21 strategies and things that they are trying to put into
22 place, and where we're hoping to get some better outcomes
23 from funding that comes into the community. Not always
24 successful, still work - a lot of people still like to work
25 in silos, but we are really trying to work and break down
26 those barriers where we believe that a collaborative
27 approach to any issues that we're dealing with is going to
28 be delivering better outcomes if that type of collaboration
29 takes place.

30
31 MR MUSTON: In the submission that you have provided you
32 refer to the role played by young and emerging leaders in
33 the assembly. Do you want to explain what that role is?

34
35 MS GORDON: As has been mentioned, most of us we've been
36 around for a long time and we're starting to come,
37 I suppose, to - without really wanting to say it - the end
38 of our lives. I've been involved for over 35 years and
39 I think, you know, we need to be smart in the way that we
40 ensure that our voices continue after we're gone. So we've
41 put into practice succession planning, we're trying to
42 get - engage our young leaders to come in and learn from
43 the Elders and the chairpersons that are sitting around the
44 table now, so that they are the ones that are next in line
45 to take up the roles that we're now filling.

46
47 MR MUSTON: Maybe you could go around and you could each

1 give us just a bit of an indication of roughly the number
2 of people who come to your working party meetings and the
3 sort of split between younger people and Elders.
4

5 MS McHUGHES: It's very difficult at the moment because of
6 the political climate, in our small communities and things,
7 and I mean the divide and rule, okay, tactic that the
8 system uses, okay, I think to keep that divide and rule in
9 place. Brewarrina I'm talking about only, okay, at this
10 point in time, and Ngemba country, it's very, very
11 difficult to have services, okay, come to the table. There
12 is no rule of law that they should be there, but I think
13 they should be, because if the First Nations dollars, okay,
14 are being injected, okay, into service provision, okay, in
15 the community, I think that it should be mandatory that
16 they attend a process such as the Community Working Party
17 that feeds up to the regional assembly and then to the
18 Accord.
19

20 Like I said, I think that the non-coordinated
21 approach, okay, of all health services in our community,
22 okay, is making it difficult for the Community Working
23 Party to function, okay, appropriately in reference to
24 health, I think. We have the AMS, okay, who is reluctant,
25 okay, even to attend our own Ngemba Community Working Party
26 and it is because of this divide and rule, okay, that has
27 been initiated since the beginning of time kind of, and
28 where if culturally, okay, the Elders of the Ngemba
29 community, okay, and they are the traditional owners, if
30 they are to trying to activate, okay, a process of them to
31 be included in the process, we get kind - and because we're
32 the minority, too, when that happens, okay, because of the
33 placement of other nations to our country, okay, through
34 the colonial processes, that's hindered the Ngemba people
35 to really, really culturally drive the agenda of their
36 principles and protocols on Country. It's very, very
37 difficult.
38

39 But I think that there should be this process of -
40 through the services, that it's mandatory for them to, if
41 they are, like I said, collecting dollars or injection of
42 dollars, okay, into their services, they should be at the
43 table with the Community Working Party so that we can all,
44 okay, progress the health of the First Nations people and
45 the rest of the community together, as one. It's not
46 happening.
47

1 MS GORDON: Yes. Just quite early in the stages of the
2 set-up of the Murdi Paaki Regional Assembly, we've gone
3 through a lot of changes with changing governments and
4 things like that, it was one of the programs that it was
5 called Two Ways Together, so there was two-way
6 accountability and transparency and that was where funded
7 services were required to attend the Community Working
8 Party meetings to bring their issues to the table and to
9 work with the First Nations community to be able to resolve
10 some of the issues, whether it was access and equity or
11 something like that, how we could work together to make it
12 so that it was more culturally available to our people in
13 the communities and I think that was where we were having
14 more traction of getting services to come, do their
15 reporting on what they were doing for the funding that they
16 were getting in the communities, and then for us, if there
17 were any problems as to why it wasn't working, being able
18 to address those issues as they sort of come to hand rather
19 than just allowing it to go on until the end of the funding
20 cycles, where then we were getting reports back that the
21 funding that was being injected to deliver programs and
22 things, there was no substantiated outcomes, or very
23 little.

24
25 THE COMMISSIONER: Can I just ask so I understand, when
26 you are saying "divide and rule", do you mean providers of
27 services not engaging with you collectively about what is
28 needed, or something different to that?

29
30 MS MCHUGHES: I think the divide and rule, when I talk
31 about the divide and rule, it's, as we see it over the
32 years, that's really been entrenched, okay, in these small
33 communities and I think, through the processes of no
34 accountability, okay, in reference to dollars being spent
35 on the wellbeing of the people, and without the service
36 delivery having no accountability to that, no inclusion,
37 okay, of a process, okay, like the Community Working Party,
38 neglecting to even attend, and - that's what I mean,
39 I don't know if I'm explaining myself properly, but it's
40 just so very hard when there is no accountability, okay, at
41 the end of the road, okay, for anybody, okay. So
42 therefore, it disallows, okay, the whole of the community
43 to be involved in the process.

44
45 THE COMMISSIONER: Do you mean something like no
46 evaluation of whether you are achieving what you are
47 supposed to be achieving.

1
2 MS McHUGHES: Yes, we know that we're not achieving
3 because of the - the stats don't lie. The death rates of
4 our people, okay, the high incarceration rates, okay, the
5 mental state of our people, okay, through the drugs and
6 alcohol and things like that there. But I think the forums
7 of the working parties, okay, are great, but I think they
8 should be supported to the fullest so that we can be all
9 working together, not in different silos, okay, where
10 no-one's talking to each other. No-one's talking to each
11 other. It's even in the - in our community, we have our
12 AMS, we have Ochre, we have primary health care, with the
13 hospital, we have community health. Please, somebody else.
14 Okay, Grace?

15
16 MS GORDON: Public health network.

17
18 MS McHUGHES: Public health network, and nobody is
19 communicating with each other, where I believe that, you
20 know, if we - such a small community as Brewarrina, 1200,
21 I think, population there, maybe a little bit more, maybe a
22 little bit less, if we can't fix the problems of health,
23 okay, in such a small population, okay, something's
24 drastically wrong. Something's drastically wrong. And
25 it's going to take all of us, okay, to sit around the
26 table, to decipher, okay, what we can do better as a whole.
27 That means, you know, being really - and another thing
28 I would like to say, I think that we should be inclusive of
29 the Ngemba Elders because a lot of the time the Elders are
30 left out of everything, and we so gracefully and graciously
31 say, you know, welcome to country, acknowledgment to
32 country, but yet, when the processes, okay, are - the
33 services, okay, are dealing with the communities, it's
34 always the traditional owners that are left out, and they
35 must be included. They must be included in everything
36 because that's going to be the foundation, okay, I believe,
37 for things to be corrected 10 years down the track.
38 Because the Elders have got a lot to offer.

39
40 MR MUSTON: Do you think that the community working groups
41 would be a good way of engaging First Nations communities
42 in these decision-making processes, if - say if the
43 Ministry of Health was wanting to engage with a particular
44 body, do you think the community working groups would be
45 a good body to play that role, or is there another body
46 within the community --
47

1 MS McHUGHES: No, I think the community working parties
2 are a great forum really to - but it's having that support,
3 okay, for the community working parties, okay, to say, you
4 know "If you are", in these small communities, okay "If you
5 are receiving dollars, okay, for X, Y and Z to address the
6 health of the First Nations people, you must be at the
7 table with the appropriate process." Or otherwise we're
8 all separated, we're all separated. That's what's happened
9 I think now, with the regional assembly - I think that they
10 are totally neglected. I think that the inclusiveness,
11 okay, that the system needs to have with the regional
12 assembly, not at the Accord level, I don't think, I think
13 it needs to be at the regional assembly level and then go
14 down to the working parties, okay, because we're all
15 connected. We're all connected. One can't be without the
16 other. We can't have the regional assembly without the
17 chairs of the working parties.

18
19 MR MUSTON: I assume in each of the communities that you
20 represent through your working parties, the issues are
21 going to be a little bit different.

22
23 MS GORDON: Yes.

24
25 MS McHUGHES: Not structurally, though, I don't think. Not
26 structurally. Once they are structured, okay, with
27 the process, I think that it's really a concrete process
28 that's going to get outcomes, we've got different belief
29 systems and things like that there, and ways, and we don't
30 speak on other people's countries and things like that
31 there, but I mean we're talking about a process, okay, that
32 is going to be developed by the system, because it's always
33 the top-down approach, okay, that happens. It doesn't come
34 from our voices up, which I think it should be. I think it
35 should be, or we should be included in that process,
36 because the status quo, okay, of our people is in dire need
37 of change at the moment for these processes to change so
38 that we can get outcomes and things for our people, and we
39 can't go on like we're going on.

40
41 I think it's, you know, listening to us, okay, and
42 being able to interpret, okay, our voice, culturally, the
43 way that we talk and we think, because if you are
44 culturally incompetent, okay, at the end of the day, how
45 can you interpret me to what I'm saying? So cultural
46 competency, okay, speaks in - the Oxford dictionary says,
47 okay, to be culturally competent you have to be able - that

1 allows you to create appropriate policies and guidelines.
2 So are we missing something? I think we are. I think we
3 are, and I think that, you know, we all need to - and this
4 is just me, this is just me saying it, okay? This is how
5 I think. I think that we need to make sure that we've all
6 got knowledge and understanding, or knowledge and knowing,
7 okay, of the First Nations of this country. Plural. We
8 need to try to - especially the system, okay, that is
9 trying to make change, but I think they are making things
10 difficult for themselves because, you know, we really don't
11 know what we're dealing with.

12
13 I think that once the system becomes savvy, okay, in
14 cultural competency and historical processes, okay, as to
15 what was and to what is now, we'll get that understanding
16 of what do we do now to fix the problem. I'm not going to
17 talk no more. I talk too much. Okay?

18
19 MR MUSTON: You can talk as much as you want to. What
20 about others? In your communities are you seeing it in the
21 same way, or do you have slightly different experiences or
22 particular issues in your communities that you want to
23 raise along those lines?

24
25 MS HAMPTON: Denise Hampton from Broken Hill CWP. I think
26 it's more around, you know, that being inclusive, being
27 able to consult with our communities, coming along and
28 engaging, because CWP is the forum, it is about engaging
29 with our community, people within our community, the
30 grassroots people. So we get our information from them.
31 They feed back in to us and then services come along and,
32 you know, they give us updates around what it is they are
33 doing in their space, whether it be health service or
34 whomever. Whoever is getting funding needs to be
35 accountable for the moneys that they receive on behalf of
36 Aboriginal people or First Nations people.

37
38 For us in Broken Hill, I think we've built that
39 relationship and tried to work collaboratively and been
40 inclusive of all, just so that we're able to see better
41 outcomes.

42
43 I might just give you an example. I mean, I'm going
44 back to 2016 but I think it's a really great example to
45 show that if we work together, we can make change. Back in
46 2016 at Broken Hill health service, or the hospital, we had
47 high rates of "did not waits". So a worker from the health

1 service came to me. I was working at the university at the
2 time, and she said "Denise, how can we resolve this issue?"
3 The rates, I might add, were high for non-Aboriginal people
4 too, but ours was much higher. So I suggested to her that
5 she go out and she communicate with our people. There was
6 actually a family fun day for NAIDOC being held that week
7 that she came to. I suggested that she go down there and
8 talk to our people, ask the question "Why is it that you
9 are leaving?" And she did. She came back with all this
10 information and we collated it, and it was just simple
11 things around place not being culturally safe, you know,
12 not inviting, there was issues around communication, you
13 know, all those little things that didn't cost money.

14
15 So we sat down as a group of people and we collated
16 all this and themed it and then we started to talk to
17 people within that department on how best to change it.
18 So, you know, they took away where our people, when they
19 went into the ED, signing in, you know, having to fill out
20 all these forms, being left to sit in a waiting room, you
21 know, without being communicated how long their wait would
22 be - you know, just little things about offering them to go
23 to - they could go and have a coffee or whether there was
24 an emergency. So it was a few little tweaks that had to be
25 done.

26
27 But after three months, when we went back and looked
28 at the data, it had dramatically improved for our people.
29 But not only just for our people, for the general
30 population as well. So sometimes, you know, it's around
31 that communication, it's around people's attitude. Auntie
32 Dor talked about cultural - being culturally aware of some
33 of those things, culturally safe, you know, in those
34 spaces, which I think's really good. But then you have the
35 issue of, when you don't have stability within staffing,
36 you know, you have constant changes, which means that
37 you've got to start all this - or things get lost, because
38 I think they have fallen back behind again now because
39 they've had that win in that space in that three months.
40 It was left because of those things, you know?

41
42 You've got to stay at it, you know. We must continue
43 doing the things that work, rather than going off, oh,
44 yeah, we're ticking this box. Because that's the way we're
45 going to get better outcomes for all.

46
47 MR MUSTON: So in your community, do you think a more

1 regular dialogue with the community working group that
2 actually enabled that feedback of information about what
3 was working, what was not working, might mean that you
4 could keep on top of those issues even in the face of
5 challenges like constant staff turnover and the like? You
6 think you could keep a better finger on the pulse of what's
7 going on?

8
9 MS HAMPTON: Absolutely, because it's about creating
10 a partnership. It's about working collaboratively with one
11 another.. but also being accountable as well, you know?
12 That's a space, the CWP is a space for them to come and
13 share their - you know, the things that aren't working or
14 the issues that they are having with my community, for
15 example, and we can sit and talk around - about that and we
16 can come up with solutions.

17
18 I notice you asked a question before around "Is each
19 community different"? Well, yes, they are, in the fact
20 that, you know, their needs may be different or they have
21 different ways of being consulted. They may have protocols
22 around that. You know, for me, I just see where that
23 system around we need systemic change, and that's talking
24 about policies and practices, how service providers do
25 that, how they implement policies. Do they align with our
26 ways as First Nations people; our ways of knowing, being
27 and doing? Not always.

28
29 And I think that, you know, if we're to see a change,
30 we, as First Nations people, need to be consulted and we
31 need to have a say in that, how things are to play out in
32 that space. That needs to be embedded, then, within those
33 policies that, you know, may be made in Canberra or Sydney
34 or wherever, you know, that they have an understanding of
35 our rural and remote areas. Even though Broken Hill is not
36 classified as rural remote, we are rural. But we do have
37 communities within our space that we look after and care
38 for as well, and I think, you know, being able to do that
39 and work together - and I'm going up the chain a bit here
40 now, because they need to come down to the grassroots
41 people.

42
43 We need to listen to the voices of our people on the
44 ground, because they are the ones that are experiencing all
45 the deficits that we're seeing, you know, whether it be
46 around access or whatever. So therefore, it's important to
47 go to those people, because who best than the ones that

1 have experienced some of the - what do I say - barriers
2 around accessing some of these services that are out there
3 that obviously aren't working for some of our community
4 people.

5
6 MR MUSTON: You mentioned that Broken Hill's not treated
7 as remote. I recall there was something in your submission
8 that talked about that distinction between regional and
9 remote and the way in which that potentially affected the
10 way health care was being delivered in some of your
11 communities. Do you want to explain a little bit about how
12 that is playing out?

13
14 MS HAMPTON: Yes. Well, we've got a very remote community
15 within our area, which is Ivanhoe, you know - just simple
16 little things around transport, getting people to
17 specialist appointments when they need to go, you know,
18 because of no access to transport, although, you know, the
19 Aboriginal community controlled health service, Maari Ma,
20 looks after that region as well and they do a good job, but
21 we still have some little gaps around that that we need to
22 look at.

23
24 Also, you've got, you know, places like Wilcannia and
25 you've got Tibooburra within the Far West LHD which is, you
26 know, further out again. Menindee, you've got all those
27 places that still experience some of the barriers around
28 that systemic racism as well, as well as the policies that
29 align. They don't align to what our needs are within
30 communities. And that's what we're seeing quite often. So
31 I think improvements there could be where, you know, that
32 consultation - and we hear this all the time as First
33 Nations people, I've heard it for over 30-odd years - going
34 out, consulting with people. I think, you know, it's great
35 that we've got the CWPs at a local level, because it allows
36 for community people to come in and just, you know, air
37 their - you know, go through the grievances that they are
38 having, the issues that they are having with some of the
39 service providers and we can sort of sit down and work with
40 them around that.

41
42 I think, you know, we give a lot of time, as the CWPs,
43 because we're voluntary as well, you know, and we give our
44 time to ensure that any service that is being delivered to
45 our people, that it's reaching our people, that service
46 providers are accountable to our people as well. Because
47 at the end of the day, they are getting funds, and we

1 expect to see improvements, and I think at the moment we're
2 falling short of that.

3
4 THE COMMISSIONER: When you used the word "consultation",
5 you don't mean just being told something's going to happen;
6 you mean active listening and a form of participation in
7 the actual decision-making? Is that it?

8
9 MS HAMPTON: Yes, yes. Not just that tokenistic word
10 where, you know - because for me, over my lifetime, I've
11 seen many a bandaid solution rolled out into numerous
12 communities, and they don't work, and they won't work
13 because community hasn't been involved in that designing.
14 It needs to be that co-design. Work with the communities
15 around what it is they are needing, what it is that they
16 feel is important to them, you know? And that's what
17 I meant when I said the communities are different, that
18 they might not see what I see as being important in our
19 community. It could be something else that they want to
20 prioritise and work with around that.

21
22 MR MUSTON: So even if different communities have what
23 might be the same or a similar problem, in each of those
24 communities, the best way to solve that problem is going to
25 be unique and depend on a whole lot of factors within the
26 community at that grassroots level.

27
28 MS HAMPTON: Well, it depends on resources, for example.
29 The community might not have the resources to be able to do
30 that, and that's where I feel that that sharing, that
31 working collaboratively with the service providers includes
32 resources as well, you know? Because a lot of our
33 communities don't have the resources to do different
34 things. So we rely on that.

35
36 MS GORDON: I think just an example is, you know, when you
37 look at community, you look at funding that comes to our
38 communities, and a lot of it is associated with health.
39 I mean, speaking from my own small community, which is
40 Brewarrina, we've got over 48 services, just services that
41 are probably non-government organisations, besides the lead
42 agencies, which are the health, shire councils, the
43 Aboriginal lands councils, the medical service and things,
44 but yet we still see, when we look at the national
45 indicators, still being probably on the lowest rung of
46 closing the gap, you know, seeing the high unemployment
47 rates, the incarceration rates, the death rates, all of

1 those things. So I believe that there needs to be
2 agreements or service level agreements or something between
3 the agencies, especially health, you know, because health
4 is a lot of things to us. It's not just primary health
5 care or community health care. Health is including having
6 appropriate housing, you know, where our health starts in
7 our lives, having decent housing. And I believe that there
8 needs to be more accountability around the distribution of
9 - or the equitable distribution of funding across our
10 community.

11
12 So if they are - just say, for example, we have shire
13 council plans, they include health in their plans. We have
14 Community Working Party action plans that are priorities
15 for our community; we have community land and business
16 plans of local Aboriginal lands council. So there are all
17 these plans, but the collaboration is not really happening
18 on what priority it is. So if the priority is health,
19 around health services and health service delivery, there
20 should be some type of real collaboration rather than
21 working in silos to be able to address those issues.

22
23 So if it's drug and alcohol, we bring all those people
24 into an agreement of how we're going to work together to be
25 able to sort those problems out. And then it goes across
26 a whole lot of - it's so complex, it's really hard to sort
27 of explain. But I don't think that it should be as complex
28 as what it is, because money can't just be kept thrown at
29 us when there are not any outcomes happening, so we've got
30 to really look at some type of real agreements, of how
31 we're going to agree first, then be accountable and be able
32 to evaluate whether something is working or whether it is
33 not and, if it is not working, why isn't it working and
34 what can we do to make it better, to work better, because
35 otherwise we're going to continue to see the disparity and
36 the - of what's happening across our communities. It's not
37 always just for our First Nations people, it's also for
38 other people that are on the low socioeconomics in
39 community as well.

40
41 That's what I see, and I mean, some of the - I could
42 focus on contributing factors like we need to have more of
43 our people on hospital boards or on health boards, they
44 need to be able to be in there to be around that table
45 where decisions are being made, where we can put our
46 solutions across the table, and then work on those projects
47 and things to hopefully get the outcomes and things that

1 we're looking at. Looking at workforce issues within our
2 community, being able to train our people up to become the
3 nurses, the nurses aids or the people that are working in
4 the kitchens or doing the gardens, all that type of stuff.
5 When you look at the, I suppose, local health plans, there
6 are not many of our mob that are working in these jobs.
7 I worked for TAFE for eight years as a community engagement
8 Aboriginal worker, and I covered Bree, Bourke, Nyngan
9 Cobar, and I tried desperately to work with the health
10 service out at Bourke, both myself, people from Aboriginal
11 affairs, a couple of people that were on the board at
12 Bourke hospital, to try to start an AIN program, so that we
13 weren't getting agency nurses and things that are coming
14 out to us that are very costly.

15
16 A lot of them have - there is language barriers
17 between them and the patients and our people, that they
18 can't converse with them in the hospitals. I've had
19 firsthand, like experience with that, where I've been
20 visiting one of my family members in the hospital, where
21 they don't even understand our people at all, and not - and
22 also the non-Aboriginal people that are in the community.
23 And therefore, they're not being able to service.

24
25 But if we were able to - that program, anyway, wasn't
26 supported. TAFE was on side, so I worked for TAFE. We had
27 Aboriginal affairs on side to work with us to try to get
28 the funding for that. The funding wasn't given for it. So
29 we wasted - we could have now had a pathway into training
30 up RNs from being AINs to start with, assistants in
31 nursing, to become - and I worked for TAFE for eight years
32 and we could not get that program off the ground because
33 nobody saw the value of training up our own workforces
34 locally.

35
36 And I always like to tell a story, you know, that when
37 our people are given an opportunity and they are supported,
38 we can compete in any arena. We could be the solicitors of
39 tomorrow. We could be the doctors of tomorrow. We could
40 be the nurses of tomorrow. But we've got to be supported
41 and be able to get the funding and stuff to be able to do
42 this stuff, and I'm sort of aligning it now to health.

43
44 Out of our community, one of the best stories that is
45 probably never told and people don't know about it is, we
46 actually have at least nine or 10 doctors that have come
47 out of our community - Aboriginal doctors. Their families

1 either lived there when they were young kids or they are
2 from the community, and we've had nine. One of those kids
3 is my granddaughter. She dropped out of school in year 8.
4 I supported her and her family for her - I like to tell the
5 story because it is a story that we know that we can
6 achieve if we're supported, okay? So through family, we
7 supported her, I made her go to TAFE to get her certificate
8 II and III in business so that she was eligible to
9 somewhere along the way be able to go to university.
10 Because she always told me that by the time she was 26, she
11 wanted to be a doctor, and I'm thinking in my head, that's
12 never going to happen, but I will support you to get you
13 there.

14
15 She did the Cert II and III. She ended up getting
16 a traineeship with the Cowra council, she had to move out
17 of our community because she wasn't being supported or
18 getting jobs locally. She moved to Cowra, she got
19 a traineeship with the Cowra council as an environmental
20 officer. And whilst she was there, they had started an
21 Aboriginal program that was training environmental health
22 workers in a bachelor degree. So because of her
23 achievements in getting the marks from TAFE doing cert II
24 and III in business, it allowed her to go to university.
25 She went to university. She was top in the class at
26 university, and this is not a pretend story, because I can
27 show you the evidence. She was top in the class in the
28 thing. She ended up winning, and you can see it online,
29 one of the new Colombo plans to study in the Asia Pacific.
30

31 So she went over to Hong Kong and while she was in
32 Hong Kong she rang me and said to me "Nan, I want to be
33 a doctor and I want to enrol this year". She enrolled
34 whilst she was in Hong Kong to Western Sydney. She is now
35 qualified - she is now a doctor and she is now in her
36 second year of becoming a paediatrician at Westmead
37 Hospital.

38
39 So this is the type of stuff that our people are
40 capable of if we can sort of, you know, get people to
41 believe in us. I don't see why we are still engaging all
42 these agency nurses and things like that out in our
43 community. We can train up our own people, if people can
44 only see the value of what we can add. Also, I suppose
45 a lot of the cost cutting, our people are going to stay in
46 these communities forever.
47

1 I've been to another small community where a young
2 girl's been working in health and she said, "All I've ever
3 wanted, aunt, was to become an RN, but under my current job
4 that I'm in, they won't allow me to go and do the RN
5 training. They want me to stay here and just be a health
6 support worker." So she lives in a community where, if we
7 had an RN trained up in some of these really remote
8 communities, they would be the first point of call while
9 they are waiting for ambulances and things to come from
10 Lightning Ridge or from Brewarrina or wherever, to be able
11 to do a lot of preparation around trying to save our
12 people's lives.

13
14 We've had people die because we have to wait for an
15 hour for them to come from either of those places out
16 there. So I think the workforce issues and things are
17 really something that health really needs to take very
18 seriously to allow us to work on training up our own
19 workforces. Our people are staying in the community for 40
20 and 50 years and sometimes until they die. So we're not
21 going to be having this changeover of staffing and things
22 like that there.

23
24 But they are the sorts of things that I believe. And
25 if there are families and things that are broken, that
26 can't support their kids, things like us in community
27 working parties and things, we can support these kids and
28 things to get them from there to there. They are the sorts
29 of things that I would like to see happening for our
30 communities, so that we can start training up our own
31 workforce, having our own nurses and doctors and solicitors
32 and whatever else we need in our communities, and starting
33 to see, you know, the real difference being made out in our
34 communities.

35
36 MR MUSTON: What about others? I think, Carl, did you
37 have an example of where some really good collaboration in
38 your community produced great outcomes?

39
40 MR MASON: Yes. We're sort of a bit luckier in Colli.
41 We've got the same problems, though, don't worry, we still
42 see services that don't provide a service, but they are
43 getting paid to provide a service, but they don't. But,
44 anyway, I was working for Centacare at this time and the
45 CEO of the RaRMS at the time came and asked me about our
46 working party plan and, you know, if he could have a look
47 at it and that. We sat down and we went over it for about

1 two weeks, talking about it, and we moved a few things
2 around and we took it back to the group, and we all said
3 "Yeah, we'd like to, you know, have a go at that." He gave
4 us his services for free, come on board with us. And he's
5 come up with a 10-year plan that we can work along with so
6 at the end of the day, I've got a medical service there,
7 right, after that 10 years is up, we want to have ourselves
8 our own ACCHO so we can take over the practice and they're
9 going to give us governance training and all that we need
10 to run the service properly. As well, we've got, down at
11 the back, a hub. The Murray-Darling Basin come on board
12 and gave us a \$1.3 million grant for that. That's all
13 fibre optic cable right through, six computer outlets in
14 the training room, we've got a makeshift training room for
15 like blood pressures and all that, with all the mannequins
16 and all that there, and at the moment now we're talking to
17 kids from school doing the TVET courses, and we've got
18 nine. We thought we would only get three or four but once
19 the word got around, some of the farmers were bringing
20 their kids in, and they're all like, "Yeah, my kid is
21 interested in being a nurse, health worker, dental
22 assistant", that sort of thing.

23
24 So when I go back this week, next week we'll get them
25 in again and we evaluate everything and have the school
26 sitting down with us so we know what their regime is for
27 training so they can come in.

28
29 Like, I'm really happy that they've come on board
30 because we were at our wit's end what to do. The hospital
31 didn't want to talk to us, AMS didn't want to come on
32 board, you know what I mean. Then these fellows come up
33 with this, and we thought righto, we'll back this horse and
34 see how we go with this. So far it's been great. It's
35 been 18 months now since we have started. We've started
36 a real good program there now, with kids coming through.
37 We've got two health workers being trained through Marathon
38 Health. In conjunction with that, we've got the foundation
39 training hub at the back.

40
41 We've got a mental health and wellbeing lady, she just
42 graduated. So she's gone through. So, yeah, we are really
43 looking into it and starting things like that. And even
44 the shire - the mayor of the shire's got on board with us,
45 so I gave him a copy of our plan, have a look, see what he
46 thought, and when he saw that I was talking about the
47 tennis courts for the kids, I said "That hasn't been used

1 for 20-odd years, 30 years, so how about we bring
2 a proposal to you, you look over it, you give us an answer
3 within a week". They come back and said "Mate, we love it.
4 It's not being used for anything. So if youse can come up
5 with a plan, we'll back it. We will let youse fellows have
6 that. They thought we just wanted the tennis courts and
7 a big block, I said "No, we want the whole lot, so we can
8 just have the kids at their own space". We've got another
9 little centre on the end which we'll have TAFE courses
10 running through there for the kids, a bit like youth
11 services, you know, work with youth. What was the other
12 one?

13
14 MS GORDON: The chemist, Carl, talk about the chemist.

15
16 MR MASON: We've got a chemist built next door and the
17 chemist wants to have an assistant trained up as well to
18 work with him. So, yeah, we're going all right. But
19 screaming out for a doctor out there really, you know?
20 Like with the medical service - oh, what do you call it up
21 there - the local health district thing, you know, like the
22 hospital up there, we used to have a doctor, but the boss
23 up there, she said "No, we don't really need a doctor for
24 a town this size", so she said no to a doctor there five
25 days a week, took it back to two days a week.

26
27 THE COMMISSIONER: Is it a multi-purpose?

28
29 MR MASON: Yes, that's the one. That's just not even
30 working at the moment, you know? People are getting sick
31 of repeating the story to different doctors each time and
32 they're getting told different things "Get off that
33 medication, go on to this one", they do that, and the next
34 time they go back to them, that medication they have given
35 is not working or sending them batty or something, you know
36 what I mean, so there is a lot of that going on and we
37 would like to have a lot more nurses out there, too, you
38 know?

39
40 THE COMMISSIONER: Yes.

41
42 MR MASON: With our foundation that I'm working for, the
43 Healthy Communities Foundation Australia, right, we've been
44 approached by Professor Elliott from Westmead Hospital and
45 we're running a FASD program now for three years, and we're
46 a pilot program for out here, we were supposed to only do,
47 say, eight communities out here, like Goodooga, Bree,

1 Walgett and that, but once the paediatrician from Dubbo
2 heard about us, we were just getting sent all over the
3 place, Peak Hill, Trangie, Warren, Dubbo, Wellington, the
4 Ridge, hey?

5
6 MR COBB: Mmm.

7
8 MR MASON: Been out to Bourke, you know? Supposed to go
9 to Cobar, but COVID kicked in and that, so that bugged
10 that around. Yes, we're trying our hardest to plug along,
11 you know what I mean, but there are services out there that
12 are saying they are providing a service and definitely
13 ain't. And, then, when you point it out to them, you are
14 an agitator or you are a liar, you know what I mean?

15
16 THE COMMISSIONER: What are some examples of that, Carl?

17
18 MR MASON: Well, like, AODs, you know, alcohol and other
19 drug workers, they've got them over there at the AMS in
20 Walgett, but for you to access them, you've got to get to
21 Walgett. They won't come over to Colli, it's only 75Ks.
22 We've got to try to get them over there or they've got to
23 try to get over there themselves.

24
25 Then they come to the working party meeting, mentioned
26 it to us, and I said "Righto, we will go to the foundation,
27 we've got a bus, we'll try to get some funding". That's
28 why I've been talking to New South Wales Transport for the
29 last month and a half, two months. We're nearly there now
30 for funding for the bus to do trips to Dubbo for
31 overnights or Moree, Narrabri, the three main places for
32 medical, you know what I mean, and the reason we're doing
33 that, because once you are off country, you can't get back.
34 A lot of people can't. They can't afford it. So we're
35 trying to come up with a solution where we can get them
36 there and once they are ready to come home, go and pick
37 them up again, you know, so they're not having the extra
38 worry financially and emotionally, you know?

39
40 THE COMMISSIONER: Yes.

41
42 MR MASON: So we're trying hard with the foundation. What
43 was the other thing I was looking at? I've got it written
44 down here. We've got a farm that we're looking into out
45 the road, a 14,000 acre farm, we're trying to turn that
46 into a training farm. On that, we want to have a vegie
47 farm so we can supply the town and the hospital and

1 everything with fruit and veg. We want to run youth
2 outreach centres out there too, which we are in talks with
3 DCJ and that about now.

4
5 We want to get a dietician out, like someone trained
6 up in dietician. Because we're looking at preventative
7 rather than waiting until they get to the hospital, you
8 know what I mean, so we can get to that. Speech therapist,
9 you can hardly find any of them out there. With the FASD
10 program, you have to get all these different bits of
11 information, you've got to wait weeks and weeks for them to
12 get back to you with the information, you know what I mean,
13 or you've got to go out there and redo it all again to find
14 the information.

15
16 Speech therapy, aged care facility that we want to
17 build in Collie and train our own workers up. We've got
18 a block of land there that the shire said that we would be
19 entitled to if we wanted it. And like I said about
20 Transport New South Wales, with the transport. And another
21 one we want to get in is the preschool, get a workforce
22 going in the preschool. So all these young fellas, we can
23 pick them up early, if they've got learning difficulties,
24 you know? We don't know whether or not they are getting
25 enough sleep at home, getting fed at home. We don't know
26 any of that until the kid gets to school and it's sad to
27 see with some of them, you know, and that's what we're
28 trying to break the barriers from the preschool, move it
29 forward so that the parents can get involved with that
30 child's learning, come and sit in the class with an hour
31 with the kid, sit and have lunch, play, talk, just become
32 a parent again, like some people just don't know how to do
33 that again anymore, you know, which is sad but it's true.

34
35 We've got a women's outreach van that's going to be
36 running around soon, and that's going to be doing women's
37 business. We want to get a men's health clinic running as
38 well, because men don't want to talk to female health
39 workers or nurses or doctors these days.

40
41 I've talked about AOD. The other thing is that more
42 housing is needed to help people out, you know what I mean?
43 Because there is overcrowding and old fellas are in houses
44 with 12 kids and that, you know, and they can't get sleep,
45 kids won't listen whatever, it's all hard for them. It's
46 hard for kids too, to learn as well, they haven't got any
47 Wi-Fi at home, no-one wants to help them do anything.

1 That's why we try to get after-school learning going for
2 them. The land council is doing a bit now, actually, so
3 that's not too bad, that's getting a bit better.
4

5 The other one, physio. We had PhysEx come from
6 Wellington and they did a 12-month thing over there. Then
7 their funding ran out. It was so sad. Fellas would be
8 going in, they could hardly walk when they went in there,
9 two days later they come out and they were jumping around,
10 like - they were like, "Oh, we love this, we love this."
11 Then we got the news that they didn't have the funding to
12 come back, so we're trying to sniff around some more for
13 that. So, like I say, we've all got our problems but Colli
14 is a little bit lucky, I suppose, we've got people like the
15 foundation to come on board to back us and all that too,
16 with them helping us get to where we need to be.
17

18 MS GORDON: But that's it. We've got solutions, but
19 getting the resources to be able to deliver on the ground
20 is one of the difficulties I think that we have, in being
21 able to implement what we see as solutions to improve the
22 health.
23

24 MR MUSTON: What about you? Weilmoringle is quite a small
25 and more remote community. Do you have particular issues
26 you experience in your community with the added remoteness
27 that you think could be solved through better
28 collaboration, or have you got examples of where good
29 collaboration has overcome some challenges?
30

31 MR KNIGHT: Well, we haven't got health in our community.
32 We had to reach out to the Royal Flying Doctor Service. We
33 go under the Brewarrina - part of their council, shire
34 council, and some of the service that's probably provided
35 for Weil hasn't been provided, especially around the
36 health. It's 107Ks to the nearest town, you know, to go in
37 there, but we reached out to the Royal Flying Doctor
38 Service to come out once a month and they bring other
39 people, you know, drug and alcohol or other providers if we
40 need it. But, yeah, we sort of missed the boat.
41

42 THE COMMISSIONER: How long are they there for?
43

44 MR KNIGHT: Just for the full day. They do others,
45 Goodooga, Enngonia.
46

47 THE COMMISSIONER: They come out with a GP?

1
2 MR KNIGHT: Yes.
3
4 THE COMMISSIONER: A nurse?
5
6 MR KNIGHT: A nurse.
7
8 THE COMMISSIONER: Drug and alcohol, you said?
9
10 MR KNIGHT: Whoever you want, yes.
11
12 THE COMMISSIONER: Any other allied health, like physio,
13 anything like that?
14
15 MR KNIGHT: No. So we just started that. But, you know,
16 like I think health, we're missing the boat with health.
17 Like I know that Brewarrina was getting funding to deliver
18 to our community, but yeah, they haven't. And some of us,
19 you know, we don't get the - who goes into the Brewarrina
20 hospital, how they - some of the staff, how they speak to
21 people, and some people go further on to Bourke, which is
22 an extra 214Ks. So it's just about where people --
23
24 THE COMMISSIONER: Because they don't want to be treated
25 there?
26
27 MR KNIGHT: Yeah, it's just the way they communicate with
28 people who live very remote, how they speak, yeah. In some
29 ways, it is very nasty. But we're trying to reach out to
30 other --
31
32 THE COMMISSIONER: By "nasty", do you mean --
33
34 MR KNIGHT: It's just the way --
35
36 THE COMMISSIONER: Do you mean it is deliberately nasty,
37 or is it just a lack of cultural competence?
38
39 MR KNIGHT: I think it is that way.
40
41 MS McHUGHES: Both.
42
43 MR KNIGHT: Doreen and Grace know the same. Some of us we
44 just travel the extra 214Ks where you get better treatment
45 and better respect.
46
47 THE COMMISSIONER: Where is that?

1
2 MR KNIGHT: In Bourke.
3
4 THE COMMISSIONER: Okay.
5
6 MR KNIGHT: So it is a round big trip.
7
8 THE COMMISSIONER: What makes the difference with Bourke?
9 Why do you feel it's a more appropriate service for your
10 people?
11
12 MR KNIGHT: I think especially where you've got to go, if
13 you've got to go to the Bree hospital, that's where the
14 dramas are. Yeah. But if you go to the medical,
15 whatever - but if you need to go up and get blood taken or
16 if there is an emergency, yeah. But, yeah. Like I said,
17 you know, they are getting funding, but they don't deliver
18 the service. I have seen people out there in the past sit
19 in the car for about - we give them an office to use - sit
20 in the car for 10 minutes and drive out of our community,
21 and it's only 18 houses, it's a one-way street.
22
23 So these are things that happen in our community,
24 especially remote.
25
26 THE COMMISSIONER: Just so I understand, who are you
27 talking about?
28
29 MR KNIGHT: The health people who come from the Brewarrina
30 hospital. The nurse - there is supposed to be a nurse or
31 whatever.
32
33 THE COMMISSIONER: What are they supposed to do when they
34 come to your community? They are meant to --
35
36 MR KNIGHT: To take people's blood pressure, you know, see
37 how their sugar is going or, you know.
38
39 THE COMMISSIONER: Whereabouts is it meant to be done?
40
41 MR KNIGHT: At the land council. Yep. That's in the
42 past.
43
44 THE COMMISSIONER: And they're just not present, they're
45 just not --
46
47 MR KNIGHT: They sit there for 10 minutes and drive off.

1 But we've got some elderly people in our community who
2 can't get around, you know. They should be going to them.

3
4 THE COMMISSIONER: Okay, so there is an issue about some
5 people can't get to the land council building.

6
7 MR KNIGHT: Yes.

8
9 THE COMMISSIONER: But are there people actually waiting
10 for some form of treatment or whatever at the land council
11 building and the people just are not coming into them?

12
13 MR KNIGHT: Well, they don't see them, they only see these
14 people drive in, sit there for 10 minutes, the time you
15 look up the road to see them and the time you go up, they
16 are gone.

17
18 MS GORDON: I think what Anthony is trying to say is that
19 Brewarrina gets funded to provide services out to
20 Weilmoringle, and the health workers are going out there,
21 where they are supposed to be there for a specified time,
22 so if say they are there from 10 till 2, they might only go
23 out there and because someone hasn't come in at 10 o'clock,
24 they are packing themselves up and they are gone by
25 2 o'clock, you know, from there, but they are still
26 receiving funds to deliver services out there. So that -
27 I think there was a bit of controversy between the - what
28 are they called, the multi-purpose service in Brewarrina in
29 trying to tell Anthony that they shouldn't be receiving
30 services from the Royal Flying Doctor Service.

31
32 MR KNIGHT: Yes.

33
34 MS GORDON: But because Weilmoringle is such a small
35 remote community, they are taking whatever services they
36 can get, and why wouldn't you, when they are so isolated.

37
38 THE COMMISSIONER: It would be reckless not to.

39
40 MS GORDON: That's exactly right. And the community is
41 happy with the services that the Royal Flying Doctor
42 Service are delivering.

43
44 THE COMMISSIONER: What do you think their attitude is
45 "Well, you're getting it from the Royal Flying Doctor so we
46 don't have to bother with you".

47

1 MS GORDON: I don't think they should be collecting
2 funding if that's the case. The money should be probably
3 channelled more towards the Royal Flying Doctor Service to
4 give more service out that way. This is what we're talking
5 about, is the accountability of service provision out in
6 the communities and things like that, there, that need to
7 be - there needs to be some type of evaluation or, you
8 know --

9
10 THE COMMISSIONER: So there is no --

11
12 MS GORDON: -- accountability processes being evaluated
13 about what they are claiming for delivering, and they are
14 not delivering on the ground.

15
16 THE COMMISSIONER: There is the accountability of actually
17 delivering the service. That's one form of accountability,
18 and the other is the accountability of what are we trying
19 to achieve - what are the outcomes we're looking for for
20 Aboriginal people's health in these remote locations, and
21 what are you doing to ensure we get there?

22
23 MS GORDON: Yes.

24
25 THE COMMISSIONER: And what else can be done to get there?

26
27 MS GORDON: I think everyone tries to avoid the
28 conversation around racism, because racism is still rife
29 out in our communities, and I mean, you know, it's not all
30 people that work in these services but there are various
31 people that really - they choose who they want to service,
32 and like I said, we're not here to really talk about those
33 complaints but in another sense we have to talk about it
34 because it deters our people from attending these hospitals
35 or institutions to be able to be serviced, if they are
36 going to be received in a very negative way.

37
38 THE COMMISSIONER: You tell me, because I don't know.
39 I got the impression, but you tell me how right and how
40 wrong this is: it's a combination of some people are
41 intentionally racist.

42
43 MS GORDON: Yes, yes.

44
45 THE COMMISSIONER: Others are racist, but they don't mean
46 it.

47

1 MS GORDON: Yes, just an example to use, okay, and I know
2 there's been, like, compensation claims against, you know,
3 someone that's gone into the hospital was really, really
4 sick and then, you know, you will have heard other examples
5 of it around the country, where they are sent home to go
6 home and take a Panadol, "You've only got a headache", or
7 something like that. Then they go home and they either die
8 of an aneurysm or they die of a heart attack or something
9 like that, and also being told "We're not going to call the
10 air ambulance in for because we don't think that you are
11 really in need of that because it costs us too much".
12 These are the conversations that are had to the patient.
13 "We can't afford to be flying people out every time someone
14 comes in sick". When somebody is really presenting and
15 thinking "I feel like I'm going to die and I'm really,
16 really sick and I need a bit more attention", rather than
17 just looking at me because I've had a few drinks.

18
19 Like I said, you know - and we know from the years
20 that we have lived in community - I know that if I go to
21 the health service because I'm a person that will speak out
22 about receiving a good service, where I get treated very
23 well. But I've also worked with women over the years,
24 because I run the women's refuge for 12 years in
25 Brewarrina, where some of the women would not go to the
26 doctors until I came back from my holidays because they
27 didn't want to go without an advocate going with them so
28 that they would get a service that they deserve when they
29 walk through that door. So it's out there, it's happening
30 and it's not good for our people to have to go there
31 expecting to get a service when they are sick and being
32 turned away because somebody just wants to treat them
33 indifferently.

34
35 THE COMMISSIONER: Millie and Allan. What can you tell us
36 about your communities?

37
38 MS SHILLINGSWORTH: I'm sort of in a similar situation
39 like Anthony. I'm more isolated, and we come under the
40 Bourke shire. Now, Bourke look after three small
41 community, Enngonia, Wudinna and Louth. Now, numerous
42 times, I've tried calling around the table to come and have
43 a meeting with us. The service provider, they don't
44 acknowledge us, they don't want to come out to any
45 meetings, and we've got the Royal Flying Doctors there.
46 Now we've got an issue with the AMS, Bourke AMS and the
47 Royal Flying Doctor Services, with shared information.

1 Now --

2

3 THE COMMISSIONER: What do you mean by that?

4

5 MS SHILLINGSWORTH: Medical information. We've got to
6 sign consent forms, it all goes to the Royal Flying
7 Doctors, and then they come out fortnightly or whenever,
8 and - but in the meantime, between then, we go back to the
9 Bourke Medical Centre and there's no record there, and we
10 can't see a doctor. And we can't get service like - we've
11 got chronic illness at Enngonia, people have got cancer and
12 all that, and they need to travel way down to Sydney.
13 There's - we've got nowhere to look, anywhere to see if we
14 can get transport, accommodation.

15

16 Now, I really thought Bourke provided all this for us,
17 because they are getting the funding, and there's a lot of
18 health organisations there. That's no help to Enngonia.
19 And we have just got to live or put up with what we have
20 got out there. Like we've got to find our own resources,
21 find our own - there is transport, but if we're under the
22 Royal Flying Doctor, we can't utilise the Bourke AMS
23 transport or any other transport.

24

25 Now, the Royal Flying Doctor, Anthony, does it come
26 from Broken Hill?

27

28 MR KNIGHT: Yes.

29

30 MS SHILLINGSWORTH: Or Dubbo. I think ours comes from
31 Dubbo.

32

33 MR KNIGHT: Same, the Royal Flying Doctors.

34

35 MS SHILLINGSWORTH: We can't utilise any other health
36 organisation. It all got to come under the Royal Flying
37 Doctors, and that's a big issue, because, you know, we are
38 isolated and it takes us weeks on end to get in touch with
39 the Flying Doctor because we've got to get down to Sydney
40 at a certain time, we need accommodation, transport.
41 There's no help.

42

43 THE COMMISSIONER: Can I just - I want to hear from you,
44 Allan, but I just want to make sure that I'm hearing your
45 big messages correctly, so you tell me if I haven't grasped
46 what your big messages are. One is, there are people being
47 paid to provide services that (a) aren't doing it and (b)

1 there's no proper accountability and no proper evaluation
2 of when they do do something, how it's going, and whether
3 it's getting the outcomes that everyone would hope for.
4

5 The other is the service providers aren't
6 communicating effectively with each other and they're not
7 communicating and listening and engaging properly with all
8 of you?
9

10 MS McHUGHES: Yes.

11
12 MS SHILLINGSWORTH: Yes.

13
14 THE COMMISSIONER: There is always there's not enough
15 services and there should be more funding, that's a given,
16 but in terms of those real big structural issues, have
17 I captured what you want to tell me with those?
18

19 MS McHUGHES: I believe so.
20

21 MR KNIGHT: I just think some of these services, we're
22 going to Bree, we're 107Ks from Bree, but they're getting
23 the funding but they're not delivering the service.
24

25 THE COMMISSIONER: Transport is an issue, too. I've
26 picked up on that.
27

28 MS SHILLINGSWORTH: Can I say something about the
29 ambulance?
30

31 THE COMMISSIONER: Yes, of course.
32

33 MS SHILLINGSWORTH: We're 100K from Bourke and it takes an
34 hour to get out there. Now, when mob or when any of our
35 people get sick, it takes us nearly - the ambulance takes
36 nearly five hours to get out there, and it's bitumen all
37 the way and it's only a one-hour drive. You know, our
38 people, in the past - I've been - they've been passing away
39 before the ambulance gets out there.
40

41 THE COMMISSIONER: Do you know why it's taking so long?
42

43 MS SHILLINGSWORTH: I think they - I don't know if they've
44 got an MOU in place, or whatever, they've got to ring the
45 police first. The police have got to assist first before
46 they can bring the ambulance out. That's the problem.
47 Why - you know, why go - they were in need to get to a

1 hospital. Why go through the police first?

2

3 THE COMMISSIONER: Sorry, there is another - I haven't
4 forgotten your other point, which I think is a really
5 important one, which is health and your people's health is
6 kind of a whole of government problem. There's housing,
7 there's education, there's early childhood interventions,
8 or making sure kids are on track at an early stage, all
9 those sorts of things.

10

11 Allan, what about Lightning Ridge?

12

13 MR COBB: Lightning Ridge, well, we've heard from the
14 girls there, and they've been involved in the health areas
15 for some time. All the issues that they have brought up,
16 I can guarantee that those issues are all across the board
17 in our Murdi Paaki region, for sure.

18

19 Lightning Ridge, being a mining town, there is a lot
20 of dust, a lot of dirt out that way. A lot of our people
21 live in what we call camps, dirt floors and all that sort
22 of stuff. So just the primary health care is - I don't
23 know what - it just doesn't seem to be there, that full
24 support that is really needed.

25

26 THE COMMISSIONER: What's the GP situation in Lightning
27 Ridge?

28

29 MR COBB: The GP situation there is that we've got fly-ins
30 and now we've got these young doctors coming on board that
31 are going to be around for 12 months or whatever and better
32 their practices and all that. So we don't know what's
33 going to happen after that, as they wouldn't either,
34 I suppose, but the problem is that you've got Ochre is one
35 lot, and then if you haven't got a permanent doctor, then
36 those doctors who are working there at the fly-ins, they
37 haven't got access to the hospital, which is a bit of a,
38 yeah, problem, because a lot of the people bring that up
39 all the time. I just don't know why that is, but that's
40 how that area works.

41

42 We did have a permanent doctor there going back some
43 time. I'm also involved with the Lightning Ridge
44 Aboriginal child and family centre, and we've had problems
45 with some kids where we've had to take them down to Ochre
46 and see the doctor, and I just can't understand this. But
47 the manager of the centre there came to me and told me that

1 they took the kids down there to see the doctor and he said
2 "I don't - I don't deal with kids". So therefore, he
3 didn't do anything, just gave them Panadol, or something,
4 and see how that goes.

5
6 A lot of the people then get irate, or they did get
7 irate after that episode, for sure, but the child and
8 family centre that we've got there, we support that sort of
9 stuff, so what we've done is we've put that kid, or those
10 kids and their family in the car and we will take them then
11 and deliver them to Dubbo or something, to see a specialist
12 down there.

13
14 So just around that primary health care, it's
15 a worrying sign. Hopefully, we can fix that in a better
16 manner, I suppose. Like I said, the girls there and all
17 their issues, it's right across the board, for sure.

18
19 THE COMMISSIONER: All right. I've got another couple of
20 questions, and we're not pressed for time, but I think it
21 might be a good idea just to have a 10-minute break to let
22 people (a) have a comfort break and (b), you might want to
23 talk to each other, get your thoughts together more to say
24 a bit more.

25
26 So I think we might have a break until, let's call it
27 3.40 and then we'll finish off after that. So we'll
28 adjourn until 3.40.

29
30 **SHORT ADJOURNMENT**

31
32 THE COMMISSIONER: All right, now that Richard's back, we
33 might recommence. Before we do, Doreen, you wanted to
34 share something?

35
36 MS MCHUGHES: To share something, yeah.

37
38 THE COMMISSIONER: It was obvious from something Millie
39 said during the break that we may not have explained
40 particularly well what we're doing, or even who we are.
41 I've been given the title of "Commissioner" for this
42 Inquiry. In the end, though, I'm just another barrister,
43 but I've been appointed by the government, the New South
44 Wales Government, to do this Inquiry into how health care
45 is funded in New South Wales, which obviously, because
46 funding also comes from the Commonwealth and other sources,
47 you can't ignore them, and it also involves not just how

1 health care is funded but issues like workforce problems,
2 training of doctors and nurses and other ancillary things
3 like innovation and procurement of services. The whole
4 range - everything you could think of with the funding of
5 health care. There is a team that is assisting me, of
6 which Ed is the senior counsel, Ross is one of the
7 barristers, and there are other people you would have met
8 that are either - also a couple of barristers, and the rest
9 are solicitors. Richard and Hernan are both barristers
10 also. They're not part of my team, they're part of
11 NSW Health's team, along with some solicitors that are also
12 here assisting them to represent the interests that
13 NSW Health has in this Inquiry.

14

15 So does that make it clearer?

16

17 MS SHILLINGSWORTH: Yes.

18

19 THE COMMISSIONER: Okay, now, Doreen, what did you want to
20 say?

21

22 MS McHUGHES: I just wanted to tell a story of myself
23 a couple of years ago when COVID was around, I presented to
24 my hospital in Brewarrina and I was taken there by
25 ambulance and I had x-rays done of my lungs. One of my
26 lungs was really all black. My oxygen levels were very,
27 very low. I was told to go back home to my house and if it
28 hadn't have been for the COVID doctor from Dubbo - when
29 somebody gets COVID, they've got to report it and things
30 like that, then they rang the next morning - she ordered
31 that I be taken back up to the hospital, rang the ambulance
32 again, taken to the hospital and I was flown out that
33 night.

34

35 I was in hospital, ICU, for five nights, and I ended
36 up in hospital for 10 days and I'm still recovering now
37 with my breath and things, and I just think, you know, the
38 way that I was treated at the hospital then was purposeful,
39 by the nurse manager, because she was - there was another
40 young girl there that was requested, that requested that -
41 and she worked there for years and years and years.
42 I think --

43

44 MS GORDON: She's an RN.

45

46 MS McHUGHES: She said "I'm sorry, Doreen, but I can't do
47 anything. I've been told that you have to go home". But

1 anyway, when I came and done my time in Dubbo Base
2 Hospital, they flew me out and when I came back home, that
3 young girl left, she resigned from the hospital, and she's
4 now at the Aboriginal health service and she said to me
5 when I went home, "I left the hospital because I never ever
6 want anybody else to be treated like you were treated when
7 you were so sick", and I nearly fell over, because she said
8 "I requested many times for you to be kept in hospital",
9 and it just wasn't done, because that woman, okay, that
10 runs that hospital up there, she's been there for years and
11 years and years and she's got a very, very racist attitude
12 and something needs to be done about it, and that's not the
13 only incident, and she - you know, she's responsible for
14 the health in our community, and I don't think she's doing
15 a very good job of it. I just wanted to have that
16 recorded. I didn't do anything about it because I was
17 scared, because I still have to present, okay, when I get
18 sick, okay, at the hospital, the same. I just left it.
19 But this is an opportunity for us to bring to light really
20 what's going on at Brewarrina hospital.

21
22 THE COMMISSIONER: There won't be exact replicas of what
23 Doreen has just told us, but this is a question for all of
24 you. Either from yourselves or from members of your
25 community, are you aware of similar types of stories like
26 the one Doreen just said?

27
28 MS GORDON: Yes.

29
30 MR KNIGHT: Yes.

31
32 THE COMMISSIONER: Is that a consistent story for all?

33
34 MR MASON: Yes.

35
36 MS GORDON: I believe that there is a lot of failed duty
37 of care, and this one's very close to me. My sister was
38 put in there with the early stages of dementia, in the aged
39 care facility, for which I put in a lot of reports to the
40 people that I was supposed to put them in to. I had
41 a phone call one day, when I was out of town, and the
42 health services manager that we're talking about today, she
43 rang me and said to me, "There's been an incident with
44 Blanche" she said, "But everything's fine because Blanche
45 came out the better end of it." I said, "Well, what
46 happened?" She said, "There was just an incident with
47 another patient."

1
2 My cousin went to the hospital that afternoon to visit
3 her mother, who was in the same section, the aged care
4 section in the multipurpose centre, and when she saw my
5 sister in the hallway she rang me and said, "What happened
6 to Blanche?" I said, "What do you mean?" I said, "Oh, you
7 know, I had a phone call to say that there was an
8 incident." She said, "She's covered in black and blue, in
9 bruises." I've got photos to show, because my cousin sent
10 me the photos. So I rang back to the HSM and said, "Now,
11 can you please really tell me exactly what happened there
12 today?" She said, "I'm really not supposed to tell you
13 because it involved another person." I said, "Well my
14 sister is black a blue with bruises, so something has
15 happened. Where were the nursing staff at the time?" "Oh,
16 no, look, they were on a meal break." I said, "Where was
17 your security person that works in the hospital? Why
18 wasn't there someone down in the section? There would have
19 been at least 20 aged people in this section of the
20 hospital when that thing occurred." I asked - I said, "Do
21 you have any - I want an investigation done into this."
22 I sent the information to the aged care complaints
23 commission, for the aged, and they wrote back and said to
24 me that they couldn't do an investigation, where I could
25 see evidence of what happened, because multipurpose centres
26 in the aged care sector are not regulated. If she had been
27 in a normal nursing home or somewhere else, they could have
28 called a proper investigation.
29

30 So everything that was given to them in relation to
31 her was just the hearsay of what the nurses said happened
32 at the time, and the stories changed that many times.
33

34 So I decided then to send my sister - to move her from
35 that hospital down to Toronto.
36

37 THE COMMISSIONER: Which hospital was that?
38

39 MS GORDON: Brewarrina hospital - and to put her into
40 a nursing home down in Toronto. The day that she left the
41 hospital, they sent me a photo, and that's a photo of my
42 sister lying on a trolley (indicating). I didn't know at
43 the time that she was heavily sedated, because I wasn't
44 there to sign the form for her. I went to Newcastle so
45 I would be there when she got there. When I got there the
46 next day - I've got some more photos - that's how I found
47 my sister (indicating). I said to the nursing staff down

1 there. "What happened here?" They said, "That's how she
2 landed here from Brewarrina hospital. Now, when I went
3 back to that photo and looked, they had her completely
4 covered up so that I couldn't see - no bruising, no nothing
5 on her. She had long-sleeved clothes on. It was hot
6 weather. The stuff that I got back - and I've got copies
7 of the replies that came - but, no, there was nothing ever
8 sorted out about what really happened to my sister.
9

10 She was a teacher for 29 years in that community. She
11 got early onset of dementia and she was treated like an
12 animal in a centre where they - there should have been
13 proper duty of care. That's the type of stuff that's
14 happening to our people out in that hospital in Brewarrina.
15 There is no explanation.
16

17 I said, you know, "You must be able to show me some
18 footage?" And when I got back home - I've got other photos
19 there for that incident that happened that day with this
20 person - her wrist, her fingers, were like that there
21 (indicating). I said, "Has she seen a doctor?" This was
22 a week after. "No, she hasn't." "Why wasn't a doctor
23 called to see her?" So they ended up getting a doctor.
24 I've got copies of messages on there where she said to me,
25 "She's fine." I said, "Well, what's this? Did this happen
26 from the incident as well?" And I think they found a
27 hairline fracture that she would have suffered for a whole
28 week before I got back there to see exactly what happened.
29

30 So this is the type of stuff that's going on, you
31 know, and, I mean, there needs to be a better process
32 around failed duty of care, and I don't see why
33 multipurpose centres are not regulated the same as any
34 other aged care facilities. Our old people up there in
35 that hospital are being treated very, very badly.
36

37 MS SHILLINGSWORTH: That's how my mum died, like that.
38 They were showering her and they dropped her. She went in
39 there fine, she only had a sore arm. They bathed her,
40 dropped her, she ended up bleeding on the brain and died.
41 Like you, I've asked questions. No answers.
42

43 THE COMMISSIONER: Okay. Can I ask all of you, in your
44 positions as working party chairs or through any other
45 role, have you had discussions directly with any people
46 from NSW Health or the Western or Far West Local Health
47 Districts about the kinds of matters we've been discussing

1 today?

2

3 MS GORDON: I've sent reports to them. I've got copies
4 still of my reports that I sent, and I never got any
5 feasible replies back about how they were going to fix
6 those problems up.

7

8 I think it's been mentioned around the table, when we
9 raise issues like that, we're labelled as troublemakers and
10 big mouths, so therefore, then when we're trying to do
11 negotiations around fixing up better service delivery and
12 stuff, they don't want to come because they don't want to
13 be accountable for what they are supposed to be delivering
14 for our people.

15

16 THE COMMISSIONER: When you say "labelled as troublemakers
17 or big mouths" is that actually said to you or is it the
18 impression you get?

19

20 MS GORDON: Well, it is said.

21

22 MR KNIGHT: It is said.

23

24 MS MCHUGHES: It is well known. It is well known.

25

26 MS GORDON: One of the comments I wrote down here, when we
27 go to the hospital and we start talking about, you know,
28 not getting appropriate service, this is one of the
29 replies, "That's the price you pay for living in remote
30 communities." "That is the price you pay." "You choose to
31 live out here so you can't get A1 health services." We
32 don't want A1 health services, but we want a service that's
33 going to prevent our people from dying too young.

34

35 THE COMMISSIONER: You tell me if I'm wrong about this,
36 then, that of the matters we have discussed - and I know,
37 Carl, you talked about making sure that kids have access to
38 what they need at a young age in those first five years,
39 but fundamentally, of course, there's aged care, but it's
40 good provision of primary health care - is that what is
41 crucial to you? You are not expecting specialists in every
42 small town, but it's fundamentally a proper delivery of
43 primary care, "primary care" being more than just a GP; it
44 could be physio, it could be other allied health. Am
45 I right about that?

46

47 MS GORDON: Yes, you are.

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THE COMMISSIONER: What about the rest of you, about any direct --

MS GORDON: Just one other thing I would like to mention as well, also, is with the morgue that's in Brewarrina at the hospital, our people can't even go into that morgue if they're going to use another provider. So, for example, there is a person that works in the hospital up there who is the agent for a funeral fund - a funeral place that is located in Nyngan. So they get priority for the bodies that she gets the work for to stay in that morgue, and if we use the undertaker from Walgett, our bodies have got to go to Walgett, and that's a fact.

THE COMMISSIONER: Grace has mentioned something - have any of you also had direct conversations with NSW Health people in your local health districts about these issues?

MS GORDON: We have them around the Murdi Paaki Regional Assembly tables and through our accords and things where we're sort of in the middle of now, you know, signing off on some of the accords that we're putting into place, and health is one of those. We talk about all these things. We're like cracked records. But I think there is an opportunity for real reform, but I believe that they should be - there should be more collaboration and conversations with the Murdi Paaki Regional Assembly to work out the best way forward, especially in relation to all of the issues and stuff that we've put together in our submission, today. I believe that, you know, when that two-way accountability process starts to really happen and they are fair dinkum about how they're going to resource a lot of the programs and projects out in these communities, if we're in that front line of working closely with the health services, we'll start to see real outcomes.

I mean, if people are in there and they're not doing the right thing, if it is because of their racist attitudes or whatever else that they're going on with and not wanting to provide a service, there should be a process where those people can really be pulled into line, I believe, you know, and not be there. I truly believe that if we had a new HSM at our hospital, I do believe that - because even in the short term where there were ones that were in there relieving, people were being treated better and they were getting better service delivery out of there. I don't know

1 what the hold is or how you get rid of the person, but all
2 the complaints that have gone in - she's rock solid.

3
4 MR KNIGHT: It is the same with us, too. We send emails.
5 Like I said, we don't want to go into the Brewarrina
6 hospital because we know how we've been treated, get
7 treated, so we go to Bourke, but we've got to travel that -
8 you know? So those are the things that are happening and
9 nothing's happening with these people. They continue to do
10 it to patients or people who go there, you know, for
11 appointments or whatever or to see someone if they're sick.

12
13 I had one of the health ladies come to Brewarrina -
14 come from Brewarrina out to Weilmoringle. She had to
15 change a bag on a patient. Made him go down - made him get
16 out of his own house to go down to his brother's house -
17 this is a couple of doors down, a few doors down - where
18 cattle run through the back of his property, he's got dogs,
19 he's got pigs. Sit him up on the back of the verandah to
20 change that bag. These are the things that are happening
21 in our communities. When we address, you know, by emails,
22 putting in complaints, then when we go to the hospital,
23 this is how we're getting treated. So that's what's
24 happening.

25
26 MS GORDON: It is a repercussion of being vocal.

27
28 MS SHILLINGSWORTH: I don't know if you knew anything -
29 you had a doctor over in Brewarrina, Dr Reed, hey? He's
30 still practising in Bourke. You know what he's saying to
31 all the young people? Like, he said to my son, "Oh, you're
32 on drugs. You're doing drugs." I said, "I beg your
33 pardon." I was putting in a complaint about him at the
34 Bourke hospital, and they said, "Oh, no", they just threw
35 it out.

36
37 We have problems, like there's no liaison - Aboriginal
38 or First Nations liaison person in this hospital. I think
39 that's where we tend to tense up and --

40
41 MS GORDON: Or there are ones there and they are too
42 frightened to bite the hand that feeds them.

43
44 MS SHILLINGSWORTH: Or they are tense, yeah, because they
45 have to follow hospital protocol.

46
47 THE COMMISSIONER: Anyone else want to say anything?

1
2 MS HAMPTON: That sort of brings us back to what I was
3 talking about earlier when I was talking about policies and
4 practices and embedding our way of knowing, being and
5 doing; making sure that those policies and practices are in
6 alignment with some of the things that are happening out
7 there on the ground in some of our communities, because
8 that's the biggest thing I've seen.
9

10 I used to work in a UDRH that worked closely with the
11 Far West LHD and my role was mainly to deliver cultural
12 training, because we have JMOs come in every 10 weeks, on
13 their 10-week placements. They come, they work in our
14 community. They were causing a lot of offence. Some of it
15 mightn't have been intentional, but they are given cultural
16 training around that, because we were tired, as community
17 people, of having to go and clean up the mess that they
18 created, because they saw it as a little adventure for
19 them, coming out for 10 weeks and then being able to go
20 back home and get on with their lives in - you know, what
21 they do in the city. So they didn't have that real
22 understanding, and that's why I was saying earlier around
23 the cultural training, that it's really important for RMOs,
24 JMOs, all those people that come out to our communities and
25 are working with our communities, that they do this, but
26 there's got to be some sort of accountability around that,
27 too, because people are just ticking the boxes.
28

29 Yes, it's monitored by the health service, but how do
30 you deal with this? Because for us - it's challenge for us
31 as Aboriginal people, First Nations people, delivering that
32 training, because we're up there continually telling our
33 stories, telling our lives, you know? And for people not
34 to, you know, even show some signs of that change, change
35 in attitudes, change in the way that they do things, you
36 know - and this has been going on for a long, long time
37 now, you know? But at the end of the day, there's got to
38 be that accountability around that, and that's with
39 everything, and that's why I mentioned earlier about that
40 systemic change, around aligning those policies and
41 practices and how important it is for the CWPs, you know?
42 Because we at Broken Hill - we say to people, because we
43 know they put in for funding for different things out
44 there, programs within our communities, but we always make
45 sure that they are bringing those submissions to us so that
46 we're all over what it is that we're actually getting in
47 our communities; that it's being endorsed by community.

1
2 You asked a question around do we get to see any
3 NSW Health people? Well, no the ones higher up. It's just
4 generally the ones on the ground and it's only limited, you
5 know? And that's generally the Aboriginal workers that
6 work within those departments. It's not the CEO or anyone
7 else in that position of power to make change.

8
9 THE COMMISSIONER: I think you made a good point there,
10 and I think Ed and Ross in the break were talking about
11 ground-up, or bottom-up, that having a service delivery
12 funded and approved without actually having had a proper
13 engagement with the people --

14
15 MS HAMPTON: Most times, there's been none.

16
17 THE COMMISSIONER: -- that it's meant to be delivered to,
18 so that it can be properly structured that way before it's
19 in it's final form and funded, is a big important step in
20 that.

21
22 MS GORDON: I have got one more thing today, it's just
23 another story. I had a friend that was training as an RN
24 in Sydney and he said to me, "What do you think the chances
25 are of me coming out to Brewarrina to do a placement?"
26 I said, "Well, first of all you don't tell them, when you
27 apply, that you know me or you won't even get a foot in the
28 door." So he actually did that and he ended up getting
29 a placement out at Brewarrina in the thing, and as soon as
30 they found out that he was a friend of mine, he wasn't
31 there for very long. He was moved out of there very
32 quickly.

33
34 MS McHUGHES: I would like just to finish up and say, you
35 know, directives for change can only be brought about by
36 the powers to be who hold the monopoly, okay, on the say-so
37 of who is right and who is wrong. I don't know who they
38 are - I don't know who they are, but that's where it's got
39 to come from. Because us on the ground, from the ground
40 level up, we've got no monopoly on anything at the moment.
41 Nothing. This is why we're here today. It must come from
42 the top. They must direct their energies into change.
43 Everybody knows the stats, you know; everybody knows. The
44 top-down approach has got to be responsible for the
45 devastation of our people out there in all the communities,
46 and until such time as our top-down - top people, who are
47 driving the agenda for progress for our people, if they're

1 not going to do their job the way that they are supposed to
2 be doing it, we are exercising a genocide for the First
3 Nations peoples of this country. That's what's happening.
4 Because our people are dying at an alarming rate and
5 somebody has to take the responsibility of saying, "Let's
6 really make a change and explore the deficit that is
7 causing this devastation and this crime." It is a human
8 rights crime, what's happening in this country, and we are
9 all responsible for it. You know, we haven't got the
10 monopoly on the say-so, the First Nations people. That
11 comes from the top down. I just wanted to say that.

12
13 THE COMMISSIONER: All right. Thank you. Ed, is there
14 anything further you wanted to explore before I ask
15 everyone if they want to have a final say?

16
17 MR MUSTON: No.

18
19 THE COMMISSIONER: Richard, I will ask you if you want to
20 ask any questions, but before I do, firstly, I want you all
21 to have a final opportunity to say anything further that
22 you would like to say, one at a time. But also, if you
23 leave here and an hour later you go, "Bugger, I wish I had
24 said that", don't worry about that, you can get in touch
25 with us. We're here - not in Dubbo, but we're around - for
26 many more months. So if that happens to you, and it does
27 happen to people, you know how to get in touch and pass on
28 any thoughts that you wish you had said, and we will pass
29 it on to who it needs to be passed on to.

30
31 Having said that, for all of you, are there any last
32 thoughts you would like to share.

33
34 MR KNIGHT: I would like to have, you know, proper health
35 service out in our remote communities, especially like
36 where we live, where I live. Some people haven't got cars.
37 You've got to ring the ambulance. By the time the
38 ambulance comes out the person could be dead, you know? We
39 had a couple of snake bites. We had to take these people
40 in our own car and meet the ambulance 10Ks out of
41 Brewarrina. These are the things that are happening in our
42 community. Not only that but health-wise reasons too.
43 Like diabetics' we've got a lad out there who has a bad
44 heart, liver problems, he's got to go and get his belly
45 drained every fortnight in Brewarrina. Some of our Elders
46 are fairly sick, too, but if we had that health out there
47 once a week or once a fortnight, instead of waiting for the

1 Royal Flying Doctor Service once a month, we could catch up
2 on some of the people who could be really ill.

3
4 THE COMMISSIONER: Yes, okay. Does anyone else want to
5 have a final say?

6
7 MS SHILLINGSWORTH: Yes, in Bourke, we're lacking
8 specialists coming up. A lot of them pulled out because
9 it's too far to travel. We've got people with chronic
10 illness and all that there and they've got to travel either
11 to Dubbo or Sydney because of these specialists who have
12 ceased coming out because it's too far. Then, you know, we
13 have problems with accommodation and travel expenses and
14 all that there.

15
16 THE COMMISSIONER: Yes, sure.

17
18 MS GORDON: I think that the submission that we put
19 together, you know, is something that we've really thought
20 about before we put it together, so I think it should be
21 taken quite seriously, with what has been put into that,
22 and I think you will get a pretty good overview of what we
23 believe as a voice for the people, which is the Murdi Paaki
24 Regional Assembly. I think if - we know that reform needs
25 to happen, and I think there is an opportunity if there is
26 real collaboration between the health services and their
27 commitment in working closely with the Murdi Paaki Regional
28 Assembly to try to alleviate some of the things that we've
29 talked about here today, to do better forward-planning on
30 health service delivery and accountability, two ways.

31
32 THE COMMISSIONER: Sure. I think your submission is
33 consistent with what you have all said to us today. Does
34 anyone else want to share?

35
36 MS McHUGHES: Yes just one more thing I have thought.
37 I think we should be really focusing on preventative
38 medicine. That is a must.

39
40 THE COMMISSIONER: Yes.

41
42 MS McHUGHES: I think that should be channelled through
43 our AMSs.

44
45 THE COMMISSIONER: That can be embedded in primary care.
46 It's part of the role.

47

1 MS McHUGHES: Even in primary care, but more so for our
2 AMSs, because they should have a connection with our
3 community in reference to home visits, checking on the
4 people for - with their referrals and things like that.
5 They are just simple things. And trying to formulate
6 a process of preventative medicine through programs and
7 things, through the AMS. I'm not blaming the multipurpose
8 centre, okay, I think that all the services in town need to
9 be accountable, and that includes the AMS too, as well.

10
11 MR MASON: Another thing about the services, now you
12 mention it, is when they come to town they only go and see
13 a certain section of the community. They don't go and ask
14 the people who really they need to be talking to, they will
15 go and ask one or two fellas over there, they will go back
16 and say, "Yeah, the community said they want this", and you
17 have never see them, and they are there writing their
18 reports up saying they've been out at Colli doing whatever
19 they are supposed to be doing, you know? Like we've had
20 them come to the regional assembly and say, "Oh, we've been
21 in such and such for two years." "We've never seen you,
22 who are you?"

23
24 You know, all the employment places out there.
25 There's bugger all jobs out there and you've got
26 14 employment agencies there to do nothing for anyone.
27 Like REDI.E, supposed to come to Colli and run programs
28 over there to get people into employment, training.
29 Nothing. You ring them up and ask them, "Oh, we're too
30 busy." So you are banging your head against the wall.

31
32 MS McHUGHES: I think the cultural aspect of the First
33 Nations person needs to be taught in the education
34 curriculum. I really do believe that, without a shadow of
35 a doubt, because at the moment our children are wandering
36 around and they don't even know who they are.

37
38 I just want to give you an example before I finish,
39 because I'm so passionate about this here, we so gracefully
40 accept, okay - and we have accepted it over the years, and
41 I have done it myself - that I am an Aboriginal. I am not
42 an Aboriginal. I have heritage that's aligned to me from
43 my forefathers, through my matriarchal line. We have
44 language, we have a nationality. My nationality is Ngemba
45 and I take offence, okay, to being referred to as an
46 Aboriginal. If we are embedding that in a child's psyche
47 from the time that it's born, we sit and wonder now about

1 the children, we need to be focusing on those children so
2 that they can be able to be empowered, spiritually, who
3 they are - not as an Aboriginal, not as an Aboriginal, not
4 as a classification, because that's what it is. It is
5 a classification by the system that has brought about the
6 demise of our children mentally, and our people, because
7 they are wandering through life and they don't know who
8 they are, they've got no belonging of any sort.

9
10 So I believe that that's what we must do to teach our
11 children to be empowered, through this process, that they
12 come from beautiful sociologies that were there before the
13 invasion. If we don't talk about those things - you know,
14 here we are putting all the bandaid solutions in place for
15 our children, and ten years down the track I want to be
16 able to see those children who are coming out through the
17 curriculum of the schools - and it is mandatory for our
18 kids to participate in the education system, but without
19 any empowerment process within themselves.

20
21 So I see that our children, 10 years down the track,
22 will be able to - if we teach them these things, their
23 history and their true history, the true history of
24 Australia - if we teach that, our children, 10 years down
25 the track, are going to be able to participate in society
26 as others do. Until we do that, we will be back around the
27 table. I will be long gone and you will be talking to
28 young kids who are coming up, okay, and we'll be trying to
29 express ourselves further, and we're driving agenda of the
30 system all the time.

31
32 Let's work together. Let's work together and see
33 what's really needed for our babies and things to be
34 empowered to be able to participate out in society as
35 others do. Because I'm not going to be - I'm past my
36 use-by date. I really am. You know? We're not going to
37 be here for much longer. So we as First Nations Elders
38 need to be able to have this conversation, free
39 conversation, and it's a hard conversation. It's a hard
40 conversation. Of course it is. Yeah? But change doesn't
41 come around, okay, by being soft to each other. We need to
42 have the strength to be able to listen to one another -
43 listen - for changes to be made.

44
45 So I'm glad I had the opportunity to be here today,
46 okay, to say what I've said, and I think that we should all
47 take it on board that our children are our future. Our

1 children are our future. So if we don't empower our
2 children to become those human beings that we want them to
3 be - the only way that they can get that is through
4 understanding who they are and where they come from, that
5 they are not just a classification of a nothingness.
6 Change the word "Aboriginal", please.

7
8 THE COMMISSIONER: Richard, do you have any questions?

9
10 MR CHENEY: No questions. I just should perhaps just
11 assure everybody, Hernan and I are here representing the
12 Department of Health, but there is a lot of people who are
13 not here for the Department of Health who have read your
14 submission and are watching this online and reading the
15 transcript and taking these concerns very seriously, so
16 that's all I can do, is assure you of that.

17
18 THE COMMISSIONER: Ed, anything further?

19
20 MR MUSTON: No.

21
22 THE COMMISSIONER: Thank you all very much for coming. We
23 are very grateful for your time and what you have said to
24 us. As I said, if something occurs to you in an hour or in
25 a week, please get back in touch. Otherwise, thank you
26 again.

27
28 <THE WITNESSES WITHDREW

29
30 THE COMMISSIONER: We'll adjourn until 10 o'clock
31 tomorrow. Thank you.

32
33 **AT 4.16PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
34 **TO WEDNESDAY, 15 MAY 2024 AT 10AM**

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