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

MR FRASER: I understand we're ready to start, Commissioner.

THE COMMISSIONER: All right. And the witnesses are Dr Chua and Dr Hoffman.

MR FRASER: That's correct, Commissioner, and they are on the screen.

THE COMMISSIONER: Yes. Good morning.

<AI-VEE CHUA, sworn: [10.01am]

<REBEKAH HOFFMAN, affirmed: [10.01am]

MR FRASER: Dr Chua, could we start with you, please. Could you please give your full name?

DR CHUA: Ai-Vee Chua.

MR FRASER: Your first name is A-I-V-E- E; is that correct?

DR CHUA: That's correct.

MR FRASER: You are a general practitioner in Dubbo; is that right?

DR CHUA: I am, yes.

MR FRASER: You are giving your evidence from your practice here in Dubbo; is that correct?

DR CHUA: I'm actually currently in Orange. I live across two towns, having my children schooled in Orange, but my practice is in Dubbo.

MR FRASER: I will ask you some questions about that in a moment. Thank you, Dr Chua.

Dr Hoffman, first of all, could you please give your full name?

DR HOFFMAN: Rebekah Isabel Hoffman.

MR FRASER: You are a general practitioner; is that correct?

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 Woolooware 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

any better?

THE COMMISSIONER: That sounded clearer, thank you.

MR FRASER: Q. I think you said that you and your husband took on the practice in 2005; is that correct?
A. We established our own practice in 2005. The surgery that we were both working at just prior was actually closing down due to practice owners, one of the practice owners in particular, moving out of the region and we were actually looking to relocate to the lovely Southern Highlands, but due to the great need and the fact that the practice that we were working at was servicing quite a large percentage of the population, and a lot of encouragement from the community, we did end up setting up Dubbo Family Doctors from scratch, as very young GPs.

Q. I will just get that background and then I will come back to some formalities. You had come first to Dubbo in 2002; is that correct?
A. That's right, yes.

Q. And is that as a registrar, GP registrar?
A. For a GP registrar placement at that time, which was to go for six months only at that point in time.

Q. And following the end of that, was that the completion of your training?
A. For myself, I had another six months of extended skills training, which I undertook in paediatrics at Dubbo Base Hospital, and during that period I had also worked at what was called Lourdes Hospital at that time, with training in geriatrics, rehabilitation medicine and palliative care as well. It was at the end of that training, and a little bit of travel later, that we returned to Dubbo after a six-month holiday and to a practice that was about to close down, and then subsequently established Dubbo Family Doctors in March 2005.

Q. Doctor, so you established it with your husband, and since that time, is it fair to say the practice has grown to include a number of other doctors? Is that right?
A. It absolutely has. We started with four doctors to begin with. We now have 13, and five nurses, plus a fairly new casual nurse as well, and - we also provide rooms for a dietician who comes to us once a week and a mental health

nurse who is with us a couple of days a week.

Q. So you employ - the practice employs the nurses; is that right?
A. Correct, yes.

Q. And in terms of those allied health staff you have referred to, the dietician and the mental health nurse, who employs those staff?
A. They are there as contractors.

Q. And they rent the rooms from you within the practice?
A. Correct. Yes.

Q. Just so that we can get some idea, you have referred to the practice that you and your husband had previously worked at closing down and the significant need in the community being really the primary factor for you and your husband deciding to stay here in Dubbo.
A. (Witness nods).

Q. From your experience, what's the level of service for GPs in Dubbo?
A. At this point in time?

Q. Yes, right now.
A. The demand far exceeds the supply, and, you know, comparable to at that point in time in 2005, we have an expanding population in Dubbo. We've got an ageing population. If you have a look at the open book/closed book situation in Dubbo general practices, at the moment the majority of our practices exist on closed books. As much as we'd love to service more of the community, there are only so many appointments that are available each day, and so most practices have elected to - once your waiting time gets beyond four weeks or six weeks for a standard consultation, you really need to look very hard at closing your books in order to properly and adequately service the population who already do come to see you for their GP care.

Q. Can I ask about your practice? What's the current position for your practice in relation to closed book versus open book?
A. We've got closed books, and for the vast majority of our existence we've had closed books. Each time that we open our books, you know, we have - we get a sudden influx

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

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

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

THE COMMISSIONER: Q. The four- to six-week time period for consultations that you mentioned, that's based on the experience within your own practice and discussions you've had with your GP colleagues at other practices?
A. Yes, that's right. Look, it's certainly the situation at our own practice. It's the feedback that we get from our hospital practitioners, our specialist, non-GP specialist colleagues, and you are left in a situation - and certainly my own patients having struggles to get in in a timely way, in particular for the semi-urgent healthcare needs. Most of our practices in town do structure our appointment system to try to accommodate that as best as possible. At our surgery, we run what's called an acute appointment system, so for things that really need to be seen that very day, you know, you've got infections or acute pain or injuries, those things we do our best to fit in.

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

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

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

MR FRASER: Q. Doctor, if I can just ask you a few things arising out of the answers you just gave. Firstly, is your current wait time in that four- to six-week period for standard consultations? Is that right?
A. For our established GPs, it is in that order. For our registrars, our GP registrars who have just been with us since February, their wait time is shorter, and we do our best to structure that so that we've got a wait time of a few days to a week for a standard consultation for our younger doctors, newer doctors - I shouldn't say necessarily younger, newer.

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

Q. So you are not able to utilise that additional training place. In terms of those numbers of training places, are those numbers as approved by the college?
A. That's correct, yes.

Q. Could I just ask you also, you referred to bulk billing. Roughly, what proportion of your patients do you bulk bill?
A. It's around a two-thirds/one-third mix. We certainly intend to be a private billing practice in terms of sustainability, but when we look at our two-thirds to one-third ratio, that's because of our population in need and who can't afford private services. We will also tend to bulk bill those services that provide sufficient remuneration - so chronic disease item numbers and health assessment item numbers - and we do bulk bill routinely our patients with intellectual disability, our aged care facility residents.

Q. Just lastly, in terms of aged care facilities, do you and your colleagues undertake GP visits into facilities here in Dubbo?
A. Absolutely. At our practice we strongly believe that general practice should be cradle to grave medicine, and any of our patients who move into an aged care facility, we will follow their care to the aged care facility.

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

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

Q. And do you have a copy there with you, in case we need to refer to it?
A. I do. Yes.

Q. Thank you, doctor. For the record, that's [SCI.0009.0093.0001]. I think it is anticipated that that will be added to the bulk tender later. Doctor, can I just ask you for completeness, you are working today at a clinic in Orange?
A. No. So when I'm in Orange, which is half of the week, I do HealthPathways writing, which is Western New South

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

Q. Now, you have referred to HealthPathways. Can you please tell us a little about what HealthPathways is?
A. Yes, sure. In brief, it's a set of localised guidelines and referral information for GPs, primarily aimed at GPs. HealthPathways exists across Australia, every region in Australia and New Zealand, and increasingly across the UK. Western HealthPathways is a fairly new venture in that NSW Health funded us a small pot of funding to get the COVID pathways up and running at the beginning of the pandemic, and subsequently our PHN has picked up the funding to deliver a kick-start version of HealthPathways in Western New South Wales across the wider breadth of conditions.

Q. Firstly, does that cover both the full area of the Western New South Wales PHN?
A. It does, yes. So it covers both Western and Far West local health footprints.

Q. You hold a position of senior clinical editor, is that correct, in relation to Western New South Wales HealthPathways?
A. That's correct, yes.

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

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

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.

Q. And the North West New South Wales representative on the AMA, Australian Medical Association, New South Wales council?
A. That's correct.

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

Q. Can you just give us a little detail about what the clinical advisory council of the PHN does?
A. Yes. Part of the remit of primary health networks, when they were set up, was that they needed to have GP-led clinical advisory councils and also elements, I think, of community council. So in our PHN we have a Far West and a Western clinical advisory council; we have a Far West and a Western community council; and we have an Aboriginal council as well.

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

Q. Something you touch on in your outline is the role of GPs in health needs assessment. I think you describe it in the outline as "limited".
A. Yes, that's right. I'm aware our primary health network has to do a tick-a-box exercise each period of time to say that they have performed a needs assessment for the region, and our local health districts undertake a similar exercise with needs assessments. I don't feel that those could be as accurate and thorough as they could be. You know, there is only so much information that you can get from mortality statistics and hospital presentations and admissions data. What nobody has visibility of is the

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

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

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

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

Q. Just in terms of that information about waiting times within general practice and waiting times for referrals to specialist services as you have given a bit of an overview of just then, just to understand or to clarify, it is the case that neither the PHN or the local health district have sought any information from your practice about that kind of data?
A. No. Certainly not our practice. No.

Q. I think you said earlier that your practice services

approximately 20 per cent of the Dubbo population.
A. (Witness nods).

Q. Just in terms of the other GP practices, are they generally of your size, or are they generally smaller than yours?
A. There is one other practice, Dubbo Medical and Allied Health Group, that are that sizeable, and I'm guessing would service around the same number of populations that we do. The other practices are smaller in size.

Q. And in terms of that concept of such information being sought from GP practices, perhaps particularly larger ones like your practice and the other practice you have just referred to, is that something that you have had the opportunity to raise, at least within the PHN, given you hold a role there?
A. Yes, absolutely. I have lost count of how many times I've raised the suggestion of monitoring waiting times so that we can have a metric to work with. You know, things like third available appointments, something we could easily work with in general practice. But a similar situation could happen in the outpatients departments in the hospital, you know, we could absolutely monitor the waiting times there. And the suggestion has been put through to both the PHN and local health district over the years, not to be taken up by anybody. It comes down to funding as well.

Q. Just to unpack that a little, you said it comes down to funding and no-one's interested in taking it up, but do you mean funding in terms of funding for gathering the data or analysing the data, that kind of funding?
A. Yes. It's administrative time. Not needing to fund general practice to do that. I think that would be - should be an expected part of one of the many things we do, but, you know, it would be feasible to set up a user-friendly online reporting system to be able to input that data, but you need the funding to have somebody set that up in the first place. But one would think, once it's established and systems are put into place for that collection of that data and the reporting of that data, it should be a low cost exercise.

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

I think that's right, isn't it, Dr Chua?
A. (Witness nods).

Q. Is that a situation, in terms of outpatient services, that has remained similar, or is it worsening, or even improving?
A. I think it is worsening, yes. When I first came to Dubbo, we only had two physicians and a few surgeons. We only had two general physicians servicing Dubbo and the surrounds, and it never felt too difficult to be able to get our patients in to those outpatient services at that point in time.

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

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

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

an inclusion of GPs within local health district clinical councils?
A. Yes. I think in the ideal world, we would have better connectivity across both our primary care and secondary care sector in terms of health service planning and delivery. We would have better connectivity in collaboration between our administrators of the organisations and the actual clinical workforce at the coalface, and that combination then to form a robust, accurate needs assessment for our region, and then to be able to prioritise the needs and plan the services in alignment across the primary and secondary care sector, to fulfil the needs of our population.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR HOFFMAN: It is, yes.

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

DR HOFFMAN: It is, yes.

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

Q. Dr Chua, putting the incentive to one side, that obviously wasn't a factor for you when you were making your decisions about training as a GP and where you were doing that training. Can I just ask you - and this is a topical issue, I think there was an article this morning about GPs undertaking GP training - for you, what attracted you to being a GP?
A. I had a fantastic experience in medical school with a GP practice in Gloucester, and so that was the inspiration to be in general practice.

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

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

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

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

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

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

Q. I think that's something you refer to in your outline, that there are a number of your colleagues in the area who are - and I don't just mean Dubbo, the wider area - at or past the usual retirement age and are perhaps continuing because there is no-one to take on the practice?
A. Absolutely. Our PHN did a study about five years ago now, and published that, to say that - as the small towns workforce report, which is that the projection was that 41 of our towns would be without a GP over the ensuing 10 years. Now, we are five years along that journey and there has certainly been closure of practices, particularly in these last few years. COVID had an impact. Right now, things like payroll tax issues are having an impact, and general burnout, I think, and fatigue, it would be fair to say, is contributing to some of that.

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

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

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

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

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

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

Q. How big of a reduction did those changes in 2020 impose?
A. If memory serves me correctly, specific to the ECG item number and Bek, if you remember, you might help me out with this - I think it was around halved, and so, you know,

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

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

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

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

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

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

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

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

Q. In terms of addressing that, doctor, from your perspective, given I think you said the two-thirds/one-third split in terms of your patient cohort and bulk billing, is the only option that you see a revision of the MBS system, or are there other options?
A. The revision of the MBS system would make a huge change. Perhaps private health insurers being able to contribute for payment of doctor and primary care nurse services would make a difference. Direct funding of general practices instead of funding primary health networks as commissioning bodies would make a difference.

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

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

THE WITNESS: Thank you.

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

THE COMMISSIONER: I just have a couple of questions.

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

Q. I think that ended in about 2014. Does that sound right?
A. That sounds about right.

Q. Firstly, can I just ask you, did you have any junior medical officers in your practice as a result of a placement through that program?
A. We didn't at our practice but there were other practices in the region who did accommodate PGPPP placements.

Q. And can you just tell me, what was the nature of that program? It offered a placement for junior medical officers in general practices, did it? It funded that?
A. That's right. So as one of the terms within the hospital rotations, to actually step out of the hospital and do one of those terms in a general practice environment, which is generally 10 weeks or so in general practice.

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

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

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

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

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

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

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

DR HOFFMAN: Absolutely.

THE COMMISSIONER: And do you consider that valuable?

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Do you want to add anything?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: What are you hearing anecdotally?

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

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

THE COMMISSIONER: Q. Can I just ask you what you mean by " opportunistic care"? Is that the example of the patient with the boil that actually should be treated for the chronic condition?
A. The chronic disease? There is that element of chronic disease, but if I get a patient, look, I will show you a few examples. So if I have a child come in for a respiratory tract infection, what will I do? I will take the child's height and the weight, have a little bit of a chat with the parent about nutrition and physical activity whilst they are there. You know, the wider, the whole - look after the whole patient. Also get a sense to see how mum and dad are coping with the new baby. Those things, because I do - generally in Dubbo, we still do manage to look after the whole family. So it is that continuity of care, holistic care.

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

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

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

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

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

MR FRASER: Just two matters.

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

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

Q. What do you mean by exacerbating in that context, doctor? How?
A. If the funding is diverted elsewhere, that means that it's an increasing struggle for that GP in that area to be able to have the practice, a viable practice. It also means there is a greater attraction for those GPs to go and work in an urgent care centre or work in the local health district.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Yes, go ahead.

<EXAMINATION OF DR CHUA BY MR CHENEY:

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

A. (Witness nods).

Q. That collaboration is a formal arrangement, is it not, between the chief executives of Far West and Western New South Wales LHDs and the Western Primary Health Network and the Rural Doctors Network; is that right?
A. It is. It is. My understanding is that that was designed to cross the bridge between primary care and secondary care sectors.

Q. By providing a forum that would facilitate communication between those representative organisations?
A. (Witness nods).

Q. Is that so?
A. That's the intention. That's my understanding. However - because the primary health --

Q. And given your former role as a primary health network board member --
A. (Witness shakes head).

Q. Sorry, are you shaking your head there?
A. No, I've never been a PHN board member.

Q. I'm sorry.
A. It would be fantastic if we had more local GPs on our PHN board.

Q. I see. You are chair of the Western New South Wales Primary Health Network's Western Clinical Advisory Council; is that right?
A. Correct.

Q. In that role, would it be your expectation that the chief executive of the PHN would be in a position to advocate the position of primary caregivers in the Western health collaboration forum?
A. They are in a position to do so, but our two chief executives who have been in that role, in times gone past, have not advocated for that.

Q. I'm sorry, the two previous chief executives did not advocate the primary caregivers' position? Is that --
A. Correct.

THE COMMISSIONER: Q. What do you mean? Can I just ask

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

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

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

Q. Do you know why?
A. There was never the opportunity to find out why that didn't pan out.

MR CHENEY: Q. In any event, Dr Chua, one of the solutions that you proposed to enhance the representation of primary caregivers in the collaboration is the inclusion of GPs in the LHD clinical councils; is that right?
A. That would be an option.

Q. And I think you point to Hunter-New England LHD as an example of a district where that has occurred?
A. I'm aware that - looking online, I'm aware that they had advertised for two GP representative positions on their district, the local health district clinical council. At one stage early in the pandemic when the chairs of our PHN clinical advisory councils attempted to come together to nut through some issues and solutions across our state, there was at least one who talked about the fact that they

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

Q. But just to direct your attention to paragraph 7(b) of your outline, you refer to inclusion of general practitioners in LHD clinical councils as a solution to the problem. You had in mind that GPs would sit on the clinical councils; is that right?
A. That's one option for a solution to increase that connectivity with general practice.

Q. Does that not in fact occur with the Western New South Wales District Clinical Council - that is, a GP, at least one GP sits on the council?
A. I'm not aware that our Western LHD clinical council has any GPs on it at present.

Q. Do you know or know of Dr Robin Williams, a GP from Molong?
A. Yes, yes.

Q. You understand he operates the multi-GP practice at Molong?
A. Yes.

Q. Do you understand he is a member of the district clinical council within the Western NSW LHD?
A. I was aware that he chaired the district clinical council previously, but I had thought that he was no longer part of the district clinical council. He does chair our PHN board.

Q. But if it were the fact that he presently sits on the council, that would give you some comfort, would it not, on the question of the amount of input that your body is receiving?
A. That would give me a little comfort. Robin is an excellent person, yes, and would advocate strongly. Look, you know, we've got 110 general practices across the Western New South Wales PHN footprint. Not exactly sure what proportion of that is within the Western LHD footprint but I would assume that's a vast majority of those 110 or so. We have towns of varying sizes. We've got very

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

Q. Just one last matter, Dr Chua. You, as we discussed, sit as the chair of the clinical advisory council with the Western New South Wales primary health network; is that right?
A. Yes. That's right.

Q. Given that role and your experience, long experience, as a rural GP, do you have a view about how the PHNs might work more collaboratively with the LHDs to improve things generally in the primary care space?
A. Yes, look, the proposal has been put forward several times for an alliance in the region, modelled off the Canterbury alliance in New Zealand, and unfortunately that has not - that has never managed to take off. But the concept behind that would be to have, as I alluded to before, primary care and secondary care organisations work together on a targeted needs assessment, align the service delivery and, you know, we do have a federal/state divide in funding that makes that particularly challenging, but if locally we were able to identify our priority issues and have aligned service delivery strategies to overcome those priority issues, that would make a big difference.

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

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

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

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

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

Q. Would there be some benefit, do you think, if the LHD was able to work directly with larger practices such as yours rather than having to deal with the primary health care networks?
A. Very much so. Absolutely. Yes. During the COVID pandemic where we - you know, there were so many challenges in the pandemic, but some really good things that happened. The Western New South Wales COVID group was one of those. So I was part of that group who met up each week or fortnight, or each month, depending on how terrible the concern was around that point in time. We had the CCIC, COVID care in the community clinicians as part of that group. We had some administrators where there was involvement of the emergency department physicians. It was very much a clinically-driven group and it was a bottom-up approach rather than a top-down approach. So what we saw as the needs, you know, we put in our suggested solutions and worked across the different sectors to make things happen.

We haven't seen --

THE COMMISSIONER: Q. Sorry, can I just ask you, you enthusiastically embraced the proposition Mr Cheney put to you of there being a benefit if the LHD was able to work directly with larger practices such as yours. What do you - in embracing that enthusiastically, what encompasses "working directly with the LHD"?
A. Oh, my goodness, the things that we could do. Look, there are simple things like access to pathology and radiology. Take a Friday afternoon and you are needing to have - if someone comes in with atypical chest pain, and you think, "Oh, look, in order to keep them safe, I really need to have that opportunity to do pathology and radiology on them now and I need to know the answer within half an hour or thereabouts."

Right now, the pathway to make that happen is not

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

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

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

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

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

MR CHENEY: Nothing further.

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

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

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

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

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

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

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

THE COMMISSIONER: Did anything arise out of any of that?

MR CHENEY: No, Commissioner.

THE COMMISSIONER: Mr Fraser, is there anything?

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

I note the next witness has been waiting.

THE COMMISSIONER: We will have a break. We will have to.

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

THE COMMISSIONER: Yes. So Dr Hoffman is staying?

MR FRASER: Yes.

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

<THE WITNESS WITHDREW

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

DR HOFFMAN: Thank you.

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

SHORT ADJOURNMENT

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

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

MR FRASER: Yes, that's correct.

THE COMMISSIONER: Dr MacIsaac, can you hear me?

DR MacISAAC: I can, yes.

<MARY BETH MacISAAC, sworn: [12.10pm]

<EXAMINATION BY MR FRASER:

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

DR HOFFMAN: Thank you.

MR FRASER: Q. Dr MacIsaac, could you give your full name, please.
A. Sure, it's Mary Elizabeth MacIsaac. I am commonly known and practice under "Mary Beth".

Q. You are giving evidence today from your rooms in the Coomealla Health Aboriginal Corporation?
A. In Dareton, yes.

Q. And that's in Dareton?
A. Yes.

Q. And Dareton's a town in the Far West Local Health District; is that right?
A. Correct, yes.

Q. And just in terms of basic geography, that's at the southern part, or very southern part, of the local health district, not far from the Victorian border; is that correct?
A. Correct, yes. So it's the very south-west corner of New South Wales, near there, yes.

Q. Just to give it a very basic orientation, how far is it to Broken Hill by car?
A. It would be - it takes just under three hours to drive to Broken Hill. It's a little under 300 kilometres, I think, perhaps about 270 kilometres. But I would have to look it up to be sure. It's about a three-hour car journey.

Q. In terms of larger towns or regional centres, is the closest regional centre Mildura?
A. Correct, yes, that's about 20 minutes away by car.

Q. And for those of us not overtly familiar with that part of the country, Mildura is in Victoria; that's correct, isn't it?
A. Yes, correct, yes.

Q. I will take you to some detail in a moment, but, doctor, you have prepared an outline in relation to your evidence; is that right?
A. Yes.

Q. Just for the record, [SCI.0009.0092.0001]. Doctor, is everything in that outline correct as far as you have ascertained; is that right?
A. Yes.

MR FRASER: That will be added to the bulk tender in due course.

Q. Doctor, firstly, you hold a salaried general practitioner position at the Coomealla Health Aboriginal Corporation; is that right?
A. Yes.

Q. And in terms of your position, how many days a week do you work at Coomealla?
A. Two.

Q. And in terms of that organisation, what other medical staff are there at the practice?
A. Do you mean doctors, by "medical staff".

Q. Firstly, doctors?
A. Yes, we have a senior GP registrar - actually, two senior GP registrars, one who works five days a week and one who works four days per week, and we occasionally get prevocational doctors from the Mildura Base Public Hospital. It's a PGY2, postgraduate year 2 position, and they would be two days a week, just the days that I am there.

Q. So you would - when you do have prevocational doctors, you are the supervisor; is that right?
A. Yes, I'm the supervisor for the prevocational doctors and as well one of the registrars, so I continue to supervise my registrar when I'm across at the base hospital as well.

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

a position over in Mildura; is that right?
A. Yes. Yes.

Q. Is that the director of medical education at the Mildura base hospital?
A. Yes. Mildura Base Public Hospital, correct.

Q. Do you work in that position for the balance of your time, three days a week?
A. Yes, the three days a week.

Q. That's a staff specialist --
A. Yes, position.

Q. -- level position?
A. Yes.

Q. Just in terms of your positions, you are also the Far West representative for the Royal Australian College of GPs; is that right?
A. Yes, that's correct.

Q. And the chair of the Far West Clinical Council of the Western New South Wales Primary Health Network; is that right?
A. Correct.

Q. Thank you. Now, you have been there in Dareton for how long?
A. I started in late January 2023. So a year and approximately four months or so.

Q. And a similar time at Mildura; is that right?
A. I started in Mildura in February 2023, so similar. Yes.

Q. And prior to that, you have said in your outline that you were a senior medical officer in primary care for the rural flying doctor service?
A. It should have said Royal Flying Doctor Service. Sorry, that's incorrect. It should say Royal Flying Doctor Service.

Q. Of course. Thank you. It is perhaps why I stumbled over it. The Royal Flying Doctor Service based in Broken Hill; is that right?
A. Yes, yes.

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 Gymea, which is in the Sydney Sutherland shire, for eight years before moving to the Far West. Before that I worked for two years at Yarrawarrah 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?

A. Yes.

Q. And you undertook your GP training in Canada; is that correct?
A. I did. Yes. And I worked for two years in a rural hospital in Canada before I - post fellowship, before I moved to Australia.

Q. I will ask you a few questions about that. Firstly - and it may be different in Canada - what was it that attracted you to general practice?
A. What attracted me to general practice? It was actually rural medicine that attracted me to general practice. I did a rural rotation as a medical student and it was a very unlikely thing to decide after that rotation, what I wanted to do. I went to a rural hospital where there were only two doctors and that meant they were on call, one and two, and they provided all of the services for the community, and they were very, very busy and my accommodation was in a room underneath the stairs in the hospital that didn't have any windows, and I ate every night in the hospital cafeteria, which was by that point empty, and the hospital cafeteria staff had kindly left a meal out, which would get colder as time went on.

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

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

Q. And that rural and regional program you referred to, was that part of your training in Canada? That was a training path?
A. Yes. I did the family medicine program at Dalhousie University. I trained in Fredericton, New Brunswick. At that point, it had a population of about 80,000. Then from Fredericton we had, like, a rural rotation from there as well.

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

Q. That effectively delayed your ability to become rural or to relocate?
A. Yes, so the effect that - so I was under what is commonly known as a 10-year moratorium, which restricts my ability to access a Medicare provider number, and I knew that when I got the provider numbers that I did in Sydney, so the one for Yarrawarrah and the one for Gymea, that I was very lucky to get those two provider numbers. I also knew that my ability to get another provider number in Sydney would be extremely limited and that if I left where I was practising, I would be asked to relinquish that provider number and I would not be able to move back into an urban area because of the closing of the geographic locations that were available to me.

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

Q. And that 10-year moratorium you refer to, that's by virtue of operation of, without going into the detail, Commonwealth legislation and rules; is that right?
A. Yes, I think the - I think it was under something called the 19AB exemption or something along those lines. I can't tell you the legislation specifically, I just knew where I was allowed to apply for a provider number or not. And so my moratorium expired in August of 2020 and that is when I started practising in Broken Hill.

Q. You have said that, putting aside the moratorium, you would not have been able to relocate except for the fact that your husband was also relocating here. Could you just expand on that?
A. Well, family support is of course important, so it is very hard to move to a rural area if your spouse is not going to have work in that rural area. So it was actually my husband that got the job in Broken Hill first and then I - I mean the job with the - the Royal Flying Doctor Service job came up and I thought that would be quite interesting, and so I moved as well. There wasn't really a drawcard or incentive, though, for me to leave suburban Sydney and move to western New South Wales. I think I got some of my relocation costs reimbursed by the - the majority were reimbursed by my husband's job but I could have had them reimbursed by the Royal Flying Doctor Service. There wasn't anything to sort of incentivise a move.

Q. I see. So really your interest and family relocation ability is what facilitated --
A. The move, yes.

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

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

Q. Some significant numbers with various social and economic disadvantages?
A. Yes.

Q. Low levels of health literacy.
A. (Witness nods).

Q. I think at one point you refer to multi morbidities?
A. Yes. So multiple health conditions that the patient experiences, both mental health and physical health conditions, and sometimes also issues with substance abuse, drug and alcohol and - yes, the difficulty of navigating. Because guidelines tend to be written for specific single

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

Q. Related to that, presumably, is access for your patients to specialist care when referred by yourself?
A. Yes. There have been numerous challenges with trying to access, in particular, mental health and psychiatric care for our patients.

Q. If we could just focus on that, firstly - and this is in relation to your current role there in Dareton at Coomealla. What are your referral pathways for patients in relation to that currently?
A. So the referral pathway is to an organisation called Buronga HealthOne, which has a psychiatrist that I believe supports them. That psychiatrist I understand is in Broken Hill.

Q. What's your experience with wait times for such referrals?
A. So I've had numerous referrals rejected, so they refuse to see the patient altogether, and I've had others with serious mental illness that waited months to even have the referral accepted that the patient actually was given an appointment time. So I think I mentioned in my affidavit, I did have a patient with schizophrenia that I felt was - I was uncertain as to which of her symptoms were schizophrenia and which were some other illness. It was very difficult for me to know how to adjust her medications, and that particular patient - and that patient has low literacy levels and intellectual challenges and has support workers, and despite the efforts of myself, the support workers and the practice, that was five months to get that patient in to get a phone call to have an appointment booked.

Q. Presumably there are - well, I will ask you, are there any psychiatrists there in Dareton?
A. No, no, there are not. There are psychiatrists - I suppose this is a conflict of interest, so I will declare that, but there are psychiatrists at the base hospital, the Mildura Base Hospital where I work, and in a moment of frustration, I said to them "You have so many psychiatrists

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

Q. It needs specialist input, from a psychiatrist?
A. They do, yes.

Q. Just in terms of access to other specialties, is it the case - I think you have said in your outline that there are other specialties that you are able to effectively refer to specialists based in Mildura?
A. Yes. So we're able to access nephrology services in Mildura; we're able to access cardiology services. I don't believe that cardiology services are via the base hospital, but they will provide low cost services for our patients, which is really appreciated, private specialists. We can access paediatric services, which is wonderful, obstetrics and gynaecology services, so there are a few services that we can refer across the border.

Q. And other than cardiology, which you specifically mentioned, as not being in the hospital, are those other specialist services based at Mildura hospital?
A. They are based at the hospital and via the Mildura Base Hospital specialist clinic, yes.

Q. And as far as you understand, there is no funding issue in that regard?
A. Not as far as I understand. I don't know exactly how the funding arrangements work, but as far as I understand, there is no funding issue, and our patients are actually - if surgery is required, they are able to access surgery at the base hospital as well.

Q. As a public patient; is that right?
A. As a public patient, yes.

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

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

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

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

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

be Broken Hill or Mildura or urgent care centres, which you refer to --
A. Mmm.

Q. -- public services, put it that way --
A. Yes.

Q. -- what's your experience in getting information - being provided routinely with information from those services, such as discharge summaries?
A. Discharge summaries? So the Broken Hill Base Hospital, when I was there, it was very, very difficult to access discharge summaries. I actually - knowing that I was going to be speaking to this Inquiry, I rang our practice manager that I used to work with in the Royal Flying Doctor Service to say was it still the case that they are expending a lot of effort in trying to track down discharge summaries. It is indeed the case.

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

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

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

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

Q. In terms of your experience, either in Broken Hill or there in Dareton, does that ever happen?
A. That I get handover of care in an adequate sense?

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

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

Q. You've referred in your outline to urgent care centres, or the urgent care clinic, and that it can sometimes take time to piece together what the presenting issue was. Just in terms of Dareton, where is the nearest urgent care clinic?
A. Mildura, Sunraysia community health has an urgent care clinic.

Q. Is it the same issue, that provision of information on proper handover of care, is that what you are referring to, or is there something additional in relation to urgent care clinics?
A. Yes. So there is issues with adequate handover of care. It can be difficult at times to know exactly what the patient presented with and what is actually going on. The urgent care centre is staffed by a nurse practitioner and I don't know that there is any additional oversight. So I don't know how well the letters are actually being

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

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

Q. And the organisation recoups money from Medicare for services you provide; is that right?
A. That's correct, yes.

Q. You have given a comment that even with - well, even with, whilst recent increases in Medicare rebates have assisted general practice to an extent, your wage isn't covered by the Medicare billings; is that correct?
A. No, it's not.

Q. Just firstly, in terms of the proportion, do you know what proportion of your salary is covered by the billings? You may not.
A. It would be hard to give an approximate number. I would just have to think about my sort of salary for the year and what actually was recouped from Medicare. I - if I was to give a rough estimate, I would say that about 50 per cent of my salary is covered by Medicare billings, just having seen my billings from a six-month period from August to February. Yes, that was about 50 per cent of the income that I made for that time period.

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

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

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

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

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

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

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

Q. And when you say it goes down, it's not the actual amount that goes down, it's the effective amount per time, or period of time?
A. It is the amount per minutes. So between 6 minutes and 20 minutes, the Medicare rebate, if that is what the clinic is accessing, is exactly the same. It's also

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

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

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

Q. I just want to ask about one other area, and I note, Dr MacIsaac, I'm told you have patients at 1; is that correct?
A. I do, and I'm the only doctor here today.

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

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

Q. Which we understand is up to $40,000 per year per registrar. Do you have any observations from your dealings with those junior medical people over in Mildura in relation to that?
A. Yes. Well, they are very interested in general practice now. They are very interested and I'm aware of at least one, but there may be more prevocational doctor, that has taken up that offer. It's wonderful for Victoria. When you are just across the border in New South Wales, it's very tricky, because if that GP registrar then decides that they are going to undertake training in New South Wales, I don't know how the Victorian government would see that. So it's a bit tricky.

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

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

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

Q. Where would the urgent care clinic they would typically go to be?
A. It is in Mildura, Sunraysia Community Health Services, Mildura.

Q. And, typically, why would they go to that urgent care clinic? Would it be because you are not open at the time, or what are the reasons that you have some patients that are going to the urgent care clinic?
A. I'm not always certain why patients will choose an urgent care clinic. I'm told that some patients think that it's very straightforward - like if they have a straightforward problem like they need a certificate for something, a certificate for time off work, they are aware that they can go to the urgent care centre and get a certificate for time off work, so a very straightforward problem. So some will access it for those reasons.

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

Q. A quick way - oh, to get a certificate. Okay.
A. Yes, so certified for time off work or --

THE COMMISSIONER: Did anything emerge out of that?

MR FRASER: No.

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

there any other GP services in Dareton itself?
A. Not in Dareton itself that I'm aware of, no.

Q. And can I ask, the service there, do you provide GP services to non-First Nations patients as well as First Nations?
A. We do. We do. Because we're the only service in town, and often - so, one, because we're the only service in town, and often Aboriginal patients are married to non-Aboriginal patients, so are actually seeing the spouse of one of our patients, rather than having that spouse access a service elsewhere.

Q. And just in terms of wait times, other than urgent appointments which you keep several aside for such matters, for what you might call a routine appointment, what's the wait time on average?
A. At the moment I think it's about two weeks or so. It fluctuates depending on who is away. So right now I have a registrar away and that might mean that wait times expand a bit, and then when she comes back they might get a bit shorter.

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

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

MR CHENEY: No, Commissioner.

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

THE WITNESS: Thank you.

<THE WITNESS WITHDREW

THE COMMISSIONER: We adjourn until 2 o'clock?

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

THE COMMISSIONER: Someone is shaking their head. Why

don't you just find out?

MR MUSTON: 2 o'clock is fine.

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

LUNCHEON ADJOURNMENT

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

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

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

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

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

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

The only reason for not talking over each other would be because we've got to record it, but other than that, I don't want anyone - anyone - to leave here today without feeling that they have said what they want to say. So that's really important to us.

Other than that, we might begin - because this is a Special Commission of Inquiry, I have to rely on evidence that would otherwise, I think, be admitted into a court, even though we're not doing it like a court. So I'm going to get you, as a group, to be sworn in or affirmed in. Do any of you wish to make an oath or an affirmation?

MS GORDON: Affirmation.

THE COMMISSIONER: Is everyone content with an affirmation? We might do it as a group, then.

<GRACE GORDON, affirmed: [2.09pm]

<DOREEN HUGHES, affirmed:

<DENISE HAMPTON, affirmed:

<MILLIE SHILLINGSWORTH, affirmed:

<CARL MASON, affirmed:

<ALLAN COBB, affirmed:

<ANTHONY KNIGHT, affirmed:

THE COMMISSIONER: Thank you very much, all of you.

I think also, Ed will no doubt use the name of the person that speaks first, but other than that, it would help for the transcript if, before you spoke, you said who you are so we know, when the transcript is written out, who is doing the talking. So I will leave it with Ed for a moment.

MR MUSTON: We might start just by doing some introductions at your end for the benefit of the transcript, and so we all know a little bit more about each of you and what your background is, maybe starting with you, Grace. Your name and role within the assembly and the

community that you come from.

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

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

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

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

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

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

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

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

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

COURT OPERATOR: We will turn them on.

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

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

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

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

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

MS GORDON: Yes.

MR MUSTON: Who else is on the assembly?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS GORDON: Public health network.

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

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

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

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

MS GORDON: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Is it a multi-purpose?

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

THE COMMISSIONER: Yes.

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

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

MR COBB: Mmm.

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

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

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

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

THE COMMISSIONER: Yes.

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: How long are they there for?

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

THE COMMISSIONER: They come out with a GP?

MR KNIGHT: Yes.

THE COMMISSIONER: A nurse?

MR KNIGHT: A nurse.

THE COMMISSIONER: Drug and alcohol, you said?

MR KNIGHT: Whoever you want, yes.

THE COMMISSIONER: Any other allied health, like physio, anything like that?

MR KNIGHT: No. So we just started that. But, you know, like I think health, we're missing the boat with health. Like I know that Brewarrina was getting funding to deliver to our community, but yeah, they haven't. And some of us, you know, we don't get the - who goes into the Brewarrina hospital, how they - some of the staff, how they speak to people, and some people go further on to Bourke, which is an extra 214Ks. So it's just about where people --

THE COMMISSIONER: Because they don't want to be treated there?

MR KNIGHT: Yeah, it's just the way they communicate with people who live very remote, how they speak, yeah. In some ways, it is very nasty. But we're trying to reach out to other --

THE COMMISSIONER: By "nasty", do you mean --

MR KNIGHT: It's just the way --

THE COMMISSIONER: Do you mean it is deliberately nasty, or is it just a lack of cultural competence?

MR KNIGHT: I think it is that way.

MS McHUGHES: Both.

MR KNIGHT: Doreen and Grace know the same. Some of us we just travel the extra 214Ks where you get better treatment and better respect.

THE COMMISSIONER: Where is that?

MR KNIGHT: In Bourke.

THE COMMISSIONER: Okay.

MR KNIGHT: So it is a round big trip.

THE COMMISSIONER: What makes the difference with Bourke? Why do you feel it's a more appropriate service for your people?

MR KNIGHT: I think especially where you've got to go, if you've got to go to the Bree hospital, that's where the dramas are. Yeah. But if you go to the medical, whatever - but if you need to go up and get blood taken or if there is an emergency, yeah. But, yeah. Like I said, you know, they are getting funding, but they don't deliver the service. I have seen people out there in the past sit in the car for about - we give them an office to use - sit in the car for 10 minutes and drive out of our community, and it's only 18 houses, it's a one-way street.

So these are things that happen in our community, especially remote.

THE COMMISSIONER: Just so I understand, who are you talking about?

MR KNIGHT: The health people who come from the Brewarrina hospital. The nurse - there is supposed to be a nurse or whatever.

THE COMMISSIONER: What are they supposed to do when they come to your community? They are meant to --

MR KNIGHT: To take people's blood pressure, you know, see how their sugar is going or, you know.

THE COMMISSIONER: Whereabouts is it meant to be done?

MR KNIGHT: At the land council. Yep. That's in the past.

THE COMMISSIONER: And they're just not present, they're just not --

MR KNIGHT: They sit there for 10 minutes and drive off.

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

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

MR KNIGHT: Yes.

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

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

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

MR KNIGHT: Yes.

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

THE COMMISSIONER: It would be reckless not to.

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

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

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

THE COMMISSIONER: So there is no --

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

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

MS GORDON: Yes.

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

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

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

MS GORDON: Yes, yes.

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

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

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

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

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

Now --

THE COMMISSIONER: What do you mean by that?

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

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

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

MR KNIGHT: Yes.

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

MR KNIGHT: Same, the Royal Flying Doctors.

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

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

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

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

MS McHUGHES: Yes.

MS SHILLINGSWORTH: Yes.

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

MS McHUGHES: I believe so.

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

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

MS SHILLINGSWORTH: Can I say something about the ambulance?

THE COMMISSIONER: Yes, of course.

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

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

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

hospital. Why go through the police first?

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

Allan, what about Lightning Ridge?

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

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

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

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

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

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

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

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

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

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

SHORT ADJOURNMENT

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

MS McHUGHES: To share something, yeah.

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

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

So does that make it clearer?

MS SHILLINGSWORTH: Yes.

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

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

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

MS GORDON: She's an RN.

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

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

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

MS GORDON: Yes.

MR KNIGHT: Yes.

THE COMMISSIONER: Is that a consistent story for all?

MR MASON: Yes.

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

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

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

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

THE COMMISSIONER: Which hospital was that?

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

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

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

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

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

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

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

today?

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

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

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

MS GORDON: Well, it is said.

MR KNIGHT: It is said.

MS McHUGHES: It is well known. It is well known.

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

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

MS GORDON: Yes, you are.

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

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

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

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

MS GORDON: It is a repercussion of being vocal.

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

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

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

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

THE COMMISSIONER: Anyone else want to say anything?

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

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

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

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

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

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

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

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

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

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

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

MR MUSTON: No.

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

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

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

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

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

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

THE COMMISSIONER: Yes, sure.

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

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

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

THE COMMISSIONER: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Richard, do you have any questions?

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

THE COMMISSIONER: Ed, anything further?

MR MUSTON: No.

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

<THE WITNESSES WITHDREW

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

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

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