Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At Level 2, 121 Macquarie Street,
Sydney, New South Wales

Wednesday, 27 November 2024 at 10.00am

(Day 065)

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

Also present:

Mr Hilbert Chiu SC with Ms Lucy Blair for NSW Health

THE COMMISSIONER: Good morning, everyone, I hope you can all hear me. I'm going to assume that you can.

Before we begin this roundtable session, the Special Commission of Inquiry into Health Care Funding, I wish to acknowledge the Gadigal people of the Eora Nation, who are the traditional owners of the land on which those of us here in Sydney today gather today and pay my respects to their Elders past, present and emerging.

To those of you online, thank you very much for attending. We've very grateful for your time.

Throughout the 14 months of this Inquiry so far, we've met a number of you, not all of you but a number of you. We do feel as though, over that period, we've at least obtained good information and understanding about the services you provide and the great importance of your organisations to your communities.

We've had various discussions with ACCHOs and AMSs on these broad topics - first of all, your funding and where that comes from and, in particular, the difficulties associated from time to time with short-term funding; issues in relation to workforce, which are sometimes related to funding; and relationships with other entities and people within the healthcare system, in particular, LHDs and PHNs but also other organisations.

I've kept that deliberately broad because it's important that neither I or Mr Muston, who you will hear from in a moment, set the agenda.

This is not an opportunity for us to talk to you; it's an opportunity for you to inform us. We have deliberately designed these roundtables in a manner that we hope encourages engagement.

By that, what I mean is we want it to be less formal than what a court hearing might be, and we would also encourage you, if you hear - if one of your colleagues makes a comment that you want to add to, please, just put up your hand and indicate you'd like to add or say something about that particular topic. Whilst this is an important information-gathering exercise, as far as possible, we want to keep it far less formal than a typical court hearing, which this isn't.

Having said that, I will now ask Mr Muston to say a few words and start the discussion off.

MR MUSTON: Thank you.

I should introduce myself. My name's Ed Muston, I've spoken to some of you. I'm one of the barristers who is assisting with the Inquiry. Sitting to my left is Hilbert Chiu. He is one of the barristers who has been retained by NSW Health to assist with the Inquiry.

As the Commissioner has said, the aim of today is, as best as possible, to keep this process largely conversational and, to the extent that there are - I'll endeavour to push you off in relation to some topics and then we can chat around them.

To the extent that any of you hear what is being said by your colleagues in other parts of the state and want to, or think it would be useful to chime in at that point to tell us about your own experiences, how they differ from those that might have been spoken of or how they line up with the experience of others, feel free to do it.

As the Commissioner said, use the "raise hand" function if you can work out how to do that. I usually, I must confess, struggle with that. If you, like me, struggle with that technology, feel free to just put your physical hand up and I'll make a note of the fact that you have done it and come to you as quickly as we can.

In saying it's largely conversational, the only real constraint that we have to keep in mind is there are two people in the room here with us who are carefully taking down what people are saying, so as best as we can, if we could sort of try and speak reasonably slowly and one at a time, that would make their job a lot easier.

I know sometimes as we get into discussions, people start speaking quickly or cutting across one another. If they look at me in a way that appears vaguely frantic and I ask you to slow down, please don't take offence, it's really for their benefit, not because we're not very, very interested to hear what you have to say.

But to kick off, perhaps it would be useful if we went

around each of you and just gave you the opportunity to tell us who you are, where you are joining us from in the state and just give us a brief description of the organisation that you are involved with and the particular role and services that it offers to its community.

Perhaps I will go through the list of people in the order I've got them here, if that's a convenient way to do it. So Lisa Penrith, joining us from the Griffith AMS.

MS PENRITH: Yes, hi. I'm Lisa from Griffith AMS. I'm the practice manager and sitting beside me is our CEO, who is the observer.

MR MUSTON: Thank you. And it is probably in the name, but where are you joining us from today?

MS PENRITH: Griffith Aboriginal Medical Service. We also auspice Murrin Bridge Aboriginal Health Service and KAMS.

MR MUSTON: In terms of the services, just in broad terms, offered by the Griffith AMS, what are the sorts of services that are offered by your organisation to the community in your region?

MS PENRITH: Okay, we have our mental health services here, our clinical team, ITC, tackling Indigenous smoking, allied health, drug and alcohol, youth services, visiting specialists and dental, yep.

MR MUSTON: Great, thank you.

MS PENRITH: I've probably missed a few, but that's it.

MR MUSTON: I'm sure they will rattle out through the course of the morning.

Isaac Simon, you are joining us from Tobwabba.

MR SIMON: Yes, so we're from Tobwabba AMS. I'm the CEO here. Much the same as Griffith, we provide a range of healthcare services and also social, emotional wellbeing services and allied health services as well, and we also provide everything from maternity to aged care - so the broad spectrum of services. Then also a lot of specialist outreach services as well from cardiac to psychiatry and, yeah, and everything in between and we're also lucky enough

to have a dental service as well.

MR MUSTON: Roughly which little patch of the state do you cover?

MR SIMON: So we cover the upper part of the Worimi country, so we're in Forster. We cover from - basically from Gloucester all the way down to Seal Rocks and inland and up to Diamond Beach on the border of Biripi country.

MR MUSTON: Thank you.

Payden Samuelsson from Bullinah Aboriginal Health Service.

MR SAMUELSSON: I'm the CEO of Bullinah Aboriginal Health Service. We're based in Ballina on Bundjalung country. Our service area covers from Byron Bay to the north, down to Evans Head in the south, across to sort of Wollongbar, and have some shared clients across with the service in Lismore as well, as people shift around a bit. Very similar to the other two services in the services we offer: a small maternity team, we're getting into the elder care support space and working towards moving into aged care a little bit more, we're still quite a new service.

We also have a couple of research projects that we participate in, which we see beneficial to community, one of those being birthing on country, at the moment, some workforce projects and some patient reported outcomes measured stuff. So same as many of us here, we get involved in research that's going to improve outcomes for community, range of allied health and visiting specialist services and a large project at the moment. We've got an infrastructure project going on which will allow us to expand our services quite soon.

MR MUSTON: Thank you.

Mark Burling from Wellington Aboriginal Corporation Health Service.

MR BURLING: I'm Mark Burling from Wellington Aboriginal Corporation Health Service. We also run Greater Western Sydney AMS as well, so and also we run Moree drug and alcohol rehab. So our services are quite - yeah, it's

large numbers. So everything from AFPP, ACTT, the aged care, two clinic tiers, allied health, drug and alcohol, dental - yes, we have it all and, you know, the footprint we have it is quite large. So I'm joining you from Mount Druitt today. So we have Mount Druitt, Penrith, Katoomba, Wellington, Dubbo and out to Moree.

MR MUSTON: Thank you.

Julie Tongs?

MS TONGS: Hi, everyone I'm Julie Tongs. I'm the CEO of Winnunga Nimmityjah Aboriginal Health Service here in Canberra. I've been the CEO now for 27 years and I'm coming from Ngunnawal, Ngambri and Wiradjuri country here in the ACT and surrounds.

We run a comprehensive primary healthcare service. We have seven doctors, four nurse practitioners, 16 nurses, 16 Aboriginal advocacy and support staff, we have an AFPP program, Australian Family Partnership Program, Connected Beginnings. We have midwives, allied health. We've got three psychologists, a psychiatrist two days a week, a site registrar five days a week. We do drug and alcohol. We provide - we can do the Buprenorphine injections, doctors prescribe methadone, we've got a needle and syringe program. We run a full-time clinic out of the prison here in Canberra, so we've got a 24/7 service for our men and women in the AMC here and so that's 365 days a year. We've been doing that since 2019. It's been very successful, lots of challenges but, yes, it's well worth it.

So, yes, we are a comprehensive - dieticians, but the struggle here in the ACT is with access to specialised services, but we can talk about that a bit more later, if that's okay.

MR MUSTON: Thank you. The transcript can probably note that there was a bit of nodding on the screen when Julie made reference to the challenges associated with the access to specialist services, which, I gather, means that's a common experience for many of you.

Dian Edwards?

MS EDWARDS: Hi, Dian Edwards. I manage Namatjira Haven drug and alcohol service for Aboriginal men 18 and over.

We've just celebrated 45 years. I've been in the service for 25. We work predominantly with men that self-refer into our centre, rather than mandated clients, and have a strong focus on working with complex health needs, so mental health, physical health. So a lot of men from the health system and referred through the health system come into our service.

We're currently really focusing on trying to get a women's service - women with children. There is absolutely no women and children's service in the state so we're working really hard on that at the moment. A lot of our focus and attention is on that. And we have a strong focus on culture, healing and culture rather than traditional medical models. That's us.

MR MUSTON: Thank you.

Christine Peckham from Peak Hill Aboriginal Medical Service.

MS PECKHAM: Hi, I'm Christine Peckham, CEO of the Peak Hill Aboriginal Medical Service. We're a small AMS. We've been going for coming on over 20 years anyway now. We rolled it out - we had no funding, we just had - we were able to secure our premises through the Ministry of Health and they still haven't handed it back to us.

But, yeah, we started off with one chair and four boxes of condoms and some help from the other AMSs. Then the Commonwealth decided to roll us out under the primary health care access program through Condobolin Aboriginal Health Service as an auspice, and then we were going to go to Dubbo, as being auspiced under them. That didn't happen, so we've been auspiced by the Weigelli Aboriginal drug and alcohol centre in Cowra for a long time now. And we also have been auspiced through the Wellington Aboriginal Medical Service for the Healthy For Life program when that rolled out.

So, you know, we've built up over the years. Like I said, when we got the keys we had nothing. Our board, you know, helped with assistance from other AMSs and through efforts of our own, built up to get - now we run primary healthcare clinics, we have a doctor three days a week, a doctor one day a weekend every month. We've recently commenced outreach clinics to Narromine. The

situation there was the GP practice was not - they stopped bulk-billing, so all the mob was turning up at the hospital, so we got together - they approached us and we got together with them and now we run a doctor clinic one day a week.

We also run allied health outreach to Narromine, podiatry and diabetics and diabetic education, which we also do here. So we do Healthy For Life, we do the health checks, healthy lifestyles, babies and kids health checks and chronic disease checks. We have an optometrist that comes at least every six weeks. We do otitis media screening from here. We do nutrition clinics with our dietitian and diabetic educator. We've just commenced our healthy ways program with a community group, mainly women, where we meet every fortnight and talk about a health issue, and we'll do a cook-up and just talk about what their priorities are, so we try to do that.

We run social, emotional wellbeing and ITC through some funding we secured from PHN. We also manage the ex Masonic hall, which is our learning and healing centre, and we have a lot of community activity there, all our health promotion activities there and the community just - a gathering place for them.

We support and advocate for women and the young people around our area. Our area includes Parkes LGA area, Peak Hill town itself, the three T towns, Tottenham, Tullamore and Trangie, and Narromine, which is in, you know, our mob's boundaries, which is the Bogan River, Wiradjuri mob.

We have medical health equipment here. We do nicotine replacement therapy and we do "check your wrist". Every few months, we'll go out on the street and set up and do a little check your wrist for anyone who wants to turn up.

We also make referrals to specialists, other allied health services, psychologists, psychiatrists, for mental health, pathology services, imaging services, et cetera. Pretty much the same as everyone else does.

We're staffed by myself, I have a full-time admin/receptionist person, Aboriginal health practitioner, ITC coordinator and our visiting health professionals including a podiatrist, optometrist and dietician, diabetic educator.

MR MUSTON: Thank you.

MS PECKHAM: That's us in a nutshell.

MR MUSTON: Finally, I think --

THE COMMISSIONER: I think Rosemary is listed at 2 o'clock but I can see her on screen.

MR MUSTON: Yes. So Rosemary Rose from Pius X Aboriginal Corporation was initially coming at 2 o'clock but is joining us this morning from Moree, I think.

Over to you, Rosemary.

MS ROSE: Sorry, about that. I got two messages, one saying 9.30 this morning and one saying 2 o'clock this afternoon, so I didn't know what to do.

MR MUSTON: You're welcome to join us.

MS ROSE: If you want I can come back this afternoon or I can stay. It's up to you.

Well, Pius X Aboriginal Corporation in Moree, where I'm on Gamilaroi country, we cover from womb to tomb. We have mums and bubs programs, we have GPs, nurses, mental health, drug and alcohol, homelessness, dental, and we do within a 100 kilometre radius of Moree, so we do Narrabri, Toomelah and Mungindi. Pretty much like everybody else. Yeah, that's us.

MR MUSTON: Thank you.

Could I start - before we get directly into the issues that we've got listed, it would be good to get a bit of a sense from each of you as to the extent to which you feel the services that you're able to offer with your current resources, when combined with services being delivered through the LHD and other sources, are actually meeting the health needs of your community in your respective areas.

Maybe starting with you, Julie Tongs, to what extent do you think that there is unmet need, if at all, from a health perspective for communities within your footprint?

THE COMMISSIONER: Just before you start, Julie, on that topic, perhaps if I could add, there are a number of things that have stuck in my mind from the discussions we've had with ACCHOs and AMSs, two I've already mentioned about, one, the centrality of your organisations to your community, and, two, issues relating to short-term funding. But the other two things that are stuck in my mind, one, Ed's just mentioned, and that is a common theme there is a growing gap between funding available and the demand for your services, which I think is the topic that Ed's introducing now.

The other would be, and I would be curious to hear from all of you about this, that sometimes there is a lack of autonomy in relation to the funding that's provided, and it seems to arise sometimes with PHNs, that you guys might have a different view about what services should be provided than what the funding is actually allocated for. So they are two big themes that have stuck with me.

Having said that, I've broken my rule that I shouldn't be setting the agenda. Ed's introduced this topic about whether the funding provided is really adequate for the demand that you now have, so over to you, Julie.

MS TONGS: Thank you. There is huge unmet need in our community. Canberra is a very middle class city or, you know, large country town, that doesn't see disadvantage. Twenty per cent of our clients come from New South Wales. That's why I'm here today. We get no funding from New South Wales.

I've spoken to every CEO and DG of ACT Health. Our hospital's a regional hospital, so people from New South Wales come in from other parts of New South Wales into the ACT. There is an agreement between ACT government and New South Wales for funding the services to the hospital, but never been an agreement for the services that Winnunga provides.

One of the biggest issues is poverty and we all know that, we all feel that. Also the "Closing the Gap" report that just came out was that Canberra's the most racist place in the country. So when you combine those two things, and we're talking about systems and services, there is huge unmet need.

We have people that are coming into Winnunga on a Monday morning or a Friday afternoon that are seriously ill, that need to go to the hospital, but they don't feel comfortable ringing an ambulance or actually going; they need validation from us to be able to do that. And you know, that just tells you how bad the system really is when people just don't have the confidence to actually pick up the phone and call an ambulance, because they could have died on their way to Winnunga. You know?

So we've got a hospital and a health system that's in crisis, and we all know that, but then that pushes that back on to our services that are the most underfunded in the whole country, you know? Like, we do what we do for $15 million a year.

We've just had an actual economist, Shane Houston, do work with us, and Robert Griew, who was a first assistant secretary of Commonwealth health years ago. They've just done a review of our services and we've got a $25 million gap - a $35 million gap. We're providing $35 million worth of services that are unfunded.

So, you know, even though we're a health service, we cross over into child protection, we cross over into, you know, court support, the prison system, all of those things, and we're not funded to do any of that, but it's the trust that our clients have in us - they want us at the table, you know, and we're not going to not be there, because our service is client-centric, it's all about them, you know?

So there's huge unmet need. I'm sick of the rhetoric of government, you know, around mental health and all this money going into mental health. My psychiatrist's been with us for 24 years, and that position's still not funded. So, you know, there is a lot of historical - a lot of our services have been funded historically, which only come with maybe 80 or even less, $80,000 or less. But, you know, then we're trying to manage, like - because the TIS, the Tackling Indigenous Smoking, and other programs come with a lot more money than we got historically. And so that's a challenge in itself because I don't like to pay one lot of staff more than what the others are getting. So when we get to workforce, that's one of the big issues.

THE COMMISSIONER: Julie, should we understand historical

funding to mean that the funding provided to you hasn't really - that the historical funding was at a particular level of demand for your services and the funding hasn't kept up with the growing demand so it's based --

MS TONGS: Yeah.

THE COMMISSIONER: So it's based on an inaccurate base or a base which doesn't represent the demand for services?

MS TONGS: No. And we get - you know, we're not funded, like, for our finance team or any of those positions in the administration. That all comes from our service delivery contracts. So, you know, the thing is that's a huge risk to our services. If you start to lose key people or funding, that then puts the service at risk. So, yeah, there's lots and lots of challenges and, you know, I'd be interested to hear what other mob have got to say, you know?

THE COMMISSIONER: Can I just ask - it may be important, probably is, but also I'd just like to know - the reference you made to the level of racism in Canberra, how does that, in particular, manifest itself? Can you give me some ideas about more specifically what you are talking about there from your own experience?

MS TONGS: Some of it's passive and other is just in your face, you know? And you get people to come in for meetings and straightaway, you know, like, you can tell by their body language and, you know, the way that they're looking around, they're looking at their watch, they're, you know, like, thinking, "We don't want to be here". You know that they don't want to be here.

But also, you know, when you ring up and you make an appointment or you've got to ring an external service and you say you're from Winnunga, straightaway, there's a deafening silence, you know, like. But even so many of our public servants, young and older, they just want to get out of the public service because it's so bad for them that, you know, their mental health is suffering and this is what happens, you know? Like, all of that stress plays out on your body, you know? And so it doesn't just do psychological damage, it actually does - that then creates physical issues and chronic disease and all sorts of other issues.

So, you know, it's a real challenge and, you know, ACT, 60 per cent voted yes, but, you know, the Productivity Commission report and the "Closing the Gap" said, you know, 76 per cent of the ACT Aboriginal community complained about the racism back in a six-month period in 2022, and that was the lead-up to The Voice. So - yeah.

THE COMMISSIONER: Okay.

MR MUSTON: Who would like to go next in terms of talking about the extent of any unmet need and perhaps telling us a little bit about the particular areas that are unmet in your area?

Christine, I see you have put your hand up. You are on mute.

MS PECKHAM: Yep. Our unmet need, like I said, we're a small organisation but we've grown over the years to the extent that we're providing services to our mob in the smaller towns around - and I mentioned Narromine.

Now, when we rolled out with Commonwealth funding - and by the way, we don't get any funding from New South Wales for any of our positions or, you know, anything. We've got a couple of one-off, and we have got some funding to upgrade our building, "thanks, Phil and Jerry", but other than that, we've had no funding whatsoever.

We've got three days a week for a doctor, and one weekend, a Friday and a Saturday, for another doctor that comes in, just to Peak Hill, and we've been operating like this for quite a number of years now. Luckily, we haven't got a high turnover with our health professional staff. Our nurse is local, our Aboriginal health worker is local, and I'm local, know all the mob, know all the family. So, you know, we know what the priorities of the community are.

You mentioned - you know, we do get some funding but sometimes it doesn't - through PHN, it doesn't meet our priorities of our mob, so we, you know, try to work around that and be as flexible as we can within all the guidelines for us. We'd just like to have - to come out of being auspiced by a drug and alcohol service, which is over, like, 150Ks away, 160Ks away, and for one program, through another AMS. All the feedback we get is, "Oh, we're doing

fine", you know, "Youse are a small organisation." We don't get any - we rolled out without a full complement of staff, like other AMSs have, and recent ones. So I guess, you know, they think we're - we are doing fine. We think we're doing fine, our mob think we're doing fine, but otherwise I wouldn't be coming here.

But our issues in regards to gaps is we don't have any specialist services coming in, they have to be referred away. We have 18 hours of transport that we transport people to Orange, Dubbo and Parkes. If they have to go to Sydney, we have to get endorsement by our board.

So then the issues there are we send people to hospitals, especially Dubbo hospital, and within an hour or two hours, they're being discharged. We don't know what happened there, or they've been sitting around waiting.

We had an incident the other day that, you know, a young girl was waiting all morning, all morning, lying in a chair in pain and she didn't get seen until another member of our staff happened to be in the hospital and went and asked, "What's going on with this girl?"

Now, we just can't have that. We're tired of our mob going over there having to sit around for hours upon hours without being seen. All the paperwork, everything's in place before they leave here. They get over there and then, all of a sudden, they have to wait, wait, wait, wait and get triaged. They already know what's going, or the health professional they've seen - we've talked to and arranged everything, all of a sudden, they've gone off duty.

So we've had little kids, you know, families, making their way, scratching for petrol money, to get over there and they have to wait, wait, wait. No feed, you know, no drink, and they're just all, you know, coming around the ED over there. Frankly, I think, you know, all they want to do is give them Panadol and send them home and we know what happened a few times when that's happened. So, you know, there's a big gap there.

Specialist services, they have to be referred and we have to, more or less, transport our patients to those services.

Julie mentioned racism and you just walk into the hospitals around, you know, country New South Wales, and you can just feel it. Yep.

MR MUSTON: In terms of the GP service that you're offering three days a week and once on a weekend, what's the waiting list to get an appointment with a GP?

MS PECKHAM: About three weeks at the moment.

MR MUSTON: And for people who present that have more urgent need for care, how do you manage that situation?

MS PECKHAM: Yeah. When the doctors aren't here and they need to be, you know, seen, you know, they obviously need to see someone, we refer them up to the doctor, to the hospital, or they will go out of town to a GP.

THE COMMISSIONER: Christine, that three-week wait list, one of the things we were consistently told is that wait lists for GP-led primary care have gradually been getting longer. That three-week period, is that because of the number of people, clients on your books, has that been something that has been growing in terms of the amount of time people have to wait?

MS PECKHAM: Yes, and they're, you know, going off and doing all their tests and, you know, being really compliant about all that. Then, you know, there might be something that comes back that's really urgent so we have to get that person in ASAP, and you know, we do a lot of - even though the doctors are only present those three days, we are able to contact them when there's something urgent come in, but it's, you know, the follow-up, we do the health checks and everything, their follow-up. There's, you know, the GP management plans that have to be done, so that takes up time as well. So, you know, it's - and they're very complex conditions a lot of our mob have out here, you know, because they haven't been to a GP for years.

Some of the younger families, they don't even like taking their kids up to mainstream GPs. So, you know, they will just wait and suffer. So we try and do as - you know, we're always there to try and do as much as we can for them. But, yeah, the wait list is growing. We're not getting any further funding to get more doctor hours or nurse hours. Our nurse is only part time as well. So

she's only here three days a week.

MR MUSTON: Mark Burling, I think I saw you give the thumbs-up sign when Christine was telling us about some of the challenges with patients who present at the hospital. Is that consistent with experience you have had?

MR BURLING: Yes, absolutely. Especially, you know, obviously Wellington, you know, Wellington's only a very small place, but in particular, Mount Druitt, we've got the largest population of Aboriginal people in Western Sydney, and that is a massive problem. They just don't trust them. They don't want to walk in there. They do not feel comfortable at all. And, you know, like some of the ladies have said previously, and other people, they're more likely, it doesn't matter how sick they are, to walk into our service than call 000 or go to the hospital, and that's extremely, extremely concerning.

THE COMMISSIONER: What could we do about that? What should be done about that?

MR BURLING: Well, in my personal opinion, like, just in my communities and stuff like that, there needs to be a lot more work done, you know, in trust and things like that. But one of the biggest things that we hear in some of our communities, especially in Sydney, is LHDs and things like that, they seem to be, I suppose, trying to mimic our services as well, and the community hate it. They absolutely hate it.

You know, with funding and things like that, you know, I think Julie brought up a really good point. So let's say they're funded $15 million for their service, we have six services, we're funded 21 million. That is not enough. And this is why, you know, we're seeing these problems, but what you guys can do about it, yeah, you know.

Specialists? We don't have any specialists, it's - you know, and we're at Mount Druitt, Penrith, all of that, Wellington, Dubbo, we can't get anything. It's just, you know, we're in some of the hardest places in New South Wales to be in and we can't obtain funding.

MR MUSTON: Payden, you put your hand up but I've also noticed you've been nodding throughout that. Is that consistent with your experience?

MR SAMUELSSON: Yeah, look, there's just a couple of - to touch on a couple of points that colleagues have made here. The racism and the way it manifests for us in our community is often in - it turns out to be a negative sort of connotation throughout our community because it turns up in people who discharge against advice or don't wait for service at emergency, and we see that quite often.

From the perspective of what can be done about it, we've trialled a couple of projects with the LHD in the area, where sometimes it's as easy as a phone call to us from the team that's on the ground at the hospital and we can support. So we did a trial of that with 100 clients registered and across a three-month period, only one per cent discharged against advice, where, before that, it was almost 50 per cent.

But it's really hard now that that project is over to get that to flow as common hospital practice, to give us a call when one of our clients are in there. And then I guess the thing with that as well, if we were to scale that up, that was not necessarily a funded project either. So that's the other thing to consider if we wanted to scale that, would be to have workforce on each end, so workforce in the hospital, in the LHD, and dedicated workforce in each AMS who could manage that integration between the public health system and the ACCHO sector. We found that as simple as a phone call, sometimes, that's been a key thing.

MR MUSTON: Just on that one, have you found, after that project has come to an end, do you know whether the discharges against advice have gone back up again or "did not wait" is another piece of terminology we've heard referred to in that space?

MR SAMUELSSON: Yes, so outside of the project, they're sort of back to normal. The staff that were involved in the project at the LHD side have moved on as well, so we don't even have that sort of resource that's still trying to work on it. We've got - the Aboriginal health director at the LHD is working on trying to get funding, but, you know, like many LHDs in many of our areas, the budgets for them are sort of overblown as well.

We're often in this space now where we talk about the

acute care that we do also, we have the same situation. We have a pod village out of at Wardell, after the floods, that's been in place for two years now and is likely to be another three years, of people displaced after floods. We have a clinic out there which is 80 per cent self-funded by the self-generated revenue that we bring in.

No-one in that whole community of 300 people will go to the hospital. They will wait for us, the two days a week that we are there, to come and seek medical care. That often means, you know, we have a GP that is trying to do some proactive chronic disease management and social care, but gets wrapped up for the first half of their day trying to treat emergency cases that come through, get them to hospital, to often then either discharge against advice or be released with no discharge information or no communication, and then we repeat that the next time they show up in sort of two to three weeks' time.

Back on the funding and the sort of funding versus demand, one of the key things that we see - you know, our footprint covers from Byron to Evans Head. We have a small service in Ballina. We're funded for the number of people who are currently coming through our doors as regular clients, so we have 1,600 regular clients; whereas our footprint is about 4,500 people. So there's really no way for us to, effectively, you know, proactively engage with people to do good comprehensive primary health care outside of those people who are already coming to our door.

That often results in, you know, people will make it to us in emergency situations or they will turn up at ED, be discharged and go through this cycle, whereas it's sort of been shown, I think there's many studies and sort of anecdotally as well, if we can effectively work - like, the clients that are coming through our doors and we're able to effectively work with, we keep them out of hospital, saves the health system, I think it is about $5,000 for every admission. So every time we prevent someone from coming in we're saving the health system money. And I've seen studies that show the sort of, I guess, efficiency for us, the care that we provide is about 25 per cent of the cost that the public health system can provide for Aboriginal or Torres Strait Islander people.

But yes, so it's something - I know there is going to be a submission going to the federal government sort of in

the next few months, I've been doing some work on a national committee there, around that, how we address the population health rather than the people who are just coming through the doors.

The other thing also, like, I guess Julie mentioned, with the amount of work that we do that we're not funded for. I think 33 per cent of our wages are self-generated. For example, our core funding under the IHP program is about $1.2 million. Our GP wages bill is 1.4. So outside of the GPs, if we weren't able to generate that Medicare and weren't doing really well with that, we wouldn't have a GP service, or we would have a much smaller service.

So I think many of our services, they all look slightly different because we're trying to do bits and pieces. Like if you go out west - I used to work for the AMS in Bourke. Self-generating a GP wage wasn't possible because you couldn't get GPs out there, and because the GPs were sporadic, keeping the books full sometimes was hard unless there were emergency situations.

I think it's great that this Commission exists because it is a complex issue, and yeah, a lot of our services are relying on business models where many bulk-billing practices are going under, so for us, we've had to do a GP wage review to be competitive with the private GP practices, but we're sort of reviewing this every six months to see if we can afford to keep our GPs on. It's becoming more and more perilous, particularly as the Medicare environment and cost of living gets worse, because all of our costs are going up as well and funding often doesn't come up to meet it.

I'll stop talking in a moment. But the other key thing someone mentioned was around the administration side of our organisations. This is something we've been talking about across the sector in - you know, we get an allocation of funding to provide these clinical services for community, for the health services, and the funding often isn't enough to meet that need, but then we also have to run the organisation on the back end of it as well.

And we do similar things, we have to take admin fees from 14 other programs that we're doing, getting individual funding for, to make up our small team. We've got one CEO, one finance manager, and sort of 0.8 FTE operations

manager, to run our entire organisation - of, I think, 60 head count, 40 FTE.

So we are all sort of working to the point of burnout, which then will bring the workforce issue in. Because none of our services can have enough staff to do all of the stuff that community expects from us, because they don't just expect us to do primary health care; they expect us to be the key point of call for every service that exists in our area.

MR MUSTON: Just on that, while that's a demand on the service, it's also, presumably, a really great benefit that the service can offer as a point of coordination for all of these other areas of need that people have, which, are often very, very difficult to navigate at the best of times, particularly if you are in a state of stress or crisis.

MR SAMUELSSON: That definitely is a benefit that we're happy to offer, but the thing is, when you've got that big gap in funding, so we've got nurses who are helping people with aged care packages and these sorts of things, where there's other, I guess, organisations in areas that due to cultural safety issues our clients won't access. So there's someone else getting funding to support them through it, but we've got staff burning out to support them through it.

I think that's the key; the key problem with all of our services - I think we will agree - is that we definitely do - we're community controlled, we want to do everything we can for community, but we have a workforce that's going to burn out if we don't get adequately funded for it. And then if our services don't exist, like, for us, there's 2,000 people who will go into the public system and either not get service or, you know, will have this issue of the public system being overrun.

MR MUSTON: Just on that, whilst your service is not funded to provide a bureaucracy navigation service, for want of a better phrase, to the extent you're providing it, do you see, even just from a health perspective, the benefits of the service that you are providing, and can you give us some examples of the way in which helping with that navigation is actually producing positive benefits for your community, even just from a health perspective?

MR SAMUELSSON: Yes, definitely. There's a couple that pop to mind, just purely from the clinical perspective. Some of this extra work in, you know, navigating some of these issues makes us really aware of them, so we can then advocate on behalf of community for certain services.

Some of the things we've been able to do are - you know, without the public system and many of our public systems, the specialist support, particularly for ENT for us, you know, we've got kids going through school with hearing issues identified and three years before they can get a service that is key for them to learn.

We had enough advocacy for community that we started to reach out to our private hospitals and other potential funding agencies to say, "Look, we can't get people through the public system. Can we work with the private hospital and try to get a little bit of money from here to pay for private surgery for these kids?" We've been able to do that for three years running now, to get 20 kids through private surgery that otherwise would be waiting, you know, two to three years, have learning difficulties, which then, down the track, leads to incarceration, all sorts of different issues. So there's those key ones.

Another big one that we're quite happy to take on and are not quite funded for is support for our clients to get on to NDIS. NDIS is great for our clients once they have a package and someone will look at them. If they don't have a package and they can't get on to it, there's a massive sort of discrepancy between what services you can get.

When we started doing this, we came across a bit of a case study where, you know, there were these two equivalent clients, one client, very, very good means, really good income, same disability as a client who was one of our clients, didn't have employment, had a number of other kids living with disabilities. It's the same exact condition, just different means. Their package on NDIS was $400,000 difference to the favour of the person who had much better means because they could get support to get on to the NDIS and have, you know, someone professionally writing that up for them.

We use one of our receptionists who has had some

experience in NDIS to support - I think she has supported about 40 clients now on to the NDIS, where there's no sort of funded service anymore that will help people get from the point of needing NDIS on to a package.

Once the package is there, it sort of runs okay, if you get a good support coordinator, which is also rare, and our receptionist monitors that for clients as well. So that's another one of those big gaps, where - I would say, you know, this receptionist is one FTE. There's probably 0.4FTE where she's doing NDIS support sort of work that we can't get - like, we're an NDIS provider but we can't get billable hours for it, but she's happy to do it and we're happy to support her to do it because it means our clients are getting on to NDIS.

That's two examples. There's a few in the out of home care space as well, where we're proactively now - we have one of our GPs, our social worker and our child maternal health nurse who now sit on bi-weekly meetings with DCJ, basically to prevent unnecessary removals.

It used to be that we would get a phone call to say, "We're about to remove this child. We know they're your client. Can you come and support", and we would have to turn around and say, "No, we've been engaging with this person, they've been getting services for the child, there is no medical neglect", we're trying to reverse a decision that's already been made.

So now we've got a GP who's paid 160 bucks an hour, a social worker $65 an hour and a nurse $65 an hour, that we're putting on to these child at risk meetings with DCJ and the LHD. We're not funded to do that, but it's another thing that really has good outcomes.

And a lot of the other things is, we are consulted a lot. The LHD will be rolling out the Aboriginal mental health implementation plan or other health plans and we will be on the committees, either meeting quarterly for four hours at a time, some meeting fortnightly, you know, others more ad hoc, and we're doing a lot of this sort of consultation to benefit community and being a part of all these committees that help these services run better for Aboriginal people.

But again, the services don't fund us to be part of

that. That's us taking people off the floor and putting them into these committees so we can make sure community gets benefit from them, and, unfortunately, sometimes it's so those committees can tick a box as well.

That's the piece that's really, in addition to the admin side of running the organisations, when you're looking at the funding - those sort of partnerships and policy support and development in that broader system, consultation is one - I know services in our area we talk about quite a lot. The amount of time and work it takes for no - I guess there's no incentive. There is incentive to support community, but from a business perspective, if we were running purely as a business, it would be hard to justify.

So, yes, I'll stop there just in case you have any more questions because I'm acknowledging I've been talking quite a bit.

MR MUSTON: Isaac, you had your hand up a while ago, and I can see, Rosemary, you are next.

MR SIMON: Yeah, definitely, thanks for that. I think everyone's - as the conversation's gone longer and longer, everyone's pretty much described our service as well, in a nutshell, and some of the pressure points that we have.

I think we've just got some real practical examples about what, say, Julie was talking about with the professional racism.

A couple of weeks ago we - we often book brokerage, appointments for specialists, which we're not funded for and we just pay for out of our own pocket. One of our clients had an appointment with an ophthalmologist and they were told that they would only be paying the gap fee. Then when they found out that, actually, no, we needed a purchase order so that Tobwabba would pay for this, all of a sudden, the fee went from a few hundred dollars to about $1,400 or $1,600, because they assume that Aboriginal people get all of this money.

For us, that conversation, when we went back to them and had that conversation, it was really difficult for them to actually see that we don't have all this money. So we were forced to pay the full fee which was, you know, over

$1,000, as opposed to paying a couple of hundred dollars, which would normally be paid from a low socioeconomic client. So those are constant issues that we have.

We've also got issues with regards to us providing our own cultural advice. We've received some funding previously from regional New South Wales, where we were actually provided some funding to hire a private firm to help us do a business case and submission for a project, and an aspect of that funding was to get some cultural advice and support to make sure that the submission was culturally appropriate.

Now, our service is made up of about 70 per cent traditional owners, all professionals that work in the field and have worked in our field for decades. So when we said to regional New South Wales, "Actually, look, we'll take that section of the funding and we'll allocate staff to be able to deliver that cultural advice, as opposed to the private organisation providing somebody from Sydney to provide cultural advice on our local issues", they actually rejected that and they told us that, "Oh, no, we won't give you that, because you can just fund that in-house." Whereas if we said we would accept the person from Sydney, they would have funded it. So we've got those types of issues in terms of professional racism.

Then we've also got the issue of competition with the private practice. So where we're located, similar to Payden, it's a bit of a - because it's by the water, we're kind of known as the Northern Beaches playground, where everyone from the Northern Beaches of Sydney comes up here and has holidays every year and it's quite - you know, it swells to become quite an affluent place during those times.

So when we get doctors and the like coming to work in the area, we're often hit with these exorbitant expectations of what they should be paid, and because of our model as a bulk-billing service, we're unable to compete. So we've got a service which is just down the road, probably about 400 metres down the road, Forster Tuncurry medical service, and they are advertising that they're paying their doctors between, you know, $350 and $600 an hour.

Now, I know everybody in this room knows exactly how

Medicare works. Under a bulk-billing arrangement, there is no way in the world that you can pay around $300 an hour and deliver quality holistic health care for Aboriginal clients and patients. So for us, you're going into the red just to compete, and then there's unnecessary pressure to service and deliver your clients in an affordable way.

So that's something where you - where we really struggle to keep up and to, you know, hold. We've got a number of doctors who live in our town who say, "I absolutely loved my time working at Tobwabba, I wish I could continue to work there, but we just simply can't afford to." You know, they can get paid far, far more working in private practice, where they get a share of their revenue and they're obviously charging privately and all of that type of stuff. So by default, we're unable to keep up with the current market and that's just the way that we're set up as AMSs.

We're also the heartbeat of the community, as was said earlier, where we don't just do the primary health care or the social, emotional wellbeing or the, you know, DV support and all of that type of stuff that we're funded to do.

There's often gaps where, you know, it might be late on a Friday and a DV client comes in and they need emergency accommodation. We're not funded to deliver that emergency accommodation. However, somebody like, you know, Samaritans or somebody like that, who are funded to deliver that, they're not available or they can't find something for a few days. So we've got an obligation to our community, and because our service is actually based on an Aboriginal community, where there's 43 houses on the community which are, you know, within 50 to 100 metres of our service, we've got an obligation to ensure that our patients are safe until the adequately funded service can provide for our patients. So we're often, again, out of our own pocket, having to pay for these services with no reimbursements.

The services that we do provide in the community, we believe they're far superior to any other services that are provided, which is why we're constantly getting mainstream people coming to our service, trying to get in and be a part of our service, so much so that during the COVID era of lock-downs, there was actually an outbreak in Forster

and Tobwabba was responsible for shutting down houses. So we actively locked down 20 - I think it was, don't quote me, 22 to 25 houses, not all Aboriginal, but we were also the first point of call for testing and contact tracing for the mainstream population.

When it first hit, I remember - and Leeann, my practice manager is here as well - we probably tested - and this is at the height of the COVID lockdown - we probably tested maybe about a couple of thousand people straight up, in a period of a day and a half, or so, and that was off our own back.

The reason why we did it was because all of the other services, including all the pathology services, said, "Unfortunately, it's a public holiday and we're closed, we can't do anything". So it was our responsibility to do that and to lock down the houses.

Then we had to actually provide the food security for the areas, and you find the other issues of no connectivity with internet or phone credit, all that type of stuff, so when you look at an AMS, it's not just: hey, we've got an Aboriginal health practitioner who's doing a 715 with the doctor, and there's a baby that's been born so we've got our maternity team and, you know, we're doing a NOFASD or a strong bubs kind of initiative; we're providing real, hard-core health care out there which is unfunded and it's not sustainable for our communities to provide.

So, yeah, look, they're the main things that I just wanted to add as well as the population. Obviously it's all good and well to say, "Hey, this is your population, this is how much we're going to fund you", but when you have large transient populations, just like everyone else, Aboriginal people like to move and they like to go around, probably a lot more so, we often get new patients who are transient coming in and coming out, and then that changes our priorities and our trends in terms of the health care needs.

When we plan annually and we put in our - you know, in our IHP planning and all of those types of things, what our spotlight topics or our health initiatives are for the year, it's all dependent on what's happening at the community at the time. So often that changes, and it's very agile in Aboriginal communities.

You know, you might have no suicides and, all of a sudden, you've had three or four in the space of a week, and things like that. You might have no - very low problems with domestic violence in February, March, then, all of a sudden, coming up to June there are heaps and then your priorities change.

We often receive funding from people like the PHN where the funding's adequate for that topic, but we're so underfunded from a different topic which has just emerged that the funding's not flexible enough to accurately service our communities and to ensure that we're keeping our community healthy. That, in turn, leads to members of the corporation saying, "Hang on a second, I'm reading that you got X amount of million dollars and you underspent in this area, but we've got all these people that are homeless here and all of these people that need drug and alcohol issues and why are you only funded, you know, a couple of dollars for that?" So the portability and the flexibility of funding to go to the areas that are truly needed, that just isn't there. So you find that there's huge overspend in one area and massive underspend in another area.

MR MUSTON: Just in relation to that, have you found you've been able to have discussions with the PHN or other funding sources which have resulted in that funding being freed up or made more flexible to meet the needs that you are actually seeing on the ground, say? To put it another way, you've got some funding for a particular program which at one point might have been a good program but, due to the emerging health needs, you have come to the view, based on your local knowledge, that this is actually a different program or a different form of care that would be a much better spend of the money - have you found that you have had any luck in engaging with funding sources to have them change any of those restrictions on the use of the money?

MR SIMON: Yeah, look, I think it's all dependent on who your PHN CEO is and also the relationship that you have with them, and also our relationship with other AMSs.

To answer your question, we have had some luck in some of our programs on a small scale, but where we have had a lot more luck is working with our partner AMSs in other areas saying, "Hey, look, we've got a real issue here and we know that you guys have got funding, is it all right if

we put some of our participants in there?" So we're actually doing that, as we speak, for some of our clients that don't engage with the service where they should be engaging, because they've got various issues. We say, "Okay, look", to other AMSs, "would you like to put a couple of people from your AMS on this program and this project as well, and can we get some help and put some people on your program in that area in which we don't have funding?"

So I think we get more support from each other, whereas with people like the PHN, as good as they are, they're kind of a bit hamstrung with their reporting obligations to the federal government as well. So, yeah, it is a difficult question to answer. So yes and no is the answer, I suppose.

MR MUSTON: Thank you.

Rosemary, you have patiently been waiting with your hand up.

MS ROSE: Finally got it. Yeah, look, I agree with everybody. I just want to come back to the racism at the local health district, our hospital. It is disgusting, it is rife. I run out of adjectives. Our clients go to the hospital. Now, I used to work - I'm a nurse manager, so I used to work at the hospital as well, in ED, so I know about triage and I know what should be seen as soon as possible.

We've had chest pains turned away from that hospital and they have come to us. Yesterday we had a child turned away from the hospital, who turned up here, and I'm going to have to use medical terminology to get the word across, but this child - well, maybe not - was having trouble breathing and the child was flat. It should have been dealt with in the emergency department. We are not equipped to deal with these children or the adults that are turned away. We are a clinic, but we end up dealing with them and the community is getting very frustrated with the hospital.

I myself am getting frustrated because I cannot address the needs of the community. Our resources are extremely limited. We have three doctors, a population of 5,000 plus on our books at the moment. We've had to close

our books. We too are the only bulk-billing service in the area. And another thing with the local health district, we don't have a problem getting specialists, but that's only because it's not what we know, it's who we know, we've used. We've become very good at using our relationships with other people, or experts in manipulation, I don't know, but we don't pay a lot of our specialists. They just take their Medicare revenue and --

MR MUSTON: Do you have a bit of an example of how those sorts of arrangements work in your community?

MS ROSE: In specialist-wise?

MR MUSTON: Yes.

MS ROSE: All right. So we had a Dr Campion used to work here, and his son is a gynaecologist in Sydney. He was in America and when he came back, we heard he was back, so we approached him and, out of the kindness of his heart, he now provides a service to Moree.

The same with the ENTs. Because we were a Catholic organisation, we approached the Daughters of Charity at St Vincent's Hospital and they got the ENTs to come to Pius, but we pay for everything out of our little, little budget, $4 million. Yes, so that's how we do it.

But some of our other specialists now are getting - are demanding that they be paid, and one wants, what is it, $220 an hour, $244.70 an hour. We can't afford that, but we need the service and our community needs the service. I hope that answered your question.

MR MUSTON: Yes. Sorry, I distracted you.

MS ROSE: Yeah. So COVID had a big impact on us as well as every other AMS in Australia, and we are still the only service providing COVID testing in this area. But apart from that, a lot of our specialists dropped off and our - we had access to theatre time at the local hospital for our ENTs and our ophthalmologists. Well, that has now dropped off and our ENTs have not been able to get back on to the operating list at the Moree hospital. So that has blown out. The waiting list for grommets, tonsillectomies and adenoidectomies, has blown out to three years, and that's Newcastle, John Hunter. Three-year waiting list. And some

of these children are actually growing out of the tonsillitis and out of the grommets because the waiting list is so long.

Ophthalmology, the waiting list, we only have four visits a year now, four lists, and we didn't have ophthalmologists for two years. We now have visiting ophthalmologists from the Sydney Eye Hospital thanks to Gerard Sutton, but we can't get them on the operating list at Moree either. They just - it's like we hit a brick wall.

The ophthalmologists have even said they will bring up an anaesthetist from Sydney, but we just can't get theatre time. So we've started looking at getting a cube, which is - we'd have to knock walls out of some of our rooms here and put a cube in, and in a cube, we could do our own theatre, our own cataracts. Hang on, I've got it here somewhere. I think it's 36 people on the waiting list for cataracts, and I can tell you, one person yesterday got a letter from the Department of Transport, he now cannot drive because his cataracts are that bad. I rang the local hospital to find out where he was on the list and they said, "Oh, he won't get seen until after April next year", and he's been on the list since February.

THE COMMISSIONER: Rosemary --

MS ROSE: We've got a solution, we don't have the money to buy the cube. We've got the building, we could put the cube in it. Yeah, we've got a solution but we don't have the funding, and the LHD, they just - we've been on and on at the LHD for two years and we can't get anywhere. Yeah.

THE COMMISSIONER: Rosemary, sorry to interrupt, just a couple of things to clarify. We were actually at John Hunter Hospital very recently, and the clinicians themselves were telling us about, well, between two- to five-year wait lists for certain paediatric services, which is consistent with what you've just told us.

MS ROSE: Yeah.

THE COMMISSIONER: But I just want to confirm, the issues at the hospital with the patient with chest pains and the child with breathing issues, that was Moree hospital, I assume you were talking about?

MS ROSE: Yes.

THE COMMISSIONER: And I'm going to assume the answer is no, but please tell me if I'm wrong: is there an Aboriginal liaison person employed at the hospital?

MS ROSE: Yes, but you never see her because she is busy with the inpatients at the hospital.

THE COMMISSIONER: Yes. That issue has been raised with us about often the hospitals have Aboriginal liaison people but they might be employed nine to five, which is no good for anyone that's an Aboriginal person coming in beyond 5 o'clock. Okay. I just wanted to clarify those things.

Sorry, also, the discussions you were talking about with - you say you've been on and on with the LHD for two years and can't get anywhere. First of all, that is Hunter New England LHD?

MS ROSE: Yes.

THE COMMISSIONER: And what have the discussions involved in particular?

MS ROSE: We've asked the general manager, David Quirk, on several occasions to put the ENTs and the ophthalmologists back on the list and there's been no action whatsoever. We've had meetings with the LHD every year - every month, sorry, and they've been cancelled every month for the last two years.

THE COMMISSIONER: But what's the reason given to you for that?

MS ROSE: They don't give a reason. They just cancel it. We're second-class citizens. We don't matter. Sorry.

I had a link-up a few weeks ago. They've put a new - my CEO has just walked in. Do you want to talk Donna? I will tell you - so Raylene Gordon, who has just been put in as the new Aboriginal health at Newcastle, and we organised, all of us together, we organised a meeting with the LHD and David Quirk was there and Raylene is like a breath of fresh air, but he promised - now, that was in September, and he promised he would look into it, but we

still haven't heard anything back and neither has Raylene.

THE COMMISSIONER: Okay. There are a few hands up at the moment.

MR MUSTON: I think Julie, you were the next to put up your hand.

MS TONGS: Yeah, I just wanted to pick up on what Isaac said about funding, and the funding and reporting. We report 100 times a year. We do 100 reports a year to the government, every year, you know, and that's just because of the way the funding is, you get funded for two social and emotional wellbeing workers, two drug and alcohol workers or one mental health, you know, like? And you've got all these funding and reporting requirements

But the work that I said that we were doing there around our economic position here is that I'm always saying to the government, you know, like, "I've been through so many red tape reviews since I've been here at Winnunga and all we get is more red tape", and they said, "But they're looking for different new ways of doing business".

So, you know, that's what we're doing, we're building a case to go to the government to get global funding that actually fits with the priorities of our service, rather than what they want to give us and what we need to report. A lot of the reporting is a waste of time because they don't even look at the data. We're collecting data for the sake of collecting data. It's not meaningful and it's not useful.

They don't look at it, you know, because they're ringing us up asking us a question. If they read the reports that we do for them, then they would know our position. So I think, you know, that's a real challenge, and I think while ever they're just - and this is why you get an underspend in one area and an overspend or whatever in another area, because of that flexibility or the lack of flexibility in funding. So, you know, watch this space.

If we can do it here and we can - you know, we'll take the government on because they say that they want a new way of doing business, well, this is a new way of doing business and we'll see where it takes us. So, you know, it's not going to be an easy road, but absolutely we'll get

there.

But I also absolutely agree with Rosemary, you know, like the challenges that we have and the attitudes towards us, you know, I've had doctors in meetings with me, you know, from universities saying, "Oh, well, it would be fair to say that you've been assimilated here in the ACT", and things like that, you know, like, and these are educated people talking like that. So these are the sorts of things that we live with and put up with on a daily basis. But nobody wants to listen.

And when it comes to racism, it's not our problem. We're not the ones - it's theirs, you know? They need to address it. The governments need to address it. It's not our problem. So until they start to address it, acknowledge it to start with, then we might be able to try and move forward, but I just think I've never seen it this bad in our community, and then it's created a lot of lateral violence as well.

So, you know, that's another challenge and that's another thing that the service has to deal with, you know. Everything just falls back on us all of the time, because nobody else is out there to pick it up.

And the same deal with domestic violence. We don't get funded to run a domestic violence crisis service, but at the end of the day, we're the ones that are putting women in safe houses. We don't get funded to do it. We'll have to put them in a motel or somewhere over the weekend, men and women - men that have come out of gaol that have got nowhere to go, you know? So it costs us money but, you know, if we weren't here, our mob would be dying on the street, and I know that for sure, you know? But until governments start to listen - well, they listen but they don't hear what we've got to say and that's the sad part about it.

MR MUSTON: You mentioned that the racism was leading to lateral violence which created a range of challenges for your organisation. Could you explain to us in a little bit of detail just what you had in mind in terms of that cycle?

MS TONGS: Well I think, you know, like, just - we'll use the constitutional changes and The Voice as a - you know,

we had families turning on one another. Some families were yes, others were strong nos, you know? And so then you've got families turning on one another, you've got community members turning on each other, and what it's done is created a huge - well, it's created a lot of anxiety and psychological distress and, you know, the abuse on Facebook and all of those things, you know?

As Winnunga, we stayed out of that debate, because we're a health service. We're here to provide services regardless of how people voted or what associations they've got. You know? The thing is that sometimes people will say, "Oh, yeah, but you're working with that perpetrator". Hello? We're a health service. We work with people that come through the door. We're not here to make judgments. We're here to provide a service, you know? So all of that stuff starts to spin around and, at the moment, it's really, really bad.

MR MUSTON: Thank you for that.

Dian, I think you've been wanting to say something but, like me, struggled to find the hand-up button.

MS EDWARDS: Yes, thank you. I had no idea how to turn that little hand-up button on.

I've been listening to everyone and us not being an AMS, it's really good to hear the perspective from the AMSs, because we sit here going, "Why aren't the AMSs doing this?" "Why aren't they doing that?" You know, a few points from me are like the waiting lists in AMSs for clients has just really impacted our services, you know? We can't - when someone rings up for help, you know, I want them to go to a drug and alcohol worker in an AMS, you know, and obviously they can't get in for weeks. Now, increasingly, we haven't got drug and alcohol workers in our area - we used to have drug and alcohol staff at AMSs. And I believe, what I've been told, is that the way the funding works for AMSs doesn't fund drug and alcohol workers because they can't claim Medicare on drug and alcohol workers.

So I just wanted to raise the point that something needs to change for Medicare funding for drug and alcohol workers, so that they can be employed in our communities, and that workforce could then grow. We've got no workforce

for drug and alcohol workers at all. We haven't had training in our region. We're the far north coast. We haven't had training for drug and alcohol for years and years and years since the NDIS popped up and all the training moved towards community service training.

We're being pushed towards resolving workforce issues with having peer workers, and that might be great for clients to be able to work with people that have a lived experience, but those workers, unless they've got direct care and supervision and support by qualified staff, do not last long and they're actually impacted and harmed and also that can cause harm then with clients.

We have, like others here, increased burden, administration burden, on our services, for compliance. So things like cybersecurity, you know, no funding for that. No funding for accreditation. Our service, because it is not an AMS, we haven't had to use the same sort of accreditation services that a clinical service would have to use, so we've used something we could afford, only because we're not funded for it, and that's ISO accreditation.

Now, I can't get funding through NSW Health, because I don't have the type of accreditation that they want. So our funding from NSW Health is only $100,000 a year and that's for two Merit beds. That doesn't even pay for one bed, that money.

The costs of everything has gone up so much, our clinical staff has shrunk and our admin staff has had to grow to be able to respond to the reporting and compliance of funding bodies. We've got five different funding bodies, but you guys have some, the same, or more, between Commonwealth and New South Wales.

They are moving more towards portals. We've all got to, you know, report in different ways with different KPIs. There was just a review done fairly recently in research, of which we also have to engage ourselves in. Any research, that our funding bodies actually push us to do, we have to do this, and that last lot of research for KPIs actually increased our KPIs. So that was really terrific.

So I was actually, in part, responsible for everyone having to have more KPIs, so that feels great.

The other thing I just wanted to talk about was the crisis. We can't - and this comes back to waiting lists as well, it comes back to our LHD and our hospitals and racism, all that stuff. You know, our clients, they want to see an Aboriginal service. The hospital treatment is terrible. They don't stay in hospital or ED for very long without support, as others have said.

You know, I've got an example of clients that, you know, they might present to the A&E because they've hurt themselves falling over with drugs and alcohol, been living on the streets, homeless for months, and then reach a point where they really need hospital care. They get put in, they get admitted, and then I get a call to say, "Can you do something with this person. Can he come to Namatjira Haven. He can't stay here", and I will go, "What's going on", you know, go in to see the fella in hospital there, curtains around him, nobody wants to talk to him, "Oh, no, he's too aggressive". You know, "Where's the ACLO?" "Oh, they don't want us to - we have zero tolerance."

You know, I talk to the fella and all he needed was someone to report for him that day with Centrelink. He was due to report. He just needed help. So his pain level, all his tolerance - he couldn't buy his smokes because he couldn't report. You know? Just simple little things can help hospitals manage clients better so that they can actually get the help they need but everyone throws their hand up. We get pulled in to, you know, sort of do the crisis stuff.

That particular example of that fellow is that he stayed here for six months. He actually couldn't look after himself, he needed aged care, and it took six months for us to get an aged care bed. We're then faced with a client that had extremely high needs, he was incontinent both ways, his memory was that he couldn't remember to take his medication or that he'd taken his medication. He couldn't shower himself. You know, he couldn't do anything for himself. So we actually had, you know, a bed taken up for six months for someone that needed to be in, you know, a long-term supported high-needs accommodation.

So we'll be getting more and more of those sorts of clients, we've got extremely high needs, so a lot more applications from young men that are out of home care that

are no longer in their foster care situation, are homeless, using drugs and alcohol, you know, horrendous stories of trauma, as you all know what the stories are, and so more and more young men coming in to our service really because they are homeless, have had trauma and are using drugs and alcohol and there's just been no system for that at all. They mightn't have addictions. So it's more that, you know, they need mental health care and counselling care and hope, you know, some sort of hope.

The other thing is that advocacy funding - you know, there's so much funding going out to services to advocate for this, to advocate for that. Homelessness is a prime example. There's millions of dollars in this community, in our community, for the services that are advocacy for homelessness. All they do when they go there is get told to ring Link to Home. You know, there's millions of dollars going into that. I would just, you know, say, "look, let's rip advocacy funding straight out of the window and put it into actual housing and services that are actually delivering." All the things that we do outside what we're funded for, they're the things that will make difference, not someone telling you to ring Link to Home.

I could bang on about, you know, the fact that we get a lot of push and clients that are - really it's a drug crime issue, so many people are getting - having criminal matters for possession of small amounts of cannabis and then being forced into treatment and that's taking up beds off people that are actually needing to come out of hospital or are in the community unwell that really need our services.

So, yeah, I just want to push a few barrows like that to reduce the - some sort of system to reduce - I would say to New South Wales, if we could just have one portal, one lot of compliance, one lot of, you know, reporting for anything to do with New South Wales, and then in the same with the Commonwealth, just one system, one lot of reviews.

It's just changing, every six months. We're trying to keep up all the time and our funding has stayed the same. Apart from this last two years where suddenly there's a little bit of CPI that's come through, we're on the same funding that we were from day dot, you know? So our clinical team shrinks, our admin team has had to expand, and it's just not right. There needs to be a complete

review, I think, of all historical funded services to make sure that they can actually be funded for what they are actually delivering and, you know, a real push to have some sort of investment from NSW Health on actually training a workforce that we just don't have anymore, and that's all the way - all allied health right up to, you know, psychiatrists, psychologists, everything, you know? From go to whoa.

Because we're just - you know, I've just had another one of my team that's just told me they're going to leave in January, you know? I can't keep clinical staff beyond 18 months; they just burn out. There's just - and I've got no-one ever to bring in. It's just getting to a crisis situation, our services. And we've just got no help in the community anymore. No - so everyone's in the same position.

I had a big long list, but that will do. Push towards accreditation being allowed so that we can get more funding. That would be great.

MR MUSTON: Dian has raised a few issues that have been recurring themes that we've heard about in our travels and so I might just identify them and, as I work through each of you who have your hand up, maybe give you an opportunity to share with us your views.

The first is the reporting challenge. I noticed a number of you were nodding enthusiastically every time someone mentioned the challenges of multiple reporting obligations. Very interested to hear about your experience of reporting obligations and the impact that that has on your ability to actually do work with the funds that you are given and in relation to which those reporting obligations attach.

The second is we have heard, and I would be really interested to hear what your experience is, around a situation where a First Nations person presents at a hospital or a government medical service, requires some further care, either specialist care or the like, that might not be available within the local area, they have to travel, and in order to get to that specialist care, some of the AMSs we've spoken to have said that they, effectively, just become the first port of call for any First Nations person who needs health care insofar as the

local health services might say - if someone says, "How can I get to Sydney for this appointment", or "How am I supposed to deal with getting access to this health care, I can't do it", they're told to go to the local Aboriginal medical service and they will sort it out for them, which, I think, based on what you've told us this morning, you guys are all doing, but I am interested to know how that impacts on your ability to deliver the services that you are delivering from a funding perspective.

And the third is the workforce issues. So Dian was sort of telling us about the challenges of retaining a workforce, and I'm really interested to hear in general about the challenges that you have getting workforce in the areas that you work, which is obviously not all in metropolitan areas, but also the extent to which the funding arrangements and the timing of funding impacts on your ability to attract and retain workforce, if at all.

Maybe starting with Christine, I think you were next to have your hand up, but if, in addition to what you were going to tell us, you could think about those three topics, that would be great.

MS PECKHAM: Okay, in addition to everything. But there was a few things that Dian raised that I was going to talk about as well: presentations at hospital and further care. Sometimes we don't know that one of our patients have been discharged, or they've been to the hospital and they haven't even been seen and, so they've just come home and then, you know, they know that if they ring us up, we'll say, "No, you've got to get back to hospital", so, you know.

MR MUSTON: Which hospital would say that?

MS PECKHAM: But then we do get discharges and sometimes it's a couple of days later, you know, it's not like immediate, and they need further specialist care. Well, yeah, we do get - we get, you know, all the work that has to go into that specialist care and the follow-up and stuff, if they have to travel.

Luckily, just recently, we have secured some ITC funding which we can use for travel to specialists, and that's for some of our patients. But in the past, we've just worn that ourselves or helped the family that have to

drive with fuel costs and accommodation costs and stuff like that. So it does impact a lot on dollars and staff time, and it impacts a great deal on the family, because, you know, we also have to support them with whatever the outcome of the presentation to the hospital has been.

We're probably lucky enough to say that retaining workforce in Peak Hill, we've been lucky enough to have the same doctors and the same allied health team, and we've got locals, local community people, employed in, you know, reception. Our social and emotional wellbeing, our health worker is local, I'm local, so we've got - and we're also, you know, supporting two local women, young women, as trainee health workers at the moment. So hopefully, we're going to grow our own and build them up, you know, we think there should be more put into the local communities growing their own health workforce, whichever area it's in.

Even to the point of, you know, contracting for different - whether it be maintenance or electrical cleaning, stuff like that, we'd like to see some - the government look at assisting particularly our AMS in that area as well. We don't get funded very much. We all wear, you know, 10 hats, come in, clean up, you know, do all the cleaning and stuff like that, because we haven't got the dollars that some of the bigger AMSs have got.

But, yeah, so we all share - share the care and share all the things like that, maintaining the premises, using our local Aboriginal Koori tradies. We call on them, 99 per cent of the time they will just come and do it because they love us.

The other thing is - yeah, so also presentations to hospital, the Aboriginal liaison officers in the hospitals, going by Dubbo experience, and we've had a lot of experiences there, they're on the - surely they can look at rostering those workers on, because a lot of the mob, they don't turn up to ED until after hours or on the weekend, things like that, there's never an Aboriginal liaison officer around. They're not around in ED. They should be based in ED. They should be the first person you see when you walk in that door.

Sure, they have these you beaut Indigenous health little signs up there, with a little room, but it's always locked, you can't get in there. It's supposed to be for -

you know, you can go in there and have a yarn and have a cuppa or something like that. When our workers go over there, that would be a great space for them to, you know, wait and talk to those liaison officers, talk to the staff there, and they would get to know our drivers, our transport workers and some of the family members as well, besides, you know, the patient.

Like I said, it's all right to have you beaut Koori stuff everywhere, and when you walk in the door, you can see there's - oh, there is an Indigenous health thing there, and you go to the door and it's never open. No-one's in there. You wait around, wait around, "Oh, where is the Aboriginal liaison officers?" "Oh, they are around, they're around." Come 5 o'clock, they're gone. Can't get any on weekends.

I had a call, an 80-year-old, came back from Sydney 1 o'clock in the morning. They brought him back to Dubbo hospital. 9 o'clock in the morning, they were ringing me, 60 kilometres away, I was in Peak Hill, Dubbo's about 60, 70Ks away, to come, "He's being discharged". So why would they do that? There should be Aboriginal liaison officers all over the hospital.

The other thing, and I was talking about, you know, trying to get funding and using local Aboriginal tradies and maintenance people and that, why can't they look at getting more Aboriginal contractors in, the cleaners, the maintenance people, in the kitchens and stuff like that, so at least when mob go there - because they can't - it's a regional hospital, they come from further out west, all around the Dubbo area, at least they will be seeing nice, you know, friendly Aboriginal faces, and probably most of the mob are related to them.

And the other thing that we do as well, with our community, and with our elders, we go on country, we get bush medicine and stuff like that, and some of the families will use that. There should be more access to traditional healers in the hospital system as well.

MR MUSTON: Thank you.

MS PECKHAM: And the biggest challenge just recently is dental care in our community. We've got no dentists around here. You have to go to bigger town, to Dubbo, Parkes,

Orange for a dentist, and then you've got to pay out of pocket for it. A lot of our mob, they just wait until their teeth rot out and fall out before they'll see a dentist. So surely the government can look at, you know, the oral health issues within Aboriginal communities again, especially with all the kids and the elderly. I haven't finished yet, sorry.

Regional programs that have been put in for, you know, to cover smaller towns like the regional programs, mental health, social and emotional wellbeing, DV, those kinds of regional programs, hub and spoke type models.

Funding goes to NGOs, mainstream NGOs, they come out, pick our brains on what they should be doing. You know, we're happy to work with them, we've built up some good relations with some of them, others we haven't. And then we don't see them. So we don't know, you know, what's going on with that program, but we know it's Aboriginal funded program, and all these NGOs in mainstream, in the bigger towns, have control of this funding, where they're supposed to be providing services to us on the ground.

Domestic violence, DCJ - they fund a position. No ongoing costs with stuff like that. When we say, "Well, this is how we would run this, in our community", "Oh, no, you'll have to partner with an NGO, a mainstream NGO, if someone's in crisis", you know? And everyone would know, all the mob would know, crises usually happen in the night, on the weekends, you know, domestic violence situation, mum and the kids are running away or the - you know, partner's running away. How are we going to get on to an NGO that's nearly 100 kilometres away, "This is a crisis. What can you do for this person"?

So we've often been left with providing, you know, just things like clothing and food and, you know, personal care kits to get these people, you know, just through until that person who is sitting in another town decides they can come out and see this person or book them into a service. So we often liaise with extended family for that person. There's no, you know, women's refuge or anything here, or men's refuge, so that's another thing that - talking about domestic violence.

Rehab. When someone's in drug and alcohol rehab and they return back to country, they might get - they get a

little bit of support for maybe a week and then we're running around looking for accommodation, supporting that person to go to all their appointments, and that person could be sitting, just say, in another town, out of Peak Hill, so we're trying to support them to go to all their appointments, to go to their medical appointments, help them with accommodation and things like that. And that's part of what we do as well.

MR MUSTON: Thank you.

MS PECKHAM: That's me, sorry.

MR MUSTON: No, not at all.

Lisa, I think you have been waiting with your hand up.

MS PENRITH: We could probably say we could echo everything that everybody else has said, so I'm not going to repeat all of that.

You want to know about workforce issues. We've been running for over 22 years. We were funded 22 years ago for one GP for $150,000. We now have 14,000 people on our books and we're still funded 150,000 for one GP.

Every time we put in a submission to get more funding, we get knocked back.

We have to see non-Aboriginal clients to enable us to bring in Medicare income to keep our administration staff employed, to pay for our nurses, to pay for the other five doctors that we need to keep the community fit, healthy, as we need them to be. Workforce issues are NDIS.

Now, NDIS are taking a lot of our staff, because they have big dollars and can pay them big money. We can't keep up with paying the rates that they want to pay our speeches, so they go off to NDIS and we lose that program.

MR MUSTON: Can I ask a question about the - you said a moment ago you need to see non-Aboriginal clients in order to cross-subsidise the funding of the services that you're delivering to Indigenous clients. What is it about seeing the non-Aboriginal clients that makes it easier for you to fund those other services? Is it just the Medicare money that's coming through?

MS PENRITH: Just the Medicare income.

MR MUSTON: Or is there - we have heard quite a lot in our travels about one of the fundamental differences sometimes between seeing Aboriginal and non-Aboriginal clients is you can see a non-Aboriginal client in that seven-eight minute medicine type space, generate your Medicare income, whereas with a lot of First Nations clients who have a range of comorbidities and needing to sort of build that personal relationship with them to deliver their health care, it's not a seven-minute proposition. Is that part of that need that you have to see non-Aboriginal clients, in order to increase the amount of Medicare revenue you've got to meet the needs of your First Nations clients?

MS PENRITH: Pretty much so. We don't want to run a production line for our Aboriginal clients as they are just - their needs are more chronic and complex. So we will see mainstream clients that have a cough or cold, a flu, we can bill Medicare, and that can subsidise the doctors, the nurses, our admin staff and all the support staff that are needed to actually run the AMS and free up the funding to provide programs.

Another issue that we have here is we don't have staff trained or have the time to write these submissions. When the government put out tenders for submissions for program money, we might have half an hour, an hour, to sit down and throw a submission together, where you've got the local health districts, the primary health networks, who actually pay people full time to write these submissions. So they are successful in getting that money from the government to provide services to our community, and they're not providing those services.

I can see you all sitting there nodding your heads. Obviously, youse are having the same problems we are, where the money is going to mainstream services to provide these services and they're just not doing it. They're not culturally appropriate, they're not culturally safe, so the clients they're funded to see continue to come back to the AMS, and we're not funded. But yes, like everyone else, we still see them because that's what we do for our mob.

THE COMMISSIONER: Lisa, can I ask you a question? When you told us that 22 years ago you were funded for one GP at

150,000, but you now, I think you said, have 14,000 clients on your books --

MS PENRITH: Yes.

THE COMMISSIONER: I wouldn't expect you to give me a precise answer, but roughly how many people were on the books 22 years ago? I take it it was a lot less than 14,000?

MS PENRITH: When we started 22 years ago our chairperson was the first client. So we had none 22 years ago. So we've gone from zero to 14,000 just at this service, and at two other satellite services that we also service, one has 2,500, the other one has 1,500 clients, still only funded for that one doctor.

THE COMMISSIONER: But the growth in the number of patients on your books, has that been because GPs are becoming thin on the ground in your area; is it because of a greater awareness of your services; is it because of an ageing population or some form of population growth; or is it multifactorial? What's the --

MR MUSTON: Can I add to that --

MS PENRITH: It is multifactorial, but the main one would be that we're the only bulk-billing service in town. That is the big one. The second one is because the clients know if they come here, they can see a doctor, they can see a nurse, they can get care all in one place, so they want to utilise the service.

THE COMMISSIONER: Yes.

MR MUSTON: So I gather from that that the increased demand is perhaps not necessarily an increase in the underlying demand so much as the demand's out there but as your service has grown, you've been able to meet more of that demand, it's not to say that you're meeting all of it, but you started with one doctor and you could meet one doctor's worth of demand because there's only so many hours in a day; if you have two doctors, there's demand out there that will occupy all of their time and no doubt that would continue to increase up to probably significantly more doctors than you currently have and other --

MS PENRITH: The waiting list for our doctors now goes up to six weeks. Our Aboriginal clients can get in on the same day, but for mainstream clients, our waiting list is over six weeks.

And the reporting - as we were saying - with the reporting, we are doing so many different reports to the same government agencies. Can't you all pull the same information from the report? Our reports that youse are getting, you're looking at numbers, you're looking at how many numbers we see. Listening to Christine and Rosemary, Dian, numbers aren't what we do. We provide a service. So while youse are looking at us seeing one person, that one person might take six hours of our time, and you're looking at us and saying, "Well, we're funding you but you're only seeing one person." The reports don't allow us to let you know what we actually do for our clients. I don't know, I don't want to take up too much time because I'm sure there are other people and there's another group after us.

MR MUSTON: You take up as much of the time as you need, don't worry about that.

MS PENRITH: And our Aboriginal health workers are doing more than one job. So we're losing them because we can't afford to pay them the same wage as the local health districts, or we're losing them to NDIS because they can pay more money. We've got workers here doing our 715s but they're also doing the eye screenings, the ear screenings, they're also out there delivering hampers. So we need to come up with our funding for our health workers to match everyone else.

Our gaps here are detox and rehab services. We can't access them. We can't put clients in detox at the hospital because they won't give us a bed. Clients, when they want to go to detox, they want to go there and then. They don't want to be told, "I need to wait a week, two weeks or six weeks". There needs to be more funding put into these detox services so the AMSs can access them.

MR MUSTON: Correct me if this assumption is wrong, but in relation to something like detox services, presumably that point in which one of your community members has that point of insight and recognises something needs to be done, "I need to go or want to go and get some detox", seizing that moment is, presumably, really important because if you

don't seize that moment while that insight is there, then a week later, two weeks later, they might not be in quite the same frame of mind in terms what they perceive to be the need for a detox service?

MS PENRITH: That's it. They might see that they're fixed. "Oh, I'm fine. I don't need it now. I was just having a crisis two weeks ago. I'm not having it now so I don't need to go." But a week later, they're still going to have that same crisis and be told, "You have to wait another two to three weeks." There needs to be more out there for detox services and mental health. They're becoming our big issues.

And with training of staff, you guys - a few of you mentioned ophthalmology. We've been working with Professor Painter. Does anybody know Geoffrey Painter? He's an ophthalmologist that comes to our private hospital here. He's been coming for two years now and he's trained all Aboriginal health practitioners up in eye screenings, so we no longer have to go through GPs or optometrists. We can directly refer to his clinic and he will see our clients on a priority basis at the private hospital here. He's looking for more organisations to work with. Maybe that's somewhere where you guys can look at approaching Professor Painter to help out your services. I think that will do me.

MR MUSTON: Thank you.

Payden, I think you were next with your hand up.

MR SAMUELSSON: Yeah, just to touch on those sort of three questions you raised. Reporting-wise, example for us, this year we've got 15 different funded programs which have staff allocated to them. One example of those was our social and emotional wellbeing funding through PHN. It funds part of our social and emotional wellbeing workforce, but for 2.2FTE in our social and emotional wellbeing workforce, we have three different funders, three different sets of reporting with varying reporting pathways in there, so to touch on the reporting as well.

Some of our reporting, I think the best funder we have reporting-wise is about 12 days' worth of work in reporting across the year. One of the worst funders we have at the moment is fortnightly meetings, monthly reporting,

quarterly financial reporting and six monthly activity reporting after that. And they only allow a 9 per cent admin fee. So it doesn't matter. So that's sort of, I guess, the range of reporting that we have across 15 different funders.

In relation to - I guess I've got it written down here as sort of "client dumping", because that's what a lot of services will do with us, clients get too complex or they don't even try to address an issue, they're just like, "Bullinah is there. Go over and see them."

One of the biggest impacts that has for us, which Lisa touched on, is it impacts our KPIs. Because that client gets dumped, we spend six hours there, there are no health checks being done at that time, there are no care plans being done at that time, there's one client being seen at that time.

That then hampers our ability to improve our funding, because, depending on the year of the funding model rollout, they're dependent on the number of clients that come to your door, weighted on how you're meeting KPIs, particularly around health checks and care plans and those sorts of things.

So not only are we not funded to do a lot of this acute care that pops up, but it directly impacts our ability to look good in the eyes of the people who are funding us for primary health care because it hampers our ability to do it.

Again, we will always do it, because we want to look after community, but there are other services, like everyone's been saying, other NGOs that have positions available to look out for when these grants are coming up, spend enough time to actually do an effective proposal for funding and then get the funding.

Then a lot of what we see is we've got a service who is funded $1.9 million to work with youth mental health, they'll try to call someone three times on a number that is an old number and discharge from the service, "We can't get on to you, that's it." We get left with it. So we often go into this cycle, then, whereas we will never discharge someone because we can't get on to them, we'll talk to uncles, aunties, everyone, to find this person.

We've had a little bit of an experience like that recently where - I'm waiting for a feedback session today to say - there was one FTE, Aboriginal domestic violence specialist family worker allocated for Ballina. We applied for that position because we're doing the work, a lot of our team are doing the work, and that's been knocked back. So one FTE Aboriginal specialist position in Ballina, there are two other Aboriginal organisations in town, which we have good partnerships with, so hopefully one of those guys got it, but if not, I'm really sort of unclear where that issue has arisen, but I'll take my time today to find that out.

MR MUSTON I noticed before, just a moment ago, you were nodding quite enthusiastically when I think it was either Rosemary or Lisa were telling us about the challenges - no, it was Christine, sorry, telling us about the challenges with NGOs coming in and, in effect, competing for grant moneys.

MR SAMUELSSON: Yes.

MR MUSTON: And through the sophistication that those organisations have and the administrative workforce they have, they are able to get that grant but then there might be issues or you might see issues around the way in which they're able to deliver the care to members of your community. Do you have particular views about that or a particular experience that you wanted to share with us about that?

MR SAMUELSSON: Oh, yes, definitely, definitely. So we have a pretty good relationship with our PHN here. So if there's funding where - this one, we weren't really competing. There was funding that was released, I think it was $1.6 million, after the floods for mental health support in community. There was a nine-month rollout. So you had to get a service in place and roll it out in nine months and then take it away, basically.

So the three AMSs in our area that have a partnership with our PHN said, "We're not bringing that on because it's just setting clients up to sort of be wound back and we probably won't find workforce in the first three months." So we sat on a tender panel to select the NGO that would then take on that funding, on the condition that they

engage with the AMSs in the area and we work together.

So they were successful in getting it. The first quarter of reporting, which we were able to see because we had that agreement with our PHN, they've reported on, you know, seeing 70-odd clients at the pod village in Wardell, done, you know, mental health assessments for all of them and they've shown an improvement in mental health assessments. I, you know, have spoken to our team who are out there two days a week, spoken to Uniting Care, who are running the pods, and spoken to community, and no-one is sure who or what they are, what they're doing. So the level of engagement is really sort of - I'm not saying they're not doing the work, but it's not being seen anywhere, and we're still picking up quite a big load of that. So 1.6 million across nine months of funding and we're still doing a lot of the work that they're being funded for. So that's one sort of prime example.

The other one for us, and one we're sort of - I'm working every angle I can around dental funding because we're going through a major capital works project and I really want a dental clinic there. It's been brought up by community since our inception back in 2006 that dental is required.

We've got a public dental service, but the waiting lists there are quite long. How they are meeting demand is sort of debatable, and we had at least 200 clients over the last 12 months whose main reason for a visit to a GP was a dental emergency, which we then had to sort of turn around and try to engage with the public dental system or the hospital. So that's not preventative work or anything like that.

So we've been working since 2008 to try to get dental funding, but we're quite often being told, "No, there's a public dental clinic there, you don't need the dental funding, it's being met". Again, if we had the resources, we could go in and say, "Okay, let's survey all the clients, let's ask these questions about whether they are accessing public dental, the service they are getting and seeing what the need is." Currently, we're getting this anecdotal information from our GPs that 80 per cent of our clients are not getting dental care. So that's another one.

And with these, I guess, the sophistication of some of these NGOs, I think some of that also comes back to the way they're funded and the way we are as well. Just through relationships in town, I know that one of our NGOs who receives federal government funding has a 30 per cent management fee. We're capped at 10 per cent. So we can't allocate the same resources that - so if we were funded the exact same, we wouldn't be allowed to allocate the same resources to the management of the organisation as other organisations are. We're working really hard against that. We've got some funders who now will agree to 17.5 per cent and these sorts of things. But yeah, so that's part of the funding model that sort of, I guess, creates that cycle of these NGOs who are able to set up their services more to attract funding and run a corporation without the same level of service, but they're still getting, you know, money through their coffers.

And I guess for the workforce, the retention is - we're lucky, I think GP-wise, I think the capital for GPs in Australia is Lennox Head, which is 15 minutes up the road from us, so we've got a steady flow of GPs who are in the area. But we are now coming up to this issue with being the only bulk-billing practice, like I said before, trying to compete with rising wages and we're sort of just holding on at the moment but we don't know how long we can do that for.

And with the increase in costs of living, and particularly the ACCHS award which most of our funders, particularly the federal government, expect us to pay our staff off, it's terrible. We pay, on average, 9 per cent above award at the moment, that's to try to compete with the LHDs and those sorts of organisations.

But what that award means is that if someone's looking at that award and going to fund you, they go, "Okay, we can get X amount of FTE for this much money", and we have to turn around and say, "You've got to take at least 10 per cent of that workforce you're expecting off", and that's sometimes a difficult conversation with funders. But it also means we're getting a smaller sort of dwindling clinical workforce. Because we have to pay people more, obviously we can't employ as many people - I've had to run a redundancy just last month - and what that's going to do now, we're going to see in the next 12 months to two years that those staff are going to gradually burn out unless we

can do something sort of drastic to change that.

And the training of workforce, sorry, would be the final thing, one thing that I sort of bang on about every chance I get, is we recruit Aboriginal identified positions first and foremost. If we can't find a skilled Aboriginal person in that role, we will employ a non-Indigenous person into that role. What we then can't do, because of our funding restrictions, is have that role train someone in community, because we can't afford to have someone shadow someone or have someone come in and supervise and provide that supervision. So we get in this cycle, then, of, you know, we have a really good non-Indigenous workforce but ideally we would be able to train and upskill our community into these roles. But if there's not that consideration of the need to build the workforce and the funding to support workforce building, it's not going to happen so we're going to get these sorts of rotating positions of people who might not be from community, whereas if you can train people who are rooted in community, much more likely to stay.

MR MUSTON: Thank you.

I note we're sort of past our 12 o'clock timeline, but there was one question I really wanted to ask all of you while Julie was with us.

Julie, you mentioned at the outset that you are providing a clinic through is it the John Maconochie correctional centre in - Alexander Maconochie.

MS TONGS: Yes, the Alexander Maconochie.

MR MUSTON: So you're providing a clinic through that centre.

MS TONGS: Yes.

MR MUSTON: Within New South Wales, health care to inmates is provided predominantly by justice health. One of you mentioned a little bit earlier the challenge associated with or challenges associated with people who have interacted with the criminal justice system, perhaps received health care through justice health, or in Julie's case, through the clinic that's operated there, whilst in that correctional environment, but then essentially get

released and they're out in the community.

Is there a way in which you think a handover of health care from, say, justice health or the clinic that Julie operates into the AMS environment could work well and, if so, what do you think a good model might be for that transition of care for First Nations people from the justice environment back into the community?

MS TONGS: Can I just say, before we went to AMC, we did deliver a service to Aboriginal men that were in Goulburn gaol, and we did that for 10 years, and we also went to Cooma gaol for four years when that reopened, because the men that got transferred from Goulburn to Cooma actually wrote to New South Wales corrections health and asked for Winnunga to provide them that service. So we went there one day a month and we went to Goulburn one day a week with a doctor and an Aboriginal health worker. But back then, we only had about 18 or 20 men, you know, that were incarcerated. Now it's 130, you know? So it's really, really grown.

The thing for us is that a lot of them men and women shouldn't even be in prison. They should be in proper - getting proper mental health and care for their addictions and their trauma, not locked up in a prison. Because, you know, what's happening, when you lock people up - and I see it all the time - is that a lot of these young ones are coming out worse than they went in, because, you know, I think for a lot of our fellows, particularly on our side of the country and particularly around this area, they have real issues with their identity and they're going to prison. They actually want to belong somewhere, so they're joining gangs or otherwise they're taking on other cultures' religious faith, and that really concerns me. But I think the great thing about Winnunga being able to provide that service to our men and women in AMC is that continuity of care and, you know, we see them on the outside, we see them on the inside.

But the whole point of us being there is because there was a young Aboriginal man who died in custody back in 2016. He had been assaulted in 2015 and he ended up in intensive care for six days. I called for an inquiry into his assault. It fell on deaf ears, and when he died in there in 2016, the minister agreed to an inquiry into his assault.

So Philip Moss did the inquiry and he had been an Integrity Commissioner, and we had a young fellow from - Sean Costello, from the Human Rights Commission, that supported Philip, and we sat with the family and, you know, asked what questions they wanted to know about his assault and everything else.

So we had two things happening at the same time. We had an inquiry into his assault, but also we were in the lead-up to the coronial inquest, and one of the recommendations from the Moss inquiry was that Winnunga be integrated into the services at AMC, into justice health.

But after the coronial inquest, and I walked out of that courtroom - because that young man died from a methadone overdose and he had only had two doses of methadone - I said to our executive director of clinical services, as we walked out the door from the coronial inquest, that under no circumstances was I prepared to share justice health's risk, and we were going to stand alone in there.

So I stood my ground, went back to the minister, he came to a NACCHO board meeting, because at that time I was on the NACCHO board, and he announced that Winnunga was going to stand alone in the prison, have a stand-alone service, and that's what we've done. One of the biggest issues was the over sharing of information between corrections and justice health. Justice health was telling corrections officers in front of other detainees why that person had been at the clinic.

One of the big issues for us, and, you know, people have bagged us about it - others, like justice health or corrections - is that we don't over share information and we do what we do on the outside, we get consent from our clients to share the information.

So, you know, there's a difference between withholding information and getting consent from that person to share that information. It's not just, you know, "Oh, you know who this person is. You've got their information. We need it." We need their consent, like we do on the outside, to get it.

But, you know, if everybody 's - I think that if there

are services out there that really want to make a difference and to get into that space, you know, it's a great space to be in. Our clients appreciate us and, you know, I think that it's really, really important that we don't leave them behind, and they deserve the best that we can deliver. But, you know, like I said about the racism, the racism is a thousand times worse in the prison than what it is out here. So, yeah, that's us.

MR MUSTON: A quick question about that. When you mentioned justice health, who was providing health care to the general prison population in the ACT? Was it Justice Health NSW or is it ACT based?

MS TONGS: ACT justice health.

MR MUSTON: Thank you.

And to others, Julie's just told us about the benefits, which seem obvious, about continuity of care from within the correctional environment back out into the community, both in terms of general health care but also making sure that people are accessing that health care and their general wellbeing from an addictions perspective and emotional wellbeing, mental health - do any of you have a view about ways in which justice health in New South Wales and the AMS sector might be able to work collaboratively together to try and avoid prospective patients or members of communities from falling between the cracks as they leave the justice sector and the care that is being provided to them by justice health in prison and then coming back out into the community where, ideally, there would be a handover, as it were, of care to your organisations or, alternatively perhaps, involvement of your organisations in the delivery of care to them in the prison environment?

Do any of you have a view about that? Payden, you've put your hand up.

MR SAMUELSSON: Yeah, look, I think for us, it's just what you said there, the handover. We're not - like, the nearest gaol to us is down in Grafton, so Scott from Bulgarr Ngaru, they work in the facilities there and they do some work, but the interaction we've had with some of our community post release has been they've just shown up at a bus stop somewhere, someone's run into them and then

called us because they knew we existed, and then it's a matter of, you know, trying to then, with the consent of the client, chase information from justice health, which is sort of patchy and takes quite a long time to come back.

So for us, I think, we would experience that direct sort of release towards us five or six times a year, like I said, Casino's a lot closer and Grafton's lot closer, but in those five or six times, that information transfer, even while we're got the client sitting and consenting, it's really difficult to get stuff out of justice health, so that's where information would be for me, yeah, anyway.

MR MUSTON: Christine, I think you made a comment there?

MS PECKHAM: Yeah, same with us. I think the gaols at Wellington that most of our mob would go to, or Bathurst - I think there should be something prior to them going into gaol, you know, to see if they've got any medical conditions and stuff, because some of them just go, get locked up, and they're put in either Bathurst or Wello, don't know what they're - if they've a medical assessment, or they're on tablets or are diabetic or something like that, but when they - we've had a few examples of when they're released there, you know, to extended family or, you know, really close, some of the mob here, they will just come and get a checkup anyway or if they've got any issues, want to see the doctor.

And then sometimes, we have, yeah, had a lot of trouble trying to get information from Justice Health about some of the fellas that have been released, you know, what treatment they had, because we know what their circumstances were before they went to gaol - you know, went into gaol and stuff, but when they come out, it's hard to see what's - you know, they've said they've gone to the clinic and all this and that, and we've found it really hard to get information from them of what - you know, where they were up to with their health.

And then we've had some fellows come home and a couple of months later they've dropped dead, so we don't know what's happened to them in gaols.

MR MUSTON: So assuming it was appropriately funded at both ends, a system where there was a collaborative relationship between justice health and the Aboriginal

Medical Services across the state, which had a discharge process, as it were, from the care of justice health into the care of the Aboriginal Medical Service, a handover process and a sharing of medical information, obviously with the consent of the patients, presumably, would be something that each of you would see as beneficial?

MS PECKHAM: I think it would be very beneficial, you know, considering some - you know, some of the personal experience from, you know, coming home from prison and, like I said, a couple of months later, you know, a 34-year-old just dies - that was my nephew - after being in gaol for a while, and it's hard to get any information from them. And it's happened to a few families as well. So I think that would be great.

MR MUSTON: Lisa, you've put your hand up?

MS PENRITH: I think the handover's really, really good, but it doesn't need to start when you are released. That handover needs to start prior to their release. It gives the AMSs and the workers time to put in place what needs to be there for the community member when they're released, not just dumped on us the day they're released and said they need this, this, this, this and this, and then we're rushing around trying to put things in place that a lot of our smaller communities don't have.

So if that handover can start even a month or so, two months, prior to the release so that it gives the AMSs time to get things in place, to best meet that client's needs. That's all I wanted to say.

MR MUSTON: Thank you.

Julie, you might get the last word.

MS TONGS: Just in relation to that, Lisa, it's challenging, because it depends on what - if they're sentenced detainees, then, sure, you can do that, like that, exit planning. But our prison is, we've got remand, we've got women, we've got sentenced, we've got all these different cohorts, and it's really challenging, because if someone goes to court on a Friday afternoon and they're given bail, and then you've got a parent ringing up saying they haven't got their mental health medication - all their meds are still back at the AMC, so if they're a client of

ours, it's easy, like, it's stressful, but we can get it done, but if they're a client of justice health, there's no hope in the world, you know, of trying to manage that situation.

So, you know, there's a lot of challenges, because we use an electronic patient information recall system, Communicare, so all our data goes into the system. So the system here at Winnunga, in Narrabundah, speaks to AMC. So if there's a new admission at AMC that was already a Winnunga client, all that information comes up for the doctors and nurses in the clinic out there. So, you know, that's one of the benefits, whereas justice health and corrections, a lot of it was paper notes and whatever, you know? And they can go missing at any time or, you know, through the shredder if they need to. But at the end of the day, with an electronic system, anything that anyone deletes in our system stays in the system. So, you know, there's no room for - that's one of the ways that we manage our risk here.

THE COMMISSIONER: I'm just wondering, for all of you, is there any final issue that you see of particular importance that we didn't cover off, a final comment you wish to make from any of you?

Perhaps start with you, Isaac, is there anything you think we missed that's of importance you would like to say now?

MR SIMON: No, also, I think probably just I didn't speak to much about attracting registrars and the competition with attracting - yeah, so I think that's something where potentially for an AMS, if you have registrars, it does mean - it does help you not only to have a doctor on site under supervision, but also from a funding perspective, it helps you to raise Medicare revenue to pay for the registrars.

So when you do get competition with private practice and the MMM loadings with registrars in your area and they are getting paid above and beyond what we can pay as an AMS, that really does hit our ability to fund the senior doctors. So that's probably something that we didn't touch on too much, but it definitely is an issue for us.

THE COMMISSIONER: Sure.

Dian, is there any final comment from you?

MS EDWARDS: I think probably just a little bit more on the flexibility of funding stuff, probably didn't come up enough. Like the short-term funding, you know, we all recognise is horrendous, and I actually heard some parliamentarians or ministers talking recently about historical funded grants need to be all put up for competitive tendering again. You know, like, that really concerns me when I hear that sort of stuff, because, you know, Aboriginal services, we've fought for years for our services, and to put them up for competitive tendering with mainstream services, exactly what a lot of people brought up today, is that we battle for our funding with mainstream services that have very, very high amounts of money and positions to be able to go for funding, you know?

North coast, if you have a look at north coast, you'll see it everywhere. The same organisations get all the funding, because they're really good at it, and we don't have the time or the amount of staff and expertise to be able to go against it. Plus, well, for us, we can't get NSW Health funding anyway.

But the flexibility of that got brought up. So, you know, like where we have got areas that we may have underspent, there was a question raised that why can't we negotiate for an underspend there to be able to be put into another area.

Our grants and specifications are that rigid that we get told if there's more than a 10 per cent variation, it won't be - you can't do it. You're not allowed to spend either 10 per cent above or 10 per cent over the line item, you know, of the grant, otherwise you have to go back and have a variation to the grant. And then that takes months and by that time it's the end of the financial year and you have to give back the money, and where you've overspent, well, you've got to find that somewhere else.

So they're not - they are very rigid. You'll get questions - like, I'm getting questions now - "What was this amount here spent on such and such?" You know, to the finest detail, you know? It's - so flexibility is a big thing.

And I think Payden brought it up, you know, no money for administration and management is where, you know, a lot of things that we could try and do and meet some of the burden with administration, we just don't have the money for. So it's us having to ask, you know, do all this all the time, you know, the wearing of 10 hats. We're the cleaners, we're the transporters, we're the funding submission writers, we're everything.

THE COMMISSIONER: If you're worried about the issues you've just raised not being dealt with in detail today, I can guarantee you they have come up at all of our face-to-face meetings with ACCHOs and AMSs and we have very consistent notes about those issues you've raised.

MS EDWARDS: Great. With corrections staff, like we take men directly out of custody for two beds. We sometimes have months to work with corrections before that man comes into our service. I'm trying to gain all the information ready for discharge at the end and to know specifically whether they've got any chronic health needs, medication needs, or whether they're using drugs and alcohol in prison and whether we're going to end up with a client arriving and going into withdrawal.

We, on our last - this is a large one. We've got a fellow in at the moment, who was the first trial to take men out of prison on Buvidal, and a lot of work went into the governance, clinical governance set-up with the LHD on managing this particular man coming out of prison. We didn't get the information from justice health until two days after he arrived. So, you know, you just can't - you can't work with them. You put in requests for information, they won't give it to you. So the moment they leave custody, we ask more questions, because - "Sorry, we can't tell you anything, he's left custody." So it's - there is a real problem there, just so you know.

THE COMMISSIONER: All right. Thank you.

Julie, any follow-on observations from you or comments?

MS TONGS: Yeah, I just think that, you know, like when we talk about, you know, what the public servants or the bureaucrats are telling us what needs to be in our contracts, I say to them, "What about our

self-determination? I'm not doing that", you know? "Don't come here and tell me what needs to be in our contract and who we need to partner with. We will make that decision", you know? So that's that.

And, you know, also around - we talked about examples of racism, well, the PHNs, they actually can fund their boards. I was on the NACCHO board, our national peak board, for 22 years, and NACCHO is not allowed to pay their board members. So they are not allowed to pay money out of their contracts for board members. PHNs get big, big money for meetings and, you know, because they've got doctors and others on there - because we're all black fellas, you know, we don't get anything. But, you know, as soon as you put a lot of professionals in the room, they're not going to do it for nothing. But there's an expectation that we will. So, you know, I will end on that.

THE COMMISSIONER: Okay, thank you.

Lisa, any final observations or comments from you?

MS PENRITH: I think that we're all sitting here today to talk about workforce retention, service provision, it's all got to start with our health workers. So we need to start coming to the party and meeting mainstream wages for our health workers. If we want to retain them, they're the ones that are providing the health service provision. They need to have pay equity.

And please streamline the reporting, because we spend three, four hours every week on each program trying to sort out reporting.

THE COMMISSIONER: Again, that issue you've just raised then is one that was just consistently raised in our face-to-face meetings when we were out visiting the regions.

MS PENRITH: They were just my two things that I wanted to finish on.

THE COMMISSIONER: Thank you.

Rosemary?

MS ROSE: Yeah, I just concur with everybody, but I think

that AMSs need to get the recognition and that being financial remuneration. We go above and beyond for everybody and if a local hospital had to fund what we do, they would be bankrupt in a week. Sorry. Thank you.

THE COMMISSIONER: Thank you.

And Christine?

MS PECKHAM: Yeah, I'd just - as well as health workers and everything everyone else has said, as we - you know, we're going to be around for - we've been around for, what, Julie, nearly 50 years, and we're going to be around a lot longer. I think there should be some investment in, you know, purpose built premises for us to do our providing our services from.

We operate from a little renovated what used to be a three-bedroom house, you know? There's a lot of money gone into investing in, you know, bricks and mortar stuff, but there also has to be some investment for that culture and connection to country that is, like, at the heart of our mob's health and the whole holistic approach that we take to health.

And I think, you know, with the new beaut NSW Health, Aboriginal health plan from 2024 to 2034, I hope that might bring some changes about. Thank you, sir.

THE COMMISSIONER: Thank you very much. Mr Chiu, there is nothing you --

MR CHIU: I don't have anything, Commissioner.

THE COMMISSIONER: To all of you, thank you very much for your time. We're very grateful for your participation today and also the assistance you have given the Inquiry. So thank you for your time. And we will leave it there. We will come back at 2 o'clock.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Good afternoon to those of you here. I'm going to assume you can hear me, unless you - well, I suppose if you can't hear me, you won't know what to do, but I assume you can hear me.

Before I pass over to Mr Muston, before we begin this roundtable session of the Special Commission of Inquiry into Health Care Funding, can I acknowledge the Gadigal people of the Eora Nation, who are the traditional owners of the land on which we gather today, at least those of us sitting here in Sydney, anyway, and pay my respects to their Elders past, present and emerging.

For the three of you online at the moment, the purpose of today is to hear from you rather than for you to hear from either me or Ed. We have, over the last 14 months in our travels to every LHD, including all the regional LHDs, met with many people from ACCHOs and AMSs to have discussions about what kind of services they offer and how they're funded. We've got, I think, a pretty good idea now of the services you offer and also your importance to your local communities.

The kinds of things that have been raised with us, though, on many occasions now and quite consistently, are things like the difficulties that short-term funding provides to you, particularly in relation to workforce; a growing gap between demand for services and the funding that's allocated, wherever that funding comes from; and we've also had discussions about relationships that your organisations have with entities like LHDs and PHNs and the like.

Having said that, I've kept those topics deliberately broad and not specific, because I don't want to set the agenda for anything that you might want to say to us.

I guess the final thing for me to say is that part of our role as a special commission of inquiry is, at the very least, to produce a report that is an indication of the truth of how healthcare services are funded, and that's part of the reason why we need to speak to you and hear your voice.

Having said that, I'll now pass over to Mr Muston.

The only other thing I want to say, though, is in the course of your discussion with Ed or with me or with anyone else, we have aimed to keep this as least like a court hearing as possible. It's going to be recorded, but other than that, we want it to be an informal discussion, and if, in the course of any of your colleagues speaking, you feel

you'd like to add something to a particular topic or issue they've raised, either raise your hand via the computer, or literally raise your hand, and we will come back to you to continue that part of the discussion.

Other than that, I'll hand over to Ed.

MR MUSTON: Thank you for joining us today. My name's Ed Muston. I'm one of the barristers who is assisting with the Inquiry, and sitting to my left, I don't know if you can see him on the screen, is Hilbert Chiu. He is a barrister who has been retained by the Ministry of Health to represent the ministry's interests in the Inquiry and also the interests of the local health districts.

As the Commissioner has said, the aim of today is to hear from you about your experiences of the interaction with the public health system, the way in which your organisations respectively are delivering health care to your respective communities, and the sort of systemic challenges that you might be facing in terms of doing that.

It would be good to keep it as conversational as possible and to that end, if, as the Commissioner said, any of you want to build on something that one of your colleagues has said, just pop your hand up and do it. Likewise, if Hilbert, Mr Chiu, has any questions along the way, instead of the more formal process where he gets to ask you questions at the end, I would encourage him to just jump in and keep it rolling in a conversational way.

But to perhaps just get us started, it would be great if you could each, maybe starting with you, Debbie, tell us who you are, the organisation that you represent, where you are joining us from and what sort of services you're providing to your community over what sort of area?

MS McCOWEN: Hi everybody, I'm Debbie McCowen. I'm the CEO of Aramajun Aboriginal Health Service. I've been the CEO for 15 years. We're based in northern New South Wales, so our main office, where I'm speaking from today, is Inverell, but we also have service outlets in Tenterfield, which is on the Queensland border, Glen Innes, Armidale and Tingha.

The services we provide, obviously, are medical service. I've got what I always claim to be, that could be

disputed, the best dental service in New South Wales, and we provide outreach dental services to all our clinics.

We also have - are very fortunate to receive NSW Rural Doctors Network funding for allied and specialist services. We have a drug and alcohol program. We have what we call a family healing, which is a domestic violence program for both victims and perpetrators. We have a homelessness service. We have funding to support people to get onto the NDIS and aged care services. We also are just in the process of setting up some very low-level aged care services under the CHAP program. We're also looking at going into out of home care. We're accredited for that. We provide some mental health services and community health promotion and support services. Yep.

MR MUSTON: Thank you.

MS McCOWEN: And I don't know how to get rid of that phone call.

MR MUSTON: That's fine. Kristine, joining us from Waminda, I know you have a facility on the banks of the beautiful Shoalhaven River at Terrara, but beyond that, tell us about you and your organisation.

MS FALZON: Hi, everyone, Kristine Falzon, I'm one of the CEOs here at Waminda, based on the south coast. I'm very thankful to be on the south coast, to be on my grandmother's land as a (indistinct) Wandi-Wandandian woman and, you know, what a privilege to be able to live my life, working for my community through our ACCHO model of care.

So for Waminda, I suppose, you know, we provide quite a number and range of services from clinical services - we don't have dental, that is absolutely a gap in our service delivery that we work towards trying to address. So it is a referral base only, but otherwise it is all clinical services, health and wellbeing, targeted youth programs, justice reinvest programs, case management services from domestic violence support, mental health, like all different specific areas; family preservation and restoration programs as well.

I'm just trying to think of all our cultural programs, and we have a whole social enterprise as well. So, you know, we've done a lot of work around population growth and

needs analysis for now, and as a community like Shoalhaven, especially being such a big tourist area that can triple in size at times, around what's required around housing and all different other needs as well. But yes, we recently opened our Black Cede cafe social enterprise re-employment pathways and catering services, and an online store due to launch next week.

So we have a range of different areas throughout our organisation, and, you know, we provide services based on community needs, and when there's a gap or when community request that, it's something that we work towards.

So some of the key areas we are working around at the moment, and similar to the dental that were gaps in our area in service delivery, is birthing on country. We're in the process of final steps, DAs approved for the first birth centre of its kind to be based in Shoalhaven, and just within walking distance will be the women's rehab and women's refuge, which have been massive gaps for our service, and that's, yes, really welcomed. It's been a struggle to be able to get them on board, but they're - you know, just to provide a bit of an insight into our model of care and the services we provide.

MR MUSTON: Thank you.

And Jessica from the Eleanor Duncan Aboriginal Services.

MS WHEELER: Yes, hi, so my name is Jessica Wheeler and my family are actually from the south coast, Yuin country, but I have been raised on Darkinjung country, where I am today, all my life. Our service is Eleanor Duncan, and I've stepped in in place of Belinda, she's actually on leave at the moment.

So Eleanor Duncan Aboriginal Services, where we have a property here at Mardi, operates all our programs. We have mental health, AOD drug rehab, day rehab. We have suicide prevention, health promotion, family preservation, out of home care. We also have a dental clinic.

Our medical centre, unfortunately, is - we're waiting on DA approval from the council to move into the property here at McPherson. That has been a very big struggle for our CEO, and because of our large footprint, we have opened

up a practice at Umina, which is unfunded at the moment, which is - we're finding very difficult. We struggle with, obviously, retaining GPs. We've got a little bit of a youth gap at the moment.

We also run an aged care and elders program. We also have a social enterprise with our kiosk and auxiliary workers as well. Bit of a gap, too, with transport. At the moment, our transport company here on Darkinjung country has, yes, ceased services, so it's been a bit difficult to try and get - we've also got chronic disease, our ITC program as well.

MR MUSTON: In terms of the gaps that you've mentioned, are they gaps that exist because there's not funding available to fill those positions or is it that you don't have access to the workforce you need to fill the positions or perhaps a combination?

MS WHEELER: Combination.

MR MUSTON: To all of you, and maybe starting with you Jessica, because we're talking with you at the minute, but to what extent do you think that your service is able to meet the needs of your community at the moment within the existing funding envelope?

Perhaps put more bluntly, is there a whole lot of unmet need out there within the First Nations community within your community?

MS WHEELER: Yes. So on Darkinjung country, we're the fastest growing Aboriginal population. Our books are closed. We have a shortage of GPs, unfortunately, and it's a struggle. There's 21,000, or over 21,000 people, on Darkinjung country and we've got about 4,000 active clients, which we would like to increase.

MR MUSTON: What sort of waiting lists do you have for your services?

MS WHEELER: So the books - we've had to close our GP books, because we cannot keep up. Yes. So we - it could be - we've got over 1,000 people on that wait list.

MR MUSTON: What about Waminda, Kristine? What's your experience been like in the Shoalhaven?

MS FALZON: Yes, we definitely have the same. I think the GP crisis is shared across the country. So we're in the position now that we're paying ridiculous amounts to get locums down here, scheduled out through the year.

I suppose our clinical or our health and wellbeing model is always - it's a little bit different, it's led by our Aboriginal health practitioners, so no-one sees a GP without having them triaged with the health practitioners, and that's for cultural safety but also timely appointments.

We have been absolutely as resourceful as possible but we don't have a full-time GP. We're booking out, throughout the year, locums just to meet the needs of community. We haven't closed books, we don't have a waiting list, however, we probably have a number of community members that will go locally to other GPs, but their care is here, especially with all the other comprehensive services.

So it may be that they might see another GP while they wait to see ours or - it's about a three-week waiting list to be able to get in to one of the GPs, but we've definitely not been able to service our community like we would be able to if we had the funding and our GPs here.

MR MUSTON: What is the rough population of people in terms of numbers that you have within your catchment who you sort of see as the community that you serve?

MS FALZON: I'll come back to you, I'll double-check so I get the right numbers for you.

MR MUSTON: No worries.

MS FALZON: Go to Jess while I get that for you.

MR MUSTON: What about you, Debbie? To what extent do you think the services that you can offer through your facility, within the current funding constraints and workforce constraints, are able to meet the needs of the First Nations?

MS McCOWEN: We're in a similar boat as everybody else with doctors. We are actually an approved training

organisation for registrars through both RACGP and ACRRM, but we've been unable - we are a priority area for RVTS and we can actually offer registrars a $25,000 bonus, a relocation bonus, yet we have not been able to attract one single registrar in the last two years.

Apparently - don't take me for granted, but this is what I've been informed - for the New England region and New South Wales, there are only six registrars available, and yet I've been down to the coast, the north coast, and I gave presentations to 60 registrars. So I think there is a definite need to reallocate registrars according to need, not according to whatever else they are assessing it on.

We have also been reliant somewhat on locums. We've taken the measure to actually investigate overseas medical graduates, and I've got five coming next year from overseas, three for Armidale and two for Inverell.

It's going to be at a significant cost to the organisation, because we anticipate for the first three months they won't understand the Australian healthcare system, and they will need quite a bit of support. Having said that, we'll have to keep locums on at $1,800 a day for at least another six months.

We were fortunate a couple of years ago, because as a relatively new AMS, we were very poorly funded when we first got established in 2005, and when the department reallocated funding, we did receive quite a significant increase in funding, which has all been basically sucked up in paying locums.

The other issue - I do have to go at 3 so I would like to dump and run, if I could - is the access to or the funding - the funding for allied and specialist health services.

As I'm sure you are very well aware, Aboriginal people do experience a lot of chronic disease and have a need for access to allied and specialist health services. The only funding we get for allied and specialist health services is through the NSW Rural Doctors Network, and I can say nothing but praise for them, but the funding is inadequate for the need.

You know, just this morning, my operations manager

said - from Armidale - they're receiving a lot of complaints about a podiatry clinics because nobody can get in because there's such a massive waiting list. We've got, for another example, a 12-month waiting list to see a paediatrician, which is so important for a child.

We've now had to go with - and this is completely unfunded - we're going to telehealth to access paediatric services because it's so essential for our children.

There has to be a better way. If you're going to provide comprehensive health care, it can't just be a doctor. It's got to encompass all the allied and specialist health services. That area of funding is woefully inadequate. Rural Doctors Network are great, terrific, but it's very limited funding. It doesn't fund. It honestly doesn't fund the services that we're trying to provide.

I got carried away there. What else did you want me to talk about?

MR MUSTON: We'll stick with that, because Jessica's put her hand up, and I suspect she wants to say something on one of the topics that you've already raised. We'll give her a chance to do that now.

MS WHEELER: Thank you. I just wanted to actually also let you know that we are the only bulk-billing medical centre on the Central Coast here. So I know our patients either refuse to go anywhere else, because they can't afford it, they're flooding the emergency departments, and the urgent care clinics that have been established here, they actually closed their books, so you can't even attend at certain times, which is very difficult. But we are more than - we would be more than happy to take our community on if we had a bit more support and the GP access.

MR MUSTON: In terms of support, can I ask in relation to the relationship that you have with - let's start with the local health district, what's the nature of that relationship and how, if at all, do you collaborate together to deliver health care to First Nations people within your catchment?

MS WHEELER: Certain programs we work well together, so our dental clinic, we've got a really good partnership with

them, so that's working really well. We've just managed to collaborate more with the diabetes clinic at our LHD. Everything else is a bit of a struggle. Our ENT is difficult - yep.

MR MUSTON: In terms of those bits of it that are working well, what is it, do you think, that has made that collaboration successful?

MS WHEELER: The people that are in them seats and that are willing to work with us and collaborate.

MR MUSTON: Is it the same answer if I were to ask you which bits are not working well?

MS WHEELER: Yes.

MR MUSTON: What about you, Kristine, at Waminda? I think we've heard in our travels about some quite positive collaboration between Waminda and the Illawarra Shoalhaven Local Health District, but what is the level and nature of collaboration that's happening, and to the extent it's working, why?

MS FALZON: I think you've probably heard positives, especially to birthing on country, but realistically, that's an eight-, nine-year track and journey, and to be perfectly honest, if it wasn't for the leadership of the existing CEO, we wouldn't have the support that we've had to date, who's really led and really taken on board what it is investing in Aboriginal community control but also decolonising, calling out racism and understanding that health and wellbeing and delivering the services for Aboriginal communities is best placed through Aboriginal services.

I think there's definitely some successes there that we could learn and share by, but unfortunately, I think if the leadership changed, it wouldn't be the case, and I think that's where - yeah, systems are people, and unless things are in the foundations, we can have a great wrap, but unless there's implementation for that or a statement of commitment that calls out racism and ensures there's accountability, you know, it's all dependent on that person's biased views or background.

So I think, moving forward, there is need for some

more foundational documentation or guidance or frameworks that ensure people are held accountable and there is implementation about that and it's followed through. So at that level absolutely we have great support, however it changes as it gets to different management levels. So on the ground, absolutely work in collaboration, but it's in pockets.

So in birthing, absolutely, there's been a lot of support and growth and it hasn't always been like that. However, when it comes to housing support, and especially with mental health and drug and alcohol, it just goes around and around and around and people fall between the gaps every single day, multiple people. You know, that's something that, as acting CEOs, we're supporting daily where you could have police called out to support someone with mental health needs, you call mental health, and then, you know, police come out. It's seems to be a revolving door, and the problem is that unless someone has, you know, issues with the law, people aren't going to be scheduled, or if they are, they're going to be released straightaway, so then we're not providing care; we're providing band-aid impacts.

Unfortunately, we're not funded and we're not that specialised a service to provide the services. The health system is. And until there's collaboration around that, we're going to continue to see communities that are so unwell, homeless rate increasing. Most of these people are so unwell and they are being excluded to get temporary accommodation because of their situation as well, so it makes it really difficult for us to be able to support.

And, you know, we get situations all the time where the specialised services are bringing the community members to Waminda because they feel safe here, but we don't have the specialised care for that. We can't enforce scheduling or be an Open Support. We don't have a mental health and wellness facility to support people with that acute care either. So that's a real struggle for us daily.

To your question before around our population, so our population - 113 in Shoalhaven and 7,500 Aboriginal people. So Waminda services about 2,500 currently. So being predominantly a women's-led organisation, but we do support the whole of family and we do have men's behaviour programs and youth programs and family preservation programs, now

the numbers for male support have absolutely increased. I hope I answered your question in all of that.

MR MUSTON: You have.

And Jessica, I saw you nodding enthusiastically, when Kristine was telling us about some of the challenges. The "rotating door", I think, was the description of the drug and alcohol services and the sort of mental health --

MS WHEELER: Mental health, drug and alcohol, yeah, we're having similar issues. We also - one thing I remembered, too, is that the allocating of funding, so headspace has received funding, but yet they tend to refer their clients to us, the Aboriginal patients, to us. So it's like well, why can't we be - we've applied for some of the funding but we don't - we missed out on it.

MR MUSTON: Just picking up on that, something we were told this morning by the panel was that there is, for a lot of funding streams, a competitive tendering process or bidding process.

MS WHEELER: Yes.

MR MUSTON: I imagine that's the same environment that you operate, or all three of you, operate within. I see some nodding, so I will take that as a yes.

To what extent are you resourced to participate in that bidding process, to write the grants and to pull together the information that you need to pull together to get access to the funding and do you think, to put it bluntly, that it is a level playing field with those other NGO organisations? Starting with you, Kristine.

MS FALZON: I will just jump in, if you like. Absolutely not. We don't find the management funding for, you know, management overheads, for transport, for admin, for submission writers, writing, does not exist for us and that's the same with, you know, insurances - you can imagine, insurances across all of our staff have gone up about 20 per cent. Our funding doesn't increase to cover that. So that's a loss for the organisation.

But, yes, what happens is that they have these grant submission writings that can do like these massive regions.

Like, Waminda covers from Wollongong right down and has services in Bega and Eden and then also inland to the mountains, so if you think about that coverage, however we have - our sites are now Wollongong and Ulladulla, but we don't have specific roles, we don't have funding. All of us write our submissions all the time, we're always doing the reporting, and if you think about the lack of sustainable funding or pilots or innovation funds, the amount of reporting to correct the evidence base, which is no guarantee of further funding from that, how much time and resources is wasted in that process, when we could be just using the funds to help and heal our community. So, yeah, it's a conversation I have every single week with our team especially around funding and budgets.

MR MUSTON: Jessica, did you want to add to that?

MS WHEELER: Yes, sorry. I just would like to add in regards to if we're well-established organisations and we have to bid for Aboriginal money to - like, that is all our resources, I do agree as well, that we've spent trying to bid for Aboriginal money and then they go to mainstream organisations who then refer back to us. So it's very frustrating.

MR MUSTON: What about you, Debbie? I suppose I'll start with the topic that we've moved to, which is this issue around bidding for funding against other NGOs who are out there looking to, no doubt with good intention, secure funding streams --

MS McCOWEN: I'd probably like to initially just confirm a little bit what Jessica said about our relationship with the LHD.

MR MUSTON: Yes, I was going to come back to that, but fire away.

MS McCOWEN: Yes, because I have been around a long time, we used to have an excellent relationship, which was probably about 10 years ago, and it was very much personality based. It was based on who the CEO was at the local health district.

It has since disintegrated quite dramatically, and I think there's actually a lack of respect and acknowledgment of Aboriginal health services. But, having

said that, we do have, once again, excellent relationships with different personalities within the health district. But there are some that have quite negative effects on our organisation because of personalities.

In the past, I have gone to the Ministry of Health to ask them to help us with our relationship, and basically have been told by the Ministry of Health, who I hold in high regard, that they have no control over LHDs and they can't make them cooperate with us, which I found very disheartening.

MR MUSTON: Can I unpack that a little bit? To the extent that you say there are individuals or the way that individuals are interacting, which is, in effect, damaging to the services that you're providing, what sort of things do you have in mind when you say that?

MS McCOWEN: Absolutely. Yes, the one that I'm very, very upset about at the moment is we had a specialist physician coming to Aramajun since 2009. A personality in Hunter New England health decided earlier this year that that specialist could no longer come to Aramajun, they would have to operate out of the local community health building. But all our doctors are very upset about it, our clients are very upset about it, and I have gone to Hunter New England health about it and I'm still waiting for a resolution.

It has had a direct impact on service delivery. And it's part of what I see, they talk the talk but they don't walk the walk about self-determination and actually including Aboriginal health services in decision-making. It's - yep. But having said that, we have excellent relationships with other parts of Hunter New England health.

MR MUSTON: I take it from that that in relation to that particular example, there wasn't a discussion with you or your organisation beforehand along the lines of, "Well, where does your community actually want to access these - this particular specialist care"?

MS McCOWEN: No, no discussion. It was, I don't know, personality based, I suppose. A person decided that - one person made that decision.

MR MUSTON: So what is it that changed, from that time in the past when your organisation had a strong relationship or a good collaboration relationship.

MS McCOWEN: I think it was from the top, leadership from the top. But having said that, Hunter New England health does have a new CEO who is trying, and for the first time in 10 years, we've actually - she's - we're trying to bring back the AMSs and the health district, at that executive level, to have meetings. So they are trying. But they still - they're still not - they're still at the talk stage; they're not actually at doing, making any positive real changes.

MR MUSTON: And what about the interactions that you had with the ministry? Was that a cold call that you made or does your organisation have some line of communication with the ministry whereby discussions around these sorts of issues can be had?

MS McCOWEN: Oh, Ministry of Health are very, very receptive. I have an excellent relationship with them. If I have an issue, I ring and talk to them. Yeah. I can't fault them. But I did find it frustrating, because I thought that they would have some sort of say over the LHD, and they told me they didn't.

MR MUSTON: In terms of that relationship with the Ministry of Health, is that a formal sort of system or structure that enables you to have that relationship, or is it just that you, over the years that you've been involved in the health space, have come to know individuals whose phone numbers you have?

MS McCOWEN: Yes, it probably is a little bit personal based but we also do have formal meetings with - oh, help me out here, girls - the health director, or whatever, what's the name? Everybody should know her name.

MS FALZON: Susan Pearce?

MS McCOWEN: Oh, no, no, no. It sounds terrible that I can't remember her name, but she's very well known. She was the face of health throughout COVID.

THE COMMISSIONER: Is it Dr Chant?

MR MUSTON: Dr Kerry Chant.

MS McCOWEN: Yes, yes, yes. She does have formal meetings with all the AMSs on a regular basis, yes. Ministry of Health are very inclusive.

MR MUSTON: In terms of those meetings, what sort of things are discussed? Is there a standing agenda or is it just a "Come and tell us how things are working"?

MS McCOWEN: An agenda does come out, and it seems - well, to me, it seems to be, you know, topical issues at the time, yep.

MR MUSTON: That distinction you drew a little bit earlier between the talking and the doing, over your years of attending those meetings, do you get the sense that they have produced changes which you've seen on the ground or is there a bit more of the talking and less of the doing?

MS McCOWEN: No, because they can't, because where the change really needs - the ones that we really need on side are the local health district. That's - yeah.

I mean, Ministry of Health can be great for - to give us some funding for different things, and, I must admit, Ministry of Health funding, we didn't receive any funding from the Ministry of Health until a few years ago, and then they actually identified the AMSs throughout New South Wales that hadn't received any funding and they did address that issue. They provide all our dental funding and I can't - I can't fault them.

MR MUSTON: I know we don't have you for much longer, so I might just come back to that issue around the funding. What has your experience been of that bidding for funding streams against other people who are wanting to try and provide the care?

MS McCOWEN: I'm a very experienced grant writer, which has been of benefit to the organisation. But having said that, we've now got over 30 different funding grants, agreements, and reporting requirements, and it's got to a point where I'm not game to write another grant because we can't manage the reporting, and you do have the issues - we're writing one at the moment and it's only for 12 months.

I've got a community connector, which I forgot to mention, but it's a role where the worker goes into the schools and helps retain kids there until they complete year 12. Excellent. I've got the best worker. She's on the verge of resigning because there's no continuity of that ongoing grant, and that is a frequent - the only one that I can say with any certainty that we're going to get, and that's only just happened, is the Department of Health, where we were on one-year grant funding and we've just been told we're going to get a four-year one. Every other funding agreement, no, you don't know. You don't know. You can't offer anyone any continuity of employment.

MR MUSTON: So there's three things come out of that, I guess. The first is the reporting obligations which attach to each of these separate funding streams which you secure, I gather you're telling us, consistent with what we heard this morning and have been told repeatedly around the state, are extremely burdensome and could be streamlined in a way that means, as a bare minimum, at least for each of the funding sources, you should only be reporting to them once and in a standard way. I take the nodding to be a broad acceptance of that proposition.

MS McCOWEN: We get $9 million through DoHA and it has the simplest reporting thing. All these other programs where we might get a few hundred thousand are the most complicated reporting requirements, each with a different software package that you have to record into, each with different parameters and reporting KPIs, and so our software - we have to end up doing half of it manually because our software can't cater for all the different KPIs set by all the different funding bodies.

MR MUSTON: I notice Jessica is nodding at that, I take it that that's the experience. In fact, everyone's nodding.

We've just been joined by Hayley. Do you want to very quickly, Hayley, tell us who you are and what your organisation is and where you're joining us from?

MS LONGBOTTOM: Yes, sorry, I was a bit late. Hayley Longbottom I actually work alongside Krissie Falzon here at Waminda.

MR MUSTON: Great, thank you.

Debbie, coming back to that funding, the first issue is the reporting and the challenges around reporting. Next issue is the length of the funding commitments, so if it's funding for a limited period of time, I gather from what you've told us, that that creates challenges in terms of being able to employ someone into a position, a funded position, if you can't guarantee that that funding will continue for more than a confined period of time. Have I understood that correctly?

MS McCOWEN: Yes.

MR MUSTON: The last thing I wanted to ask about, just based on some things that we were told, have been told in our travels, it's been suggested that a lot of those funding streams, particularly a lot of the smaller ones that you might gather together, have quite restrictive terms in terms of the way in which the funding is able to be used. So these are program-specific funding streams that might require you, if you succeed, to deliver a particular program.

Some of the AMSs we've visited have suggested that it's great to get the funding but it would be much better if the funding, once it had been secured, could actually be deployed within the community in a way that the local people feel best would meet the needs of the community. Is that an issue which you have encountered?

MS McCOWEN: Yes, can I give you two specific examples?

MR MUSTON: Please do.

MS McCOWEN: One is with domestic violence funding. The majority of domestic violence funding is targeted victims only. We have always not applied for any of that funding, because we believe that if you don't support the perpetrator, you're not going to solve the issue, because people - victims go back to perpetrators. So you have to deal with it, with the unit, with the whole family unit.

He only domestic violence funding we have is through NIAA, where we - they allowed us to detail what we were going to provide, and we said "victims and perpetrators".

The other area is mental health funding, and, you

know, the PHN have the majority of the mental health funding and put it out. We do not apply for any mental health funding through the PHN, because they try and tell us what to do, and we do not believe that what they propose is culturally appropriate for our clients, and so we will not participate in their mental health funding.

THE COMMISSIONER: Debbie, what do you mean by they try and tell what you to do? Can you give me a concrete example?

MS McCOWEN: Oh, they set, I suppose, guidelines or eligibility or what we're allowed to deliver and what we aren't allowed to deliver. We don't actually have any say in helping design a program that would be suitable for our client group. So therefore we do not --

THE COMMISSIONER: These are people, I take it, that don't have the familiarity with your community that you do?

MS McCOWEN: No, no, no. But I don't even think they are - not only with our community but with Aboriginal culture.

THE COMMISSIONER: Yes, okay.

MS McCOWEN: I just think they lack the understanding to develop a program that will be of the most benefit. And because we're on the ground and our community holds us to very high standards and expectations of what we should be delivering to them, and if we can't deliver that, we are open to that community criticism. So if we can't provide them with what they want, we're not going to do something that they don't want.

MR MUSTON: While we have you, Debbie, just for the last few minutes that you're available, can I ask this question: if you took all of the funding streams that you manage to get access to and perhaps a few that you have resisted getting access to for the reasons you've just given to us and had that as a single pool of money that your organisation was able to deploy in the ways in which you felt best would meet the needs of your community, would you be doing things differently to the way you are, putting to one side that you would be doing a lot less reporting and the like?

MS McCOWEN: Absolutely.

MR MUSTON: What sort of things do you think would be different from what you're doing?

MS McCOWEN: But having said that - I don't know if I should say this in a special commission --

MR MUSTON: Please.

MS McCOWEN: -- but if we get funding, we make sure we report according to whatever they want, but quite often we will do what we think is necessary for the community, regardless of the funding guidelines. So long as we don't cross any legal lines, yeah, we will do what the community wants and needs.

THE COMMISSIONER: Don't take it as an endorsement but that makes perfect sense to me.

MS McCOWEN: Yep. Yeah, I know. But that's the way I see it. Yep.

MR MUSTON: We have heard some stories in our travels of examples of services that were being delivered through program-based funding which were very well received and providing, apparently, great benefit to a community, only to have that particular program base funding come to an end and the organisation was told, "Well, we're not going to fund you to do that anymore but if you want funding you've got to go and do something else." Is that an experience you've had in your organisation and if so, how have you dealt with it?

MS McCOWEN: We have had a couple of programs finish, and it does take a little bit of adjusting to. And probably the hardest part is dealing with the community, letting them know that you can't do something anymore. Yeah.

MR MUSTON: What about others? Maybe either of you from Waminda, do you have similar experiences in terms of those challenges around the funding streams?

MS FALZON: Yes, absolutely, and it's probably to my earlier point about - you know, I think Cancer Institute can be a perfect example as well, you know, you can lobby for funding around cancer for Aboriginal communities at

a national level, but in New South Wales it's different because you have Cancer Institute, and then how it is implemented by that point. So that's something I struggle with in the work that I do in cancer and have done for many years now.

All the funding that comes out targeted for Aboriginal communities are always innovation funds, so, you know, any program delivery takes about three years to really implement a successful program, but if it is a 12-month, 18-month, if you're lucky, project, then it's innovation you can't reapply for, you have to apply for another project model, and this is for like $120,000 per year, so I think absolutely.

I'll let Hayley - I didn't mention before, but Hayley leads all the health and wellbeing programs across the service, including ITC and a few of the other ones we've talked to, so I might let Hayley talk to that as well.

MS LONGBOTTOM: Yes, I think what some of the biggest struggles would be, you know, you get funded to deliver a program, but under-funded for, you know, management and administration, transport, so how are you supposed to provide the program without any of that?

And also, you know, all the same across the board by the sounds of it, you know, the 12-month funding, you've got to let staff go, the impacts that it has on not just the staff member, the family and then the whole community as a whole. Realistically, how is that closing the gap?

You know, there are plenty of ways that we do our work in our organisation. Of course we do our KPIs, but it is a stretch, you know? Palliative care, for example, we were funded there and then it stopped, and then now had to reapply for another round of funding for that. I mean, palliative care, everyone dies, so that, you know, should just be a given. And I think that, you know, realistically, Aboriginal organisations know their community, know how to, you know, support our community, and it has to absolutely be what that needs to be.

And minimise the funding - minimise the reporting frameworks, the same as everywhere else, and you know, the datasets, like it's just next level.

MS FALZON: Can I add to that, too, sorry, because the other part of that was just to your question around, you know, target and KPIs and numbers, versus actual impact and positive change for lives, that's not asked for in reporting. So, you know, most reports could be - and back to the point around specific funding, and I will use PHN as an example of that, too, being told how - like, you know, being so prescriptive of how the program needs to be delivered in the community, but it doesn't meet your community needs. It's not place based, it's not ACCHO led, it's people that have no idea what it's like being Koori and growing up in community and what the needs are, dictating how it needs to go.

Like Debbie talked to, it is about being flexible and how, like, we always meet the target numbers needs - that's fine. But the importance about actually closing the gap, smashing the gap and creating positive change for community, it's almost like it's not even relevant, it's just numbers and targets, which, you know, is a problem in itself.

MR MUSTON: I take it from that, you're saying - sorry.

MS LONGBOTTOM: I think the GP shortage is a huge problem in our organisation, having to pay locums, accommodation, transport, sometimes even their partners, like, you know. And we're trying to push for - the reason you want to work in this organisation is for the betterment of the first people of this country, the oldest living culture in the world, so you know, we need support in being able to provide a GP service to the community.

MR MUSTON: Because within the Shoalhaven, the market or GP market outside of that which you are providing is thin to non-existent in some communities; would that be right?

MS LONGBOTTOM: Exactly. Yes, exactly right.

MS FALZON: I think the other part is, like, even trying to get registrars as well. So you have private, like, you know, mainstream services that are just rolling in and out Medicare revenue, you know. They're not providing comprehensive care but they are providing scripts or appointments in 15 minutes. Like, that's not going to heal our community or make our community well, because we're actually - Waminda is still providing all the care, but you

know, they have plenty of GPs, registrars just pumping through, no continuation of care because they're only there for the 12 months and then the new doctors come in.

But, yes, you've got these little setups that are either bulk-billed or not bulk-billed, and then no specialist pathways locally, if you're not waiting more than three months, if you're lucky, and then, yeah, no funds for transport or support around that as well.

MS LONGBOTTOM: They're literally diagnosing and prescribing and, you know, mainstream services, a registrar T3 can earn up to $300 an hour.

MR MUSTON: That's putting wage pressure on your organisation, presumably?

MS LONGBOTTOM: Next level. And, you know, a big gap in our organisation, too, is, you know, dental. Population health, you know, they give minimal funding as well so we have to push and push and push to get what we need out of them. You know, the ITC program, minimal funding, and yet we're supposed to reach all these targets, provide all of this to the community and no-one's looking at enhancing the funding there, like, $220,000 a year to provide the transport, the admin, the care to the clients, opening up the doors, and then the holistic wrap-around approach is insane.

MR MUSTON: I see, Jessica, you're nodding. That's also been your experience of the Central Coast; would I be right?

MS WHEELER: Yes, especially around the ITC team as well. But we've also had a housing program that the funding was cut, so it was - we worked with the client for two years with stable housing, and then they cut the funding for that.

We also had a cancer navigator through the Cancer Institute, but now she's only - her employment is run now, we've been able to get some donations from Tour de Cure, and yet the LHD have got two - I think they've got two positions for the cancer navigator, only one of them is filled there, but yet we could fill it if we had that funding. So we've got one cancer navigator for all our community here.

MR MUSTON: Just to make sure I've understood that, the LHD has a desire for there to be two cancer navigators within your region.

MS WHEELER: I believe so, yes.

MR MUSTON: Due to workforce issues, they've not been able to fill both of those positions and they've only filled one?

MS WHEELER: Mmm.

MR MUSTON: You have a cancer navigator who would happily do that work particularly targeted towards the First Nations community within your area, but the funding that employs that person is coming from philanthropy?

MS WHEELER: Mmm.

MS FALZON: Can I --

MR MUSTON: Okay. Are there other workforce challenges that you - sorry, I think I interrupted one of you.

MS FALZON: I was just going to say I look at the cancer navigators. I think that's a really good example of the challenges with Cancer Institute and how it's rolled out to the local health districts, because we have the exact same - so I was actually really involved in those positions coming out of the state and the pilot of the three sites. Maybe you guys, Jess, might have been one of the pilot sites and now they've rolled out across the 15 districts.

Shoalhaven - I lobbied the whole time because it was actually based off one of Waminda's projects from 2012 about having a conduit that works between Waminda and the cancer centre as an example, and we still have momentum, and that's the work I do today even in cancer from that role in 2011/2012.

What's happened, they've rolled out across the state and they can't be filled, and then similar to the palliative care positions, so there's funding that sits in - funded through - there's even a shared project sitting in health that's half funded through PHN and the district for a palliative care position that can't be filled.

The cancer navigator role, they've just advertised twice and I was contacted yesterday to ask me do I have any ideas of how they can recruit, and I said, "Well, this was raised at the start when we first did all of the advocacy work: the funding needs to come to an ACCHO and then you need to be able to do it in partnership." So it's the cultural safety that's missing. The amount of support that we provide to Aboriginal and Torres Strait Islander staff within the system that work in the district is massive, around corporate safety, we've done cultural support, we've come in as a support person when, you know, racism's been raised and there are incidents and there are investigations.

So there's all this work within the system that's happening, and that's why the retention rate for Aboriginal staff within the health district is a challenge, but we know to increase, you know, cultural safety in a workplace, you employ more Aboriginal people, but you have to start somewhere and they need to feel safe, and it can't be just one person.

Then my other thought is around having two positions. That's amazing, because you could have a male and a female employed through you and providing services in your cancer centre. So what a missed opportunity.

MR MUSTON: Do any of you have any experience of collaboration with the local health district where funding for employed positions to deliver health care within the wider community within your geographic areas has perhaps come through one or other of your organisations but been used to employ a position in the other, say, for example, LHD money being used, in this instance, to potentially employ a cancer navigator, or vice versa? Does that sort of discussion happen or do you have any --

MS FALZON: It does. For us, we have two specific roles that we've had for about three years that come from the district, and they were - Hayley, you might remember exactly, I'm thinking of the acronym, but they were child sexual assault positions that were in the Shoalhaven, they couldn't be filled, so eventually they weren't meeting needs for the community, so eventually they came across to Waminda.

We've had no issues with that funding or having retention for the staff and servicing through - they're not called those roles anymore, and I'm sure it's written differently now, but I remember the time that it happened.

Yeah, obviously with that Aboriginal cancer project, that was a direct partnership with Waminda and the cancer centre when we first opened, and that was funded through Cancer Institute and that was a subcontract, the funds went to the district and came straight to Waminda and then employed across the week between both sites.

And I thought of another example, too, but I can't think of it right now.

MS LONGBOTTOM: I think where you have to think in that respect is that they came to us because they needed to. So, you know, realistically, if the money was sitting with an ACCHO in the first place, it wouldn't be a problem. So ACCHOs are always at the forefront of trying to get up partnerships, you know, trying to service the local health districts and the mainstream organisations in how to take care of our people because, at the end of the day, our mob are going to access those spaces, so how do they be anti-racist so that mob are okay to go and get the health care that they deserve?

Realistically, Aboriginal health funds need to sit with Aboriginal organisations, because then we'll be able to provide the care that we need. We wouldn't have, you know, shortages of GPs, we wouldn't, you know, have to travel to Sydney to the dental hospital to take patients there. You know?

We tried to get a partnership with the local health district down at the Ulladulla building that's practically empty to utilise their dentist chair and they wanted to actually take our data, and I'm like, "No, you're not doing that." Like, come on now, be fair about this stuff and realistic and honest about why mob, you know, don't go to these spaces.

MR MUSTON: Just on that data piece, is there, to what extent, if at all, is there data sharing around medical records to potentially facilitate the crossover of people within your care who then present in an acute setting and vice versa with people transferring from an acute setting

back into your care?

MS LONGBOTTOM: We've got, I think, major issues with discharge summaries and all that sort of stuff. We absolutely can share care, but sometimes, you know, they'll send them to the wrong clinic, that the GP works at another site and so they'll be sent there, and so it's very tricky. But, you know, it doesn't need to be that tricky but it can be tricky, yep.

I think, too, like what we're looking at, at the moment, is, you know, where are we sending our mob that are going through drug psychosis? So, you know, mental health don't want nothing to do with them because it's their drug use, you know, no-one wants to - they're not ready to go into rehab so what are we doing with these people? No-one wants to house them. So what are we doing with our community that are in drug psychosis? There's nowhere for them to be. You only have to ring the police or the ambulance and then, you know, they wipe their hands of them, too. We are not equipped to provide that support to these people because we don't have the resources to do that.

MR MUSTON: Just on that, people within your community, I gather from what you're saying that that is an issue within your community. There are individuals who are --

MS LONGBOTTOM: Massive right now.

MR MUSTON: -- having drug psychosis. Where are they going?

MS LONGBOTTOM: Yeah, we don't know. Good question. We actually don't know. Either they get locked up for the night, released the next day, they go to the hospital, they get --

MS FALZON: They're with us, Hayley. They're here. As soon as we're open, at our cafe, we have people there as we open the doors at 6.30 in the morning.

MS LONGBOTTOM: But at night, like, they're wandering the streets, probably getting locked up or getting sedated up at the hospital, getting released the next morning to Waminda, and it's like we can't do that. We provide them with a shower, wash their clothes, food, try and get them

to - even put shoes on their feet so you're not getting blistered in the hot sun.

MR MUSTON: What about you, Jessica? I see you nodding. These are similar situations --

MS WHEELER: Yeah, we have similar issues as well. We also have found, too, that as soon as we have any mob released from gaol, they'll just send them on to the Aboriginal medical centre still in their greens and they are like, "I need help." It's like, "Well, what are" - like, we'll do what we can, but - and even speaking back to the mental health and drug and alcohol, the reason why they've got drug and alcohol issues is because of their mental health, but yet when they go to the - they don't treat both. So - and then, yeah, we're not a crisis centre, but it's - they've got nowhere else to go.

MR MUSTON: You've jumped to something that I was going to ask you about, and that is the First Nations people who are incarcerated are receiving medical care during that period of their lives through justice health, within that prison setting. Do you think there would be potential benefit, and assuming that both sides of the equation were adequately funded to do it, but do you think there would be potential benefit in having, as it were, a clinical handover from justice health to the appropriate local Aboriginal medical service for someone - and perhaps even in the other direction, if someone is detained and it's ascertained, ideally, pretty quickly in that process that they have an existing clinical relationship with an Aboriginal medical service, a clinical handover from the AMS to justice health, and then, in the lead-up to their release, that there be a clinical handover back to just try and avoid a situation where, much like what you've just told us, Jessica, the person who turns up in their greens unannounced and says, you know --

MS WHEELER: They've got no housing. Like, we can't support - obviously our housing got taken off us for the funding, so no, we can't do that. And also it comes down to, like, our books are closed and that's devastating. And the GPs are very risk averse here in regards to, like, we've got Frank Baxter, the juvenile justice, just here at Kariong, that we're looking at trying to kind of build a bridge to - for the community in there, but then we are just under-resourced, we've got no GP. The follow-up care,

who - like, where does that risk lie with that?

MS LONGBOTTOM: For us, we actually have a justice health worker, so we've got a justice health program. We've got a worker that goes into, does in-reach, into the - women only, though, so we're able to provide them that support.

With our youth justice space, so we've got, you know, a youth justice program, but we also need to be looking at, you know, that prevention side of things and what are they actually getting incarcerated for, and then when they are coming home, like, they don't have any housing. Like, where are they supposed to go? So it's a big thing.

Also it's like very - like one worker within the justice health has to go to like six different prisons to do all this work with that many women, like it's across the state, and they're, you know, at our organisation, and so can you imagine the travel that she has to do, the work that she has to do, the supports that these women need, you know, coming back into the community - it's a lot. It's a lot.

MS FALZON: And just to add on that, too, we've had women that our staff have engaged with that have moved to the Shoalhaven just to have the support of Waminda, when they're not - we now have, like, transitional housing, but most of the time it's lobbying and, you know, with our local housing provider, that is very culturally unsafe and, you know, that's is a whole other conversation with struggles of trying to get support through them, which is known, but, yeah, that's what we're seeing.

MR MUSTON: Just in relation to that comment you made a moment ago Hayley around needing to focus on prevention and asking ourselves why some of these individuals are being detained, do you have in mind appropriate diversion? I mean, obviously there is a life trajectory aspect to that, but if you do reach the point where you are having that interaction with the justice system, do you have in mind that some diversion programs to identify what is really a mental health problem as opposed to a criminal justice or criminogenic problem might be useful?

MS LONGBOTTOM: I think the systems in this country are set up for us to fail. We have to be honest about that. So when we're looking at our mob, you know, they're

spiritually unwell. No-one is thinking about how spiritually unwell we are and how dispossessed we are as a people. But when we're resourced properly we're able to provide the care and the love and the nurturing that we need, and no better people can do that but our own people, you know? So it is very important that diversionary programs are just, you know, supporting people, giving them love, nurturing, a kick up the arse when they need it, too, we're not perfect, but also providing them with safe spaces to be able to come and vent, rant, rave, do what they need to do, in order to get that out of them. Like, it's not rocket science. It's just not.

MR MUSTON: I gather at the moment, the funding which is available to organisations like yours, or at least to your organisation, is not sufficient to meet all of the need that is out there in your local community on that front?

MS LONGBOTTOM: No, it is not. It is really not. We're struggling for space, like, you know, we've got all these amazing programs. Our youth program, they get up to 70 young people a week in that youth program, and so that's that prevention work, you know, being proud of your identity, who you are, what our culture is about, connecting to your elders and your peers and looking after each other, and, you know, what is the essence of our culture. Like we're not violent, you know, drugs and alcohol are suppressants and a self-harm mechanism literally - that's what we have to look at that as - and so what do you want to be when you are older? And when we're working with our adults, we've got to be talking to them, like, "What did you dream about when you were young? What did you want to be when you grew up?", you know, getting those things in their head. Because we're always talking about ourselves in a deficit, and that's how this country treats us, in a deficit, like the referendum is a very clear answer to what this country thinks about us.

MS FALZON: Can I just add about diversion, too, like when we think about the whole pathways to mental health, and that's the public and private options, and how long it takes to see a psychiatrist, to get medication reviews, and back to the point - and you'll probably hear it because it's something that Hayley and myself and our team are at our wits end of how to support community that is so unwell, but I'm having the conversations with the police to say that unless they break the law, they can't do anything, so

the only thing they do is, if the ambulance is called because someone's not well, police have to come. Police will escort the person to the hospital. They get an assessment, 12 hours, or sometimes they might be scheduled overnight until they see the psychiatrist and then they're released, and similar to when people are leaving justice, we will get phone calls saying, "Oh, look, I'm letting you know" - that's lucky, if we get a phone call, because half the time we don't even know - "They've just been given an Opal Card and they're on their way back to Nowra, they're on their way back to Waminda", and we're like, "Hang on, this person is at absolute risk for themselves, we can't keep them safe. She's at risk to others." And we might ring mental health and they'll say, "Ring the 1800 number". And police hands are tied; the hospital, if people are assessed that way, their hands are tied, because if you're assessed well, you - it's just, I think, probably like a bed shortage, too, but even when we're advocating with our specialised mental health services and saying, "These persons are at risk and really they should be scheduled under the Mental Health Act", they are saying, "Oh, well, we don't deem that", "Oh, it's not my job to look into this, it's drug induced", meanwhile, they are back on the street and this is happening on a daily occurrence with the same people over and over and over.

MS LONGBOTTOM: Mmm, yes.

MR MUSTON: Are there any mechanisms, at least within your local health district, where you can sit down and talk to people within the LHD, the mental health team at the LHD, about these people who are in this cycle, to try --

MS LONGBOTTOM: They are strapped because their policy states, right - and the - you know, we've got many, many examples where they will call us because they deemed the person unsafe, so they will call us to go and do it, because, you know, it's okay for us to go and see an unsafe person, but it's not okay for them. Like literally, that's what they do. We've had these conversations, we've been at the table, but their policies state.

MR MUSTON: So these are people who they have determined are a risk either to themselves or to others?

MS LONGBOTTOM: To them - to them, yes.

MS FALZON: Even if they raise their voice in a meeting - like we have clients that are banned from services, where that's not even meant to be a thing under the health district, people can't be banned by mental health or drug and alcohol, but they are refused service and that's why they are at Waminda's door waiting for support continuously.

I think investment and funds needs - like even how hard it is, you can't get that support around seeing a psychiatrist, it's so hard. Even for a well person, if you needed, you know, just some follow-up care for psychology as well as for any needs, it's not available, and the quickest way to see a psychiatrist is to be scheduled. It's not good enough. You can't wait six months to see a psychiatrist with these ridiculous amounts, when ITC might be funding there or different areas.

We actually fundraise for funds around cancer investigation funds and for other things like to get specialist appointments that can't be covered under any other care and aren't bulk-billed.

MR MUSTON: Do you see, just through the community that you engage with, a connection between this mental and spiritual wellbeing on the one hand and the more physical health type issues, chronic disease and the like - that is to say, the individuals who you are not able to provide that mental health --

MS LONGBOTTOM: I will tell you, in our town, we've literally just had five cigarette shops open up - cigarettes and vapes and they have promoted gifts and confectionery on the front of their shops, right? Who are they targeting? Gifts and confectionery, "Go in there". Like that's kids. One of the lowest socioeconomic areas in the area, and they've got alcohol shops there, tobacconists and vapes popping up left, right and centre.

And then we've got that many take-away shops on this main strip, it ridiculous. That is all deliberate. It is deliberate. It is there for us to be sick, to go and do all those things. No-one's employing us apart from Aboriginal organisations, so where else are people going to go? We can't provide everyone with a job, and we certainly know that when people start and have an opportunity and have that wrap-around support, then of course their futures

are going to be different. You know, you've got to look at the social investment of people.

MR MUSTON: But just where you make that investment, do you see that the physical health of members of your community in terms of chronic disease, diabetes and --

MS LONGBOTTOM: A hundred per cent. We've actually got a diabetes remission and Aboriginal women's program. Massive. So we support these women to change their nutrition, first and foremost, and then they wear a CGM monitor, and so they can literally see if, you know, the food they are eating is shitty for them - sorry for swearing.

MR MUSTON: That's totally fine

MS LONGBOTTOM: That's self determining, right? So they are literally going to see how bad their sugar levels are and it's up to them whether they are going to eat that or not. I'm telling, you people come off medications and then they start to feel better about themselves, "I'm going to go for a walk", so they're starting to get active, and then socially they're going on camps and doing good things. A hundred per cent. A hundred per cent.

MR MUSTON: In order to achieve those sorts of outcomes through your organisation, what would need to change, or to achieve more of those outcomes is probably a better way of putting it?

MS LONGBOTTOM: Well, firstly, we need to be resourced properly to be able to provide - and like we want to take this down to, you know, Wallaga Lake, and now we go up into Coomaditchie as well. So resource, for starters. We need people resource, we need space resource, we need medical equipment resource. I mean, we do all of our shared medical appointments - sometimes it goes online with an endocrinologist for, you know, women's business stuff, but that works, right? That shared medical appointment works. It's just properly resourcing and not having to borrow from Peter to pay Paul, as the saying goes. And then the multiple list of things you have to provide for, you know, funding; and then making sure that we're, you know, literally going off the CTG target, like, we do so much more than that, as well. Like literally just resource organisations and communities to do the work that they know

that works.

MS FALZON: The Aboriginal target funding needs to be Aboriginal community controlled. I do understand that people say not all Aboriginal people want to go to an ACCHO - well, not all Aboriginal people go to an ACCHO - but I would challenge that, because if we were resourced and people weren't waiting three weeks for an appointment with a doctor or could get into a doctor if we had five doctors operating daily to meet the community needs, I would challenge that that's even a statement. Because I hear that time and time again, and especially for other people that hold specific Aboriginal funds.

I think also when we talked about the population and our area that we cover in the Shoalhaven for Waminda, I would also make a note, too, in COVID times, we didn't close our books but we reduced our criteria because - just to try to meet the needs just based on our resources and our funding. So our numbers were probably double what they were, but we couldn't meet the community needs around appointments and that so we targeted for Aboriginal women and their families.

MS LONGBOTTOM: We also have to acknowledge the Aboriginal health practitioner. You know, in the wider health profession, that's not understood or valued enough either, and an Aboriginal health practitioner does so much more than, you know, your generalised nurse. They are very, very undervalued. Our clinical space is health practitioner led. They are, you know, how locums work in our communities, because of the continuity of care. They take bloods. They don't prescribe and diagnose is the only thing that they don't do. So, you know, when the Aboriginal health practitioner is just as valued as any other health professional, that will change as well. That will change things. As well as pathways into being a GP from an Aboriginal health practitioner. Those things need to change within the universities as well. And the allied health, actually.

MR MUSTON: Just coming back to a question I asked Debbie before she left, do you think that if all of the different strands of funding that you gather together were just put in a single pool and you were able to make decisions as an organisation about how best to deploy those funds to meet the needs of your community, do you think that you would be

able to produce better outcomes, health outcomes, for your communities?

MS FALZON: Absolutely. The amount of targeted Aboriginal funds that are in the country that go to mainstream services instead of coming directly to ACCHOs to deliver services through our models of care from our community, for our community, is unbelievable.

But, yeah, absolutely, if funding comes to our services so we can deliver the needs, instead of, like Hayley said, having 70 youth attending youth programs, and around that prevention and support and opportunities for pathways of employment and - you know, where do they want to be when they are older? But we actually can't cater to the numbers because we don't have the space. There is no infrastructure, there is no investment in - you know, to build spaces, youth spaces or specific culturally safe spaces, but yes, absolutely.

MS LONGBOTTOM: I agree, and I need to back Krissie up with, you know, mainstream organisations getting Aboriginal money. They don't need it, either. So put it where it needs to be and belongs.

MR MUSTON: What about you, Jessica, I noticed were you nodding, but do I take it that that means you share those views.

MS WHEELER: Yes, definitely. Yes. And it would also mean less time that we'd have to spend on admin, doing the reporting. All different portals that we have to navigate is a nightmare. So.

MR MUSTON: We've sort of touched on most of the issues that we've spoken to people and heard from people about around the state, but are there other issues that we haven't spoken about that any of you think really should be on the table in terms of changing the way that either the funding or the interaction between ACCHOs and PHNs, and more specifically LHDs, could be changed in order to help you to do more with the resources you've got?

MS FALZON: I think flipping the narrative about, you know, you have all these different streams and different parts of a person, where if you flipped it and looked at it from what does the ACCHO model of care look like, what is

a whole of life service approach, soft entry point, no wrong door approach to care, whole of life, from birth right through to palliative, end of life and everything in between - if that narrative was flipped and that's where it started, through the ACCHO lens, instead of, you know, "Oh, hang on, can we apply for this funding? It is targeted for mental health but we need this or that", "Oh, no, you can't have this, that doesn't fit that criteria" - so if the narrative flipped and it went from place based care through the ACCHO lens, that's where the funding - that's where it needs to start.

MR MUSTON: Accepting that it might be impossible, even with the best will in the world, to get rid of all of the grant based and program based funding streams, if for no other reason than that would require multiple different levels of government to agree, but if there was a block of funding that was provided to your organisation to provide health care in a way which was delivered in the way that you felt, in each of your individual communities, would best use that money, possibly supplemented by grant money on the edges, would that make a substantial difference?

MS FALZON: Absolutely. You have, like, you know, fund folders like - and I will say PHN or NIAA - like there are funds being used and being wasted in positions just to hold funds, than to deliver us. Those funds could be employing positions on the ground, and if you think of all the administration and everything else that goes into everything that has to be set up for that - like it just should be direct funding to ACCHOs and for comprehensive health and wellbeing care.

MS LONGBOTTOM: Yes, if you take out the middle person, the middle person in those organisations, and that comes to Aboriginal organisations, then sweet, of course it is. But you have to actually look at, you know, the population we take care of. The funding obviously needs to be substantial because there is a lot of work to do, and I think when those - you know, the LHD - when they realise, you know, the care that they provide is very not okay, then that's when they should be, "Okay, then, yes, I agree with that. We really don't know how to look after Aboriginal people. Aboriginal people know how to look after Aboriginal people", and they should just be fine with that.

MS FALZON: And I think the other part of that is - and we

understand that there are not ACCHOs that cover every single - because, you know, we have a lot of peaks, like AH&MRC, the peaks for the state, and not all regions are covered by an ACCHO, but that's okay, because you do have to work in collaboration. But as a rule, no mainstream or no not-for-profit should be applying for specific Aboriginal funds without the endorsement or support of the local ACCHO.

MR MUSTON: Just to pick up on something you said a moment ago, Hayley, to the extent that services being delivered through the LHD are "not okay", to use your words, for whatever reason, do you find, within your local area at least, you have an ability to communicate that fact to the LHD - that is, say to them, "Look, here's what we've been told on the ground"?

MS LONGBOTTOM: Look, a hundred per cent. A hundred per cent. We make no bones about making complaints or, you know, we've got a good relationship with our local health district CEO and we're quite happy to have those conversations. You know, they have invested in coming to do our decolonisation workshops, so that's really good. But at the same time, too, like it's the belief of people that just think that they are better than, you know, Aboriginal people, and that's the stuff that we need to discuss.

So, you know, very good having a conversation with the CEO, but what about the staff that are taking care of our mob walking through their doors.

MR MUSTON: That was sort of my next question. To the extent you have these discussions and you have a good relationship with the CEO, do you find that that's something that translates into changes on the ground?

MS LONGBOTTOM: Well, you know, we've got an MGP up in the hospital at the moment, so you know, there's obviously still a lot of work to be done. Very, very slow progress, but it absolutely can.

MR MUSTON: Yep. What about you, Jessica? You have a different - not quite the same relationship with the LHD.

MS WHEELER: Or the PHN. Our relationship with the PHN is pretty much non - like they are not supportive or helpful.

I'm not sure when - the last time I spoke to my practice liaison worker in the PHN. So it took the CEO to respond back to Belinda, our CEO. I'm not even sure if he has even responded back to her, actually, in regards to our transport issue. Our ITC program, when they lost the transport access to that company, we reached out to them to get them to help support us and they did nothing. They just told us to try elsewhere. So that's what we're dealing with.

MR MUSTON: Did you have any other issues that you wanted to raise that we have managed to skilfully skirt around or unintentionally skirt around?

MS WHEELER: No.

MR MUSTON: Do any of you have any other issues? I've sort of asked questions based on the things that we've heard around the state, but equally, you guys are on the ground dealing with this day in day out and you know a lot of stuff that we don't, so if there are changes or if there are things that you think could be improved, let us know, and if we end this and then you think of one, don't hesitate to communicate with us about it.

MS WHEELER: Will do.

MS FALZON: I think a lot of the areas across the state are doing their renewing their statement of commitment with the district, so I think being able to have that with the implementation, and like I said at the start, like, yes, we have a great relationship with the CE here, but if she was to go, and that's - we know people don't stay in these roles forever - what's going to happen? We're going to lose that momentum. So it needs to be embedded as part of the process and the expectation, and there needs to be, like, processes for accountability and monitoring how things are tracking.

I think to the PHN as well, you know, at a state level AH&MRC and PHN have come together with a statement of commitment, too, of how they are going to work in communities, and the discussions we're having - and this was the proposed discussion as well with PHN - around decommissioning and recommissioning to the ACCHOs directly, that hasn't been picked up since one of the CEs that were leading it from PHN left his role last year. And my

feedback about being involved in that process is all ACCHOs are going to be hesitant to sign a statement of commitment with the PHN, for good reasons, like for trust or mistrust, everything that we face daily as Aboriginal people.

But on the flip side, how you had some CEOs of different areas refusing to sign it, when those funds are targeted for our communities, I cannot understand. And, you know, their reason why they wouldn't sign that statement of commitment to decommission and recommission to ACCHOs, it needs to be questioned why they are even in their roles for health and wellbeing care and the work that they are doing as PHN.

But, yeah, I think coming back to all the districts, looking at the statement of commitment, making sure that there are ways to have accountability, monitoring, and being able to have reviews and audits and cultural audits across - I know a lot of different areas in the health district, they do their own self cultural audits. Like, what is that? How do you self audit yourself as a mainstream service around culture? That's just - I can't understand that at all.

THE COMMISSIONER: To all three of you, thank you very much for your time. We're very grateful for it and for the assistance you have given us, so thank you once again.

And we will adjourn until 10 o'clock at Redfern tomorrow for the in-person roundtable.

Thank you.

AT 3.42PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO THE NATIONAL CENTRE FOR INDIGENOUS EXCELLENCE AT 10AM

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