

**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

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

3
4 Before we begin this roundtable session, the Special
5 Commission of Inquiry into Health Care Funding, I wish to
6 acknowledge the Gadigal people of the Eora Nation, who are
7 the traditional owners of the land on which those of us
8 here in Sydney today gather today and pay my respects to
9 their Elders past, present and emerging.

10
11 To those of you online, thank you very much for
12 attending. We're very grateful for your time.

13
14 Throughout the 14 months of this Inquiry so far, we've
15 met a number of you, not all of you but a number of you.
16 We do feel as though, over that period, we've at least
17 obtained good information and understanding about the
18 services you provide and the great importance of your
19 organisations to your communities.

20
21 We've had various discussions with ACCHOs and AMSs on
22 these broad topics - first of all, your funding and where
23 that comes from and, in particular, the difficulties
24 associated from time to time with short-term funding;
25 issues in relation to workforce, which are sometimes
26 related to funding; and relationships with other entities
27 and people within the healthcare system, in particular,
28 LHDs and PHNs but also other organisations.

29
30 I've kept that deliberately broad because it's
31 important that neither I or Mr Muston, who you will hear
32 from in a moment, set the agenda.

33
34 This is not an opportunity for us to talk to you; it's
35 an opportunity for you to inform us. We have deliberately
36 designed these roundtables in a manner that we hope
37 encourages engagement.

38
39 By that, what I mean is we want it to be less formal
40 than what a court hearing might be, and we would also
41 encourage you, if you hear - if one of your colleagues
42 makes a comment that you want to add to, please, just put
43 up your hand and indicate you'd like to add or say
44 something about that particular topic. Whilst this is an
45 important information-gathering exercise, as far as
46 possible, we want to keep it far less formal than a typical
47 court hearing, which this isn't.

1
2 Having said that, I will now ask Mr Muston to say
3 a few words and start the discussion off.
4

5 MR MUSTON: Thank you.
6

7 I should introduce myself. My name's Ed Muston, I've
8 spoken to some of you. I'm one of the barristers who is
9 assisting with the Inquiry. Sitting to my left is Hilbert
10 Chiu. He is one of the barristers who has been retained by
11 NSW Health to assist with the Inquiry.
12

13 As the Commissioner has said, the aim of today is, as
14 best as possible, to keep this process largely
15 conversational and, to the extent that there are - I'll
16 endeavour to push you off in relation to some topics and
17 then we can chat around them.
18

19 To the extent that any of you hear what is being said
20 by your colleagues in other parts of the state and want to,
21 or think it would be useful to chime in at that point to
22 tell us about your own experiences, how they differ from
23 those that might have been spoken of or how they line up
24 with the experience of others, feel free to do it.
25

26 As the Commissioner said, use the "raise hand"
27 function if you can work out how to do that. I usually,
28 I must confess, struggle with that. If you, like me,
29 struggle with that technology, feel free to just put your
30 physical hand up and I'll make a note of the fact that you
31 have done it and come to you as quickly as we can.
32

33 In saying it's largely conversational, the only real
34 constraint that we have to keep in mind is there are two
35 people in the room here with us who are carefully taking
36 down what people are saying, so as best as we can, if we
37 could sort of try and speak reasonably slowly and one at
38 a time, that would make their job a lot easier.
39

40 I know sometimes as we get into discussions, people
41 start speaking quickly or cutting across one another. If
42 they look at me in a way that appears vaguely frantic and
43 I ask you to slow down, please don't take offence, it's
44 really for their benefit, not because we're not very, very
45 interested to hear what you have to say.
46

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

1 around each of you and just gave you the opportunity to
2 tell us who you are, where you are joining us from in the
3 state and just give us a brief description of the
4 organisation that you are involved with and the particular
5 role and services that it offers to its community.
6

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

10
11 MS PENRITH: Yes, hi. I'm Lisa from Griffith AMS. I'm
12 the practice manager and sitting beside me is our CEO, who
13 is the observer.

14
15 MR MUSTON: Thank you. And it is probably in the name,
16 but where are you joining us from today?
17

18 MS PENRITH: Griffith Aboriginal Medical Service. We also
19 auspice Murrin Bridge Aboriginal Health Service and KAMS.
20

21 MR MUSTON: In terms of the services, just in broad terms,
22 offered by the Griffith AMS, what are the sorts of services
23 that are offered by your organisation to the community in
24 your region?
25

26 MS PENRITH: Okay, we have our mental health services
27 here, our clinical team, ITC, tackling Indigenous smoking,
28 allied health, drug and alcohol, youth services, visiting
29 specialists and dental, yep.
30

31 MR MUSTON: Great, thank you.
32

33 MS PENRITH: I've probably missed a few, but that's it.
34

35 MR MUSTON: I'm sure they will rattle out through the
36 course of the morning.
37

38 Isaac Simon, you are joining us from Tobwabba.
39

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

1 to have a dental service as well.

2

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

5

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

10

11 MR MUSTON: Thank you.

12

13 Payden Samuelsson from Bullinah Aboriginal Health
14 Service.

15

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

27

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

38

39 MR MUSTON: Thank you.

40

41 Mark Burling from Wellington Aboriginal Corporation
42 Health Service.

43

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

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

7
8 MR MUSTON: Thank you.

9
10 Julie Tongs?

11
12 MS TONGS: Hi, everyone I'm Julie Tongs. I'm the CEO of
13 Winnunga Nimmityjah Aboriginal Health Service here in
14 Canberra. I've been the CEO now for 27 years and I'm
15 coming from Ngunnawal, Ngambri and Wiradjuri country here
16 in the ACT and surrounds.

17
18 We run a comprehensive primary healthcare service. We
19 have seven doctors, four nurse practitioners, 16 nurses,
20 16 Aboriginal advocacy and support staff, we have an AFPP
21 program, Australian Family Partnership Program, Connected
22 Beginnings. We have midwives, allied health. We've got
23 three psychologists, a psychiatrist two days a week, a site
24 registrar five days a week. We do drug and alcohol. We
25 provide - we can do the Buprenorphine injections, doctors
26 prescribe methadone, we've got a needle and syringe
27 program. We run a full-time clinic out of the prison here
28 in Canberra, so we've got a 24/7 service for our men and
29 women in the AMC here and so that's 365 days a year. We've
30 been doing that since 2019. It's been very successful,
31 lots of challenges but, yes, it's well worth it.

32
33 So, yes, we are a comprehensive - dieticians, but the
34 struggle here in the ACT is with access to specialised
35 services, but we can talk about that a bit more later, if
36 that's okay.

37
38 MR MUSTON: Thank you. The transcript can probably note
39 that there was a bit of nodding on the screen when Julie
40 made reference to the challenges associated with the access
41 to specialist services, which, I gather, means that's
42 a common experience for many of you.

43
44 Dian Edwards?

45
46 MS EDWARDS: Hi, Dian Edwards. I manage Namatjira Haven
47 drug and alcohol service for Aboriginal men 18 and over.

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

8
9 We're currently really focusing on trying to get
10 a women's service - women with children. There is
11 absolutely no women and children's service in the state so
12 we're working really hard on that at the moment. A lot of
13 our focus and attention is on that. And we have a strong
14 focus on culture, healing and culture rather than
15 traditional medical models. That's us.

16
17 MR MUSTON: Thank you.

18
19 Christine Peckham from Peak Hill Aboriginal Medical
20 Service.

21
22 MS PECKHAM: Hi, I'm Christine Peckham, CEO of the Peak
23 Hill Aboriginal Medical Service. We're a small AMS. We've
24 been going for coming on over 20 years anyway now. We
25 rolled it out - we had no funding, we just had - we were
26 able to secure our premises through the Ministry of Health
27 and they still haven't handed it back to us.

28
29 But, yeah, we started off with one chair and four
30 boxes of condoms and some help from the other AMSs. Then
31 the Commonwealth decided to roll us out under the primary
32 health care access program through Condobolin Aboriginal
33 Health Service as an auspice, and then we were going to go
34 to Dubbo, as being auspiced under them. That didn't
35 happen, so we've been auspiced by the Weigelli Aboriginal
36 drug and alcohol centre in Cowra for a long time now. And
37 we also have been auspiced through the Wellington
38 Aboriginal Medical Service for the Healthy For Life program
39 when that rolled out.

40
41 So, you know, we've built up over the years. Like
42 I said, when we got the keys we had nothing. Our board,
43 you know, helped with assistance from other AMSs and
44 through efforts of our own, built up to get - now we run
45 primary healthcare clinics, we have a doctor three days
46 a week, a doctor one day a weekend every month. We've
47 recently commenced outreach clinics to Narromine. The

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

6
7 We also run allied health outreach to Narromine,
8 podiatry and diabetics and diabetic education, which we
9 also do here. So we do Healthy For Life, we do the health
10 checks, healthy lifestyles, babies and kids health checks
11 and chronic disease checks. We have an optometrist that
12 comes at least every six weeks. We do otitis media
13 screening from here. We do nutrition clinics with our
14 dietitian and diabetic educator. We've just commenced
15 our healthy ways program with a community group, mainly
16 women, where we meet every fortnight and talk about
17 a health issue, and we'll do a cook-up and just talk about
18 what their priorities are, so we try to do that.

19
20 We run social, emotional wellbeing and ITC through
21 some funding we secured from PHN. We also manage the ex
22 Masonic hall, which is our learning and healing centre, and
23 we have a lot of community activity there, all our health
24 promotion activities there and the community just -
25 a gathering place for them.

26
27 We support and advocate for women and the young people
28 around our area. Our area includes Parkes LGA area, Peak
29 Hill town itself, the three T towns, Tottenham, Tullamore
30 and Trangie, and Narromine, which is in, you know, our
31 mob's boundaries, which is the Bogan River, Wiradjuri mob.

32
33 We have medical health equipment here. We do nicotine
34 replacement therapy and we do "check your wrist". Every
35 few months, we'll go out on the street and set up and do a
36 little check your wrist for anyone who wants to turn up.

37
38 We also make referrals to specialists, other allied
39 health services, psychologists, psychiatrists, for mental
40 health, pathology services, imaging services, et cetera.
41 Pretty much the same as everyone else does.

42
43 We're staffed by myself, I have a full-time
44 admin/receptionist person, Aboriginal health practitioner,
45 ITC coordinator and our visiting health professionals
46 including a podiatrist, optometrist and dietician, diabetic
47 educator.

1
2 MR MUSTON: Thank you.

3
4 MS PECKHAM: That's us in a nutshell.

5
6 MR MUSTON: Finally, I think --

7
8 THE COMMISSIONER: I think Rosemary is listed at 2 o'clock
9 but I can see her on screen.

10
11 MR MUSTON: Yes. So Rosemary Rose from Pius X Aboriginal
12 Corporation was initially coming at 2 o'clock but is
13 joining us this morning from Moree, I think.

14
15 Over to you, Rosemary.

16
17 MS ROSE: Sorry, about that. I got two messages, one
18 saying 9.30 this morning and one saying 2 o'clock this
19 afternoon, so I didn't know what to do.

20
21 MR MUSTON: You're welcome to join us.

22
23 MS ROSE: If you want I can come back this afternoon or
24 I can stay. It's up to you.

25
26 Well, Pius X Aboriginal Corporation in Moree, where
27 I'm on Gamilaroi country, we cover from womb to tomb. We
28 have mums and bubs programs, we have GPs, nurses, mental
29 health, drug and alcohol, homelessness, dental, and we do
30 within a 100 kilometre radius of Moree, so we do Narrabri,
31 Toomelah and Mungindi. Pretty much like everybody else.
32 Yeah, that's us.

33
34 MR MUSTON: Thank you.

35
36 Could I start - before we get directly into the issues
37 that we've got listed, it would be good to get a bit of
38 a sense from each of you as to the extent to which you feel
39 the services that you're able to offer with your current
40 resources, when combined with services being delivered
41 through the LHD and other sources, are actually meeting the
42 health needs of your community in your respective areas.

43
44 Maybe starting with you, Julie Tongs, to what extent
45 do you think that there is unmet need, if at all, from
46 a health perspective for communities within your footprint?
47

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

12
13 The other would be, and I would be curious to hear
14 from all of you about this, that sometimes there is a lack
15 of autonomy in relation to the funding that's provided, and
16 it seems to arise sometimes with PHNs, that you guys might
17 have a different view about what services should be
18 provided than what the funding is actually allocated for.
19 So they are two big themes that have stuck with me.

20
21 Having said that, I've broken my rule that I shouldn't
22 be setting the agenda. Ed's introduced this topic about
23 whether the funding provided is really adequate for the
24 demand that you now have, so over to you, Julie.

25
26 MS TONGS: Thank you. There is huge unmet need in our
27 community. Canberra is a very middle class city or, you
28 know, large country town, that doesn't see disadvantage.
29 Twenty per cent of our clients come from New South Wales.
30 That's why I'm here today. We get no funding from
31 New South Wales.

32
33 I've spoken to every CEO and DG of ACT Health. Our
34 hospital's a regional hospital, so people from New South
35 Wales come in from other parts of New South Wales into the
36 ACT. There is an agreement between ACT government and
37 New South Wales for funding the services to the hospital,
38 but never been an agreement for the services that Winnunga
39 provides.

40
41 One of the biggest issues is poverty and we all know
42 that, we all feel that. Also the "Closing the Gap" report
43 that just came out was that Canberra's the most racist
44 place in the country. So when you combine those two
45 things, and we're talking about systems and services, there
46 is huge unmet need.

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

10
11 So we've got a hospital and a health system that's in
12 crisis, and we all know that, but then that pushes that
13 back on to our services that are the most underfunded in
14 the whole country, you know? Like, we do what we do for
15 \$15 million a year.

16
17 We've just had an actual economist, Shane Houston, do
18 work with us, and Robert Griew, who was a first assistant
19 secretary of Commonwealth health years ago. They've just
20 done a review of our services and we've got a \$25 million
21 gap - a \$35 million gap. We're providing \$35 million worth
22 of services that are unfunded.

23
24 So, you know, even though we're a health service, we
25 cross over into child protection, we cross over into, you
26 know, court support, the prison system, all of those
27 things, and we're not funded to do any of that, but it's
28 the trust that our clients have in us - they want us at the
29 table, you know, and we're not going to not be there,
30 because our service is client-centric, it's all about them,
31 you know?

32
33 So there's huge unmet need. I'm sick of the rhetoric
34 of government, you know, around mental health and all this
35 money going into mental health. My psychiatrist's been
36 with us for 24 years, and that position's still not funded.
37 So, you know, there is a lot of historical - a lot of our
38 services have been funded historically, which only come
39 with maybe 80 or even less, \$80,000 or less. But, you
40 know, then we're trying to manage, like - because the TIS,
41 the Tackling Indigenous Smoking, and other programs come
42 with a lot more money than we got historically. And so
43 that's a challenge in itself because I don't like to pay
44 one lot of staff more than what the others are getting. So
45 when we get to workforce, that's one of the big issues.

46
47 THE COMMISSIONER: Julie, should we understand historical

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

5
6 MS TONGS: Yeah.

7
8 THE COMMISSIONER: So it's based on an inaccurate base or
9 a base which doesn't represent the demand for services?

10
11 MS TONGS: No. And we get - you know, we're not funded,
12 like, for our finance team or any of those positions in the
13 administration. That all comes from our service delivery
14 contracts. So, you know, the thing is that's a huge risk
15 to our services. If you start to lose key people or
16 funding, that then puts the service at risk. So, yeah,
17 there's lots and lots of challenges and, you know, I'd be
18 interested to hear what other mob have got to say, you
19 know?

20
21 THE COMMISSIONER: Can I just ask - it may be important,
22 probably is, but also I'd just like to know - the reference
23 you made to the level of racism in Canberra, how does that,
24 in particular, manifest itself? Can you give me some ideas
25 about more specifically what you are talking about there
26 from your own experience?

27
28 MS TONGS: Some of it's passive and other is just in your
29 face, you know? And you get people to come in for meetings
30 and straightaway, you know, like, you can tell by their
31 body language and, you know, the way that they're looking
32 around, they're looking at their watch, they're, you know,
33 like, thinking, "We don't want to be here". You know that
34 they don't want to be here.

35
36 But also, you know, when you ring up and you make an
37 appointment or you've got to ring an external service and
38 you say you're from Winnunga, straightaway, there's
39 a deafening silence, you know, like. But even so many of
40 our public servants, young and older, they just want to get
41 out of the public service because it's so bad for them
42 that, you know, their mental health is suffering and this
43 is what happens, you know? Like, all of that stress plays
44 out on your body, you know? And so it doesn't just do
45 psychological damage, it actually does - that then creates
46 physical issues and chronic disease and all sorts of other
47 issues.

1
2 So, you know, it's a real challenge and, you know,
3 ACT, 60 per cent voted yes, but, you know, the Productivity
4 Commission report and the "Closing the Gap" said, you know,
5 76 per cent of the ACT Aboriginal community complained
6 about the racism back in a six-month period in 2022, and
7 that was the lead-up to The Voice. So - yeah.

8
9 THE COMMISSIONER: Okay.

10
11 MR MUSTON: Who would like to go next in terms of talking
12 about the extent of any unmet need and perhaps telling us a
13 little bit about the particular areas that are unmet in
14 your area?

15
16 Christine, I see you have put your hand up. You are
17 on mute.

18
19 MS PECKHAM: Yep. Our unmet need, like I said, we're
20 a small organisation but we've grown over the years to the
21 extent that we're providing services to our mob in the
22 smaller towns around - and I mentioned Narromine.

23
24 Now, when we rolled out with Commonwealth funding -
25 and by the way, we don't get any funding from New South
26 Wales for any of our positions or, you know, anything.
27 We've got a couple of one-off, and we have got some funding
28 to upgrade our building, "thanks, Phil and Jerry", but
29 other than that, we've had no funding whatsoever.

30
31 We've got three days a week for a doctor, and one
32 weekend, a Friday and a Saturday, for another doctor that
33 comes in, just to Peak Hill, and we've been operating like
34 this for quite a number of years now. Luckily, we haven't
35 got a high turnover with our health professional staff.
36 Our nurse is local, our Aboriginal health worker is local,
37 and I'm local, know all the mob, know all the family. So,
38 you know, we know what the priorities of the community are.

39
40 You mentioned - you know, we do get some funding but
41 sometimes it doesn't - through PHN, it doesn't meet our
42 priorities of our mob, so we, you know, try to work around
43 that and be as flexible as we can within all the guidelines
44 for us. We'd just like to have - to come out of being
45 auspiced by a drug and alcohol service, which is over,
46 like, 150Ks away, 160Ks away, and for one program, through
47 another AMS. All the feedback we get is, "Oh, we're doing

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

7
8 But our issues in regards to gaps is we don't have any
9 specialist services coming in, they have to be referred
10 away. We have 18 hours of transport that we transport
11 people to Orange, Dubbo and Parkes. If they have to go to
12 Sydney, we have to get endorsement by our board.

13
14 So then the issues there are we send people to
15 hospitals, especially Dubbo hospital, and within an hour or
16 two hours, they're being discharged. We don't know what
17 happened there, or they've been sitting around waiting.

18
19 We had an incident the other day that, you know,
20 a young girl was waiting all morning, all morning, lying in
21 a chair in pain and she didn't get seen until another
22 member of our staff happened to be in the hospital and went
23 and asked, "What's going on with this girl?"

24
25 Now, we just can't have that. We're tired of our mob
26 going over there having to sit around for hours upon hours
27 without being seen. All the paperwork, everything's in
28 place before they leave here. They get over there and
29 then, all of a sudden, they have to wait, wait, wait, wait
30 and get triaged. They already know what's going, or the
31 health professional they've seen - we've talked to and
32 arranged everything, all of a sudden, they've gone off
33 duty.

34
35 So we've had little kids, you know, families, making
36 their way, scratching for petrol money, to get over there
37 and they have to wait, wait, wait. No feed, you know, no
38 drink, and they're just all, you know, coming around the ED
39 over there. Frankly, I think, you know, all they want to
40 do is give them Panadol and send them home and we know what
41 happened a few times when that's happened. So, you know,
42 there's a big gap there.

43
44 Specialist services, they have to be referred and we
45 have to, more or less, transport our patients to those
46 services.

1 Julie mentioned racism and you just walk into the
2 hospitals around, you know, country New South Wales, and
3 you can just feel it. Yep.
4

5 MR MUSTON: In terms of the GP service that you're
6 offering three days a week and once on a weekend, what's
7 the waiting list to get an appointment with a GP?
8

9 MS PECKHAM: About three weeks at the moment.
10

11 MR MUSTON: And for people who present that have more
12 urgent need for care, how do you manage that situation?
13

14 MS PECKHAM: Yeah. When the doctors aren't here and they
15 need to be, you know, seen, you know, they obviously need
16 to see someone, we refer them up to the doctor, to the
17 hospital, or they will go out of town to a GP.
18

19 THE COMMISSIONER: Christine, that three-week wait list,
20 one of the things we were consistently told is that wait
21 lists for GP-led primary care have gradually been getting
22 longer. That three-week period, is that because of the
23 number of people, clients on your books, has that been
24 something that has been growing in terms of the amount of
25 time people have to wait?
26

27 MS PECKHAM: Yes, and they're, you know, going off and
28 doing all their tests and, you know, being really compliant
29 about all that. Then, you know, there might be something
30 that comes back that's really urgent so we have to get that
31 person in ASAP, and you know, we do a lot of - even though
32 the doctors are only present those three days, we are able
33 to contact them when there's something urgent come in, but
34 it's, you know, the follow-up, we do the health checks and
35 everything, their follow-up. There's, you know, the GP
36 management plans that have to be done, so that takes up
37 time as well. So, you know, it's - and they're very
38 complex conditions a lot of our mob have out here, you
39 know, because they haven't been to a GP for years.
40

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

1 she's only here three days a week.

2

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

7

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

19

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

22

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

31

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

38

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

44

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

1
2 MR SAMUELSSON: Yeah, look, there's just a couple of - to
3 touch on a couple of points that colleagues have made here.
4 The racism and the way it manifests for us in our community
5 is often in - it turns out to be a negative sort of
6 connotation throughout our community because it turns up in
7 people who discharge against advice or don't wait for
8 service at emergency, and we see that quite often.
9

10 From the perspective of what can be done about it,
11 we've trialled a couple of projects with the LHD in the
12 area, where sometimes it's as easy as a phone call to us
13 from the team that's on the ground at the hospital and we
14 can support. So we did a trial of that with 100 clients
15 registered and across a three-month period, only
16 one per cent discharged against advice, where, before that,
17 it was almost 50 per cent.
18

19 But it's really hard now that that project is over to
20 get that to flow as common hospital practice, to give us
21 a call when one of our clients are in there. And then
22 I guess the thing with that as well, if we were to scale
23 that up, that was not necessarily a funded project either.
24 So that's the other thing to consider if we wanted to scale
25 that, would be to have workforce on each end, so workforce
26 in the hospital, in the LHD, and dedicated workforce in
27 each AMS who could manage that integration between the
28 public health system and the ACCHO sector. We found that
29 as simple as a phone call, sometimes, that's been a key
30 thing.
31

32 MR MUSTON: Just on that one, have you found, after that
33 project has come to an end, do you know whether the
34 discharges against advice have gone back up again or "did
35 not wait" is another piece of terminology we've heard
36 referred to in that space?
37

38 MR SAMUELSSON: Yes, so outside of the project, they're
39 sort of back to normal. The staff that were involved in
40 the project at the LHD side have moved on as well, so we
41 don't even have that sort of resource that's still trying
42 to work on it. We've got - the Aboriginal health director
43 at the LHD is working on trying to get funding, but, you
44 know, like many LHDs in many of our areas, the budgets for
45 them are sort of overblown as well.
46

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

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

7
8 No-one in that whole community of 300 people will go
9 to the hospital. They will wait for us, the two days
10 a week that we are there, to come and seek medical care.
11 That often means, you know, we have a GP that is trying to
12 do some proactive chronic disease management and social
13 care, but gets wrapped up for the first half of their day
14 trying to treat emergency cases that come through, get them
15 to hospital, to often then either discharge against advice
16 or be released with no discharge information or no
17 communication, and then we repeat that the next time they
18 show up in sort of two to three weeks' time.

19
20 Back on the funding and the sort of funding versus
21 demand, one of the key things that we see - you know, our
22 footprint covers from Byron to Evans Head. We have a small
23 service in Ballina. We're funded for the number of people
24 who are currently coming through our doors as regular
25 clients, so we have 1,600 regular clients; whereas our
26 footprint is about 4,500 people. So there's really no way
27 for us to, effectively, you know, proactively engage with
28 people to do good comprehensive primary health care outside
29 of those people who are already coming to our door.

30
31 That often results in, you know, people will make it
32 to us in emergency situations or they will turn up at ED,
33 be discharged and go through this cycle, whereas it's sort
34 of been shown, I think there's many studies and sort of
35 anecdotally as well, if we can effectively work - like, the
36 clients that are coming through our doors and we're able to
37 effectively work with, we keep them out of hospital, saves
38 the health system, I think it is about \$5,000 for every
39 admission. So every time we prevent someone from coming in
40 we're saving the health system money. And I've seen
41 studies that show the sort of, I guess, efficiency for us,
42 the care that we provide is about 25 per cent of the cost
43 that the public health system can provide for Aboriginal or
44 Torres Strait Islander people.

45
46 But yes, so it's something - I know there is going to
47 be a submission going to the federal government sort of in

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

5
6 The other thing also, like, I guess Julie mentioned,
7 with the amount of work that we do that we're not funded
8 for. I think 33 per cent of our wages are self-generated.
9 For example, our core funding under the IHP program is
10 about \$1.2 million. Our GP wages bill is 1.4. So outside
11 of the GPs, if we weren't able to generate that Medicare
12 and weren't doing really well with that, we wouldn't have
13 a GP service, or we would have a much smaller service.

14
15 So I think many of our services, they all look
16 slightly different because we're trying to do bits and
17 pieces. Like if you go out west - I used to work for the
18 AMS in Bourke. Self-generating a GP wage wasn't possible
19 because you couldn't get GPs out there, and because the GPs
20 were sporadic, keeping the books full sometimes was hard
21 unless there were emergency situations.

22
23 I think it's great that this Commission exists because
24 it is a complex issue, and yeah, a lot of our services are
25 relying on business models where many bulk-billing
26 practices are going under, so for us, we've had to do a GP
27 wage review to be competitive with the private GP
28 practices, but we're sort of reviewing this every six
29 months to see if we can afford to keep our GPs on. It's
30 becoming more and more perilous, particularly as the
31 Medicare environment and cost of living gets worse, because
32 all of our costs are going up as well and funding often
33 doesn't come up to meet it.

34
35 I'll stop talking in a moment. But the other key
36 thing someone mentioned was around the administration side
37 of our organisations. This is something we've been talking
38 about across the sector in - you know, we get an allocation
39 of funding to provide these clinical services for
40 community, for the health services, and the funding often
41 isn't enough to meet that need, but then we also have to
42 run the organisation on the back end of it as well.

43
44 And we do similar things, we have to take admin fees
45 from 14 other programs that we're doing, getting individual
46 funding for, to make up our small team. We've got one CEO,
47 one finance manager, and sort of 0.8 FTE operations

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

3
4 So we are all sort of working to the point of burnout,
5 which then will bring the workforce issue in. Because none
6 of our services can have enough staff to do all of the
7 stuff that community expects from us, because they don't
8 just expect us to do primary health care; they expect us to
9 be the key point of call for every service that exists in
10 our area.

11
12 MR MUSTON: Just on that, while that's a demand on the
13 service, it's also, presumably, a really great benefit that
14 the service can offer as a point of coordination for all of
15 these other areas of need that people have, which, are
16 often very, very difficult to navigate at the best of
17 times, particularly if you are in a state of stress or
18 crisis.

19
20 MR SAMUELSSON: That definitely is a benefit that we're
21 happy to offer, but the thing is, when you've got that big
22 gap in funding, so we've got nurses who are helping people
23 with aged care packages and these sorts of things, where
24 there's other, I guess, organisations in areas that due to
25 cultural safety issues our clients won't access. So
26 there's someone else getting funding to support them
27 through it, but we've got staff burning out to support them
28 through it.

29
30 I think that's the key; the key problem with all of
31 our services - I think we will agree - is that we
32 definitely do - we're community controlled, we want to do
33 everything we can for community, but we have a workforce
34 that's going to burn out if we don't get adequately funded
35 for it. And then if our services don't exist, like, for
36 us, there's 2,000 people who will go into the public system
37 and either not get service or, you know, will have this
38 issue of the public system being overrun.

39
40 MR MUSTON: Just on that, whilst your service is not
41 funded to provide a bureaucracy navigation service, for
42 want of a better phrase, to the extent you're providing it,
43 do you see, even just from a health perspective, the
44 benefits of the service that you are providing, and can you
45 give us some examples of the way in which helping with that
46 navigation is actually producing positive benefits for your
47 community, even just from a health perspective?

1
2 MR SAMUELSSON: Yes, definitely. There's a couple that
3 pop to mind, just purely from the clinical perspective.
4 Some of this extra work in, you know, navigating some of
5 these issues makes us really aware of them, so we can then
6 advocate on behalf of community for certain services.

7
8 Some of the things we've been able to do are - you
9 know, without the public system and many of our public
10 systems, the specialist support, particularly for ENT for
11 us, you know, we've got kids going through school with
12 hearing issues identified and three years before they can
13 get a service that is key for them to learn.

14
15 We had enough advocacy for community that we started
16 to reach out to our private hospitals and other potential
17 funding agencies to say, "Look, we can't get people through
18 the public system. Can we work with the private hospital
19 and try to get a little bit of money from here to pay for
20 private surgery for these kids?" We've been able to do
21 that for three years running now, to get 20 kids through
22 private surgery that otherwise would be waiting, you know,
23 two to three years, have learning difficulties, which then,
24 down the track, leads to incarceration, all sorts of
25 different issues. So there's those key ones.

26
27 Another big one that we're quite happy to take on and
28 are not quite funded for is support for our clients to get
29 on to NDIS. NDIS is great for our clients once they have
30 a package and someone will look at them. If they don't
31 have a package and they can't get on to it, there's
32 a massive sort of discrepancy between what services you can
33 get.

34
35 When we started doing this, we came across a bit of
36 a case study where, you know, there were these two
37 equivalent clients, one client, very, very good means,
38 really good income, same disability as a client who was one
39 of our clients, didn't have employment, had a number of
40 other kids living with disabilities. It's the same exact
41 condition, just different means. Their package on NDIS was
42 \$400,000 difference to the favour of the person who had
43 much better means because they could get support to get on
44 to the NDIS and have, you know, someone professionally
45 writing that up for them.

46
47 We use one of our receptionists who has had some

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

5
6 Once the package is there, it sort of runs okay, if
7 you get a good support coordinator, which is also rare, and
8 our receptionist monitors that for clients as well. So
9 that's another one of those big gaps, where - I would say,
10 you know, this receptionist is one FTE. There's probably
11 0.4FTE where she's doing NDIS support sort of work that we
12 can't get - like, we're an NDIS provider but we can't get
13 billable hours for it, but she's happy to do it and we're
14 happy to support her to do it because it means our clients
15 are getting on to NDIS.

16
17 That's two examples. There's a few in the out of home
18 care space as well, where we're proactively now - we have
19 one of our GPs, our social worker and our child maternal
20 health nurse who now sit on bi-weekly meetings with DCJ,
21 basically to prevent unnecessary removals.

22
23 It used to be that we would get a phone call to say,
24 "We're about to remove this child. We know they're your
25 client. Can you come and support", and we would have to
26 turn around and say, "No, we've been engaging with this
27 person, they've been getting services for the child, there
28 is no medical neglect", we're trying to reverse a decision
29 that's already been made.

30
31 So now we've got a GP who's paid 160 bucks an hour, a
32 social worker \$65 an hour and a nurse \$65 an hour, that
33 we're putting on to these child at risk meetings with DCJ
34 and the LHD. We're not funded to do that, but it's another
35 thing that really has good outcomes.

36
37 And a lot of the other things is, we are consulted
38 a lot. The LHD will be rolling out the Aboriginal mental
39 health implementation plan or other health plans and we
40 will be on the committees, either meeting quarterly for
41 four hours at a time, some meeting fortnightly, you know,
42 others more ad hoc, and we're doing a lot of this sort of
43 consultation to benefit community and being a part of all
44 these committees that help these services run better for
45 Aboriginal people.

46
47 But again, the services don't fund us to be part of

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

5
6 That's the piece that's really, in addition to the
7 admin side of running the organisations, when you're
8 looking at the funding - those sort of partnerships and
9 policy support and development in that broader system,
10 consultation is one - I know services in our area we talk
11 about quite a lot. The amount of time and work it takes
12 for no - I guess there's no incentive. There is incentive
13 to support community, but from a business perspective, if
14 we were running purely as a business, it would be hard to
15 justify.

16
17 So, yes, I'll stop there just in case you have any
18 more questions because I'm acknowledging I've been talking
19 quite a bit.

20
21 MR MUSTON: Isaac, you had your hand up a while ago, and
22 I can see, Rosemary, you are next.

23
24 MR SIMON: Yeah, definitely, thanks for that. I think
25 everyone's - as the conversation's gone longer and longer,
26 everyone's pretty much described our service as well, in a
27 nutshell, and some of the pressure points that we have.

28
29 I think we've just got some real practical examples
30 about what, say, Julie was talking about with the
31 professional racism.

32
33 A couple of weeks ago we - we often book brokerage,
34 appointments for specialists, which we're not funded for
35 and we just pay for out of our own pocket. One of our
36 clients had an appointment with an ophthalmologist and they
37 were told that they would only be paying the gap fee. Then
38 when they found out that, actually, no, we needed
39 a purchase order so that Tobwabba would pay for this, all
40 of a sudden, the fee went from a few hundred dollars to
41 about \$1,400 or \$1,600, because they assume that Aboriginal
42 people get all of this money.

43
44 For us, that conversation, when we went back to them
45 and had that conversation, it was really difficult for them
46 to actually see that we don't have all this money. So we
47 were forced to pay the full fee which was, you know, over

1 \$1,000, as opposed to paying a couple of hundred dollars,
2 which would normally be paid from a low socioeconomic
3 client. So those are constant issues that we have.
4

5 We've also got issues with regards to us providing our
6 own cultural advice. We've received some funding
7 previously from regional New South Wales, where we were
8 actually provided some funding to hire a private firm to
9 help us do a business case and submission for a project,
10 and an aspect of that funding was to get some cultural
11 advice and support to make sure that the submission was
12 culturally appropriate.
13

14 Now, our service is made up of about 70 per cent
15 traditional owners, all professionals that work in the
16 field and have worked in our field for decades. So when we
17 said to regional New South Wales, "Actually, look, we'll
18 take that section of the funding and we'll allocate staff
19 to be able to deliver that cultural advice, as opposed to
20 the private organisation providing somebody from Sydney to
21 provide cultural advice on our local issues", they actually
22 rejected that and they told us that, "Oh, no, we won't give
23 you that, because you can just fund that in-house."
24 Whereas if we said we would accept the person from Sydney,
25 they would have funded it. So we've got those types of
26 issues in terms of professional racism.
27

28 Then we've also got the issue of competition with the
29 private practice. So where we're located, similar to
30 Payden, it's a bit of a - because it's by the water, we're
31 kind of known as the Northern Beaches playground, where
32 everyone from the Northern Beaches of Sydney comes up here
33 and has holidays every year and it's quite - you know, it
34 swells to become quite an affluent place during those
35 times.
36

37 So when we get doctors and the like coming to work in
38 the area, we're often hit with these exorbitant
39 expectations of what they should be paid, and because of
40 our model as a bulk-billing service, we're unable to
41 compete. So we've got a service which is just down the
42 road, probably about 400 metres down the road, Forster
43 Tuncurry medical service, and they are advertising that
44 they're paying their doctors between, you know, \$350 and
45 \$600 an hour.
46

47 Now, I know everybody in this room knows exactly how

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

7
8 So that's something where you - where we really
9 struggle to keep up and to, you know, hold. We've got
10 a number of doctors who live in our town who say,
11 "I absolutely loved my time working at Tobwabba, I wish
12 I could continue to work there, but we just simply can't
13 afford to." You know, they can get paid far, far more
14 working in private practice, where they get a share of
15 their revenue and they're obviously charging privately and
16 all of that type of stuff. So by default, we're unable to
17 keep up with the current market and that's just the way
18 that we're set up as AMSs.

19
20 We're also the heartbeat of the community, as was said
21 earlier, where we don't just do the primary health care or
22 the social, emotional wellbeing or the, you know, DV
23 support and all of that type of stuff that we're funded to
24 do.

25
26 There's often gaps where, you know, it might be late
27 on a Friday and a DV client comes in and they need
28 emergency accommodation. We're not funded to deliver that
29 emergency accommodation. However, somebody like, you know,
30 Samaritans or somebody like that, who are funded to deliver
31 that, they're not available or they can't find something
32 for a few days. So we've got an obligation to our
33 community, and because our service is actually based on an
34 Aboriginal community, where there's 43 houses on the
35 community which are, you know, within 50 to 100 metres of
36 our service, we've got an obligation to ensure that our
37 patients are safe until the adequately funded service can
38 provide for our patients. So we're often, again, out of
39 our own pocket, having to pay for these services with no
40 reimbursements.

41
42 The services that we do provide in the community, we
43 believe they're far superior to any other services that are
44 provided, which is why we're constantly getting mainstream
45 people coming to our service, trying to get in and be
46 a part of our service, so much so that during the COVID era
47 of lock-downs, there was actually an outbreak in Forster

1 and Tobwabba was responsible for shutting down houses. So
2 we actively locked down 20 - I think it was, don't quote
3 me, 22 to 25 houses, not all Aboriginal, but we were also
4 the first point of call for testing and contact tracing for
5 the mainstream population.
6

7 When it first hit, I remember - and Leeann, my
8 practice manager is here as well - we probably tested - and
9 this is at the height of the COVID lockdown - we probably
10 tested maybe about a couple of thousand people straight up,
11 in a period of a day and a half, or so, and that was off
12 our own back.
13

14 The reason why we did it was because all of the other
15 services, including all the pathology services, said,
16 "Unfortunately, it's a public holiday and we're closed, we
17 can't do anything". So it was our responsibility to do
18 that and to lock down the houses.
19

20 Then we had to actually provide the food security for
21 the areas, and you find the other issues of no connectivity
22 with internet or phone credit, all that type of stuff, so
23 when you look at an AMS, it's not just: hey, we've got an
24 Aboriginal health practitioner who's doing a 715 with the
25 doctor, and there's a baby that's been born so we've got
26 our maternity team and, you know, we're doing a NOFASD or a
27 strong bubs kind of initiative; we're providing real,
28 hard-core health care out there which is unfunded and it's
29 not sustainable for our communities to provide.
30

31 So, yeah, look, they're the main things that I just
32 wanted to add as well as the population. Obviously it's
33 all good and well to say, "Hey, this is your population,
34 this is how much we're going to fund you", but when you
35 have large transient populations, just like everyone else,
36 Aboriginal people like to move and they like to go around,
37 probably a lot more so, we often get new patients who are
38 transient coming in and coming out, and then that changes
39 our priorities and our trends in terms of the health care
40 needs.
41

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

1
2 You know, you might have no suicides and, all of
3 a sudden, you've had three or four in the space of a week,
4 and things like that. You might have no - very low
5 problems with domestic violence in February, March, then,
6 all of a sudden, coming up to June there are heaps and then
7 your priorities change.

8
9 We often receive funding from people like the PHN
10 where the funding's adequate for that topic, but we're so
11 underfunded from a different topic which has just emerged
12 that the funding's not flexible enough to accurately
13 service our communities and to ensure that we're keeping
14 our community healthy. That, in turn, leads to members of
15 the corporation saying, "Hang on a second, I'm reading that
16 you got X amount of million dollars and you underspent in
17 this area, but we've got all these people that are homeless
18 here and all of these people that need drug and alcohol
19 issues and why are you only funded, you know, a couple of
20 dollars for that?" So the portability and the flexibility
21 of funding to go to the areas that are truly needed, that
22 just isn't there. So you find that there's huge overspend
23 in one area and massive underspend in another area.

24
25 MR MUSTON: Just in relation to that, have you found
26 you've been able to have discussions with the PHN or other
27 funding sources which have resulted in that funding being
28 freed up or made more flexible to meet the needs that you
29 are actually seeing on the ground, say? To put it another
30 way, you've got some funding for a particular program which
31 at one point might have been a good program but, due to the
32 emerging health needs, you have come to the view, based on
33 your local knowledge, that this is actually a different
34 program or a different form of care that would be a much
35 better spend of the money - have you found that you have
36 had any luck in engaging with funding sources to have them
37 change any of those restrictions on the use of the money?

38
39 MR SIMON: Yeah, look, I think it's all dependent on who
40 your PHN CEO is and also the relationship that you have
41 with them, and also our relationship with other AMSs.

42
43 To answer your question, we have had some luck in some
44 of our programs on a small scale, but where we have had
45 a lot more luck is working with our partner AMSs in other
46 areas saying, "Hey, look, we've got a real issue here and
47 we know that you guys have got funding, is it all right if

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

10
11 So I think we get more support from each other,
12 whereas with people like the PHN, as good as they are,
13 they're kind of a bit hamstrung with their reporting
14 obligations to the federal government as well. So, yeah,
15 it is a difficult question to answer. So yes and no is the
16 answer, I suppose.

17
18 MR MUSTON: Thank you.

19
20 Rosemary, you have patiently been waiting with your
21 hand up.

22
23 MS ROSE: Finally got it. Yeah, look, I agree with
24 everybody. I just want to come back to the racism at the
25 local health district, our hospital. It is disgusting, it
26 is rife. I run out of adjectives. Our clients go to the
27 hospital. Now, I used to work - I'm a nurse manager, so
28 I used to work at the hospital as well, in ED, so I know
29 about triage and I know what should be seen as soon as
30 possible.

31
32 We've had chest pains turned away from that hospital
33 and they have come to us. Yesterday we had a child turned
34 away from the hospital, who turned up here, and I'm going
35 to have to use medical terminology to get the word across,
36 but this child - well, maybe not - was having trouble
37 breathing and the child was flat. It should have been
38 dealt with in the emergency department. We are not
39 equipped to deal with these children or the adults that are
40 turned away. We are a clinic, but we end up dealing with
41 them and the community is getting very frustrated with the
42 hospital.

43
44 I myself am getting frustrated because I cannot
45 address the needs of the community. Our resources are
46 extremely limited. We have three doctors, a population of
47 5,000 plus on our books at the moment. We've had to close

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

9
10 MR MUSTON: Do you have a bit of an example of how those
11 sorts of arrangements work in your community?

12
13 MS ROSE: In specialist-wise?

14
15 MR MUSTON: Yes.

16
17 MS ROSE: All right. So we had a Dr Campion used to work
18 here, and his son is a gynaecologist in Sydney. He was in
19 America and when he came back, we heard he was back, so we
20 approached him and, out of the kindness of his heart, he
21 now provides a service to Moree.

22
23 The same with the ENTs. Because we were a Catholic
24 organisation, we approached the Daughters of Charity at
25 St Vincent's Hospital and they got the ENTs to come to
26 Pius, but we pay for everything out of our little, little
27 budget, \$4 million. Yes, so that's how we do it.

28
29 But some of our other specialists now are getting -
30 are demanding that they be paid, and one wants, what is it,
31 \$220 an hour, \$244.70 an hour. We can't afford that, but
32 we need the service and our community needs the service.
33 I hope that answered your question.

34
35 MR MUSTON: Yes. Sorry, I distracted you.

36
37 MS ROSE: Yeah. So COVID had a big impact on us as well
38 as every other AMS in Australia, and we are still the only
39 service providing COVID testing in this area. But apart
40 from that, a lot of our specialists dropped off and our -
41 we had access to theatre time at the local hospital for our
42 ENTs and our ophthalmologists. Well, that has now dropped
43 off and our ENTs have not been able to get back on to the
44 operating list at the Moree hospital. So that has blown
45 out. The waiting list for grommets, tonsillectomies and
46 adenoidectomies, has blown out to three years, and that's
47 Newcastle, John Hunter. Three-year waiting list. And some

1 of these children are actually growing out of the
2 tonsillitis and out of the grommets because the waiting
3 list is so long.
4

5 Ophthalmology, the waiting list, we only have four
6 visits a year now, four lists, and we didn't have
7 ophthalmologists for two years. We now have visiting
8 ophthalmologists from the Sydney Eye Hospital thanks to
9 Gerard Sutton, but we can't get them on the operating list
10 at Moree either. They just - it's like we hit a brick
11 wall.
12

13 The ophthalmologists have even said they will bring up
14 an anaesthetist from Sydney, but we just can't get theatre
15 time. So we've started looking at getting a cube, which
16 is - we'd have to knock walls out of some of our rooms here
17 and put a cube in, and in a cube, we could do our own
18 theatre, our own cataracts. Hang on, I've got it here
19 somewhere. I think it's 36 people on the waiting list for
20 cataracts, and I can tell you, one person yesterday got
21 a letter from the Department of Transport, he now cannot
22 drive because his cataracts are that bad. I rang the local
23 hospital to find out where he was on the list and they
24 said, "Oh, he won't get seen until after April next year",
25 and he's been on the list since February.
26

27 THE COMMISSIONER: Rosemary --
28

29 MS ROSE: We've got a solution, we don't have the money to
30 buy the cube. We've got the building, we could put the
31 cube in it. Yeah, we've got a solution but we don't have
32 the funding, and the LHD, they just - we've been on and on
33 at the LHD for two years and we can't get anywhere. Yeah.
34

35 THE COMMISSIONER: Rosemary, sorry to interrupt, just
36 a couple of things to clarify. We were actually at John
37 Hunter Hospital very recently, and the clinicians
38 themselves were telling us about, well, between two- to
39 five-year wait lists for certain paediatric services, which
40 is consistent with what you've just told us.
41

42 MS ROSE: Yeah.
43

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

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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

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

2

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

5

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

8

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

17

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

24

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

33

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

42

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

1 there.

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 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,

1 we had families turning on one another. Some families were
2 yes, others were strong nos, you know? And so then you've
3 got families turning on one another, you've got community
4 members turning on each other, and what it's done is
5 created a huge - well, it's created a lot of anxiety and
6 psychological distress and, you know, the abuse on Facebook
7 and all of those things, you know?
8

9 As Winnunga, we stayed out of that debate, because
10 we're a health service. We're here to provide services
11 regardless of how people voted or what associations they've
12 got. You know? The thing is that sometimes people will
13 say, "Oh, yeah, but you're working with that perpetrator".
14 Hello? We're a health service. We work with people that
15 come through the door. We're not here to make judgments.
16 We're here to provide a service, you know? So all of that
17 stuff starts to spin around and, at the moment, it's
18 really, really bad.
19

20 MR MUSTON: Thank you for that.
21

22 Dian, I think you've been wanting to say something
23 but, like me, struggled to find the hand-up button.
24

25 MS EDWARDS: Yes, thank you. I had no idea how to turn
26 that little hand-up button on.
27

28 I've been listening to everyone and us not being an
29 AMS, it's really good to hear the perspective from the
30 AMSs, because we sit here going, "Why aren't the AMSs doing
31 this?" "Why aren't they doing that?" You know, a few
32 points from me are like the waiting lists in AMSs for
33 clients has just really impacted our services, you know?
34 We can't - when someone rings up for help, you know, I want
35 them to go to a drug and alcohol worker in an AMS, you
36 know, and obviously they can't get in for weeks. Now,
37 increasingly, we haven't got drug and alcohol workers in
38 our area - we used to have drug and alcohol staff at AMSs.
39 And I believe, what I've been told, is that the way the
40 funding works for AMSs doesn't fund drug and alcohol
41 workers because they can't claim Medicare on drug and
42 alcohol workers.
43

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

1 for drug and alcohol workers at all. We haven't had
2 training in our region. We're the far north coast. We
3 haven't had training for drug and alcohol for years and
4 years and years since the NDIS popped up and all the
5 training moved towards community service training.
6

7 We're being pushed towards resolving workforce issues
8 with having peer workers, and that might be great for
9 clients to be able to work with people that have a lived
10 experience, but those workers, unless they've got direct
11 care and supervision and support by qualified staff, do not
12 last long and they're actually impacted and harmed and also
13 that can cause harm then with clients.
14

15 We have, like others here, increased burden,
16 administration burden, on our services, for compliance. So
17 things like cybersecurity, you know, no funding for that.
18 No funding for accreditation. Our service, because it is
19 not an AMS, we haven't had to use the same sort of
20 accreditation services that a clinical service would have
21 to use, so we've used something we could afford, only
22 because we're not funded for it, and that's ISO
23 accreditation.
24

25 Now, I can't get funding through NSW Health, because
26 I don't have the type of accreditation that they want. So
27 our funding from NSW Health is only \$100,000 a year and
28 that's for two Merit beds. That doesn't even pay for one
29 bed, that money.
30

31 The costs of everything has gone up so much, our
32 clinical staff has shrunk and our admin staff has had to
33 grow to be able to respond to the reporting and compliance
34 of funding bodies. We've got five different funding
35 bodies, but you guys have some, the same, or more, between
36 Commonwealth and New South Wales.
37

38 They are moving more towards portals. We've all got
39 to, you know, report in different ways with different KPIs.
40 There was just a review done fairly recently in research,
41 of which we also have to engage ourselves in. Any
42 research, that our funding bodies actually push us to do,
43 we have to do this, and that last lot of research for KPIs
44 actually increased our KPIs. So that was really terrific.
45

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

1
2 The other thing I just wanted to talk about was the
3 crisis. We can't - and this comes back to waiting lists as
4 well, it comes back to our LHD and our hospitals and
5 racism, all that stuff. You know, our clients, they want
6 to see an Aboriginal service. The hospital treatment is
7 terrible. They don't stay in hospital or ED for very long
8 without support, as others have said.

9
10 You know, I've got an example of clients that, you
11 know, they might present to the A&E because they've hurt
12 themselves falling over with drugs and alcohol, been living
13 on the streets, homeless for months, and then reach a point
14 where they really need hospital care. They get put in,
15 they get admitted, and then I get a call to say, "Can you
16 do something with this person. Can he come to Namatjira
17 Haven. He can't stay here", and I will go, "What's going
18 on", you know, go in to see the fella in hospital there,
19 curtains around him, nobody wants to talk to him, "Oh, no,
20 he's too aggressive". You know, "Where's the ACL0?" "Oh,
21 they don't want us to - we have zero tolerance."

22
23 You know, I talk to the fella and all he needed was
24 someone to report for him that day with Centrelink. He was
25 due to report. He just needed help. So his pain level,
26 all his tolerance - he couldn't buy his smokes because he
27 couldn't report. You know? Just simple little things can
28 help hospitals manage clients better so that they can
29 actually get the help they need but everyone throws their
30 hand up. We get pulled in to, you know, sort of do the
31 crisis stuff.

32
33 That particular example of that fellow is that he
34 stayed here for six months. He actually couldn't look
35 after himself, he needed aged care, and it took six months
36 for us to get an aged care bed. We're then faced with
37 a client that had extremely high needs, he was incontinent
38 both ways, his memory was that he couldn't remember to take
39 his medication or that he'd taken his medication. He
40 couldn't shower himself. You know, he couldn't do anything
41 for himself. So we actually had, you know, a bed taken up
42 for six months for someone that needed to be in, you know,
43 a long-term supported high-needs accommodation.

44
45 So we'll be getting more and more of those sorts of
46 clients, we've got extremely high needs, so a lot more
47 applications from young men that are out of home care that

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

10
11 The other thing is that advocacy funding - you know,
12 there's so much funding going out to services to advocate
13 for this, to advocate for that. Homelessness is a prime
14 example. There's millions of dollars in this community, in
15 our community, for the services that are advocacy for
16 homelessness. All they do when they go there is get told
17 to ring Link to Home. You know, there's millions of
18 dollars going into that. I would just, you know, say,
19 "look, let's rip advocacy funding straight out of the
20 window and put it into actual housing and services that are
21 actually delivering." All the things that we do outside
22 what we're funded for, they're the things that will make
23 difference, not someone telling you to ring Link to Home.

24
25 I could bang on about, you know, the fact that we get
26 a lot of push and clients that are - really it's a drug
27 crime issue, so many people are getting - having criminal
28 matters for possession of small amounts of cannabis and
29 then being forced into treatment and that's taking up beds
30 off people that are actually needing to come out of
31 hospital or are in the community unwell that really need
32 our services.

33
34 So, yeah, I just want to push a few barrows like that
35 to reduce the - some sort of system to reduce - I would say
36 to New South Wales, if we could just have one portal, one
37 lot of compliance, one lot of, you know, reporting for
38 anything to do with New South Wales, and then in the same
39 with the Commonwealth, just one system, one lot of reviews.

40
41 It's just changing, every six months. We're trying to
42 keep up all the time and our funding has stayed the same.
43 Apart from this last two years where suddenly there's a
44 little bit of CPI that's come through, we're on the same
45 funding that we were from day dot, you know? So our
46 clinical team shrinks, our admin team has had to expand,
47 and it's just not right. There needs to be a complete

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

9
10 Because we're just - you know, I've just had another
11 one of my team that's just told me they're going to leave
12 in January, you know? I can't keep clinical staff beyond
13 18 months; they just burn out. There's just - and I've got
14 no-one ever to bring in. It's just getting to a crisis
15 situation, our services. And we've just got no help in the
16 community anymore. No - so everyone's in the same
17 position.

18
19 I had a big long list, but that will do. Push towards
20 accreditation being allowed so that we can get more
21 funding. That would be great.

22
23 MR MUSTON: Dian has raised a few issues that have been
24 recurring themes that we've heard about in our travels and
25 so I might just identify them and, as I work through each
26 of you who have your hand up, maybe give you an opportunity
27 to share with us your views.

28
29 The first is the reporting challenge. I noticed
30 a number of you were nodding enthusiastically every time
31 someone mentioned the challenges of multiple reporting
32 obligations. Very interested to hear about your experience
33 of reporting obligations and the impact that that has on
34 your ability to actually do work with the funds that you
35 are given and in relation to which those reporting
36 obligations attach.

37
38 The second is we have heard, and I would be really
39 interested to hear what your experience is, around
40 a situation where a First Nations person presents at
41 a hospital or a government medical service, requires some
42 further care, either specialist care or the like, that
43 might not be available within the local area, they have to
44 travel, and in order to get to that specialist care, some
45 of the AMSs we've spoken to have said that they,
46 effectively, just become the first port of call for any
47 First Nations person who needs health care insofar as the

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

10
11 And the third is the workforce issues. So Dian was
12 sort of telling us about the challenges of retaining
13 a workforce, and I'm really interested to hear in general
14 about the challenges that you have getting workforce in the
15 areas that you work, which is obviously not all in
16 metropolitan areas, but also the extent to which the
17 funding arrangements and the timing of funding impacts on
18 your ability to attract and retain workforce, if at all.

19
20 Maybe starting with Christine, I think you were next
21 to have your hand up, but if, in addition to what you were
22 going to tell us, you could think about those three topics,
23 that would be great.

24
25 MS PECKHAM: Okay, in addition to everything. But there
26 was a few things that Dian raised that I was going to talk
27 about as well: presentations at hospital and further care.
28 Sometimes we don't know that one of our patients have been
29 discharged, or they've been to the hospital and they
30 haven't even been seen and, so they've just come home and
31 then, you know, they know that if they ring us up, we'll
32 say, "No, you've got to get back to hospital", so, you
33 know.

34
35 MR MUSTON: Which hospital would say that?

36
37 MS PECKHAM: But then we do get discharges and sometimes
38 it's a couple of days later, you know, it's not like
39 immediate, and they need further specialist care. Well,
40 yeah, we do get - we get, you know, all the work that has
41 to go into that specialist care and the follow-up and
42 stuff, if they have to travel.

43
44 Luckily, just recently, we have secured some ITC
45 funding which we can use for travel to specialists, and
46 that's for some of our patients. But in the past, we've
47 just worn that ourselves or helped the family that have to

1 drive with fuel costs and accommodation costs and stuff
2 like that. So it does impact a lot on dollars and staff
3 time, and it impacts a great deal on the family, because,
4 you know, we also have to support them with whatever the
5 outcome of the presentation to the hospital has been.
6

7 We're probably lucky enough to say that retaining
8 workforce in Peak Hill, we've been lucky enough to have the
9 same doctors and the same allied health team, and we've got
10 locals, local community people, employed in, you know,
11 reception. Our social and emotional wellbeing, our health
12 worker is local, I'm local, so we've got - and we're also,
13 you know, supporting two local women, young women, as
14 trainee health workers at the moment. So hopefully, we're
15 going to grow our own and build them up, you know, we think
16 there should be more put into the local communities growing
17 their own health workforce, whichever area it's in.
18

19 Even to the point of, you know, contracting for
20 different - whether it be maintenance or electrical
21 cleaning, stuff like that, we'd like to see some - the
22 government look at assisting particularly our AMS in that
23 area as well. We don't get funded very much. We all wear,
24 you know, 10 hats, come in, clean up, you know, do all the
25 cleaning and stuff like that, because we haven't got the
26 dollars that some of the bigger AMSs have got.
27

28 But, yeah, so we all share - share the care and share
29 all the things like that, maintaining the premises, using
30 our local Aboriginal Koori tradies. We call on them,
31 99 per cent of the time they will just come and do it
32 because they love us.
33

34 The other thing is - yeah, so also presentations to
35 hospital, the Aboriginal liaison officers in the hospitals,
36 going by Dubbo experience, and we've had a lot of
37 experiences there, they're on the - surely they can look at
38 rostering those workers on, because a lot of the mob, they
39 don't turn up to ED until after hours or on the weekend,
40 things like that, there's never an Aboriginal liaison
41 officer around. They're not around in ED. They should be
42 based in ED. They should be the first person you see when
43 you walk in that door.
44

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

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

8
9 Like I said, it's all right to have you beaut Koori
10 stuff everywhere, and when you walk in the door, you can
11 see there's - oh, there is an Indigenous health thing
12 there, and you go to the door and it's never open.
13 No-one's in there. You wait around, wait around, "Oh,
14 where is the Aboriginal liaison officers?" "Oh, they are
15 around, they're around." Come 5 o'clock, they're gone.
16 Can't get any on weekends.

17
18 I had a call, an 80-year-old, came back from Sydney
19 1 o'clock in the morning. They brought him back to Dubbo
20 hospital. 9 o'clock in the morning, they were ringing me,
21 60 kilometres away, I was in Peak Hill, Dubbo's about 60,
22 70Ks away, to come, "He's being discharged". So why would
23 they do that? There should be Aboriginal liaison officers
24 all over the hospital.

25
26 The other thing, and I was talking about, you know,
27 trying to get funding and using local Aboriginal tradies
28 and maintenance people and that, why can't they look at
29 getting more Aboriginal contractors in, the cleaners, the
30 maintenance people, in the kitchens and stuff like that, so
31 at least when mob go there - because they can't - it's
32 a regional hospital, they come from further out west, all
33 around the Dubbo area, at least they will be seeing nice,
34 you know, friendly Aboriginal faces, and probably most of
35 the mob are related to them.

36
37 And the other thing that we do as well, with our
38 community, and with our elders, we go on country, we get
39 bush medicine and stuff like that, and some of the families
40 will use that. There should be more access to traditional
41 healers in the hospital system as well.

42
43 MR MUSTON: Thank you.

44
45 MS PECKHAM: And the biggest challenge just recently is
46 dental care in our community. We've got no dentists around
47 here. You have to go to bigger town, to Dubbo, Parkes,

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

8
9 Regional programs that have been put in for, you know,
10 to cover smaller towns like the regional programs, mental
11 health, social and emotional wellbeing, DV, those kinds of
12 regional programs, hub and spoke type models.

13
14 Funding goes to NGOs, mainstream NGOs, they come out,
15 pick our brains on what they should be doing. You know,
16 we're happy to work with them, we've built up some good
17 relations with some of them, others we haven't. And then
18 we don't see them. So we don't know, you know, what's
19 going on with that program, but we know it's Aboriginal
20 funded program, and all these NGOs in mainstream, in the
21 bigger towns, have control of this funding, where they're
22 supposed to be providing services to us on the ground.

23
24 Domestic violence, DCJ - they fund a position. No
25 ongoing costs with stuff like that. When we say, "Well,
26 this is how we would run this, in our community", "Oh, no,
27 you'll have to partner with an NGO, a mainstream NGO, if
28 someone's in crisis", you know? And everyone would know,
29 all the mob would know, crises usually happen in the night,
30 on the weekends, you know, domestic violence situation, mum
31 and the kids are running away or the - you know, partner's
32 running away. How are we going to get on to an NGO that's
33 nearly 100 kilometres away, "This is a crisis. What can
34 you do for this person"?

35
36 So we've often been left with providing, you know,
37 just things like clothing and food and, you know, personal
38 care kits to get these people, you know, just through until
39 that person who is sitting in another town decides they can
40 come out and see this person or book them into a service.
41 So we often liaise with extended family for that person.
42 There's no, you know, women's refuge or anything here, or
43 men's refuge, so that's another thing that - talking about
44 domestic violence.

45
46 Rehab. When someone's in drug and alcohol rehab and
47 they return back to country, they might get - they get a

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

9
10 MR MUSTON: Thank you.

11
12 MS PECKHAM: That's me, sorry.

13
14 MR MUSTON: No, not at all.

15
16 Lisa, I think you have been waiting with your hand up.

17
18 MS PENRITH: We could probably say we could echo
19 everything that everybody else has said, so I'm not going
20 to repeat all of that.

21
22 You want to know about workforce issues. We've been
23 running for over 22 years. We were funded 22 years ago for
24 one GP for \$150,000. We now have 14,000 people on our
25 books and we're still funded 150,000 for one GP.

26
27 Every time we put in a submission to get more funding,
28 we get knocked back.

29
30 We have to see non-Aboriginal clients to enable us to
31 bring in Medicare income to keep our administration staff
32 employed, to pay for our nurses, to pay for the other five
33 doctors that we need to keep the community fit, healthy, as
34 we need them to be. Workforce issues are NDIS.

35
36 Now, NDIS are taking a lot of our staff, because they
37 have big dollars and can pay them big money. We can't keep
38 up with paying the rates that they want to pay our
39 speeches, so they go off to NDIS and we lose that program.

40
41 MR MUSTON: Can I ask a question about the - you said
42 a moment ago you need to see non-Aboriginal clients in
43 order to cross-subsidise the funding of the services that
44 you're delivering to Indigenous clients. What is it about
45 seeing the non-Aboriginal clients that makes it easier for
46 you to fund those other services? Is it just the Medicare
47 money that's coming through?

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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

1 150,000, but you now, I think you said, have 14,000 clients
2 on your books --

3
4 MS PENRITH: Yes.

5
6 THE COMMISSIONER: I wouldn't expect you to give me
7 a precise answer, but roughly how many people were on the
8 books 22 years ago? I take it it was a lot less than
9 14,000?

10
11 MS PENRITH: When we started 22 years ago our chairperson
12 was the first client. So we had none 22 years ago. So
13 we've gone from zero to 14,000 just at this service, and at
14 two other satellite services that we also service, one has
15 2,500, the other one has 1,500 clients, still only funded
16 for that one doctor.

17
18 THE COMMISSIONER: But the growth in the number of
19 patients on your books, has that been because GPs are
20 becoming thin on the ground in your area; is it because of
21 a greater awareness of your services; is it because of an
22 ageing population or some form of population growth; or is
23 it multifactorial? What's the --

24
25 MR MUSTON: Can I add to that --

26
27 MS PENRITH: It is multifactorial, but the main one would
28 be that we're the only bulk-billing service in town. That
29 is the big one. The second one is because the clients know
30 if they come here, they can see a doctor, they can see
31 a nurse, they can get care all in one place, so they want
32 to utilise the service.

33
34 THE COMMISSIONER: Yes.

35
36 MR MUSTON: So I gather from that that the increased
37 demand is perhaps not necessarily an increase in the
38 underlying demand so much as the demand's out there but as
39 your service has grown, you've been able to meet more of
40 that demand, it's not to say that you're meeting all of it,
41 but you started with one doctor and you could meet one
42 doctor's worth of demand because there's only so many hours
43 in a day; if you have two doctors, there's demand out there
44 that will occupy all of their time and no doubt that would
45 continue to increase up to probably significantly more
46 doctors than you currently have and other --

47

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

5
6 And the reporting - as we were saying - with the
7 reporting, we are doing so many different reports to the
8 same government agencies. Can't you all pull the same
9 information from the report? Our reports that youse are
10 getting, you're looking at numbers, you're looking at how
11 many numbers we see. Listening to Christine and Rosemary,
12 Dian, numbers aren't what we do. We provide a service. So
13 while youse are looking at us seeing one person, that one
14 person might take six hours of our time, and you're looking
15 at us and saying, "Well, we're funding you but you're only
16 seeing one person." The reports don't allow us to let you
17 know what we actually do for our clients. I don't know,
18 I don't want to take up too much time because I'm sure
19 there are other people and there's another group after us.

20
21 MR MUSTON: You take up as much of the time as you need,
22 don't worry about that.

23
24 MS PENRITH: And our Aboriginal health workers are doing
25 more than one job. So we're losing them because we can't
26 afford to pay them the same wage as the local health
27 districts, or we're losing them to NDIS because they can
28 pay more money. We've got workers here doing our 715s but
29 they're also doing the eye screenings, the ear screenings,
30 they're also out there delivering hampers. So we need to
31 come up with our funding for our health workers to match
32 everyone else.

33
34 Our gaps here are detox and rehab services. We can't
35 access them. We can't put clients in detox at the hospital
36 because they won't give us a bed. Clients, when they want
37 to go to detox, they want to go there and then. They don't
38 want to be told, "I need to wait a week, two weeks or six
39 weeks". There needs to be more funding put into these
40 detox services so the AMSs can access them.

41
42 MR MUSTON: Correct me if this assumption is wrong, but in
43 relation to something like detox services, presumably that
44 point in which one of your community members has that point
45 of insight and recognises something needs to be done,
46 "I need to go or want to go and get some detox", seizing
47 that moment is, presumably, really important because if you

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

5
6 MS PENRITH: That's it. They might see that they're
7 fixed. "Oh, I'm fine. I don't need it now. I was just
8 having a crisis two weeks ago. I'm not having it now so
9 I don't need to go." But a week later, they're still going
10 to have that same crisis and be told, "You have to wait
11 another two to three weeks." There needs to be more out
12 there for detox services and mental health. They're
13 becoming our big issues.

14
15 And with training of staff, you guys - a few of you
16 mentioned ophthalmology. We've been working with
17 Professor Painter. Does anybody know Geoffrey Painter?
18 He's an ophthalmologist that comes to our private hospital
19 here. He's been coming for two years now and he's trained
20 all Aboriginal health practitioners up in eye screenings,
21 so we no longer have to go through GPs or optometrists. We
22 can directly refer to his clinic and he will see our
23 clients on a priority basis at the private hospital here.
24 He's looking for more organisations to work with. Maybe
25 that's somewhere where you guys can look at approaching
26 Professor Painter to help out your services. I think that
27 will do me.

28
29 MR MUSTON: Thank you.

30
31 Payden, I think you were next with your hand up.

32
33 MR SAMUELSSON: Yeah, just to touch on those sort of three
34 questions you raised. Reporting-wise, example for us, this
35 year we've got 15 different funded programs which have
36 staff allocated to them. One example of those was our
37 social and emotional wellbeing funding through PHN. It
38 funds part of our social and emotional wellbeing workforce,
39 but for 2.2FTE in our social and emotional wellbeing
40 workforce, we have three different funders, three different
41 sets of reporting with varying reporting pathways in there,
42 so to touch on the reporting as well.

43
44 Some of our reporting, I think the best funder we have
45 reporting-wise is about 12 days' worth of work in reporting
46 across the year. One of the worst funders we have at the
47 moment is fortnightly meetings, monthly reporting,

1 quarterly financial reporting and six monthly activity
2 reporting after that. And they only allow a 9 per cent
3 admin fee. So it doesn't matter. So that's sort of,
4 I guess, the range of reporting that we have across 15
5 different funders.
6

7 In relation to - I guess I've got it written down here
8 as sort of "client dumping", because that's what a lot of
9 services will do with us, clients get too complex or they
10 don't even try to address an issue, they're just like,
11 "Bullinah is there. Go over and see them."
12

13 One of the biggest impacts that has for us, which Lisa
14 touched on, is it impacts our KPIs. Because that client
15 gets dumped, we spend six hours there, there are no health
16 checks being done at that time, there are no care plans
17 being done at that time, there's one client being seen at
18 that time.
19

20 That then hampers our ability to improve our funding,
21 because, depending on the year of the funding model
22 rollout, they're dependent on the number of clients that
23 come to your door, weighted on how you're meeting KPIs,
24 particularly around health checks and care plans and those
25 sorts of things.
26

27 So not only are we not funded to do a lot of this
28 acute care that pops up, but it directly impacts our
29 ability to look good in the eyes of the people who are
30 funding us for primary health care because it hampers our
31 ability to do it.
32

33 Again, we will always do it, because we want to look
34 after community, but there are other services, like
35 everyone's been saying, other NGOs that have positions
36 available to look out for when these grants are coming up,
37 spend enough time to actually do an effective proposal for
38 funding and then get the funding.
39

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

1
2 We've had a little bit of an experience like that
3 recently where - I'm waiting for a feedback session today
4 to say - there was one FTE, Aboriginal domestic violence
5 specialist family worker allocated for Ballina. We applied
6 for that position because we're doing the work, a lot of
7 our team are doing the work, and that's been knocked back.
8 So one FTE Aboriginal specialist position in Ballina, there
9 are two other Aboriginal organisations in town, which we
10 have good partnerships with, so hopefully one of those guys
11 got it, but if not, I'm really sort of unclear where that
12 issue has arisen, but I'll take my time today to find that
13 out.

14
15 MR MUSTON I noticed before, just a moment ago, you were
16 nodding quite enthusiastically when I think it was either
17 Rosemary or Lisa were telling us about the challenges - no,
18 it was Christine, sorry, telling us about the challenges
19 with NGOs coming in and, in effect, competing for grant
20 moneys.

21
22 MR SAMUELSSON: Yes.

23
24 MR MUSTON: And through the sophistication that those
25 organisations have and the administrative workforce they
26 have, they are able to get that grant but then there might
27 be issues or you might see issues around the way in which
28 they're able to deliver the care to members of your
29 community. Do you have particular views about that or
30 a particular experience that you wanted to share with us
31 about that?

32
33 MR SAMUELSSON: Oh, yes, definitely, definitely. So we
34 have a pretty good relationship with our PHN here. So if
35 there's funding where - this one, we weren't really
36 competing. There was funding that was released, I think it
37 was \$1.6 million, after the floods for mental health
38 support in community. There was a nine-month rollout. So
39 you had to get a service in place and roll it out in nine
40 months and then take it away, basically.

41
42 So the three AMSs in our area that have a partnership
43 with our PHN said, "We're not bringing that on because it's
44 just setting clients up to sort of be wound back and we
45 probably won't find workforce in the first three months."
46 So we sat on a tender panel to select the NGO that would
47 then take on that funding, on the condition that they

1 engage with the AMSs in the area and we work together.
2

3 So they were successful in getting it. The first
4 quarter of reporting, which we were able to see because we
5 had that agreement with our PHN, they've reported on, you
6 know, seeing 70-odd clients at the pod village in Wardell,
7 done, you know, mental health assessments for all of them
8 and they've shown an improvement in mental health
9 assessments. I, you know, have spoken to our team who are
10 out there two days a week, spoken to Uniting Care, who are
11 running the pods, and spoken to community, and no-one is
12 sure who or what they are, what they're doing. So the
13 level of engagement is really sort of - I'm not saying
14 they're not doing the work, but it's not being seen
15 anywhere, and we're still picking up quite a big load of
16 that. So 1.6 million across nine months of funding and
17 we're still doing a lot of the work that they're being
18 funded for. So that's one sort of prime example.
19

20 The other one for us, and one we're sort of - I'm
21 working every angle I can around dental funding because
22 we're going through a major capital works project and
23 I really want a dental clinic there. It's been brought up
24 by community since our inception back in 2006 that dental
25 is required.
26

27 We've got a public dental service, but the waiting
28 lists there are quite long. How they are meeting demand is
29 sort of debatable, and we had at least 200 clients over the
30 last 12 months whose main reason for a visit to a GP was
31 a dental emergency, which we then had to sort of turn
32 around and try to engage with the public dental system or
33 the hospital. So that's not preventative work or anything
34 like that.
35

36 So we've been working since 2008 to try to get dental
37 funding, but we're quite often being told, "No, there's
38 a public dental clinic there, you don't need the dental
39 funding, it's being met". Again, if we had the resources,
40 we could go in and say, "Okay, let's survey all the
41 clients, let's ask these questions about whether they are
42 accessing public dental, the service they are getting and
43 seeing what the need is." Currently, we're getting this
44 anecdotal information from our GPs that 80 per cent of our
45 clients are not getting dental care. So that's another
46 one.
47

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

18
19 And I guess for the workforce, the retention is -
20 we're lucky, I think GP-wise, I think the capital for GPs
21 in Australia is Lennox Head, which is 15 minutes up the
22 road from us, so we've got a steady flow of GPs who are in
23 the area. But we are now coming up to this issue with
24 being the only bulk-billing practice, like I said before,
25 trying to compete with rising wages and we're sort of just
26 holding on at the moment but we don't know how long we can
27 do that for.

28
29 And with the increase in costs of living, and
30 particularly the ACCHS award which most of our funders,
31 particularly the federal government, expect us to pay our
32 staff off, it's terrible. We pay, on average, 9 per cent
33 above award at the moment, that's to try to compete with
34 the LHDs and those sorts of organisations.

35
36 But what that award means is that if someone's looking
37 at that award and going to fund you, they go, "Okay, we can
38 get X amount of FTE for this much money", and we have to
39 turn around and say, "You've got to take at least
40 10 per cent of that workforce you're expecting off", and
41 that's sometimes a difficult conversation with funders.
42 But it also means we're getting a smaller sort of dwindling
43 clinical workforce. Because we have to pay people more,
44 obviously we can't employ as many people - I've had to run
45 a redundancy just last month - and what that's going to do
46 now, we're going to see in the next 12 months to two years
47 that those staff are going to gradually burn out unless we

1 can do something sort of drastic to change that.

2
3 And the training of workforce, sorry, would be the
4 final thing, one thing that I sort of bang on about every
5 chance I get, is we recruit Aboriginal identified positions
6 first and foremost. If we can't find a skilled Aboriginal
7 person in that role, we will employ a non-Indigenous person
8 into that role. What we then can't do, because of our
9 funding restrictions, is have that role train someone in
10 community, because we can't afford to have someone shadow
11 someone or have someone come in and supervise and provide
12 that supervision. So we get in this cycle, then, of, you
13 know, we have a really good non-Indigenous workforce but
14 ideally we would be able to train and upskill our community
15 into these roles. But if there's not that consideration of
16 the need to build the workforce and the funding to support
17 workforce building, it's not going to happen so we're going
18 to get these sorts of rotating positions of people who
19 might not be from community, whereas if you can train
20 people who are rooted in community, much more likely to
21 stay.

22
23 MR MUSTON: Thank you.

24
25 I note we're sort of past our 12 o'clock timeline, but
26 there was one question I really wanted to ask all of you
27 while Julie was with us.

28
29 Julie, you mentioned at the outset that you are
30 providing a clinic through is it the John Maconochie
31 correctional centre in - Alexander Maconochie.

32
33 MS TONGS: Yes, the Alexander Maconochie.

34
35 MR MUSTON: So you're providing a clinic through that
36 centre.

37
38 MS TONGS: Yes.

39
40 MR MUSTON: Within New South Wales, health care to inmates
41 is provided predominantly by justice health. One of you
42 mentioned a little bit earlier the challenge associated
43 with or challenges associated with people who have
44 interacted with the criminal justice system, perhaps
45 received health care through justice health, or in Julie's
46 case, through the clinic that's operated there, whilst in
47 that correctional environment, but then essentially get

1 released and they're out in the community.

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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.

1
2 So Philip Moss did the inquiry and he had been an
3 Integrity Commissioner, and we had a young fellow from -
4 Sean Costello, from the Human Rights Commission, that
5 supported Philip, and we sat with the family and, you know,
6 asked what questions they wanted to know about his assault
7 and everything else.

8
9 So we had two things happening at the same time. We
10 had an inquiry into his assault, but also we were in the
11 lead-up to the coronial inquest, and one of the
12 recommendations from the Moss inquiry was that Winnunga be
13 integrated into the services at AMC, into justice health.

14
15 But after the coronial inquest, and I walked out of
16 that courtroom - because that young man died from
17 a methadone overdose and he had only had two doses of
18 methadone - I said to our executive director of clinical
19 services, as we walked out the door from the coronial
20 inquest, that under no circumstances was I prepared to
21 share justice health's risk, and we were going to stand
22 alone in there.

23
24 So I stood my ground, went back to the minister, he
25 came to a NACCHO board meeting, because at that time I was
26 on the NACCHO board, and he announced that Winnunga was
27 going to stand alone in the prison, have a stand-alone
28 service, and that's what we've done. One of the biggest
29 issues was the over sharing of information between
30 corrections and justice health. Justice health was telling
31 corrections officers in front of other detainees why that
32 person had been at the clinic.

33
34 One of the big issues for us, and, you know, people
35 have bagged us about it - others, like justice health or
36 corrections - is that we don't over share information and
37 we do what we do on the outside, we get consent from our
38 clients to share the information.

39
40 So, you know, there's a difference between withholding
41 information and getting consent from that person to share
42 that information. It's not just, you know, "Oh, you know
43 who this person is. You've got their information. We need
44 it." We need their consent, like we do on the outside, to
45 get it.

46
47 But, you know, if everybody 's - I think that if there

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

9
10 MR MUSTON: A quick question about that. When you
11 mentioned justice health, who was providing health care to
12 the general prison population in the ACT? Was it Justice
13 Health NSW or is it ACT based?

14
15 MS TONGS: ACT justice health.

16
17 MR MUSTON: Thank you.

18
19 And to others, Julie's just told us about the
20 benefits, which seem obvious, about continuity of care from
21 within the correctional environment back out into the
22 community, both in terms of general health care but also
23 making sure that people are accessing that health care and
24 their general wellbeing from an addictions perspective and
25 emotional wellbeing, mental health - do any of you have
26 a view about ways in which justice health in New South
27 Wales and the AMS sector might be able to work
28 collaboratively together to try and avoid prospective
29 patients or members of communities from falling between the
30 cracks as they leave the justice sector and the care that
31 is being provided to them by justice health in prison and
32 then coming back out into the community where, ideally,
33 there would be a handover, as it were, of care to your
34 organisations or, alternatively perhaps, involvement of
35 your organisations in the delivery of care to them in the
36 prison environment?

37
38 Do any of you have a view about that? Payden, you've
39 put your hand up.

40
41 MR SAMUELSSON: Yeah, look, I think for us, it's just what
42 you said there, the handover. We're not - like, the
43 nearest goal to us is down in Grafton, so Scott from
44 Bulgarr Ngaru, they work in the facilities there and they
45 do some work, but the interaction we've had with some of
46 our community post release has been they've just shown up
47 at a bus stop somewhere, someone's run into them and then

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

5
6 So for us, I think, we would experience that direct
7 sort of release towards us five or six times a year, like
8 I said, Casino's a lot closer and Grafton's lot closer, but
9 in those five or six times, that information transfer, even
10 while we're got the client sitting and consenting, it's
11 really difficult to get stuff out of justice health, so
12 that's where information would be for me, yeah, anyway.

13
14 MR MUSTON: Christine, I think you made a comment there?

15
16 MS PECKHAM: Yeah, same with us. I think the gaols at
17 Wellington that most of our mob would go to, or Bathurst -
18 I think there should be something prior to them going into
19 gaol, you know, to see if they've got any medical
20 conditions and stuff, because some of them just go, get
21 locked up, and they're put in either Bathurst or Wello,
22 don't know what they're - if they've a medical assessment,
23 or they're on tablets or are diabetic or something like
24 that, but when they - we've had a few examples of when
25 they're released there, you know, to extended family or,
26 you know, really close, some of the mob here, they will
27 just come and get a checkup anyway or if they've got any
28 issues, want to see the doctor.

29
30 And then sometimes, we have, yeah, had a lot of
31 trouble trying to get information from Justice Health about
32 some of the fellas that have been released, you know, what
33 treatment they had, because we know what their
34 circumstances were before they went to gaol - you know,
35 went into gaol and stuff, but when they come out, it's hard
36 to see what's - you know, they've said they've gone to the
37 clinic and all this and that, and we've found it really
38 hard to get information from them of what - you know, where
39 they were up to with their health.

40
41 And then we've had some fellows come home and a couple
42 of months later they've dropped dead, so we don't know
43 what's happened to them in gaols.

44
45 MR MUSTON: So assuming it was appropriately funded at
46 both ends, a system where there was a collaborative
47 relationship between justice health and the Aboriginal

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

7
8 MS PECKHAM: I think it would be very beneficial, you
9 know, considering some - you know, some of the personal
10 experience from, you know, coming home from prison and,
11 like I said, a couple of months later, you know,
12 a 34-year-old just dies - that was my nephew - after being
13 in gaol for a while, and it's hard to get any information
14 from them. And it's happened to a few families as well.
15 So I think that would be great.

16
17 MR MUSTON: Lisa, you've put your hand up?

18
19 MS PENRITH: I think the handover's really, really good,
20 but it doesn't need to start when you are released. That
21 handover needs to start prior to their release. It gives
22 the AMSs and the workers time to put in place what needs to
23 be there for the community member when they're released,
24 not just dumped on us the day they're released and said
25 they need this, this, this, this and this, and then we're
26 rushing around trying to put things in place that a lot of
27 our smaller communities don't have.

28
29 So if that handover can start even a month or so, two
30 months, prior to the release so that it gives the AMSs time
31 to get things in place, to best meet that client's needs.
32 That's all I wanted to say.

33
34 MR MUSTON: Thank you.

35
36 Julie, you might get the last word.

37
38 MS TONGS: Just in relation to that, Lisa, it's
39 challenging, because it depends on what - if they're
40 sentenced detainees, then, sure, you can do that, like
41 that, exit planning. But our prison is, we've got remand,
42 we've got women, we've got sentenced, we've got all these
43 different cohorts, and it's really challenging, because if
44 someone goes to court on a Friday afternoon and they're
45 given bail, and then you've got a parent ringing up saying
46 they haven't got their mental health medication - all their
47 meds are still back at the AMC, so if they're a client of

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

5
6 So, you know, there's a lot of challenges, because we
7 use an electronic patient information recall system,
8 Communicare, so all our data goes into the system. So the
9 system here at Winnunga, in Narrabundah, speaks to AMC. So
10 if there's a new admission at AMC that was already
11 a Winnunga client, all that information comes up for the
12 doctors and nurses in the clinic out there. So, you know,
13 that's one of the benefits, whereas justice health and
14 corrections, a lot of it was paper notes and whatever, you
15 know? And they can go missing at any time or, you know,
16 through the shredder if they need to. But at the end of
17 the day, with an electronic system, anything that anyone
18 deletes in our system stays in the system. So, you know,
19 there's no room for - that's one of the ways that we manage
20 our risk here.

21
22 THE COMMISSIONER: I'm just wondering, for all of you, is
23 there any final issue that you see of particular importance
24 that we didn't cover off, a final comment you wish to make
25 from any of you?

26
27 Perhaps start with you, Isaac, is there anything you
28 think we missed that's of importance you would like to say
29 now?

30
31 MR SIMON: No, also, I think probably just I didn't speak
32 to much about attracting registrars and the competition
33 with attracting - yeah, so I think that's something where
34 potentially for an AMS, if you have registrars, it does
35 mean - it does help you not only to have a doctor on site
36 under supervision, but also from a funding perspective, it
37 helps you to raise Medicare revenue to pay for the
38 registrars.

39
40 So when you do get competition with private practice
41 and the MMM loadings with registrars in your area and they
42 are getting paid above and beyond what we can pay as an
43 AMS, that really does hit our ability to fund the senior
44 doctors. So that's probably something that we didn't touch
45 on too much, but it definitely is an issue for us.

46
47 THE COMMISSIONER: Sure.

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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.

1 And I think Payden brought it up, you know, no money
2 for administration and management is where, you know, a lot
3 of things that we could try and do and meet some of the
4 burden with administration, we just don't have the money
5 for. So it's us having to ask, you know, do all this all
6 the time, you know, the wearing of 10 hats. We're the
7 cleaners, we're the transporters, we're the funding
8 submission writers, we're everything.
9

10 THE COMMISSIONER: If you're worried about the issues
11 you've just raised not being dealt with in detail today,
12 I can guarantee you they have come up at all of our
13 face-to-face meetings with ACCHOs and AMSs and we have very
14 consistent notes about those issues you've raised.
15

16 MS EDWARDS: Great. With corrections staff, like we take
17 men directly out of custody for two beds. We sometimes
18 have months to work with corrections before that man comes
19 into our service. I'm trying to gain all the information
20 ready for discharge at the end and to know specifically
21 whether they've got any chronic health needs, medication
22 needs, or whether they're using drugs and alcohol in prison
23 and whether we're going to end up with a client arriving
24 and going into withdrawal.
25

26 We, on our last - this is a large one. We've got
27 a fellow in at the moment, who was the first trial to take
28 men out of prison on Buvidal, and a lot of work went into
29 the governance, clinical governance set-up with the LHD on
30 managing this particular man coming out of prison. We
31 didn't get the information from justice health until two
32 days after he arrived. So, you know, you just can't - you
33 can't work with them. You put in requests for information,
34 they won't give it to you. So the moment they leave
35 custody, we ask more questions, because - "Sorry, we can't
36 tell you anything, he's left custody." So it's - there is
37 a real problem there, just so you know.
38

39 THE COMMISSIONER: All right. Thank you.
40

41 Julie, any follow-on observations from you or
42 comments?
43

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

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

5
6 And, you know, also around - we talked about examples
7 of racism, well, the PHNs, they actually can fund their
8 boards. I was on the NACCHO board, our national peak
9 board, for 22 years, and NACCHO is not allowed to pay their
10 board members. So they are not allowed to pay money out of
11 their contracts for board members. PHNs get big, big money
12 for meetings and, you know, because they've got doctors and
13 others on there - because we're all black fellas, you know,
14 we don't get anything. But, you know, as soon as you put
15 a lot of professionals in the room, they're not going to do
16 it for nothing. But there's an expectation that we will.
17 So, you know, I will end on that.

18
19 THE COMMISSIONER: Okay, thank you.

20
21 Lisa, any final observations or comments from you?

22
23 MS PENRITH: I think that we're all sitting here today to
24 talk about workforce retention, service provision, it's all
25 got to start with our health workers. So we need to start
26 coming to the party and meeting mainstream wages for our
27 health workers. If we want to retain them, they're the
28 ones that are providing the health service provision. They
29 need to have pay equity.

30
31 And please streamline the reporting, because we spend
32 three, four hours every week on each program trying to sort
33 out reporting.

34
35 THE COMMISSIONER: Again, that issue you've just raised
36 then is one that was just consistently raised in our
37 face-to-face meetings when we were out visiting the
38 regions.

39
40 MS PENRITH: They were just my two things that I wanted to
41 finish on.

42
43 THE COMMISSIONER: Thank you.

44
45 Rosemary?

46
47 MS ROSE: Yeah, I just concur with everybody, but I think

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

5
6 THE COMMISSIONER: Thank you.

7
8 And Christine?

9
10 MS PECKHAM: Yeah, I'd just - as well as health workers
11 and everything everyone else has said, as we - you know,
12 we're going to be around for - we've been around for, what,
13 Julie, nearly 50 years, and we're going to be around a lot
14 longer. I think there should be some investment in, you
15 know, purpose built premises for us to do our providing our
16 services from.

17
18 We operate from a little renovated what used to be
19 a three-bedroom house, you know? There's a lot of money
20 gone into investing in, you know, bricks and mortar stuff,
21 but there also has to be some investment for that culture
22 and connection to country that is, like, at the heart of
23 our mob's health and the whole holistic approach that we
24 take to health.

25
26 And I think, you know, with the new beaut NSW Health,
27 Aboriginal health plan from 2024 to 2034, I hope that might
28 bring some changes about. Thank you, sir.

29
30 THE COMMISSIONER: Thank you very much. Mr Chiu, there is
31 nothing you --

32
33 MR CHIU: I don't have anything, Commissioner.

34
35 THE COMMISSIONER: To all of you, thank you very much for
36 your time. We're very grateful for your participation
37 today and also the assistance you have given the Inquiry.
38 So thank you for your time. And we will leave it there.
39 We will come back at 2 o'clock.

40
41 **LUNCHEON ADJOURNMENT**

42
43 THE COMMISSIONER: Good afternoon to those of you here.
44 I'm going to assume you can hear me, unless you - well,
45 I suppose if you can't hear me, you won't know what to do,
46 but I assume you can hear me.

1 Before I pass over to Mr Muston, before we begin this
2 roundtable session of the Special Commission of Inquiry
3 into Health Care Funding, can I acknowledge the Gadigal
4 people of the Eora Nation, who are the traditional owners
5 of the land on which we gather today, at least those of us
6 sitting here in Sydney, anyway, and pay my respects to
7 their Elders past, present and emerging.
8

9 For the three of you online at the moment, the purpose
10 of today is to hear from you rather than for you to hear
11 from either me or Ed. We have, over the last 14 months in
12 our travels to every LHD, including all the regional LHDs,
13 met with many people from ACCHOs and AMSs to have
14 discussions about what kind of services they offer and how
15 they're funded. We've got, I think, a pretty good idea now
16 of the services you offer and also your importance to your
17 local communities.
18

19 The kinds of things that have been raised with us,
20 though, on many occasions now and quite consistently, are
21 things like the difficulties that short-term funding
22 provides to you, particularly in relation to workforce;
23 a growing gap between demand for services and the funding
24 that's allocated, wherever that funding comes from; and
25 we've also had discussions about relationships that your
26 organisations have with entities like LHDs and PHNs and the
27 like.
28

29 Having said that, I've kept those topics deliberately
30 broad and not specific, because I don't want to set the
31 agenda for anything that you might want to say to us.
32

33 I guess the final thing for me to say is that part of
34 our role as a special commission of inquiry is, at the very
35 least, to produce a report that is an indication of the
36 truth of how healthcare services are funded, and that's
37 part of the reason why we need to speak to you and hear
38 your voice.
39

40 Having said that, I'll now pass over to Mr Muston.
41

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

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

5
6 Other than that, I'll hand over to Ed.

7
8 MR MUSTON: Thank you for joining us today. My name's
9 Ed Muston. I'm one of the barristers who is assisting with
10 the Inquiry, and sitting to my left, I don't know if you
11 can see him on the screen, is Hilbert Chiu. He is
12 a barrister who has been retained by the Ministry of Health
13 to represent the ministry's interests in the Inquiry and
14 also the interests of the local health districts.

15
16 As the Commissioner has said, the aim of today is to
17 hear from you about your experiences of the interaction
18 with the public health system, the way in which your
19 organisations respectively are delivering health care to
20 your respective communities, and the sort of systemic
21 challenges that you might be facing in terms of doing that.

22
23 It would be good to keep it as conversational as
24 possible and to that end, if, as the Commissioner said, any
25 of you want to build on something that one of your
26 colleagues has said, just pop your hand up and do it.
27 Likewise, if Hilbert, Mr Chiu, has any questions along the
28 way, instead of the more formal process where he gets to
29 ask you questions at the end, I would encourage him to just
30 jump in and keep it rolling in a conversational way.

31
32 But to perhaps just get us started, it would be great
33 if you could each, maybe starting with you, Debbie, tell us
34 who you are, the organisation that you represent, where you
35 are joining us from and what sort of services you're
36 providing to your community over what sort of area?

37
38 MS McCOWEN: Hi everybody, I'm Debbie McCowen. I'm the
39 CEO of Aramajun Aboriginal Health Service. I've been the
40 CEO for 15 years. We're based in northern New South Wales,
41 so our main office, where I'm speaking from today, is
42 Inverell, but we also have service outlets in Tenterfield,
43 which is on the Queensland border, Glen Innes, Armidale and
44 Tingha.

45
46 The services we provide, obviously, are medical
47 service. I've got what I always claim to be, that could be

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

3
4 We also have - are very fortunate to receive NSW Rural
5 Doctors Network funding for allied and specialist services.
6 We have a drug and alcohol program. We have what we call
7 a family healing, which is a domestic violence program for
8 both victims and perpetrators. We have a homelessness
9 service. We have funding to support people to get onto the
10 NDIS and aged care services. We also are just in the
11 process of setting up some very low-level aged care
12 services under the CHAP program. We're also looking at
13 going into out of home care. We're accredited for that.
14 We provide some mental health services and community health
15 promotion and support services. Yep.

16
17 MR MUSTON: Thank you.

18
19 MS McCOWEN: And I don't know how to get rid of that phone
20 call.

21
22 MR MUSTON: That's fine. Kristine, joining us from
23 Waminda, I know you have a facility on the banks of the
24 beautiful Shoalhaven River at Terrara, but beyond that,
25 tell us about you and your organisation.

26
27 MS FALZON: Hi, everyone, Kristine Falzon, I'm one of the
28 CEOs here at Waminda, based on the south coast. I'm very
29 thankful to be on the south coast, to be on my
30 grandmother's land as a (indistinct) Wandj-Wandandian woman
31 and, you know, what a privilege to be able to live my life,
32 working for my community through our ACCHO model of care.

33
34 So for Waminda, I suppose, you know, we provide quite
35 a number and range of services from clinical services - we
36 don't have dental, that is absolutely a gap in our service
37 delivery that we work towards trying to address. So it is
38 a referral base only, but otherwise it is all clinical
39 services, health and wellbeing, targeted youth programs,
40 justice reinvest programs, case management services from
41 domestic violence support, mental health, like all
42 different specific areas; family preservation and
43 restoration programs as well.

44
45 I'm just trying to think of all our cultural programs,
46 and we have a whole social enterprise as well. So, you
47 know, we've done a lot of work around population growth and

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

8
9 So we have a range of different areas throughout our
10 organisation, and, you know, we provide services based on
11 community needs, and when there's a gap or when community
12 request that, it's something that we work towards.

13
14 So some of the key areas we are working around at the
15 moment, and similar to the dental that were gaps in our
16 area in service delivery, is birthing on country. We're in
17 the process of final steps, DAs approved for the first
18 birth centre of its kind to be based in Shoalhaven, and
19 just within walking distance will be the women's rehab and
20 women's refuge, which have been massive gaps for our
21 service, and that's, yes, really welcomed. It's been
22 a struggle to be able to get them on board, but they're -
23 you know, just to provide a bit of an insight into our
24 model of care and the services we provide.

25
26 MR MUSTON: Thank you.

27
28 And Jessica from the Eleanor Duncan Aboriginal
29 Services.

30
31 MS WHEELER: Yes, hi, so my name is Jessica Wheeler and my
32 family are actually from the south coast, Yuin country, but
33 I have been raised on Darkinjung country, where I am today,
34 all my life. Our service is Eleanor Duncan, and I've
35 stepped in in place of Belinda, she's actually on leave at
36 the moment.

37
38 So Eleanor Duncan Aboriginal Services, where we have
39 a property here at Mardi, operates all our programs. We
40 have mental health, AOD drug rehab, day rehab. We have
41 suicide prevention, health promotion, family preservation,
42 out of home care. We also have a dental clinic.

43
44 Our medical centre, unfortunately, is - we're waiting
45 on DA approval from the council to move into the property
46 here at McPherson. That has been a very big struggle for
47 our CEO, and because of our large footprint, we have opened

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

5
6 We also run an aged care and elders program. We also
7 have a social enterprise with our kiosk and auxiliary
8 workers as well. Bit of a gap, too, with transport. At
9 the moment, our transport company here on Darkinjung
10 country has, yes, ceased services, so it's been a bit
11 difficult to try and get - we've also got chronic disease,
12 our ITC program as well.

13
14 MR MUSTON: In terms of the gaps that you've mentioned,
15 are they gaps that exist because there's not funding
16 available to fill those positions or is it that you don't
17 have access to the workforce you need to fill the positions
18 or perhaps a combination?

19
20 MS WHEELER: Combination.

21
22 MR MUSTON: To all of you, and maybe starting with you
23 Jessica, because we're talking with you at the minute, but
24 to what extent do you think that your service is able to
25 meet the needs of your community at the moment within the
26 existing funding envelope?

27
28 Perhaps put more bluntly, is there a whole lot of
29 unmet need out there within the First Nations community
30 within your community?

31
32 MS WHEELER: Yes. So on Darkinjung country, we're the
33 fastest growing Aboriginal population. Our books are
34 closed. We have a shortage of GPs, unfortunately, and it's
35 a struggle. There's 21,000, or over 21,000 people, on
36 Darkinjung country and we've got about 4,000 active
37 clients, which we would like to increase.

38
39 MR MUSTON: What sort of waiting lists do you have for
40 your services?

41
42 MS WHEELER: So the books - we've had to close our GP
43 books, because we cannot keep up. Yes. So we - it could
44 be - we've got over 1,000 people on that wait list.

45
46 MR MUSTON: What about Waminda, Kristine? What's your
47 experience been like in the Shoalhaven?

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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

1 organisation for registrars through both RACGP and ACRRM,
2 but we've been unable - we are a priority area for RVTS and
3 we can actually offer registrars a \$25,000 bonus, a
4 relocation bonus, yet we have not been able to attract one
5 single registrar in the last two years.
6

7 Apparently - don't take me for granted, but this is
8 what I've been informed - for the New England region and
9 New South Wales, there are only six registrars available,
10 and yet I've been down to the coast, the north coast, and
11 I gave presentations to 60 registrars. So I think there is
12 a definite need to reallocate registrars according to need,
13 not according to whatever else they are assessing it on.
14

15 We have also been reliant somewhat on locums. We've
16 taken the measure to actually investigate overseas medical
17 graduates, and I've got five coming next year from
18 overseas, three for Armidale and two for Inverell.
19

20 It's going to be at a significant cost to the
21 organisation, because we anticipate for the first three
22 months they won't understand the Australian healthcare
23 system, and they will need quite a bit of support. Having
24 said that, we'll have to keep locums on at \$1,800 a day for
25 at least another six months.
26

27 We were fortunate a couple of years ago, because as
28 a relatively new AMS, we were very poorly funded when we
29 first got established in 2005, and when the department
30 reallocated funding, we did receive quite a significant
31 increase in funding, which has all been basically sucked up
32 in paying locums.
33

34 The other issue - I do have to go at 3 so I would like
35 to dump and run, if I could - is the access to or the
36 funding - the funding for allied and specialist health
37 services.
38

39 As I'm sure you are very well aware, Aboriginal people
40 do experience a lot of chronic disease and have a need for
41 access to allied and specialist health services. The only
42 funding we get for allied and specialist health services is
43 through the NSW Rural Doctors Network, and I can say
44 nothing but praise for them, but the funding is inadequate
45 for the need.
46

47 You know, just this morning, my operations manager

1 said - from Armidale - they're receiving a lot of
2 complaints about a podiatry clinics because nobody can get
3 in because there's such a massive waiting list. We've got,
4 for another example, a 12-month waiting list to see
5 a paediatrician, which is so important for a child.
6

7 We've now had to go with - and this is completely
8 unfunded - we're going to telehealth to access paediatric
9 services because it's so essential for our children.
10

11 There has to be a better way. If you're going to
12 provide comprehensive health care, it can't just be
13 a doctor. It's got to encompass all the allied and
14 specialist health services. That area of funding is
15 woefully inadequate. Rural Doctors Network are great,
16 terrific, but it's very limited funding. It doesn't fund.
17 It honestly doesn't fund the services that we're trying to
18 provide.
19

20 I got carried away there. What else did you want me
21 to talk about?
22

23 MR MUSTON: We'll stick with that, because Jessica's put
24 her hand up, and I suspect she wants to say something on
25 one of the topics that you've already raised. We'll give
26 her a chance to do that now.
27

28 MS WHEELER: Thank you. I just wanted to actually also
29 let you know that we are the only bulk-billing medical
30 centre on the Central Coast here. So I know our patients
31 either refuse to go anywhere else, because they can't
32 afford it, they're flooding the emergency departments, and
33 the urgent care clinics that have been established here,
34 they actually closed their books, so you can't even attend
35 at certain times, which is very difficult. But we are more
36 than - we would be more than happy to take our community on
37 if we had a bit more support and the GP access.
38

39 MR MUSTON: In terms of support, can I ask in relation to
40 the relationship that you have with - let's start with the
41 local health district, what's the nature of that
42 relationship and how, if at all, do you collaborate
43 together to deliver health care to First Nations people
44 within your catchment?
45

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

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

5
6 MR MUSTON: In terms of those bits of it that are working
7 well, what is it, do you think, that has made that
8 collaboration successful?

9
10 MS WHEELER: The people that are in them seats and that
11 are willing to work with us and collaborate.

12
13 MR MUSTON: Is it the same answer if I were to ask you
14 which bits are not working well?

15
16 MS WHEELER: Yes.

17
18 MR MUSTON: What about you, Kristine, at Waminda? I think
19 we've heard in our travels about some quite positive
20 collaboration between Waminda and the Illawarra Shoalhaven
21 Local Health District, but what is the level and nature of
22 collaboration that's happening, and to the extent it's
23 working, why?

24
25 MS FALZON: I think you've probably heard positives,
26 especially to birthing on country, but realistically,
27 that's an eight-, nine-year track and journey, and to be
28 perfectly honest, if it wasn't for the leadership of the
29 existing CEO, we wouldn't have the support that we've had
30 to date, who's really led and really taken on board what it
31 is investing in Aboriginal community control but also
32 decolonising, calling out racism and understanding that
33 health and wellbeing and delivering the services for
34 Aboriginal communities is best placed through Aboriginal
35 services.

36
37 I think there's definitely some successes there that
38 we could learn and share by, but unfortunately, I think if
39 the leadership changed, it wouldn't be the case, and
40 I think that's where - yeah, systems are people, and unless
41 things are in the foundations, we can have a great wrap,
42 but unless there's implementation for that or a statement
43 of commitment that calls out racism and ensures there's
44 accountability, you know, it's all dependent on that
45 person's biased views or background.

46
47 So I think, moving forward, there is need for some

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

8
9 So in birthing, absolutely, there's been a lot of
10 support and growth and it hasn't always been like that.
11 However, when it comes to housing support, and especially
12 with mental health and drug and alcohol, it just goes
13 around and around and around and people fall between the
14 gaps every single day, multiple people. You know, that's
15 something that, as acting CEOs, we're supporting daily
16 where you could have police called out to support someone
17 with mental health needs, you call mental health, and then,
18 you know, police come out. It's seems to be a revolving
19 door, and the problem is that unless someone has, you know,
20 issues with the law, people aren't going to be scheduled,
21 or if they are, they're going to be released straightaway,
22 so then we're not providing care; we're providing band-aid
23 impacts.

24
25 Unfortunately, we're not funded and we're not that
26 specialised a service to provide the services. The health
27 system is. And until there's collaboration around that,
28 we're going to continue to see communities that are so
29 unwell, homeless rate increasing. Most of these people are
30 so unwell and they are being excluded to get temporary
31 accommodation because of their situation as well, so it
32 makes it really difficult for us to be able to support.

33
34 And, you know, we get situations all the time where
35 the specialised services are bringing the community members
36 to Waminda because they feel safe here, but we don't have
37 the specialised care for that. We can't enforce scheduling
38 or be an Open Support. We don't have a mental health and
39 wellness facility to support people with that acute care
40 either. So that's a real struggle for us daily.

41
42 To your question before around our population, so our
43 population - 113 in Shoalhaven and 7,500 Aboriginal people.
44 So Waminda services about 2,500 currently. So being
45 predominantly a women's-led organisation, but we do support
46 the whole of family and we do have men's behaviour programs
47 and youth programs and family preservation programs, now

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

3
4 MR MUSTON: You have.

5
6 And Jessica, I saw you nodding enthusiastically, when
7 Kristine was telling us about some of the challenges. The
8 "rotating door", I think, was the description of the drug
9 and alcohol services and the sort of mental health --

10
11 MS WHEELER: Mental health, drug and alcohol, yeah, we're
12 having similar issues. We also - one thing I remembered,
13 too, is that the allocating of funding, so headspace has
14 received funding, but yet they tend to refer their clients
15 to us, the Aboriginal patients, to us. So it's like well,
16 why can't we be - we've applied for some of the funding but
17 we don't - we missed out on it.

18
19 MR MUSTON: Just picking up on that, something we were
20 told this morning by the panel was that there is, for a lot
21 of funding streams, a competitive tendering process or
22 bidding process.

23
24 MS WHEELER: Yes.

25
26 MR MUSTON: I imagine that's the same environment that you
27 operate, or all three of you, operate within. I see some
28 nodding, so I will take that as a yes.

29
30 To what extent are you resourced to participate in
31 that bidding process, to write the grants and to pull
32 together the information that you need to pull together to
33 get access to the funding and do you think, to put it
34 bluntly, that it is a level playing field with those other
35 NGO organisations? Starting with you, Kristine.

36
37 MS FALZON: I will just jump in, if you like. Absolutely
38 not. We don't find the management funding for, you know,
39 management overheads, for transport, for admin, for
40 submission writers, writing, does not exist for us and
41 that's the same with, you know, insurances - you can
42 imagine, insurances across all of our staff have gone up
43 about 20 per cent. Our funding doesn't increase to cover
44 that. So that's a loss for the organisation.

45
46 But, yes, what happens is that they have these grant
47 submission writings that can do like these massive regions.

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

15
16 MR MUSTON: Jessica, did you want to add to that?

17
18 MS WHEELER: Yes, sorry. I just would like to add in
19 regards to if we're well-established organisations and we
20 have to bid for Aboriginal money to - like, that is all our
21 resources, I do agree as well, that we've spent trying to
22 bid for Aboriginal money and then they go to mainstream
23 organisations who then refer back to us. So it's very
24 frustrating.

25
26 MR MUSTON: What about you, Debbie? I suppose I'll start
27 with the topic that we've moved to, which is this issue
28 around bidding for funding against other NGOs who are out
29 there looking to, no doubt with good intention, secure
30 funding streams --

31
32 MS McCOWEN: I'd probably like to initially just confirm a
33 little bit what Jessica said about our relationship with
34 the LHD.

35
36 MR MUSTON: Yes, I was going to come back to that, but
37 fire away.

38
39 MS McCOWEN: Yes, because I have been around a long time,
40 we used to have an excellent relationship, which was
41 probably about 10 years ago, and it was very much
42 personality based. It was based on who the CEO was at the
43 local health district.

44
45 It has since disintegrated quite dramatically, and
46 I think there's actually a lack of respect and
47 acknowledgment of Aboriginal health services. But, having

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

5
6 In the past, I have gone to the Ministry of Health to
7 ask them to help us with our relationship, and basically
8 have been told by the Ministry of Health, who I hold in
9 high regard, that they have no control over LHDs and they
10 can't make them cooperate with us, which I found very
11 disheartening.

12
13 MR MUSTON: Can I unpack that a little bit? To the extent
14 that you say there are individuals or the way that
15 individuals are interacting, which is, in effect, damaging
16 to the services that you're providing, what sort of things
17 do you have in mind when you say that?

18
19 MS McCOWEN: Absolutely. Yes, the one that I'm very, very
20 upset about at the moment is we had a specialist physician
21 coming to Aramajun since 2009. A personality in Hunter New
22 England health decided earlier this year that that
23 specialist could no longer come to Aramajun, they would
24 have to operate out of the local community health building.
25 But all our doctors are very upset about it, our clients
26 are very upset about it, and I have gone to Hunter New
27 England health about it and I'm still waiting for
28 a resolution.

29
30 It has had a direct impact on service delivery. And
31 it's part of what I see, they talk the talk but they don't
32 walk the walk about self-determination and actually
33 including Aboriginal health services in decision-making.
34 It's - yep. But having said that, we have excellent
35 relationships with other parts of Hunter New England
36 health.

37
38 MR MUSTON: I take it from that that in relation to that
39 particular example, there wasn't a discussion with you or
40 your organisation beforehand along the lines of, "Well,
41 where does your community actually want to access these -
42 this particular specialist care"?

43
44 MS McCOWEN: No, no discussion. It was, I don't know,
45 personality based, I suppose. A person decided that - one
46 person made that decision.

47

1 MR MUSTON: So what is it that changed, from that time in
2 the past when your organisation had a strong relationship
3 or a good collaboration relationship.
4

5 MS McCOWEN: I think it was from the top, leadership from
6 the top. But having said that, Hunter New England health
7 does have a new CEO who is trying, and for the first time
8 in 10 years, we've actually - she's - we're trying to bring
9 back the AMSs and the health district, at that executive
10 level, to have meetings. So they are trying. But they
11 still - they're still not - they're still at the talk
12 stage; they're not actually at doing, making any positive
13 real changes.
14

15 MR MUSTON: And what about the interactions that you had
16 with the ministry? Was that a cold call that you made or
17 does your organisation have some line of communication with
18 the ministry whereby discussions around these sorts of
19 issues can be had?
20

21 MS McCOWEN: Oh, Ministry of Health are very, very
22 receptive. I have an excellent relationship with them. If
23 I have an issue, I ring and talk to them. Yeah. I can't
24 fault them. But I did find it frustrating, because
25 I thought that they would have some sort of say over the
26 LHD, and they told me they didn't.
27

28 MR MUSTON: In terms of that relationship with the
29 Ministry of Health, is that a formal sort of system or
30 structure that enables you to have that relationship, or is
31 it just that you, over the years that you've been involved
32 in the health space, have come to know individuals whose
33 phone numbers you have?
34

35 MS McCOWEN: Yes, it probably is a little bit personal
36 based but we also do have formal meetings with - oh, help
37 me out here, girls - the health director, or whatever,
38 what's the name? Everybody should know her name.
39

40 MS FALZON: Susan Pearce?
41

42 MS McCOWEN: Oh, no, no, no. It sounds terrible that
43 I can't remember her name, but she's very well known. She
44 was the face of health throughout COVID.
45

46 THE COMMISSIONER: Is it Dr Chant?
47

1 MR MUSTON: Dr Kerry Chant.

2

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

6

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

10

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

14

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

20

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

24

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

33

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

39

40 MS McCOWEN: I'm a very experienced grant writer, which
41 has been of benefit to the organisation. But having said
42 that, we've now got over 30 different funding grants,
43 agreements, and reporting requirements, and it's got to
44 a point where I'm not game to write another grant because
45 we can't manage the reporting, and you do have the issues -
46 we're writing one at the moment and it's only for
47 12 months.

1
2 I've got a community connector, which I forgot to
3 mention, but it's a role where the worker goes into the
4 schools and helps retain kids there until they complete
5 year 12. Excellent. I've got the best worker. She's on
6 the verge of resigning because there's no continuity of
7 that ongoing grant, and that is a frequent - the only one
8 that I can say with any certainty that we're going to get,
9 and that's only just happened, is the Department of Health,
10 where we were on one-year grant funding and we've just been
11 told we're going to get a four-year one. Every other
12 funding agreement, no, you don't know. You don't know.
13 You can't offer anyone any continuity of employment.

14
15 MR MUSTON: So there's three things come out of that,
16 I guess. The first is the reporting obligations which
17 attach to each of these separate funding streams which you
18 secure, I gather you're telling us, consistent with what we
19 heard this morning and have been told repeatedly around the
20 state, are extremely burdensome and could be streamlined in
21 a way that means, as a bare minimum, at least for each of
22 the funding sources, you should only be reporting to them
23 once and in a standard way. I take the nodding to be
24 a broad acceptance of that proposition.

25
26 MS McCOWEN: We get \$9 million through DoHA and it has the
27 simplest reporting thing. All these other programs where
28 we might get a few hundred thousand are the most
29 complicated reporting requirements, each with a different
30 software package that you have to record into, each with
31 different parameters and reporting KPIs, and so our
32 software - we have to end up doing half of it manually
33 because our software can't cater for all the different KPIs
34 set by all the different funding bodies.

35
36 MR MUSTON: I notice Jessica is nodding at that, I take it
37 that that's the experience. In fact, everyone's nodding.

38
39 We've just been joined by Hayley. Do you want to
40 very quickly, Hayley, tell us who you are and what your
41 organisation is and where you're joining us from?

42
43 MS LONGBOTTOM: Yes, sorry, I was a bit late. Hayley
44 Longbottom I actually work alongside Krissie Falzon here
45 at Waminda.

46
47 MR MUSTON: Great, thank you.

1
2 Debbie, coming back to that funding, the first issue
3 is the reporting and the challenges around reporting. Next
4 issue is the length of the funding commitments, so if it's
5 funding for a limited period of time, I gather from what
6 you've told us, that that creates challenges in terms of
7 being able to employ someone into a position, a funded
8 position, if you can't guarantee that that funding will
9 continue for more than a confined period of time. Have
10 I understood that correctly?

11
12 MS McCOWEN: Yes.

13
14 MR MUSTON: The last thing I wanted to ask about, just
15 based on some things that we were told, have been told in
16 our travels, it's been suggested that a lot of those
17 funding streams, particularly a lot of the smaller ones
18 that you might gather together, have quite restrictive
19 terms in terms of the way in which the funding is able to
20 be used. So these are program-specific funding streams
21 that might require you, if you succeed, to deliver
22 a particular program.

23
24 Some of the AMSs we've visited have suggested that
25 it's great to get the funding but it would be much better
26 if the funding, once it had been secured, could actually be
27 deployed within the community in a way that the local
28 people feel best would meet the needs of the community. Is
29 that an issue which you have encountered?

30
31 MS McCOWEN: Yes, can I give you two specific examples?

32
33 MR MUSTON: Please do.

34
35 MS McCOWEN: One is with domestic violence funding. The
36 majority of domestic violence funding is targeted victims
37 only. We have always not applied for any of that funding,
38 because we believe that if you don't support the
39 perpetrator, you're not going to solve the issue, because
40 people - victims go back to perpetrators. So you have to
41 deal with it, with the unit, with the whole family unit.

42
43 He only domestic violence funding we have is through
44 NIAA, where we - they allowed us to detail what we were
45 going to provide, and we said "victims and perpetrators".

46
47 The other area is mental health funding, and, you

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

7
8 THE COMMISSIONER: Debbie, what do you mean by they try
9 and tell what you to do? Can you give me a concrete
10 example?

11
12 MS McCOWEN: Oh, they set, I suppose, guidelines or
13 eligibility or what we're allowed to deliver and what we
14 aren't allowed to deliver. We don't actually have any say
15 in helping design a program that would be suitable for our
16 client group. So therefore we do not --

17
18 THE COMMISSIONER: These are people, I take it, that don't
19 have the familiarity with your community that you do?

20
21 MS McCOWEN: No, no, no. But I don't even think they
22 are - not only with our community but with Aboriginal
23 culture.

24
25 THE COMMISSIONER: Yes, okay.

26
27 MS McCOWEN: I just think they lack the understanding to
28 develop a program that will be of the most benefit. And
29 because we're on the ground and our community holds us to
30 very high standards and expectations of what we should be
31 delivering to them, and if we can't deliver that, we are
32 open to that community criticism. So if we can't provide
33 them with what they want, we're not going to do something
34 that they don't want.

35
36 MR MUSTON: While we have you, Debbie, just for the last
37 few minutes that you're available, can I ask this question:
38 if you took all of the funding streams that you manage to
39 get access to and perhaps a few that you have resisted
40 getting access to for the reasons you've just given to us
41 and had that as a single pool of money that your
42 organisation was able to deploy in the ways in which you
43 felt best would meet the needs of your community, would you
44 be doing things differently to the way you are, putting to
45 one side that you would be doing a lot less reporting and
46 the like?

1 MS McCOWEN: Absolutely.
2
3 MR MUSTON: What sort of things do you think would be
4 different from what you're doing?
5
6 MS McCOWEN: But having said that - I don't know if
7 I should say this in a special commission --
8
9 MR MUSTON: Please.
10
11 MS McCOWEN: -- but if we get funding, we make sure we
12 report according to whatever they want, but quite often we
13 will do what we think is necessary for the community,
14 regardless of the funding guidelines. So long as we don't
15 cross any legal lines, yeah, we will do what the community
16 wants and needs.
17
18 THE COMMISSIONER: Don't take it as an endorsement but
19 that makes perfect sense to me.
20
21 MS McCOWEN: Yep. Yeah, I know. But that's the way I see
22 it. Yep.
23
24 MR MUSTON: We have heard some stories in our travels of
25 examples of services that were being delivered through
26 program-based funding which were very well received and
27 providing, apparently, great benefit to a community, only
28 to have that particular program base funding come to an end
29 and the organisation was told, "Well, we're not going to
30 fund you to do that anymore but if you want funding you've
31 got to go and do something else." Is that an experience
32 you've had in your organisation and if so, how have you
33 dealt with it?
34
35 MS McCOWEN: We have had a couple of programs finish, and
36 it does take a little bit of adjusting to. And probably
37 the hardest part is dealing with the community, letting
38 them know that you can't do something anymore. Yeah.
39
40 MR MUSTON: What about others? Maybe either of you from
41 Waminda, do you have similar experiences in terms of those
42 challenges around the funding streams?
43
44 MS FALZON: Yes, absolutely, and it's probably to my
45 earlier point about - you know, I think Cancer Institute
46 can be a perfect example as well, you know, you can lobby
47 for funding around cancer for Aboriginal communities at

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

6
7 All the funding that comes out targeted for Aboriginal
8 communities are always innovation funds, so, you know, any
9 program delivery takes about three years to really
10 implement a successful program, but if it is a 12-month,
11 18-month, if you're lucky, project, then it's innovation
12 you can't reapply for, you have to apply for another
13 project model, and this is for like \$120,000 per year, so
14 I think absolutely.

15
16 I'll let Hayley - I didn't mention before, but Hayley
17 leads all the health and wellbeing programs across the
18 service, including ITC and a few of the other ones we've
19 talked to, so I might let Hayley talk to that as well.

20
21 MS LONGBOTTOM: Yes, I think what some of the biggest
22 struggles would be, you know, you get funded to deliver
23 a program, but under-funded for, you know, management and
24 administration, transport, so how are you supposed to
25 provide the program without any of that?

26
27 And also, you know, all the same across the board by
28 the sounds of it, you know, the 12-month funding, you've
29 got to let staff go, the impacts that it has on not just
30 the staff member, the family and then the whole community
31 as a whole. Realistically, how is that closing the gap?

32
33 You know, there are plenty of ways that we do our work
34 in our organisation. Of course we do our KPIs, but it is
35 a stretch, you know? Palliative care, for example, we were
36 funded there and then it stopped, and then now had to
37 reapply for another round of funding for that. I mean,
38 palliative care, everyone dies, so that, you know, should
39 just be a given. And I think that, you know,
40 realistically, Aboriginal organisations know their
41 community, know how to, you know, support our community,
42 and it has to absolutely be what that needs to be.

43
44 And minimise the funding - minimise the reporting
45 frameworks, the same as everywhere else, and you know, the
46 datasets, like it's just next level.

47

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

14
15 Like Debbie talked to, it is about being flexible and
16 how, like, we always meet the target numbers needs - that's
17 fine. But the importance about actually closing the gap,
18 smashing the gap and creating positive change for
19 community, it's almost like it's not even relevant, it's
20 just numbers and targets, which, you know, is a problem in
21 itself.

22
23 MR MUSTON: I take it from that, you're saying - sorry.

24
25 MS LONGBOTTOM: I think the GP shortage is a huge problem
26 in our organisation, having to pay locums, accommodation,
27 transport, sometimes even their partners, like, you know.
28 And we're trying to push for - the reason you want to work
29 in this organisation is for the betterment of the first
30 people of this country, the oldest living culture in the
31 world, so you know, we need support in being able to
32 provide a GP service to the community.

33
34 MR MUSTON: Because within the Shoalhaven, the market or
35 GP market outside of that which you are providing is thin
36 to non-existent in some communities; would that be right?

37
38 MS LONGBOTTOM: Exactly. Yes, exactly right.

39
40 MS FALZON: I think the other part is, like, even trying
41 to get registrars as well. So you have private, like, you
42 know, mainstream services that are just rolling in and out
43 Medicare revenue, you know. They're not providing
44 comprehensive care but they are providing scripts or
45 appointments in 15 minutes. Like, that's not going to heal
46 our community or make our community well, because we're
47 actually - Waminda is still providing all the care, but you

1 know, they have plenty of GPs, registrars just pumping
2 through, no continuation of care because they're only there
3 for the 12 months and then the new doctors come in.
4

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

10
11 MS LONGBOTTOM: They're literally diagnosing and
12 prescribing and, you know, mainstream services, a registrar
13 T3 can earn up to \$300 an hour.

14
15 MR MUSTON: That's putting wage pressure on your
16 organisation, presumably?
17

18 MS LONGBOTTOM: Next level. And, you know, a big gap in
19 our organisation, too, is, you know, dental. Population
20 health, you know, they give minimal funding as well so we
21 have to push and push and push to get what we need out of
22 them. You know, the ITC program, minimal funding, and yet
23 we're supposed to reach all these targets, provide all of
24 this to the community and no-one's looking at enhancing the
25 funding there, like, \$220,000 a year to provide the
26 transport, the admin, the care to the clients, opening up
27 the doors, and then the holistic wrap-around approach is
28 insane.
29

30 MR MUSTON: I see, Jessica, you're nodding. That's also
31 been your experience of the Central Coast; would I be
32 right?
33

34 MS WHEELER: Yes, especially around the ITC team as well.
35 But we've also had a housing program that the funding was
36 cut, so it was - we worked with the client for two years
37 with stable housing, and then they cut the funding for
38 that.
39

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

1
2 MR MUSTON: Just to make sure I've understood that, the
3 LHD has a desire for there to be two cancer navigators
4 within your region.
5
6 MS WHEELER: I believe so, yes.
7
8 MR MUSTON: Due to workforce issues, they've not been able
9 to fill both of those positions and they've only filled
10 one?
11
12 MS WHEELER: Mmm.
13
14 MR MUSTON: You have a cancer navigator who would happily
15 do that work particularly targeted towards the First
16 Nations community within your area, but the funding that
17 employs that person is coming from philanthropy?
18
19 MS WHEELER: Mmm.
20
21 MS FALZON: Can I --
22
23 MR MUSTON: Okay. Are there other workforce challenges
24 that you - sorry, I think I interrupted one of you.
25
26 MS FALZON: I was just going to say I look at the cancer
27 navigators. I think that's a really good example of the
28 challenges with Cancer Institute and how it's rolled out to
29 the local health districts, because we have the exact
30 same - so I was actually really involved in those positions
31 coming out of the state and the pilot of the three sites.
32 Maybe you guys, Jess, might have been one of the pilot
33 sites and now they've rolled out across the 15 districts.
34
35 Shoalhaven - I lobbied the whole time because it was
36 actually based off one of Waminda's projects from 2012
37 about having a conduit that works between Waminda and the
38 cancer centre as an example, and we still have momentum,
39 and that's the work I do today even in cancer from that
40 role in 2011/2012.
41
42 What's happened, they've rolled out across the state
43 and they can't be filled, and then similar to the
44 palliative care positions, so there's funding that sits
45 in - funded through - there's even a shared project sitting
46 in health that's half funded through PHN and the district
47 for a palliative care position that can't be filled.

1
2 The cancer navigator role, they've just advertised
3 twice and I was contacted yesterday to ask me do I have any
4 ideas of how they can recruit, and I said, "Well, this was
5 raised at the start when we first did all of the advocacy
6 work: the funding needs to come to an ACCHO and then you
7 need to be able to do it in partnership." So it's the
8 cultural safety that's missing. The amount of support that
9 we provide to Aboriginal and Torres Strait Islander staff
10 within the system that work in the district is massive,
11 around corporate safety, we've done cultural support, we've
12 come in as a support person when, you know, racism's been
13 raised and there are incidents and there are
14 investigations.

15
16 So there's all this work within the system that's
17 happening, and that's why the retention rate for Aboriginal
18 staff within the health district is a challenge, but we
19 know to increase, you know, cultural safety in a workplace,
20 you employ more Aboriginal people, but you have to start
21 somewhere and they need to feel safe, and it can't be just
22 one person.

23
24 Then my other thought is around having two positions.
25 That's amazing, because you could have a male and a female
26 employed through you and providing services in your cancer
27 centre. So what a missed opportunity.

28
29 MR MUSTON: Do any of you have any experience of
30 collaboration with the local health district where funding
31 for employed positions to deliver health care within the
32 wider community within your geographic areas has perhaps
33 come through one or other of your organisations but been
34 used to employ a position in the other, say, for example,
35 LHD money being used, in this instance, to potentially
36 employ a cancer navigator, or vice versa? Does that sort
37 of discussion happen or do you have any --

38
39 MS FALZON: It does. For us, we have two specific roles
40 that we've had for about three years that come from the
41 district, and they were - Hayley, you might remember
42 exactly, I'm thinking of the acronym, but they were child
43 sexual assault positions that were in the Shoalhaven, they
44 couldn't be filled, so eventually they weren't meeting
45 needs for the community, so eventually they came across to
46 Waminda.

47

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

5
6 Yeah, obviously with that Aboriginal cancer project,
7 that was a direct partnership with Waminda and the cancer
8 centre when we first opened, and that was funded through
9 Cancer Institute and that was a subcontract, the funds went
10 to the district and came straight to Waminda and then
11 employed across the week between both sites.

12
13 And I thought of another example, too, but I can't
14 think of it right now.

15
16 MS LONGBOTTOM: I think where you have to think in that
17 respect is that they came to us because they needed to.
18 So, you know, realistically, if the money was sitting with
19 an ACCHO in the first place, it wouldn't be a problem. So
20 ACCHOs are always at the forefront of trying to get up
21 partnerships, you know, trying to service the local health
22 districts and the mainstream organisations in how to take
23 care of our people because, at the end of the day, our mob
24 are going to access those spaces, so how do they be
25 anti-racist so that mob are okay to go and get the health
26 care that they deserve?

27
28 Realistically, Aboriginal health funds need to sit
29 with Aboriginal organisations, because then we'll be able
30 to provide the care that we need. We wouldn't have, you
31 know, shortages of GPs, we wouldn't, you know, have to
32 travel to Sydney to the dental hospital to take patients
33 there. You know?

34
35 We tried to get a partnership with the local health
36 district down at the Ulladulla building that's practically
37 empty to utilise their dentist chair and they wanted to
38 actually take our data, and I'm like, "No, you're not doing
39 that." Like, come on now, be fair about this stuff and
40 realistic and honest about why mob, you know, don't go to
41 these spaces.

42
43 MR MUSTON: Just on that data piece, is there, to what
44 extent, if at all, is there data sharing around medical
45 records to potentially facilitate the crossover of people
46 within your care who then present in an acute setting and
47 vice versa with people transferring from an acute setting

1 back into your care?

2

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

10

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

24

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

28

29 MS LONGBOTTOM: Massive right now.

30

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

33

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

38

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

42

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

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

3
4 MR MUSTON: What about you, Jessica? I see you nodding.
5 These are similar situations --

6
7 MS WHEELER: Yeah, we have similar issues as well. We
8 also have found, too, that as soon as we have any mob
9 released from gaol, they'll just send them on to the
10 Aboriginal medical centre still in their greens and they
11 are like, "I need help." It's like, "Well, what are" -
12 like, we'll do what we can, but - and even speaking back to
13 the mental health and drug and alcohol, the reason why
14 they've got drug and alcohol issues is because of their
15 mental health, but yet when they go to the - they don't
16 treat both. So - and then, yeah, we're not a crisis
17 centre, but it's - they've got nowhere else to go.

18
19 MR MUSTON: You've jumped to something that I was going to
20 ask you about, and that is the First Nations people who are
21 incarcerated are receiving medical care during that period
22 of their lives through justice health, within that prison
23 setting. Do you think there would be potential benefit,
24 and assuming that both sides of the equation were
25 adequately funded to do it, but do you think there would be
26 potential benefit in having, as it were, a clinical
27 handover from justice health to the appropriate local
28 Aboriginal medical service for someone - and perhaps even
29 in the other direction, if someone is detained and it's
30 ascertained, ideally, pretty quickly in that process that
31 they have an existing clinical relationship with an
32 Aboriginal medical service, a clinical handover from the
33 AMS to justice health, and then, in the lead-up to their
34 release, that there be a clinical handover back to just try
35 and avoid a situation where, much like what you've just
36 told us, Jessica, the person who turns up in their greens
37 unannounced and says, you know --

38
39 MS WHEELER: They've got no housing. Like, we can't
40 support - obviously our housing got taken off us for the
41 funding, so no, we can't do that. And also it comes down
42 to, like, our books are closed and that's devastating. And
43 the GPs are very risk averse here in regards to, like,
44 we've got Frank Baxter, the juvenile justice, just here at
45 Kariong, that we're looking at trying to kind of build
46 a bridge to - for the community in there, but then we are
47 just under-resourced, we've got no GP. The follow-up care,

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

2

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

7

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

14

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

23

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

33

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

44

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

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

13

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

18

19 MS LONGBOTTOM: No, it is not. It is really not. We're
20 struggling for space, like, you know, we've got all these
21 amazing programs. Our youth program, they get up to
22 70 young people a week in that youth program, and so that's
23 that prevention work, you know, being proud of your
24 identity, who you are, what our culture is about,
25 connecting to your elders and your peers and looking after
26 each other, and, you know, what is the essence of our
27 culture. Like we're not violent, you know, drugs and
28 alcohol are suppressants and a self-harm mechanism
29 literally - that's what we have to look at that as - and so
30 what do you want to be when you are older? And when we're
31 working with our adults, we've got to be talking to them,
32 like, "What did you dream about when you were young? What
33 did you want to be when you grew up?", you know, getting
34 those things in their head. Because we're always talking
35 about ourselves in a deficit, and that's how this country
36 treats us, in a deficit, like the referendum is a very
37 clear answer to what this country thinks about us.

38

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

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

26
27 MS LONGBOTTOM: Mmm, yes.

28
29 MR MUSTON: Are there any mechanisms, at least within your
30 local health district, where you can sit down and talk to
31 people within the LHD, the mental health team at the LHD,
32 about these people who are in this cycle, to try --

33
34 MS LONGBOTTOM: They are strapped because their policy
35 states, right - and the - you know, we've got many, many
36 examples where they will call us because they deemed the
37 person unsafe, so they will call us to go and do it,
38 because, you know, it's okay for us to go and see an unsafe
39 person, but it's not okay for them. Like literally, that's
40 what they do. We've had these conversations, we've been at
41 the table, but their policies state.

42
43 MR MUSTON: So these are people who they have determined
44 are a risk either to themselves or to others?

45
46 MS LONGBOTTOM: To them - to them, yes.

47

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

8
9 I think investment and funds needs - like even how
10 hard it is, you can't get that support around seeing
11 a psychiatrist, it's so hard. Even for a well person, if
12 you needed, you know, just some follow-up care for
13 psychology as well as for any needs, it's not available,
14 and the quickest way to see a psychiatrist is to be
15 scheduled. It's not good enough. You can't wait six
16 months to see a psychiatrist with these ridiculous amounts,
17 when ITC might be funding there or different areas.

18
19 We actually fundraise for funds around cancer
20 investigation funds and for other things like to get
21 specialist appointments that can't be covered under any
22 other care and aren't bulk-billed.

23
24 MR MUSTON: Do you see, just through the community that
25 you engage with, a connection between this mental and
26 spiritual wellbeing on the one hand and the more physical
27 health type issues, chronic disease and the like - that is
28 to say, the individuals who you are not able to provide
29 that mental health --

30
31 MS LONGBOTTOM: I will tell you, in our town, we've
32 literally just had five cigarette shops open up -
33 cigarettes and vapes and they have promoted gifts and
34 confectionery on the front of their shops, right? Who are
35 they targeting? Gifts and confectionery, "Go in there".
36 Like that's kids. One of the lowest socioeconomic areas in
37 the area, and they've got alcohol shops there, tobacconists
38 and vapes popping up left, right and centre.

39
40 And then we've got that many take-away shops on this
41 main strip, it ridiculous. That is all deliberate. It is
42 deliberate. It is there for us to be sick, to go and do
43 all those things. No-one's employing us apart from
44 Aboriginal organisations, so where else are people going to
45 go? We can't provide everyone with a job, and we certainly
46 know that when people start and have an opportunity and
47 have that wrap-around support, then of course their futures

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

3
4 MR MUSTON: But just where you make that investment, do
5 you see that the physical health of members of your
6 community in terms of chronic disease, diabetes and --

7
8 MS LONGBOTTOM: A hundred per cent. We've actually got
9 a diabetes remission and Aboriginal women's program.
10 Massive. So we support these women to change their
11 nutrition, first and foremost, and then they wear a CGM
12 monitor, and so they can literally see if, you know, the
13 food they are eating is shitty for them - sorry for
14 swearing.

15
16 MR MUSTON: That's totally fine

17
18 MS LONGBOTTOM: That's self determining, right? So they
19 are literally going to see how bad their sugar levels are
20 and it's up to them whether they are going to eat that or
21 not. I'm telling, you people come off medications and then
22 they start to feel better about themselves, "I'm going to
23 go for a walk", so they're starting to get active, and then
24 socially they're going on camps and doing good things. A
25 hundred per cent. A hundred per cent.

26
27 MR MUSTON: In order to achieve those sorts of outcomes
28 through your organisation, what would need to change, or to
29 achieve more of those outcomes is probably a better way of
30 putting it?

31
32 MS LONGBOTTOM: Well, firstly, we need to be resourced
33 properly to be able to provide - and like we want to take
34 this down to, you know, Wallaga Lake, and now we go up into
35 Coomaditchie as well. So resource, for starters. We need
36 people resource, we need space resource, we need medical
37 equipment resource. I mean, we do all of our shared
38 medical appointments - sometimes it goes online with an
39 endocrinologist for, you know, women's business stuff, but
40 that works, right? That shared medical appointment works.
41 It's just properly resourcing and not having to borrow from
42 Peter to pay Paul, as the saying goes. And then the
43 multiple list of things you have to provide for, you know,
44 funding; and then making sure that we're, you know,
45 literally going off the CTG target, like, we do so much
46 more than that, as well. Like literally just resource
47 organisations and communities to do the work that they know

1 that works.

2

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

14

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

24

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

41

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

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

3
4 MS FALZON: Absolutely. The amount of targeted Aboriginal
5 funds that are in the country that go to mainstream
6 services instead of coming directly to ACCHOs to deliver
7 services through our models of care from our community, for
8 our community, is unbelievable.

9
10 But, yeah, absolutely, if funding comes to our
11 services so we can deliver the needs, instead of, like
12 Hayley said, having 70 youth attending youth programs, and
13 around that prevention and support and opportunities for
14 pathways of employment and - you know, where do they want
15 to be when they are older? But we actually can't cater to
16 the numbers because we don't have the space. There is no
17 infrastructure, there is no investment in - you know, to
18 build spaces, youth spaces or specific culturally safe
19 spaces, but yes, absolutely.

20
21 MS LONGBOTTOM: I agree, and I need to back Krissie up
22 with, you know, mainstream organisations getting Aboriginal
23 money. They don't need it, either. So put it where it
24 needs to be and belongs.

25
26 MR MUSTON: What about you, Jessica, I noticed were you
27 nodding, but do I take it that that means you share those
28 views.

29
30 MS WHEELER: Yes, definitely. Yes. And it would also
31 mean less time that we'd have to spend on admin, doing the
32 reporting. All different portals that we have to navigate
33 is a nightmare. So.

34
35 MR MUSTON: We've sort of touched on most of the issues
36 that we've spoken to people and heard from people about
37 around the state, but are there other issues that we
38 haven't spoken about that any of you think really should be
39 on the table in terms of changing the way that either the
40 funding or the interaction between ACCHOs and PHNs, and
41 more specifically LHDs, could be changed in order to help
42 you to do more with the resources you've got?

43
44 MS FALZON: I think flipping the narrative about, you
45 know, you have all these different streams and different
46 parts of a person, where if you flipped it and looked at it
47 from what does the ACCHO model of care look like, what is

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

12
13 MR MUSTON: Accepting that it might be impossible, even
14 with the best will in the world, to get rid of all of the
15 grant based and program based funding streams, if for no
16 other reason than that would require multiple different
17 levels of government to agree, but if there was a block of
18 funding that was provided to your organisation to provide
19 health care in a way which was delivered in the way that
20 you felt, in each of your individual communities, would
21 best use that money, possibly supplemented by grant money
22 on the edges, would that make a substantial difference?

23
24 MS FALZON: Absolutely. You have, like, you know, fund
25 folders like - and I will say PHN or NIAA - like there are
26 funds being used and being wasted in positions just to hold
27 funds, than to deliver us. Those funds could be employing
28 positions on the ground, and if you think of all the
29 administration and everything else that goes into
30 everything that has to be set up for that - like it just
31 should be direct funding to ACCHOs and for comprehensive
32 health and wellbeing care.

33
34 MS LONGBOTTOM: Yes, if you take out the middle person,
35 the middle person in those organisations, and that comes to
36 Aboriginal organisations, then sweet, of course it is. But
37 you have to actually look at, you know, the population we
38 take care of. The funding obviously needs to be
39 substantial because there is a lot of work to do, and
40 I think when those - you know, the LHD - when they realise,
41 you know, the care that they provide is very not okay, then
42 that's when they should be, "Okay, then, yes, I agree with
43 that. We really don't know how to look after Aboriginal
44 people. Aboriginal people know how to look after
45 Aboriginal people", and they should just be fine with that.

46
47 MS FALZON: And I think the other part of that is - and we

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

9
10 MR MUSTON: Just to pick up on something you said a moment
11 ago, Hayley, to the extent that services being delivered
12 through the LHD are "not okay", to use your words, for
13 whatever reason, do you find, within your local area at
14 least, you have an ability to communicate that fact to the
15 LHD - that is, say to them, "Look, here's what we've been
16 told on the ground"?

17
18 MS LONGBOTTOM: Look, a hundred per cent. A hundred
19 per cent. We make no bones about making complaints or, you
20 know, we've got a good relationship with our local health
21 district CEO and we're quite happy to have those
22 conversations. You know, they have invested in coming to
23 do our decolonisation workshops, so that's really good.
24 But at the same time, too, like it's the belief of people
25 that just think that they are better than, you know,
26 Aboriginal people, and that's the stuff that we need to
27 discuss.

28
29 So, you know, very good having a conversation with the
30 CEO, but what about the staff that are taking care of our
31 mob walking through their doors.

32
33 MR MUSTON: That was sort of my next question. To the
34 extent you have these discussions and you have a good
35 relationship with the CEO, do you find that that's
36 something that translates into changes on the ground?

37
38 MS LONGBOTTOM: Well, you know, we've got an MGP up in the
39 hospital at the moment, so you know, there's obviously
40 still a lot of work to be done. Very, very slow progress,
41 but it absolutely can.

42
43 MR MUSTON: Yep. What about you, Jessica? You have
44 a different - not quite the same relationship with the LHD.

45
46 MS WHEELER: Or the PHN. Our relationship with the PHN is
47 pretty much non - like they are not supportive or helpful.

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

10
11 MR MUSTON: Did you have any other issues that you wanted
12 to raise that we have managed to skilfully skirt around or
13 unintentionally skirt around?

14
15 MS WHEELER: No.

16
17 MR MUSTON: Do any of you have any other issues?
18 I've sort of asked questions based on the things that we've
19 heard around the state, but equally, you guys are on the
20 ground dealing with this day in day out and you know a lot
21 of stuff that we don't, so if there are changes or if there
22 are things that you think could be improved, let us know,
23 and if we end this and then you think of one, don't
24 hesitate to communicate with us about it.

25
26 MS WHEELER: Will do.

27
28 MS FALZON: I think a lot of the areas across the state
29 are doing their renewing their statement of commitment with
30 the district, so I think being able to have that with the
31 implementation, and like I said at the start, like, yes, we
32 have a great relationship with the CE here, but if she was
33 to go, and that's - we know people don't stay in these
34 roles forever - what's going to happen? We're going to
35 lose that momentum. So it needs to be embedded as part of
36 the process and the expectation, and there needs to be,
37 like, processes for accountability and monitoring how
38 things are tracking.

39
40 I think to the PHN as well, you know, at a state level
41 AH&MRC and PHN have come together with a statement of
42 commitment, too, of how they are going to work in
43 communities, and the discussions we're having - and this
44 was the proposed discussion as well with PHN - around
45 decommissioning and recommissioning to the ACCHOs directly,
46 that hasn't been picked up since one of the CEs that were
47 leading it from PHN left his role last year. And my

1 feedback about being involved in that process is all ACCHOs
2 are going to be hesitant to sign a statement of commitment
3 with the PHN, for good reasons, like for trust or mistrust,
4 everything that we face daily as Aboriginal people.
5

6 But on the flip side, how you had some CEOs of
7 different areas refusing to sign it, when those funds are
8 targeted for our communities, I cannot understand. And,
9 you know, their reason why they wouldn't sign that
10 statement of commitment to decommission and recommission to
11 ACCHOs, it needs to be questioned why they are even in
12 their roles for health and wellbeing care and the work that
13 they are doing as PHN.
14

15 But, yeah, I think coming back to all the districts,
16 looking at the statement of commitment, making sure that
17 there are ways to have accountability, monitoring, and
18 being able to have reviews and audits and cultural audits
19 across - I know a lot of different areas in the health
20 district, they do their own self cultural audits. Like,
21 what is that? How do you self audit yourself as
22 a mainstream service around culture? That's just - I can't
23 understand that at all.
24

25 THE COMMISSIONER: To all three of you, thank you very
26 much for your time. We're very grateful for it and for the
27 assistance you have given us, so thank you once again.
28

29 And we will adjourn until 10 o'clock at Redfern
30 tomorrow for the in-person roundtable.
31

32 Thank you.
33

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