Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At the National Centre for Indigenous Excellence,
166-180 George Street, Redfern, NSW

Thursday, 28 November 2024 at 10.00am

(Day 066)

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 for NSW Health

(Acknowledgement of country delivered by Mr Grant Cameron)

MR CAMERON: Yaama, everybody. Hello. My name is Grant Cameron, a proud Gamilaroi man and chief executive officer here at the NCIE.

First and foremost, I'd just like to kick off with an acknowledgment to country, so acknowledging that we are meeting here today on the beautiful lands of the Gadigal people of the Eora Nation. I just always like to show my sincere respects to Elders past, present and emerging.

Obviously lots of mob in the room, so acknowledging everyone in the room and the lands where they come from, and our non-First Nations brothers and sisters who are our allies who help us to do all great the work that we do.

I just always also like to acknowledge that this always was and always will be Aboriginal land. So welcome to NCIE.

A little bit about the centre. We're a First Nations not-for-profit charity. We've been here for 16 years. Our whole purpose is to serve the community in many ways, every way that we can. We have a strong focus on our kids, our youth and also our Elders.

Lots of programs happening here that, you know, we fund and that we seek grants for - after school programs, school holiday programs, youth events on Friday evenings. We collaborate with the local police and other key stakeholders in the area to try to get kids off the street. Due to us running those events we've seen crime rates drop in the area. Kids are engaged in sport more, healthy routines, healthy lifestyle. Lots of stuff with our Elders, AMS and Wyanga, so, you know there's always Elders here on site.

Obviously the fitness and aquatics is our main source of revenue. We have over 1,000 members in the gym, 400 are Aboriginal or Torres Strait Islander; about 450 members in the pool, about 100 are Aboriginal or Torres Strait Islander. So really for us, it is all about, you know, health and wellbeing.

I've got Cass here. She can introduce herself. She is our Aboriginal mental health clinician. So, Cass, can

you continue?

MS CARLEY: Yes. I'll probably forget half the stuff I do, so sorry.

My name is Cassandra and I am the Aboriginal mental health worker here at NCIE. A little bit of my background. I started in child protection. I did that for a few years and started to notice the gaps in mental health and how mental health was held predominantly the reason for child removal, but it wasn't really explored, so I decided to study and I did that for a few years and then I went into the health space.

That was a big eye opener for me and it was a really hard space for me to work as well, so really having to work under the way that health works with our people. So I was able to work in - I started in adult mental health, I went to perinatal infant mental health, really enjoyed that, adult and youth, then I went to community and forensic mental health. So, I guess, all of those different places that I was able to engage and work with - you know, adults, children - I felt that I was more so able to provide ways to support Indigenous and the ways of how - what they were doing was great, but kind of shifting that to understand their trauma, understand their background and then work towards, I guess, not so much just checking them into the system, supporting them and then putting them back out in the community, really understanding what those barriers were and that stigma and also why they weren't coming to the health space, why they didn't want to get the help from whatever service it is.

Once I was kind of finished there, I met with Grant and started working here. My role is quite new. So I am trying to utilise everything, all the knowledge that I have gathered along the way, and then really put that in to the space that we're in here now, working with children, identifying, you know, where those mental health gaps may be, but also, I guess, getting the youth to understand that it's not an illness, it doesn't mean there's something wrong with them; speak about it, have those yarns and feel safe to speak when they're feeling depressed or even understanding what that looks like.

We're also trying to run some SMART groups, which is something else that I used to do, instead of having those

SMART recovery groups in a rehab, just having it in community so they feel safe, comfortable, and really supporting that.

I think that's it. Have I forgotten anything?

MR GRANT: No, that's a lot. That's great.

In the whole time that NCIE has existed, we've never had that type of support here on site, so I think it's crucial to have Cass join the team, as I said, trying to offer that real holistic wrap-around support to our community.

I would like to thank you for choosing NCIE as the venue today. All the revenue that we get from the conference base, from our membership, from the accommodation and everything all goes into community to help us keep running the programs that we do, so I would like to say a huge thank you for choosing us.

I'm not sure if you notice but around the room we've actually got an art roadshow here at the moment. The art comes from a gallery up in Brisbane called the Birunga Gallery. It runs a cultural creative development program for emerging artists. This is, like, some of their artwork around the room. So if anyone's interested to purchase that, we get 20 per cent of the proceeds, which will go straight to our children's services. So, you know, in the lead-up to Christmas, if you know someone who is looking for some art, there is some beautiful art around the room. All the information is on the cards underneath.

Enjoy your stay here. Thank you for choosing NCIE and thanks for having us this morning.

THE COMMISSIONER: Thank you, thanks very much.

Good morning, everyone. My name is Richard Beasley. I'm the Commissioner of this Inquiry. This is Ed Muston, who is senior counsel assisting, and there are other members of the team here and also some representatives, including legal representatives, from NSW Health.

Thank you for coming. Most of today should be us listening to you, rather than you listening to me or Ed, but I will just say a couple of introductory remarks.

This Inquiry has been going for about 14 months now and we have travelled to every LHD in the state, including the regional LHDs. We've spoken with some of you, and we've certainly spoken to a lot of your colleagues.

Most of those meetings have been meetings like this, where we sit around and discuss issues that are important to you. We also had some roundtables yesterday with some of your colleagues who weren't able to travel to Sydney, and they were held remotely.

I don't want to set the agenda about anything you might like to raise, but I will say a couple of things about the themes that have been fairly consistent in our travels, particularly our travels in regional New South Wales.

We've got a good idea of the services you offer and we have a good, I think, appreciation of how important your entities are to your communities and your people. These are some of the things your colleagues have raised with us or you have raised with us: in relation to funding, often there have been concerns raised about the short-term nature of some funding and the impact that has on workforce and retaining staff.

I also think there's been a common theme that money allocated to Aboriginal people should be in the control of Aboriginal people, and there is often not enough autonomy or trust about where you see the money would be best spent in relation to the services you provide.

There have been some general workforce issues that are actually, in relation to regional New South Wales in particular, fairly consistent, no matter who we're talking to, whether it's the LHDs, whether it's an AMS or an ACCHO, or whoever, about the difficulty of attracting and retaining staff in rural areas.

I think the other matter we've had some discussions about is your relationships with other people in the health system, whether it's relationships with people that are within the ministry or the LHDs or PHNs, and whether they can be improved in any way.

So I think they are the key themes.

MR MUSTON: There's also the reporting obligations.

THE COMMISSIONER: Yes. Ed just mentioned the burden of reporting obligations in relation to some of the grants which, again, is something that has been consistently raised with us.

Having said that, though, first of all, please don't feel as though they're the only topics we would be interested to hear about today.

Secondly, don't feel as though you shouldn't raise those topics that I have just mentioned, because it's important, when things are challenges for you in relation to the services you provide - we're keen to here those issues again and again because it just reinforces to us the evidence base for those potential difficulties.

So, having said that, I'm going to hand over to Ed and we might kick things off. In terms of this discussion, obviously we have designed it so that it's, as far as possible, not anything like a court hearing. What I encourage you to do is, if one of your colleagues says something, if you want to add something to that, please just put your hand up, and we can have that kind of discussion. So please feel free to let us know if you want to add something more or clarify something in relation to anything one of your colleagues says today.

Having said that, I will hand over to Ed.

MR MUSTON: I think that's probably one of the most important points. The aim of today is to keep it relatively conversational. The only slight caveat to that is the person sitting here to my left has to take down what everyone says, and so if we could try and keep it one person speaking at a time and try to speak reasonably slowly - I do slip up quite often myself and I'm usually close enough to her to get a nudge, but if one of you is speaking quickly, and I get that nudge, then I'll let you know.

THE COMMISSIONER: I'll probably just say one more thing. I hope everyone will feel comfortable in speaking as directly and as freely as they want to with us. A commission of inquiry like this, at the end of it like a

royal commission, we produce a report, we make recommendations, but we don't become the government and we don't become the New South Wales or the Commonwealth treasury. It will be up to government as to what they do with any recommendations we might make, but at a minimum - and the report will be this - the report has to be a reflection about how things actually are, what the truth of the healthcare system is, what the truth of the funding is and what the truth is for you.

We'll only learn that from you speaking really directly to us, as freely as you feel comfortable. So I hope do you that, because one of the main aims of an inquiry like this is to be an investigation into truth.

MR MUSTON: Those of you who I have spoken to in our travels, I am pretty comfortable that you will be pretty frank and forthright in the expression of your views.

Perhaps the best way to start, though, is for us to just perhaps go around, identify who you are, the organisation that you're from and the rough footprint of the state that you provide services across and the sorts of services that your organisation provides.

MR DUROUX: My name is Kevin Duroux. I'm the deputy CEO of the Tamworth AMS. We provide GP services. We have nine full-time GPs, 21 visiting specialist services and mental health and social and emotional wrap-around services.

MR RAUDINO: Caine Raudino. Office manager, Albury Wodonga Aboriginal Health Service in Albury. We cover Albury Wodonga. We've actually got five offices, so we've got quite a large footprint in that area, New South Wales and Victoria. So it's a bit unique. We're able to tap into both sides of the river, state funding, so that is quite unique.

We started out as a clinic 15 years ago. Now we have morphed into basically full wrap-around services, everything you can think of barring child protection services and housing, and that's only because it's too much to sort of say. We've got about 4,000 patients on our books, so it's quite extensive.

We've got a similar amount of GPs, a few registrars. We're a bit lucky in that sense. Yeah, so very fortunate

to be where we are sort of between Melbourne and Canberra and Sydney, so we do have, yes, that fortunate position where we are situated. Even though we are regional, we still are semi like what a larger regional city is.

MR MUSTON: While you've got the microphone, I might just ask you a couple of questions. You say you have 4,000 patients on the books. To what extent do you think the services that you are able to offer within the funding constraints you currently have enable you to actually meet the needs of the First Nations population in your footprint?

THE COMMISSIONER: I remember you telling us about increasing wait times just for primary care clients.

MR RAUDINO: Yes, if you take our lead GP, or any GP, we've got a 10-week wait, you know. As much as we're fortunate enough to have a few GPs, the service is only - you know, it will come up, everyone talks about funding. They give you funding, but where's the capital funding to come with that to expand your service? We would love to have more GPs. We would love to have more services to meet the community needs, to cut down the wait times, however, we've got nowhere to sit people, and that's the reality of it.

You know, we can get the funding to get more GPs or get more services in our SEWP team, however, we just haven't got the space. Our wait times are quite extensive. Then if a GP has a sick day, I mean, you know, the community ring up, it's the end of the world. They are human, they have sick days, they have families, but then they've got another 10-week wait.

THE COMMISSIONER: What's driving the extension of those wait times? First of all, 4,000 people, obviously over the years there's been an increasing awareness of the services you offer, but otherwise, is the GP market generally thinning and the bulk-billing market generally thinning; is it ageing; is it population increase; is it a combination of all of those things?

MR RAUDINO: Bulk-billing, that's, you know, the elephant in the room. We're one of the only services that bulk-bills, so now everyone becomes Aboriginal. You know, everyone wants to jump on board and get a free service.

That's something we're juggling with at the moment, looking at our attending policy, I suppose you could say, or who can access the service policy, because it is getting out of hand.

Our lead GPs won't see any new community members. We get a lot of registrars, so there's no continuum of care. So, you know, the mob want to see someone and don't want to tell their story to four different GPs or four different SEWP workers; they want to tell their story to one person, get that continuum of care so that they feel comfortable and it's better to make connections. So that's a big issue.

Registrars are good, yeah, great, but you only get them for 12, 24 months. We might get a casual locum float in, float out, and they're really good, they're really friendly, but they're here for six weeks, you know? So that's the issue.

And then GPs go - our lead GP recently reduced his days from five days to three days and took a job with the army, so - you know, that's for two days, because of the remuneration. That will come up too, no doubt.

MR MUSTON: So I've noticed, Kevin, you have been nodding enthusiastically through most of that. I gather your experience in Tamworth is pretty similar; would that be fair to say?

MR DUROUX: Yes, very, very similar to what's been described there, particularly having to compete, you know, for remuneration, to be able to secure GPs that can be stable in the service to create that kinship, I guess, and that friendship that we ask them to have with patients, yeah.

We, in Tamworth, provide a lot of services that Aboriginal people prefer to source from an AMS. We're not entirely funded for everything that we provide.

MR MUSTON: What sorts of services, just in general, fit into that category of things that your community is wanting to get access through the AMS but you're not really funded to deliver?

MR DUROUX: A classic example of ours is the transport

service we provide.

MS L BELLEAR: Tell us about it.

MR DUROUX: So we go and pick patients up, take them for their appointments. I've got a transport officer in Newcastle today, taking a patient there. That's all off our own back.

MR MUSTON: Maybe the record could note that with the mention of transport, everyone in the circle smiled and nodded. That's a common problem.

MR ROXBURGH: Yeah, we're not funded for that.

MR MacQUEEN: Good morning, my name is David MacQueen. I'm the CEO at Katungul AMS. Our footprint goes from Ulladulla to the Victorian border. We have clinics in Batemans Bay, Narooma and Bega. We have a clinic one day a fortnight at Wallaga Lake, and we're just opening up at Queanbeyan.

Some of these things have been mentioned by two of my colleagues on the right here. We offer GP services. I've got 1.5 FTEs split across three facilities. We fill the gap by bringing in locums and really that's not financially sustainable but that's the only way that we can get to service our community there. Attracting GPs down there is a really major problem for us, when competing with mainstream clinics who - some of them bulk-bill but they can pay their GPs more than we can.

And I'll just mention that we are a bulk-billing facility as well, so revenue for that area comes to us from Medicare.

We offer allied health services and we get specialist staff coming out there from time to time. We have dental services there. We have a dental room in Narooma and a dental room in Bega. The Bega room hasn't been operational for two years, and in Narooma we have a dentist coming down six days a month. We have a waiting list, that we know of, of over 120 and that is really a major problem for us. We also have a dental bus that hasn't been used for 18 months to two years.

THE COMMISSIONER: I take it that the lack of use is

because you can't find someone to take the role, or is it the funding --

MR MacQUEEN: No, it's the first. We can't find someone - when we have found somebody interested, they wanted us to pay $350 an hour, so we weren't interested.

At the moment, on that space, I'm working with Coordinaire and ForHealth, who have dental rooms nationally, and they're to work through, I guess, a possibility of coming down south with our dental program down there.

We have mental health services, chronic disease, eye and ear health, women and men's health, drug and alcohol, patient transport. We go up and down the coast taking all our members, community, to appointments - to Canberra, to Nowra, to Sydney. So we have 2.5 FTEs in that space.

Yes. Funding from our point of view, we like dealing directly with the feds and the state government with the funding, it's more direct and it all comes to us. It maybe the same everywhere, but down on our footprint, there's a whole lot of other organisations that get government funding for Aboriginal services. They obviously take their administration costs off the top and then either get us to deliver the services or try and find them themselves. They get resources. There's so much funding down there for Aboriginal services --

THE COMMISSIONER: This is like NGOs are getting the money but then --

MR MacQUEEN: Yes, they're very good at getting funding particularly from the Federal Government, but they also come to us for us to help them provide the services.

But their administration - I mean, finding Indigenous workers down there is really difficult, because you've got all these other players in the field, and they also offer higher wages than us. I mean, we struggle to keep our team. I think I have said enough.

MS T LAYER: Good morning. I'm Taasha, CEO of Ungooroo Aboriginal Corporation. I'm based in Singleton, Hunter Valley. Our traditional owners are the Wannaruah people in the valley. Ungooroo is celebrating its 30-year

anniversary this year, which is amazing.

We're an ACCHO and I'd like to reiterate everybody else's sentiments around the struggles with, you know, GPs, and I think one of the things - we've got four GPs, we're lucky to have two Indigenous GPs in that, so they are very, very booked all the time.

I think the struggle is they're reducing their days because they are getting burnt out. Mental health care plans are now our predominant thing that they're dealing with. They call it "heavy patients", so I think it's putting a strain on the GPs in that sense.

We have a good SEWP team.

THE COMMISSIONER: "Heavy patient", I take it, is someone with complex problems?

MS T LAYER: Yes, mental health.

THE COMMISSIONER: You can't address it in six minutes; you've got to really --

MS T LAYER: Yes, and I think it is the balance, because it is bulk-billing, however, we really pride ourselves on taking the time in longer appointments so it's that quality of care for mob and community as well.

THE COMMISSIONER: Someone was telling us yesterday, when certain grants are looked at, you know, you've got to report, you might say a certain number of patients, and the bureaucrat is only looking at the statistic of the number, whereas one of your colleagues was saying, "But hang on, that patient, I know, took an hour", or "This patient actually took six hours because it was such a difficult issue", and there's an imbalance between just looking at a stat and actually what you do is provide a service, not try and create statistics.

MS T LAYER: Yes, exactly, you know. Then you've got the admin team, because they're running so far behind, they're struggling, and things like that. So it's not just as easy, I think, as a commercial surgery where you would be 10 minutes, you know, 10, 15 minutes, and they're just sort of pushing it out. We have a very different model, but it is putting a strain on the GPs.

We've got a partnership with ACRRM and RACGP. We've just had a placement for another registrar coming in, and, you know, we're looking at that alternative. But again, fi they're cutting their hours, part time, it reduces the clinical supervision that they can provide, so it reduces the days that we can offer for the registrar, particularly if they're a T3. So there are those sorts of things that they're very strict on on-site supervision in that circumstance.

You know, we've got our AHP, registered nurse, the clinical support team around that, and we're really trying to build up our SEWP program, which is funded under the ministry, for suicide prevention and to support those, you know, internal referrals into those more non-clinical programs.

We're a registered NDIS provider as well, so again, there's a lot of internal referrals sort of happening. We've got a contract with Rural Doctors Network so we provide allied therapies.

We really struggle with psychology. You know, we have psychologists who we're trying to interview, they're 300, 350 an hour, more than what the GPs are even charging. If you combine NDIS and even the funding, we can't cover the cost of that psychology service, you know? So it really falls back again on the GPs and what they can provide.

We have OT and exercise physiology, so there's a lot of internal referrals from NDIS for that. Then we've got other contracts, a specialist homelessness service with DCJ and we've got Barranggirra , and Craig is the contract manager for that, but that area covers from the Hunter Newcastle area, right up to the Tweed. So that's a massive footprint. We've got remote workers from the mid north coast and north coast that cover it.

We did have a PSP program, out of home care. We actually terminated that contract - we had it for two years - purely because we couldn't staff it. It was putting the kids at risk. We could not staff qualified caseworkers in that area, so the board made the decision to terminate that in June.

MR C LAYER: My name is Craig. I'm the chief operational

officer for Ungoorroo. Pretty much what Taasha said, but my main role is to support her in those endeavours, to help create other opportunities as well to support the medical side of what we do.

So the other programs that Taasha mentioned, I look after the management of those, which is mentoring apprentices/trainees, but also trying to create other business arms that we can utilise to generate income to come in and service or support the ongoing sustainability of the medical stuff and the range of medical services that we do provide.

That, in itself, becomes a challenge, because any small business, no matter what it is, is a challenge. It's getting traction in those different things that we create so that they actually don't become a burden to what we're trying to achieve, but help support. So, you know, we're trying to be proactive to create things ourselves, but again, it comes back to the funding and whether it's adequate, the way it is managed, the way it is, I guess, given out to AMSs and other Aboriginal services, to ensure that we don't have to keep, you know, trying to create all these other things and, in a sense, creating extra burden on the overall business itself.

When they work - you know, for example, at the moment we do things like work-wear and PPE. Being in the Hunter Valley, that's not a bad thing to be focused on because of the mining and construction, civil construction and so forth, but it's a very competitive thing as well. So we're not just a small operator, we're a very small operator in comparison to the competition, but it's all these little things that we try and create to assist with the sustainability.

But the core of it really is just how that funding is farmed out, managed, so we can utilise it to its best effect, so that our clients, our community and patients, are being cared for effectively.

MR MUSTON: In terms of your operations, to the extent you're able to earn that revenue through these other businesses where they're working and effective, what does that buffer of completely untied money allow you to do - that is to say, it's not tied to any particular program, that's money, I assume, that just goes in that you can use

at your discretion for the operations of the service. What does that allow you to do that you couldn't do if you didn't have that parcel of untied money?

MR C LAYER: I guess one of the things is staffing, ensuring we have the right people, adequate staff, but even resources, you know, like, just making sure we have resources. It was mentioned before about transport. Transport is an issue for everyone in the room when it comes to ensuring we can get our mob to where they need to be. So, you know, there's no real definitive answer to that other than whatever we can to support in regards to keeping those core services bubbling along and building.

One of the things that we have done, Taasha's been the main mover of this, of course, is we're currently in the process of establishing a specialist unit within Ungooroo. That will attract different specialist services, cardiology, paediatrics, et cetera, ear/nose/throat, all that sort of stuff, so it cuts that travel distance and access to specialists for our mob as well.

So we're just always trying to improve what we've got and find more things that the community needs to have access to. So there are other little things that we try and create and build around it. Again, it doesn't provide a lot but it provides something that can just support what we've trying to achieve.

MR LESTER: Cecil Lester from Condobolin Aboriginal Health Service. We have our primary health care, which is funded by the Commonwealth. We have a dentist, social and emotional wellbeing, mental health, which are funded by NSW Health. We have two full-time doctors, one who has been with us for five years, and we have a female doctor who does three days a week and she's funded out of generated income.

Our dentist, we have a full-time dentist, we have a full-time dental therapist. We have four social and emotional wellbeing workers, they're all more recent.

A lot of the stuff that we have done over the years has been paid for by generated income because of the lack of funding. We get 1.5 million from the Commonwealth to run the primary health care. Our client numbers are 3,000, of which 800 are Aboriginal. We generate enough income to

support other services that we can't attract funding for.

An example is we needed a dentist out there, so we bought the old Westpac bank, we converted that over to two-chair dental, with accommodation upstairs for students from Charles Sturt University who spend time with our doctors and nurses and clinical staff. We've put over $1 million in generated income into setting up the dental.

Pretty much the same thing with social and emotional wellbeing, we bought the old fire station and converted that over. We got a funding grant from NSW Health to help with the renovations.

We're on to our last building now, which we bought out of generated income and we put in for a loan, funding from the Commonwealth, for 270,000, they gave us 124,000, so we've got to come up with the difference.

The Commonwealth funding hasn't changed. I've been there 18 years, the Commonwealth funding hasn't changed, except the CPI increases, and if it wasn't for NSW Health, we wouldn't be able to do the other services that we do.

Another big problem we have is we're the only medical service in town. The other council-run health service folded a long time ago, and they don't have a doctor at the Condobolin hospital. So a lot of it falls back on our staff.

Also, other organisations are funded to run programs in the area, CatholicCare is a prime example. We find that a lot of the issues, they don't deal with, so my staff in social and emotional wellbeing and mental health have got to deal with those issues.

DV is another area we have taken on board. Mental health, social and emotional wellbeing and DV is only going to get worse over the years.

We run a program for school kids for breakfast five days a week in which they can have a proper meal, and at least I know for five days they've got something to eat.

Not long ago, one of the young girls turned up with her brother and sister and we said, "What did you do on the weekend?" She said, "We slept on the steps of the Catholic

church because mum and dad were fighting." They didn't want to go home.

THE COMMISSIONER: The funding you get from the Commonwealth for the GPs --

MR LESTER: The primary health care, yeah.

THE COMMISSIONER: Yes, the primary health care, so that enables you to employ clinicians?

MR LESTER: One doctor, yes. We have no problems with finding doctors, no problems with finding clinical staff. They are all paid above award, they are well paid and well looked after. Why we pay them above award is we don't end up in industrial court should an incident arise.

MS L BELLEAR: My name is LaVerne Bellear. I'm from AMS Redfern. I think, you know, we concur with all the issues that have arisen around the room, although a lot of people would argue we are filled with resources because we are in the middle of metropolitan Sydney, but, you know, if you looked at our patients, a lot of our patients wouldn't access the mainstream, and they would only come because it's an Aboriginal community-controlled organisation. So that's a factor within itself. So if we weren't there, we'd have a lot of --

THE COMMISSIONER: Is that a lack of trust with --

MS L BELLEAR: Racism. Racism pure and simple, and NSW Health have no idea how to combat that.

You know, there was an issue out at Dubbo, I think one of the doctors there were racial profiling and they made a very wrong decision that ended up in a death of a young Aboriginal man, and that's how simple it is.

THE COMMISSIONER: This is racism within the public hospital system?

MS L BELLEAR: That's right. His decision to send that person home was merely classified on that. We would probably have the same within the inner city as well.

That brings me to the fact that I strongly believe, in my 40 years of working in health, that there needs to be

a representation, an Aboriginal representation, on every single health district board. You know, that's a strong aim at mainstream, because they're making big decisions on our behalf, the same as the ministry. I've got no time for them because they don't come out and listen to what the actual issues are.

THE COMMISSIONER: When you say, "they don't come out and listen", is it that you've invited them to have discussions --

MS L BELLEAR: No, they've invited themselves but never turn up on the appointment day, which I think is very rude. I've had several meetings over the years, pre-COVID, and I'm yet to still meet up, you know, with the state director, God bless their soul. But, you know, that - because how do you listen? You know, I had a couple of years back, there was someone coming out, reviewing the mental health policy for NSW Health. I don't think they even read the document. When I brought up a couple of issues, they, you know, didn't want to listen, didn't want to --

THE COMMISSIONER: This was at some particular meeting in relation to --

MS L BELLEAR: No, they'd come to interview me. So, you know, I quickly read the document and went hell for leather, but, you know, that's no use to us, if the recipient of that information hasn't read the document, so, you know, that's just wasting my time, unfortunately.

But, as you said, "Do you have a long waiting list?", we have the luxury of if our waiting list blows out to three or four hours, we have complaints. So, you know, we don't have an appointment system, which could be some of the issues, even though our doctors do want an appointment book rather than walk-ins, but that's not how the AMS was established in the first instance, so it is historical that we remain a walk-in. So we can see anything up to one to two hundred patients a day.

You know, sometimes it does put a glitch in the system if there is someone there that, you know, we have to spend, you know, a couple of hours on. But it is what it is. You know, we pay our GPs very well, so they just need to suck it up and deal with it. You know, we manage with a kind

manner as well. I say that tongue in cheek. But, you know, I think at the end of the day, where we can afford to provide luxuries or thank yous, then we do that as well.

And that brings me to another issue, which is the workforce. So we have a partnership, metropolitan local health partnership, with three districts and two networks, hospital networks.

Now, one of their KPIs is to increase Aboriginal employment, and I think it's 3-point-something per cent, so that's a burden on us because all our trained staff and our staff that we've held on to end up going over to the local health districts or the hospital networks, because they get more money. We can't match what they're giving. You know, our staff want to have a flexi-day and all that. We just can't afford to do, that because if one person's off, then that program or service doesn't run, and that's not fair to the patients as well.

THE COMMISSIONER: Can I just explore something with you in relation to your idea or suggestion that an Aboriginal person should be on the board of the LHDs?

MS L BELLEAR: Yes.

THE COMMISSIONER: I was in a royal commission a few years back - I wasn't the commissioner - but the commissioner in that made a recommendation that there be two First Nations people on the board of the Murray-Darling Basin Authority for the basin plan.

The reason he made that recommendation was because he felt - rightly or wrongly, but this was his finding - that the Commonwealth bureaucrats were displaying a tokenistic attitude towards First Nations people and not properly considering Aboriginal water rights and not understanding what proper consultation was and not understanding even what was fully meant by cultural flows in relation to that.

I can see the advantages of a First Nations person being on the board of LHDs, but I'd rather hear from you as to why you think that would be a good idea, rather than making my own assumptions. So tell me why you --

MS L BELLEAR: Well, we would have our own spokesperson, more or less, per se, that has equal rights around that

board table, because you're appointed by the minister. So, you know - and as long as you're there for all the right reasons - sometimes I find it pointless putting an academic in there when they don't really - they miss what's really happening at the grassroots level. But, you know, it merely goes on the minister's choice, I suppose, or selection. But that can be represented by the community, if they want, and that's just exercising the rights of community control.

I think we've just bastardised community control along the way. But, you know, we can review it, can look at it, you know, and have some sort of model of care that's going to be for all.

You know, especially out in the rural areas, where they really need a say in what's happening and where the services are going, you know, and it could be a way of working together.

I know we've got a robust working relationship with the three districts and two hospital networks, because I co-chair it. Mate, there is nothing too small, too little, that I don't bring it to the table, and those CEOs sitting around that room have to come up with strategies, or if it's not - and some things, you know, that I suggest would go around statewide, you know? Like why reinvent the wheel? What's happening with us and with our partnership could benefit other people, you know? Like where the resources are lacking, you know, the hospitals and the districts can support that.

Going back a little bit further, we used to have "Closing the Gap". There were several KPIs, I can't remember them now, but it's just like the deaths in custody: had they implemented some of those recommendations, we wouldn't be in the position we are now, as a people.

I think we need to relook at that and what's working, because what's working now is not working, you know? If you're collecting data, as you said, data, that's there - everyone's great on data, mate, as long as the numbers are there, everything's sweet, but they don't really look at how we get there or how resourceful it has taken to provide that, and so that's not looked at. And I think that's where everyone's getting burnt out, you know?

We also had a couple of years ago, I think NSW Health funded it, it was an executive services management program, I forget the thing, but through the ACHSE, New South Wales branch. That helped develop our up and coming executives, and they had the opportunity to both do some training in a New South Wales health system and also in an aboriginal medical service as well, and it's just about developing and growing our own.

But because the competition is so great, like, we're vying for the same workforce, and whoever's going to win is the one with the most money, you know, and that's where we're going to fall over.

THE COMMISSIONER: Yes.

MS L BELLEAR: That's all we do, is train, recruit, recruit. Have a look through the SEEK. We've got all the ads up there, you know, because it is quite difficult to secure professional clinicians.

THE COMMISSIONER: Can I just explore one more thing with you, but before I do, does anyone in the room have a different view than LaVerne about what might be the benefits of having Aboriginal representation on the boards of LHDs? Is everyone in agreement or does anyone have a different view?

MS L BELLEAR: I sit on a board, too, by the way.

THE COMMISSIONER: Yes, I know.

MR NEWMAN: Jamie Newman, Orange Aboriginal Medical Service. I support what LaVerne is saying, but two people. Not one, two.

THE COMMISSIONER: I might have raised two. LaVerne was on one.

MR NEWMAN: Two, because if you'd have such a - especially for rural, it's such a large area.

I'd also like an Aboriginal advisory group. You know, two people on the board - you can could have an academic, you can have community people, but you need people who are operating in the health sector on the ground. That can

provide advice, because you put too much pressure on one or two people on the board - they're in the minority anyway. So having that collective knowledge at an advisory level - the PHN did it out at Nowra, they staffed the PHN with two Aboriginal people on the board and we had an Aboriginal advisory group.

That's how you have some buy-in at your local LHD level. That's crucial if you want continuation. One person is going to be seen tokenistic, two, we would have a balance, great - hopefully male and female. But having people that then can report to and be held accountable by the advisory group.

MR MUSTON: Can I ask you a question? With the advisory group, do you think there would be benefit in it having, as essentially mandatory members, a nominee from each of the AMSs or ACCHOs that provide care in community within the footprint of the LHD?

MR NEWMAN: There's not an AMS in every town, so the LHD has to - I'd ask the LHD to work with - if there isn't one, AMS, if there's no AMS, you've got land councils, you've got other Aboriginal organisations, you've got CAPOs, so talk to those groups about how we have governance. That will keep the LHD accountable and keep the CEO accountable.

I have a great relationship with the CEO back home, but we need to have KPIs that are monitored by, not just the two board members, the Aboriginal advisory group. That would be the biggest change that we would see, where you'd get a lot more buy-in and support of mainstream working with our sector.

Where you don't have an AMS or an Aboriginal Land Council, that's where you need to look broader, so I would rest that with the LHD. This Inquiry can say, "This is one of the strategies we're looking at moving forward." It gets them thinking outside the square at the same time.

THE COMMISSIONER: Keep the microphone, because this is a question for everyone, it's something that was raised by LaVerne. The issue of racism in the public hospitals has been raised before today. We obviously won't solve that today, but yesterday at the roundtable someone said that at Moree hospital recently an Aboriginal person had chest pains and was sent home, an Aboriginal child was taken in

with breathing difficulties and sent home, when they shouldn't have been. Obviously that's said to us at a roundtable, it's untested, but that's what we were told, but racism as an issue in public hospitals has been raised with us.

The use of Aboriginal liaison officers in public hospitals, do people think that's a good model? Some of the - not criticisms of it, in fact, I think it's generally felt to be a good thing, but one of the issues that is raised with us is that, you know, the hospital might have an Aboriginal liaison officer that's employed between 7 and 3 or 9 and 5 and then they're not there when Aboriginal people are coming in after those hours, which makes it useless at that time; and also, even if they're there, they may not be in the ED when they're needed, they might be on a ward, so it's sort of an insufficient resource. What do people think about it as a model, if it was better resourced, or is there something else that is a better idea?

MR NEWMAN: My professional and personal view is that ALOs are an ashtray on a motorbike.

THE COMMISSIONER: I didn't hear that, sorry.

MR NEWMAN: ALOs are an ashtray on a motorbike. They're not getting support. We have had Aboriginal people working in hospital systems for years. They are pulled from pillar to post and expected to be everywhere in the hospital.

Our hospital is a $300 million facility, multiple units out there, and we've got two people. Now, they are not equipped still or have the authority to be able to challenge people around racism, so you can have all the EAP and EEO principles under the sun, but if they don't have the authority to be able to pull somebody up, then they're an ashtray on a motorbike.

Racism has not just happened in the last 10 years, it has been happening for generations, yet we've done training, we've had resources, we've had promotions, we've had policies and it still happens.

The worst thing from my perspective is that we now call it "unconscious bias". It gives people a window, an opportunity, to be racist.

Unless there are ramifications for racism, people are still going to do it. If you are called out as a racist, you're, what - are they banned from the service? Are they put on leave? What are the ramifications to somebody that is a pure out and out racist in the system?

THE COMMISSIONER: Sometimes there are no ramifications.

MR NEWMAN: No ramifications. It's, "Well, you know, it's unconscious bias". I challenge that. Our people are leaving at 10 o'clock at night - if our people go to hospital at 10 o'clock at night, they need help. If they're not understanding of the systems and the wait times - and it's us, an AMS, or any other ACCHO, to educate our community on what they're going to expect when they get out there - but if they get out there and they face racism, they're going to leave, and yet it will be documented as "Discharged against medical advice", or "just walked out".

We don't even look at that sort of data. If our people say it's racism, deal with it. We've engaged with Gerry and the team to have something different, and that's in the works now, it's going to be up to us to practise that. We don't know what that would look like, but it's how it's going to be promoted, saying that we won't tolerate racism.

Those things have happened over many generations, they've done multiple things, and yet, as LaVerne says, we still have racism in our system. Unless we get really serious about it, people are still going to do it. Because there's no ramification for it. Whilever it's kept internally, our people will not go to the HCCC because of the process of that and because they don't get responded back to. Let's make it a local issue and then have it like the circle sentencing, bring in people from community, say, "This is the case of racism," and let the community, with the systems, deal with it.

Whilever racism is perpetrated within any system, education, health, housing, whatever, if it's dealt with internally, we are never going to feel safe about calling it out. Because we don't hear the feedback from - "What's happened to that person who was out and out racist to me? I don't feel like going to hospital. What's happened to that person?" I'm missing out on getting health care but

that person's still working there. They're still moving on with their life and I'm not.

THE COMMISSIONER: Would anyone else care to comment?

MR RAUDINO: Can I just add from a different point of view with the hospital. The hospital just got, I think, a $450 million redevelopment fund in Albury.

THE COMMISSIONER: I thought it was 558 but they forgot the car park. It has to come off the 558.

MR RAUDINO: Anyway, it is a lot of money. Anyway, we've obviously been in the districts for 15, 16 years, like I mentioned earlier. We're obviously doing something right. We started out with 12, 13 people, now 100. Obviously there's a model there that we know how to deliver a quality service to the community.

So with that, this new redevelopment, what input did we have in the design or the implementation of it - an Aboriginal room, ward, whatever you want to call it - nothing. So racism's not just yarning to someone and making an incorrect diagnosis, it's in the background, isn't it?

You know, we had no say at all. We have basically no relationship at all - it will come up later in partnerships, so forgive me - but we have no relationship with the hospital at all, basically.

It would be nice, would have been nice, to have some input into the redevelopment. Yeah. "We'll go and do an acknowledgment and put a plaque on the wall to open the new emergency department", which we got an invite to, you know? Tokenistic.

Yeah, we had no input in anything, basically. So it's disappointing. We're the only medical service in, like I said, 200, 300Ks one way and 400 the other. It's a big area, a big catchment, but we had no input. We're doing something right, so it would have been nice to get a foot at the table.

MS T LAYER: I was just going to say from a different perspective, in our experience with the hospital liaison officers, the Aboriginal liaison officers - and they are

lovely girls - where we find it really lacking, it's the duplication of services, and they only do part roles. So it's almost like they are competing with the AMS to deliver on their KPIs, but it's actually causing frustrations in community.

An example of that would be we went to Muswellbrook for NAIDOC, so we took a full clinic team, we had a couple of GPs, a couple of AHPs and a registered nurse. We did about 38 715 Aboriginal health assessments on the day.

They pulled up next to us, set up a tent, and did part 715s. So we have Aunty Denise, every year she does an Aboriginal design for the shirt that gets given to all the patients that complete the 715. They didn't have that. But the riot it caused in community, because then they come to us, then we had to redo the whole thing again.

So there's just this constant duplication of what the AMSs are delivering, but they're not actually doing it to completion or full circle and that's just creating more confusion and more - you know, it doesn't help the relationship because it's almost a competitive stream, which isn't good for, you know, collaboration and those things.

MR C LAYER: I just go back to Caine's point about when there's a new development proposed and constructed, where we are in the Hunter, John Hunter Hospital's doing a massive extension there at the moment.

THE COMMISSIONER: Yes.

MR C LAYER: Cessnock Hospital is another one, Maitland Hospital, we had a brand new hospital built there a couple of years ago, all these sorts of things are happening around us, but the only sort of input from us they want, from the community in the Hunter, is what kind of artwork they want in the corridor and that sort of thing - which is nice, the artists get recognised, you know, it's great, but, you know, where's the input into the delivery of service? Where's the input into, "Well, how do we as a hospital connect to you as an AMS in the community and improve our services when they come in?"

You know, that situation about racism, that can be dealt with if we're part of the planning and they implement

what we do in community to what they do in the hospital, but it just doesn't happen; it's just, "Yes, let's put some nice pictures up, it looks great." And I don't want to not do that, either, because our local artists get recognition, they get opportunity, but the hospital is there for one reason and that is the health of its people and, unfortunately, our people are sort of on the outer when it comes to that.

So bring us in, let us be a part of that system, part of that redevelopment, so the service that's provided is going to be efficient and effective.

MR LESTER: You have racism in hospital, you also have factionalism in the hospital, where the ALO might be from one faction in the community, another person, who is not well, comes into the hospital, they're asked by the staff if they want to see the ALO and they get the choice of saying "yes" or "no". I mean, I could walk into Queanbeyan Hospital, I can go to Canberra Hospital. Within an hour, I've got the ALO there, irrespective of who he is and who I am, and you know, that should be across the board, otherwise a lot of people - when I worked down in Queanbeyan, I had an ALO at Moruya Hospital. The Aboriginal people down there used to go to her house and say to her, "Glenda, will you come to the hospital with me", and she would go with them, it didn't matter what time of day it was.

MS K BELLEAR: I'm Karinya, clinical governance and corporate services manager at AMS Redfern. I think LaVerne has covered most of it for us.

MS L BELLEAR: We could go on and on.

MS K BELLEAR: Yeah.

MR ROXBURGH: I'm Josh. I look after mental health, drug and alcohol and public health. Similar with the staffing, we've also got the not-for-profit and the non-government sector and the non-Aboriginal sector that gets Aboriginal money, and we fight for the same staff in the city area.

Within Redfern there are five Aboriginal services and a whole host of other services that are getting Aboriginal money for Aboriginal people, and we're all fighting for the same person, for our leadership positions and right down to

our health worker positions. We battle the LHD for the same staff. We usually train --

THE COMMISSIONER: What's your theory on why that happens?

MR ROXBURGH: We offer a training program, the health worker training program. Once they are nearing completion, they're scooped up. We do further education, trying to retain them and stuff like that, but we can't fight the wage. The ACCHO wage and the NSW Health wage for health workers, there's a massive difference in even starting wage, I think it's about 15 grand. So it is very difficult.

THE COMMISSIONER: But why isn't the money going straight to you if you are providing the services?

MR ROXBURGH: We employ them, recruit them, educate them, do all the training, but then they will apply for a job or get headhunted for NSW Health, because they've got employment quotas of 3.5 per cent. So they do a lot more active marketing, even through our partnership, we bring it up at every meeting, you know, "You've stolen another one", all that kind of stuff.

With the ALOs, you have got - I know when I used to work in health there was one ALO that covered two hospitals that are about 15Ks apart from each other. The ALOs are expected to be across every discipline - maternity, emergency, chronic care, aged care, you know? You've got specialised services and staff in each of those units, but an Aboriginal health worker has to be across everything. So the burnout rates are really high there, too.

MR LESTER: Just in addition to what my brother said, when you've got your ministers saying, "Less than 50 per cent of Aboriginal people go to AMSs", that's why they fund mainstream.

THE COMMISSIONER: When I've got who?

MR LESTER: Ministers. Ministers have been saying forever and a day, "Aboriginal people - not all Aboriginal people go to AMSs." We know that. But it's more than that; it's not less than 50 per cent, come on. That's why they justify equitable distribution of funding. That's why we're in competition not only with each AMS, but with

mainstream. Mainstream have been around longer, except for Redfern, but they have reputation, they have connection.

When ministers continue to say, "Less than 50 per cent of Aboriginal people in any population, where there's an AMS, access that AMS", then we're fighting against that.

We can provide the data, we can provide models of care, we can provide continuity of care, specialist care, but we still are challenged by this "less than 50 per cent".

MR MUSTON: Can I test an aspect of that. I gather from what you've all told us so far that none of you have periods in the day when you're not treating patients; you are treating as many patients as you possibly can within the funding envelope that you've got and possibly more. Let's accept the premise that that's less than 50 per cent of First Nations people in the community - it might be wrong or might be right, but just let's for argument's sake accept it - is it your view, based on what you know about your respective communities, that if you had more resources and were able to treat more people, then you would have more than that 50 per cent coming in to your --

MR NEWMAN: Absolutely. What we're saying here and what all my colleagues have said before is, if you - state health is great. We have a great relationship with Gerry and her team and the ministry and other units, but every AMS is funded on a budget - not our budget, government budget. That's always going to be restrictive of how many people we can see.

Every AMS here is on a waiting period with our staff, for our staff, to get more people through the door. But that's because we're struggling to budget. We're paid 1.5 million, some of us, or 2 million, for some of us, yet it costs us 4 million a year to run it.

So we're very reliant on Medicare, and when there is a GP shortage in this country and GPs - no GP, no Medicare, so if we don't have that resource, then how are we supposed to grow?

We've got a brother over here in Albury, got a brilliant facility out there, and doesn't even - you know, without any input into what that should look like so we

have acute focus on Aboriginal health.

It happened the same thing at Orange. We had some input into it, but they established something that was completely different to what we asked them to do, to have an Aboriginal unit within the hospital so that our people did not have to sit in the ED, they'd sit in that Aboriginal room, where people are manned 24/7. I know that might be difficult, but that's where we have to get to if we want our people to feel safe out there.

Resource the AMS sector. It's not difficult. Even when we had the roundtable with the Commonwealth this year and we sat at the table with New South Wales, new strategy, new targets, no new money. They're setting us up to fail.

Our people - I don't believe our people lose trust in us, I think our people lose confidence when we're not able to deliver. People in our community don't understand what it costs or takes to run our services. I don't think people in government understand it either. So when you say, "This is what the budget is" - the Commonwealth do it regularly, we know that New South Wales does it - for every entity that we get funds off, there is always a budget. If it was actual funding to our sector, we would be a lot better off. We would reduce burden at a quicker rate.

Capital funding has to be major capital funding from NSW Health, not just minor capital funding, because the Commonwealth holds the tender for that and we're competing with 140 other AMSs in Australia for capital works.

Fund us, as well, for those who see non-Aboriginal people, fund us for that, because we're reducing the burden on mainstream, but we don't get recognised for that.

Throughout the referendum we took all this crap about $40 billion in our sector. Not even 8 billion is in our sector. So I don't know where someone pulled this $32 billion from. That's ridiculous. Yet we are seeing everybody in our community. I know AMSs that choose only Aboriginal people to be there, that's fine, that's their call. Our call is to see whoever walks through the front door.

But when we do our reporting, all the number-crunchers only read "Aboriginal uptake". Thirty per cent who come to

us are non-Aboriginal people, but they are connected to our community, they are either married or living with Aboriginal people. How are we supposed to say to an Aboriginal man, "Oh, your white wife can't come in, brother"? We'd lose trust, confidence and everything in our community by doing that sort of stuff. I think that takes away from who we are as Aboriginal people about community wellbeing.

You can't say cultural - a cultural focus on who we are and then eliminate people in our community who need health care. We found through COVID everybody's struggling, through the cost of living, people are struggling, we are the go-to. The AMS is probably the only service now that bulk-bills and can provide a range of wrap-around services that aren't dispersed within the community. Siloed health care has never worked for us.

So we have the model about how we get health outcomes for all people, but we're not recognised for it and definitely not funded for it. We have to generate income so we can say yes to non-Aboriginal people coming to our services, rather than them going to hospital and waiting, sometimes eight hours. My mother-in-law, a non-Aboriginal woman, sat at hospital for 14 hours, 82 years of age, only two weeks ago. Unacceptable. So if we're not funded what we know it costs us to run our services, if we aren't allowed to apply self-determination because process, policy, procedure, access to funding is distributed within all elements within our communities, then we seem to be the one missing out.

Brother is right, racism doesn't just happen in healthcare delivery, racism happens in systems. So we're dealing with individual racism but we're also dealing with systemic racism. That's been around for generations, yet we have more people wanting to come to us, especially in Orange. We're not going to say no. We employ eight GPs part time. They don't want to work full time. We have medical students, we have registrars who come to us. We're a multi-disciplined service. We do out of home care, NDIS, aged care and now more into child care, if we get funded for it.

We've already bought a block of land, we are visionaries. We want to see that our people are accessible to us from birth to death. That's what we do. Our model

is the only model that's going to get health outcomes for the whole of Australia. It's been around long enough now that we know how to provide good health care to our people. The majority of our growth is up to us, though. We're competing with one another, we're competing with mainstream.

When the government says there's no more money, then how come you've got tenders running out left right and centre for services that we're already running?

Just fund the same service. Don't worry about putting a tender up for chronic care, when the AMS is providing chronic care or the LHD is providing chronic care. Get these people to come together and work together, and where you might have personality or character clashes, if you're going to fund services in the community, say, "Okay, you guys need to come together, under your funding contract", because if there is character or personality that separates us, the people who say, "We're going to fund this, and this is what we expect", if it doesn't come from the contract provider, if there's clashes of personality at a local level, our people miss out.

So whether it's the CEO of an AMS or the CEO of an LHD, if they don't get on, "Suck it up, big fellas, this is what we're going to fund and you will have to work with these people. No ifs, buts or maybes." You know how that will happen? Two Aboriginal people on the board and an Aboriginal advisory group making sure it happens, because if you've got CEOs of LHDs who are not really sure about the CEO KPIs, then we have to be accountable for it.

Every AMS in this room is held accountable for the failure of "Close the Gap." Mainstream aren't. That's from my perspective. When the "Close the Gap" reports came out, all the negativity, everybody looks to us. "What are you doing?"

Look at our national uptake, we're providing more episodes of care and occasions of care than anybody and yet we're funded way less than everybody. I don't think - I don't see how that could work. That's certainly not sustainable.

Fund us for what we know we need. It still won't be anywhere the 40 billion, by the way. At the national

roundtable - Gerry was there - all you need is another $10 billion across the whole country, not just in New South Wales. Still nowhere near 40 billion. But you are funding AMSs to run what we know is the actual, not a budget.

We're always in competition. We train our people and skill our people but if they get 15,000 or 20,000 more at the hospital, they will go there. I don't blame them. We can't hold them. If you say, "Well, you can go to the hospital and get paid 15,000, 20,000 more", they are going to go there, whether you like it or not. GPs will use us as leverage to say, "Well, I'm getting $50,000 up the road", well, our position is, "Go up the road."

We've got to be able to say, if we're going to be sustainable, we need that initial resourcing, finance and material, to allow us to grow to what we know we need in the community. It's not that difficult, from my perspective. I'm not a politician. I don't want to be a politician. But we know there are disparities when it comes to health allocation, whether it's capital or whether it's service. Issues of racism are going to be around forever. Until we do something different, they're always going to be there.

I said my name earlier, so I don't need to say it again.

MR PITT: Thanks, firstly I would like to thank everyone for sharing and being honest. My name is Fred and I'm from Rekindling the Spirit organisation, based on Bundjalung country. We've got a growing health service, we're looking to transition into an AMS over the next 12 months or so. You know, we face pretty much the same issues as everyone here and, you know, with these advisory groups and putting two people on the board, listen. We don't want to be tokenistic or anything like that, they're the people who are in a position to make a decision. Listen.

MR BINGE: Thanks, Fred. Chris Binge, I'm the CEO of Rekindling the Spirit. I've been there probably about four and a half months now, five months.

I think, basically now, going last, I think everyone's said it, particularly the last conversation we just had with brother. I think being in this, being here today, having the conversation with you guys, I think the biggest

lesson for me in this space is not so much about, you know, coming up with these ideas, because these ideas haven't just been hashed up now, these have been generational issues.

You know, brother just said, we can sit around here and we can have these discussions - I think for me, when you look at funding particularly and how that's going to be administered on the ground, we have the answers, we've had the answers for generations, but we just don't seem to be listened to or our voices don't seem to be loud enough.

By having them on advisory committees, yeah, that's great - and I agree with Fred, unless that's a tokenistic opportunity, then what is that worth?

As for advisory committees, we all know, there's not one person sitting in the room that probably couldn't tell you that there's been advisory committee after advisory committee after advisory committee. What are we advising on? Health care to our people. If we can't adequately meet the need for our mob on the ground by delivering the most appropriate services that get all the measures in, the wonderful thing called "Close the Gap", we will be coming back here in 10 years having the same conversation.

So for me being here today, my component, I suppose, from my people back where I come from, is what are we willing to do to make a difference and what does this - what are going to be the outcomes of something like this that actually hits the ground so that I can actually go back and say to my people, "We are going to try - we are going to try and do better", but to do that, we all need to be able to work better together.

I mean, I could sit here and probably raise the same issues as everyone else, but I think everyone else has said what needs to be said to this point. But my concern about these sorts of, I suppose, opportunities is: what are the actions and outcomes that are coming from these sorts of, you know, conversations?

THE COMMISSIONER: We might just take a break now, because everyone has had one say and Ed wants to move on to issues concerning funding streams, which is a big topic. So we might take a 20-minute break and start again. We will break until 20 to 12.

SHORT ADJOURNMENT

THE COMMISSIONER: All right, we might recommence with funding streams.

MR MUSTON: Some of you have touched on it already this morning, and in our travels around the state and through the roundtable hearings we had remotely yesterday, a couple of common issues around funding: first, the reporting obligations, having to report multiple times for multiple different funding streams, often to the same organisation using different platforms and different sorts of measurements and different software, we're told, is unnecessarily burdensome and eats up a lot of internal resources that could be used to actually deliver care to people. If that's your experience, feel free to tell us, but equally, you could take it that we have heard that loud and clear.

The other issue that has been raised a few times is the tied nature of funding such that a grant that you might apply for and obtain successfully is confined in a way that means you're effectively forced to deliver a particular program or a particular type of care with that grant which might not necessarily be, viewed through the eyes of you guys who are on the ground and know about the needs of your respective communities, the best way of using that money to produce good health outcomes for your communities.

Then, related to that, we've been told about some of the challenges with the short-term nature of that funding and the tied nature of that funding meaning you can't necessarily easily employ someone to fill a role in circumstances where you can't guarantee them anything more than, say, a year or two years' worth of employment, because if you don't get the funding to continue - and these things seem to come and go - then the ability to deliver that service is severely compromised.

So taking all of those problems, again, feel free to tell us of your particular experience with them, or if you disagree and you don't experience those problems in your respective facilities, but I guess the big question that we would really like to hear from you about is what might be changed about the way in which you're funded to make your jobs easier and perhaps to make sure that you can deliver

the best health outcomes for your respective communities by shaping the particular services that each of them need.

Of course, like any health service or other service, in fact, the needs will be slightly different from one community to the next and they probably will change from one year to the next, and it feels like that dynamic ability to shape your service to meet those needs would be useful.

Over to you, LaVerne.

MS L BELLEAR: I would like to make comment on that. You've got a very soft voice, but I picked up bits and pieces. It just reminds me of health promotion and preventative medicine. You know, in my books, preventative medicine is just as important as throwing a tablet down the drain, and we don't get funded for that, per se.

You know, we have many diseases - and it may change as you go from community to community, but we're across all the different chronic diseases known to mankind; we've got it. Just trying to promote, you know, awareness and, you know, give people information about how you can change your lifestyle and even having healthy lifestyle programs is hard done by to get funding, but yet that is the most important component to anyone's health going forward and holding up disease.

Years ago, there used to be $3 million, I think, from the state for health promotion activities. I don't know where that's gone or it's just slipped off, but there is nothing specific there, funding, for health promotion, and you know, that's a big part of providing our service to our people, if we're going to look to stop disease or hold up disease.

So, you know, they talk about closing the gap, well, give us some health promotion money. It shouldn't be just, you know, for 12 months. Like, the duration of these programs is frustrating too, you know? It's not only the workforce, but it's setting up the programs, getting and buying in resources to provide those services, and it's all about trying to hold up disease.

MR MUSTON: What sort of programs do you have in mind, just as some examples?

MS L BELLEAR: We promote, you know, healthy living and that type of thing. So we have a community day. We try to provide healthy foods. You know, we promote healthy juices for our kids, because in the inner city, we're in competition with McDonald's and all of the fast-food stores. If you would have walked down Redfern Street, there's not one fresh shop there available for you. You know, we've got Pizza Hut, we have, you know, those rolled over flatbread things, kebabs. So that's what we're contending with. It is easy for people to give their kids $5, you'll get five cents change and you have a complete meal. Like, what the hell is that? So we try and, you know, have cooking classes and all that, but it's very ad hoc and inconsistent, because it's only when we have, you know, money.

Because we are very good at diagnosing, you know, we screen till the cows come in, but once those people have been screened, we need to do an intervention. You know, these people really need to change their lifestyle. If we can't do that, you know, by way of encouragement, information, you know, or sending them off to allied health services, you know, for exercise and all that, then we're lost. We're just going to be content to give them, "Here's your medication. Go home." You know?

But there's a whole range of other things. Once you have been diagnosed - you know, I had an argument once with a doctor on this - it was a panel. She was saying, "Oh", more or less, that "Aboriginal people, they celebrate when they have been diagnosed with diabetes", and I thought, "What the hell? I've never heard of anyone jumping up and down that they've got diabetes." And I said to the doctor, "How did you come to that?" And she reckoned - so she gave all the information - see, health literacy is a big thing, too. Giving people information, when people are challenged for reading and writing, then, of course, you know, they're going to have a problem there.

So she gave this person information, and I said, "Well, you know" - and they never changed their diet, I said, "Well, they've probably got 10 people in that house and you are asking them to eat, you know, fillet steak", and I said, "All they can afford is minced meat and not the lean minced meat." So it was all those type of things, and she just thought I was mean. But it was not knowing the

demographics of our people, which we're serving, we're behind the eight ball before we even start, and that's an issue.

MR MUSTON: So in terms of that funding structure, though, obviously one answer to that is more money to deliver more programs. To the extent you've got money currently available to you through a range of different funding sources, is there anything about the way that that funding is delivered that prevents you from using it in the areas that you think are best?

MS L BELLEAR: We don't really get funding directly for health promotion. It may come out of program money for - you know, it could be for BBV, STI, we may have a couple of thousand left at the end of the financial year. Then we'll do a promotion. That's what we spend the money on. Nothing's really dedicated, you know?

Then again, if we do have dedicated funding, then you've got to count all the heads, you know, how many people participated and all that. You've got to really work with people that, when you're trying to change ideology and the way that you're doing things, not only is it going to challenge them at the bank, but it's going to challenge their mindset as well. And so that's why we need that intervention. But if it's not dedicated money going into that, you know, it could be a pseudo service, but, you know, prevention has got to be just as important as the primary health care.

MR MUSTON: I think Craig?

MR C LAYER: Yes, often those preventative programs are short-lived, they don't last very long. There isn't a lot of money associated with them so they've got a very short lifecycle, when they should be a lot better. They should be the primary focus.

Obviously we've got to focus on people with health issues, but if we prevent the health issues, we take a lot of pressure off the other end of it, which is, at the moment, almost crumbling into the ground because of the pressure.

That's one issue with those sorts of preventative measures, whether it be healthy eating, exercise,

et cetera, is the short term nature of the programs. They're often very light on when it comes to the funding that's associated with them.

In most cases, I just think the box is full of resources, like posters and pamphlets and booklets, and that's it. So you throw all those things out, but there's nothing to follow up. There's no person on the ground that actually can provide, for example, you know, some professional advice on healthy eating, what to eat, how to do it within a budget, that sort of thing.

As our sister mentioned, you know, a lot of our mob can't go out and buy lean steak and that sort of stuff if they have a family of six, seven, eight people. So it's looking at what the alternatives are for a family with a limited budget as well.

One of the things that we do as a social venture that helps out NDIS, is we run a cafe on site called Wattake Cafe. One of the biggest battles we had initially, and we overcame it without any problems, was establishing a healthy food option for the cafe. So it's not just, you know, people coming in to get a big juicy hamburger, which saying it makes me hungry, but anyway, you know, hot chips, all that sort of stuff, which people love, but the options are healthy options. So, yeah, have a hamburger, but the hamburger is a healthy option, you know, salads, salad sandwiches, salad rolls, that sort of thing.

But that venture is supported pure and simple by us as an organisation. We get no outside help for it and it's a perfect vehicle to really promote - and our community use it. They come in to see the doctor or our other services, they always go to the cafe and get a coffee, a juice, a shake, a sandwich, whatever. So if it's there, our people will use it, but they've got to be shown how to use it and have that follow-up long-term process so that that support is there for them when they need it the most.

MR MUSTON: Do you find, though, whilst that service is great, LaVerne's point is that the day they come to see you, they may make use of that service, but every other day of the week they've got a range of other options, which, if individuals haven't been given good healthy eating education, then --

MR C LAYER: Well, that's it, yes. They walk past Maccas, they walk past KFC, all those sorts of places, to get to us. So, yeah, it's the battle of competing with that as well.

MR MUSTON: We might quickly come back to you, just to save traipsing the microphone all the way across and back.

MS T LAYER: Just further to what Craig said, we've had a similar situation, where you have a dietitian and their methodology was to put everybody on a paleo diet, so again, that's just not the answer. We've got to fund our diabetes program. We actually just, out of good faith, the board support with some meals for some of those kids that just don't, you, know, get lunches and things like that. So we make things work so that we can provide some out of the cafe. We just send over fruit and things like that so we can make it work.

But I think if you have dieticians/nutritionists, you just have to understand their approach, that it's not a costly approach, because community just cannot afford it.

MR NEWMAN: In the majority of plans, whether they're strategic or action plans or activity work plans, every government department puts in early intervention and prevention, but they don't fund it.

At OAMS we built a facility. We got $385,000 off the ministry, but we invested 1.4 of our own, to build this resource where we can do recovery, rehabilitation and exercise, but every position in there is funded through our Medicare.

We are still funded for illness and disease. We're not funded for early intervention and prevention, but it's in every plan. The only way we can help the outcomes is if we intervene and prevent, which we're still dealing with at the moment. To run our services it's based on Medicare, our bigger ticket items are health checks, GPMPs, mental healthcare plans. The individual allied health items don't bring in a lot of money. It can if you get the volumes, but in the smaller communities, you're not going to maintain the service delivery.

Fund it. Put it in one of your key actions under the strategies of NSW Health or Commonwealth health, but put

a dollar figure to it. It's going to be a lot more attractive to us and to any service you're saying - dieticians, audiologists, OTs, exercise physiologists, physios, access to sports GPs, for people going to hospital for any type of condition, rehabilitation needs to happen at home. You can't say to our people, "Oh, we might be able to get you access to a dietician, but we need you to do exercise and diet, based on whatever condition you have, but you have to go to a gym." That's not going to happen.

We see more people now not even exercising. So if you want to do early intervention and prevention that engages our people, what we push at our services is a medically led wellbeing program. So people have to come in through our GPs, so we generate income off that, but it still isn't sustainable if we lose GPs.

MR MUSTON: So you said that's funded through Medicare billings. Can you just explain how that works?

MR NEWMAN: So all of our clients who come to us have to see our GPs. If they're Aboriginal people, they can get health checks done; for non-Aboriginal people, a long consult and a care plan is done for them. So in most of those you'll find there are some points of intervention and prevention. The majority of them are still dealing with illness and disease, so either a general practice management plan, or if there's a mental health issue, which we found through COVID is increasing - they're going to get you money into your organisation. Whether we like it or not, that's what ticks our bank balance up, because we need it. But if we don't do it, then we're not providing good health care for our people at the same time. So if we do all those methods of health check, GP and mental health care plan, attach all the items that you can under the MBS items under Medicare, we can make some money, but we are reliant on it.

MR MUSTON: So you use that money that you make through those activities to fund --

MR NEWMAN: To develop our intervention and prevention - early intervention and prevention, because like everybody said, if you said, "Here is your early intervention and prevention funding for a dietician, a nutritionist, exercise physiologist, physio", we'd be laughing. We have to generate almost an extra 800,000 a year to cover that

wellbeing team.

MR MUSTON: I'm assuming, but tell me if I'm wrong, that sending you a box of posters that have a picture of the food pyramid on them is not going to cut it?

MR NEWMAN: Oh, no, we can help co-design a poster. Put some red, black and yellow lines on it and, yeah, you beauty. Our people are still not going to go to the gym. Instead of wasting money on those posters, give us the dollars and we'll do the work.

MR RAUDINO: Just with the funding, you're talking about early prevention, but I think we need a flexible funding model. You know, like, there are always KPIs you've got to meet but there's never any flexibility in delivering those services, especially on the border. I keep banging on about the border, because there's a river there, but does it mean anything to us? No. But to the local NGOs, it does.

We get funded - we get funding on the Victorian side, but the majority of our clients are New South Wales based, but, "No, you can't come over and deliver a service over here, you've got to stop at the river and drop them off", you know. Well, we don't. I'm being sarcastic. We'd take them home, but it's not funded, so you've got to pick up that slack for when you travel interstate, as they call it. But, yeah, it doesn't help in being able to put them services in place when, you know, there's red tape which is everywhere. Yeah.

MS T LAYER: So in relation to what we were saying about the billing, at Ungooroo, that's how we pay our GPs. So we try to structure it that you have X amount of 715s per day. They sort of have their own KPIs. The mental health care plans, we do that for two reasons, billing, but then also it doesn't burn out the GPs.

But, for example, you know, you might have - we get RDN funding for psychology. The wage they pay hourly is $68, but it's $300 for a psych. So we have NDIS billing, that's $193 per hour for psychology, but that still doesn't make up the hourly rate for those sorts of things. So that's where - you know, that's the funding component.

But I think preventative is better than cure, and

that's where that should be a separate thing, because that could really stop a lot of the complex and chronic diseases that communities are facing.

MR MUSTON: You mentioned a moment ago that some of that funding is short term. I gather that turning the corner for individuals in terms of that healthy eating, preventative health type work, that's not something you can do within a one- or two-year funding cycle.

MS T LAYER: No.

MR C LAYER: Well, you might have one as short as six months or 12 months, but the person may have issues that relate back to when they were children, and they're now adults, so you're trying to overturn these ingrained habits when it comes to eating, exercise and so forth. You can't do it in six months or in 12 months. It takes a long time to do that and to make that change.

But to that point Taasha made in regards to the funding as opposed to the hourly rate of practitioners with mental health and so on, there's a huge shortfall between what we get and what we've got to give. So that really can grind us to a halt when it comes to some of those essentials around mental health and so forth.

MR MUSTON: How does that work in the context of, say, a particular piece of program funding? If you receive some program funding to deliver some psychological care, for example, you're getting a particular amount of money, it's not enough to meet the cost of delivering that service, how does that play out?

MS T LAYER: Using our example of - yes, we get funded from the PHN for a groups program, so it's more of a clinical-based program, so that's to run three 12-week programs, so 36 groups all up. But the amount of funding that we get, you know, to cover the costs of specific criteria that they have to have identified to run the program and that they're trained in mental health, it is hard to get that staffing. But covering the costs, the group program, catering it, just barely covers what we have to do.

It has significant improvement for community. A lot of the GPs who have the patients on mental health care

plans refer them to the group program, because it is very culturally appropriate. But again, it just covers the costs of that. So sometimes we're pulling out of other buckets just to cover some of the catering of that.

MR MUSTON: Caine, I thought when we were in Albury, you - I think it was you - told us about the experience you had of services that had been funded through a particular funding stream, had been well received by your community and were providing benefit, but then the funding for that particular program dried up and funding was diverted into different areas by the funding bodies. Can you just tell us --

MR RAUDINO: Oh, there's a couple. So we had a family violence/domestic violence program, Victorian-based funding - so we couldn't go to New South Wales; there's a river there. That's finished up. So a three-year funding agreement, the old "three years", you know? Delivered a quality service, you know, with a coordinator and three workers or three caseworkers, so, you know, quite a substantial outlay. Just, you know, didn't give us the funding ongoing.

It met all the KPIs, did everything that we could ask, and then they basically put out the tender again and it went to another - not an AMS but a local non-Aboriginal organisation in New South Wales, so that was a bit weird.

Then they gave us one position in New South Wales, so we lost four but we gained one. So we're just picking it up - talking about Medicare dollars, we're picking it up ourselves just for another six months to try to regenerate, to try to get into the ears of the government to try to give us some funding or generate some other streams.

The other one is through YAC Vic, we had a youth program.

THE COMMISSIONER: That's what I remember, a youth intervention one.

MR RAUDINO: That one's finishing up now, or in December. That was similar, so based around youth. We put a lot of time and effort into developing youth programs. They drive it. So the whole agenda was they could have meetings and they would run the meetings, so the youth would be the

voice and they would say what they want to do to keep them off the streets and what-have-you. Same thing. Three years. That's finished. Never had the opportunity to apply or, you know, to reapply or to get that bucket back, so those youth now, we're trying to think of ways of how we can pick that up and keep them - even if it's 15 youths, 16 youths, whatever it was, how do we keep them engaged in the community, because they'll get lost.

MR MUSTON: I gather from that, it was, at least as you saw it, a good program, which was --

MR RAUDINO: Yes, most definitely.

MR MUSTON: -- delivering great wrap-around care.

MR RAUDINO: It is driven by youth, so we're not running the agenda. The government tells us how to run the agenda but we - you know, you put it on them so that the youth - if they're developing a program themselves and if they are leading it internally, you know, young teenagers, it's what they want, and you think it'd be a continuum of care, because - it's hard to say.

MS L BELLEAR: They're probably doing research about that program, project. I know Go4Fun, NSW Health, when it initially started, I had a lot of issues, because they were just isolating the fat kid from the family and they could go, but not the whole family. So I had big problems with that. But they wouldn't listen, and that was because they were - it was a research project initially.

I mean, they did make changes. I've had it presented to me and it still, I think, fails, you know, fails Aboriginal people. We still send people there because we're desperate for programs like that. But because it's mainstream, a lot of people may only go once or twice, you know? We get a lot of letters back, "Did not attend", "Did not attend", God bless their souls, for whatever reason. I hope someone is actually evaluating why people don't turn up to these programs.

But, yeah, there is a lot of money that NSW Health's putting into and they're just merely research. And that doesn't help us, because we can see what our needs are, but they're not being met or they're skewed and trying to, you know, get to their outcomes instead of ours, for our

clients or patients.

MR MUSTON: Are there other experiences of programs that you have been running on a tied piece of funding that you found have been very effective within your communities but then the funding for that particular program is discontinued?

MS L BELLEAR: Well, this Go4Fun is a statewide program. It's not that we're running it, it's the state government. Initially - I don't know whether it still is - it was based on a research project, and a lot of - some of the programs are based on research.

So when you, you know, identify what your patient needs are, then they probably won't change it, because they're on a strict deadline or agenda.

The other one was the Koori Knockout health challenge. They took out "Koori" and then they mainstreamed it, or tried to introduce the mainstream, so you applied, and it was specifically designed for the AMSs to participate in that.

MR MUSTON: Roll it back and tell us about what the program was before the change was made.

MS L BELLEAR: It was a weight loss program.

MR MUSTON: And how did work?

MS L BELLEAR: A weight loss program, and we were competing against other AMSs. We had a cohort that weighed in before and weighed in at the end. We had healthy eating challenges and all that type of thing. It was good rivalry amongst the AMSs that did participate.

But when I sat in on one of the newer meetings, they've removed the word "Koori", and I thought, "Oh, this is no good." So they're duplicating what's working for us, and it doesn't necessarily benefit us, and so we pulled out. I don't know how many other people. They're looking for a name change now, that I've seen.

But that's just another program that - and I think that was - it had good reviews and evaluations when it initially started but it's just changed over time. And

that's the problem that we have with NSW Health, is that they just duplicate our programs and possibly have more resources and expertise to put into those programs, and then we're left high and dry, and it's just frustrating.

MR BINGE: I think the issue that I find in a lot of this space, particularly coming from a different government component where I used to work, to this space, is the difference in relation to the way that health-specific programs are funded and the streamlines that they're funded in, and the short-term timeframes on that funding where programs like - as have been mentioned already, have what we would quantify as good results, but then, for some reason, I'm not quite sure why, but from a government perspective that seems to stop at given points

For me, unless government are realistic about trusting Aboriginal people - the majority of people have got significant health concerns, it's taken a lifetime to get to that point, yet we're going to fund programs for short-term timeframes with expected - I'm not quite sure what the expectation is, but with the expected outcomes of this wonderful, you know, health outcome that's going to make the difference, but on that cycle, it finishes, and in three years you're back in the battleground and you are trying to compete with other AMSs, with other NGOs, you know, in the sector, to be able to try to continue a program that we would deem as worthwhile

So for one, the funding streams aren't aligned with what our health outcomes should be, and it needs to be looked at in that perspective, I think, because we can continue the pathway that we're all heading down with these - and I think everyone's got sort of - everything I'm hearing right now is a common story, not just in the health services, but it's a common story in community. Everyone knows. Like, the first thing you get asked when a new program comes in is, "So how long is this going to go for?" It's a hard thing to answer, but you get the investment, you get the buy-in, you do see some outcomes, but there's no sustainability in those outcomes because the program is cut short.

MR MUSTON: When you say the first question that you get asked is "How long is this going to last for", is that asked by community members or --

MR BINGE: That's community, yeah.

MR MUSTON: What's the impact on the --

MR BINGE: The other alternative is, "So is that the same program as you did two years ago?" And you sort of have to really think about it, because you go, "Well, it sort of is, but they've just given it a different name." You know, I just think it's really confusing for our people. It's really confusing for the client base that really need that particular service, and to have to continually explain to community about why a certain program is finishing up, considering that you've met all the KPIs and you've got a wonderful report that follows that, that then gets used from a data perspective by government, and we can sit here and say, "Well, that was a research program" - how many - you guys have been around a lot longer than me in this space, but how many research programs have you gone through? That's continuous.

Everything we do is research. Everything we do is data statistics. Everything we do in relation to health outcomes is reading information that we continually provide to state government, federal government, but yet the reverse of that is when we look at funding to fund the programs that are of significance, that's not funded in an adequate time frame.

Then the KPIs that are reporting that - I think everyone in this room would be reporting about, you know, 10 or 15 different reports for the same thing. Like, that, in itself, is just ridiculous. We continually see the trend and we raise these issues, but nothing happens.

MR MUSTON: So those services that are brought to an end by reason of funding ceasing, there are community members who are using those services and getting benefit from them, obviously to the extent that the service ceases, they cease to get the benefit that that service is providing, but does it have an impact on the way in which you are engaging with them or more widely?

MR BINGE: It has an impact on the organisation, sure.

MR MUSTON: What is it?

MR BINGE: We have to go home and have a conversation with

our youth program, similar to everyone, to tell them that at 31 December it's finished, and we have an engagement group of well in excess of 300, 400 kids. Then, whether we like it or not, that's a reflection on the service. That's a reflection on the AMS. That's a reflection on everyone. They'll come back and say, "Well why did it stop? What happened?", and you have to have an explanation.

Then a year or two later, you'll say, "Oh, we've got that funding back again, but it's just a different name. We've now got to focus on this aspect of youth work." So it's just - it's repetitive, it's frustrating. As I said, there are a lot of people in this room that have been around a lot longer than me - I come from a different government space to where I am now - but the similarities with what we do with funding is no different, particularly when it comes to Indigenous-based specific funding for community and community programs. We've got it so wrong for so many years, and we'll be coming back here with you guys in about another five years, I could say that, to answer the same questions, sorry.

MR RAUDINO: We're so reliant on Medicare for funding.

MR C LAYER: Just on that point, what happens when something stops, you know, when a program is pulled, for whatever the reason might be, we don't just move on. We become the target because we're part of the community. We live there. We're part of the family. We're part of the fabric of that community. We can't just move on and go on to something new. We've still got to stand there and be accountable for the fact that this service that was working no longer exists. So they blame who they see and that's us.

In some cases, it's the people we have working on our front desk that get abused because one minute this is available, next minute it's not. So again, the people who make those decisions, the people looking at figures on a piece of paper, don't live there, they don't feel the community, they don't have that buy-in, but we do. We can't go away. We've got to stay there. So we become the focus of the frustration as well.

I think the other thing, too, is an AMS - if I go to my local GP down the road, I walk in the door, it's a GP, it's a clinic, it's a doctor, it's this, it's that. An AMS

is so much more than just that, it's everything to the community. That's why we're all very multifaceted. We don't just provide those health services. We provide so many other services that attach themselves to that because, again, we're part of the community, we live there, our families are there. So we're the focal point when things are either going well, and certainly when they're not going so well we're the focal point as well.

MS T LAYER: And again just to the point that it's the qualitative stuff not the quantitative, you know. For the youth program that finishes in December, we had a whole lot of young fellas come out of juvenile justice, they went into the youth program.

There was one young fella, he's 16, and he had his foot run over when he was about eight but never had really any medical attention to it, so he came into the youth program and went and saw Dr Joel Wentong and got a 715. He booked in to the podiatrist, went in to the optometrist and found out that he couldn't hardly see, so we got him some glasses. He now has a job in a car dealership doing parts. So the effect and impact that it has had on him and his family in getting that job - but then to say that that program is finished in December, you know, there's no words to say that, the impact that it has on them and the next generation of young people coming through.

THE COMMISSIONER: So what's the --

MR LESTER: "Close the Gap" was supposed to --

THE COMMISSIONER: Just let me ask you this, sorry to interrupt. What's the big picture problem here? I mean, if someone breaks their arm, an acute care issue, they get seen for the broken arm; if they've got a skin rash, go and get seen for the skin rash. But what we're talking about is the gradual development of things like chronic disease, or where children that might have a particular paediatric issue that needs an early intervention and then constant monitoring and work to assist with whatever that issue is, whether it's an illness issue or a developmental issue or whatever, but both of those things, the gradual development of the chronic disease or an intervention that's required in a child that needs ongoing work and services is like a long-term generational thing, but the investments that have been put in are just constantly on short-term cycles.

Is that the fundamental problem or is it something --

MS L BELLEAR: I think that's our life. That's our livelihood, that's how we live and breathe and manage the circumstance. You know, we're held accountable for, you know, for our kids, from birth right through to, you know, our Elders, but what we have to manage on is cycles, you know? It's a 12-month funding deal or two years or whatever. I think NSW Health promised, what was it, five years or four years or something, and we all, you know, rejoiced with that, but I'm yet to see that happen.

We're funded historically, so whatever they give us is not going to be enough. It doesn't reach, you know, the workforce entitlements. So we pick that up as well. And, you know, it continues. It's just a continuous vicious cycle. You just have to make do with what you've got, you know?

THE COMMISSIONER: I mean, I can understand discontinuing funding of a program where it's obvious that it's not doing any good. That's fine. But if --

MS L BELLEAR: But by whose standards are you referring to is what my issue is. You know, the evaluations of these programs have never been completed or, you know, we don't - we very rarely get the feedback from an evaluation, and that's an issue in itself, because we think we're doing a good job, you know, on the ground. If we can see, you know, a 15-year-old get a job and, you know, get up and go to work every day, I reckon that's a success. But do you equate that, you know, or evaluate that side of things? I don't think so.

THE COMMISSIONER: What we're talking about, and I imagine what you're hoping for, is actually looking at your entire communities, your entire populations you represent, and making them healthier.

MS L BELLEAR: Yes.

THE COMMISSIONER: That requires, I think, a longer term and longer investment horizon than these constant, "Let's try this program", "Let's try that program."

MS L BELLEAR: Exactly. I can tell you now, when I have a look at our database, 67 per cent of our patients are

either obese or overweight. That's terrible. But they start putting on weight when they're nine. We used to run a volunteer surf club, you know, surf lifesaving. We'd take them down the beach Saturday morning, and we had, you know, our workers that put their hands up, we would go, because it's not funded. We got great success out of that. Not the fact that they did learn to surf, but it was that the kids went on and did bigger and better things. They really appreciated our effort in taking them.

There was one mum that came to me and said she can't get her child out of bed Monday to Friday, "but Saturday morning, boom, we're there at 8 o'clock." So, you know, it's those little things, and it was, for us, an opportunity to teach them to eat healthily. You know? We thought we did that, didn't we? These two used to come, too. But it was not funded, you know? That's not sustainable. I can't expect, you know, after working a five-day week, then the staff - we would be there at 8 o'clock in the morning and we wouldn't come back until 3. So it was a big day, a big day out.

But those programs, there's nowhere where we can apply for funding or, you know, if they're going to give it to us for 12 months, we're in the same position, we may as well just do it volunteer, then we don't have to acquit either. The acquitting is just brutal, sometimes, for a little amount of money and, you know, they're only after numbers and, you know, nothing quantitative - quality. So, you know, that's the difference in thinking. You know, what's your success doesn't necessarily mean that it's mine, or for my community.

THE COMMISSIONER: Yes.

MS L BELLEAR: That's where the two don't meet sometimes.

MR MUSTON: That also gets us into another issue, which maybe is if you've got someone centrally within a funding body, be it a government body or some other agency, who is deciding what the program is and what the funds are for, built into that assumption is that that's what's going to work in every single community, as opposed to maybe what's going to work in your community, which will be quite different to what will work in another one of your communities.

MS L BELLEAR: Exactly. If you look at those KPIs that we're subjected to, it doesn't make sense, you know? They're pulling clinical data, but what does that mean to someone sitting in North Sydney, you know? That's what I would like to know. Because it certainly - the data that they're pulling doesn't necessarily give me any leverage to, you know, manage things differently.

MR MUSTON: What do you mean by that? So that in terms of --

MS L BELLEAR: Well, it's clinical data that they're pulling. You know, it could be how many times you've measured HbA1c. I'm more interested, as a manager, in how many new diagnoses do we have for diabetes, you know? That would tell me things are working, things aren't. But we're just stuck, hell-bent on numbers, you know, counting heads on seats, and that's it. Not really an outcome. You know, "How many times did you do a kidney check?" But what does that really mean, you know? And do the people asking for that data really understand what that means and what the results are?

MR MUSTON: So to take that example, the sort of question might be, "How many times have you done a kidney check" but if there's not that second question, "And what were the outcomes?" --

MS L BELLEAR: Yes, "What were the outcomes?" You know? And, "What have you done about it?" You know, "Why isn't this person referred to a nephrologist for dialysis?" None of that.

MR MUSTON: How long have they had to wait for that nephrologist?

MS L BELLEAR: Yeah. None of that comes around, but they just continually pull the data and, you know, some of it could be very well meaningful, as managers, but --

MR MUSTON: Just using that example, accepting that reporting is a burden, would you feel differently about some of these reporting obligations if you did feel that there was some consequence, just to use your example, "How many times have you done a kidney check", and if there was then a follow-up question, "How many of those people were found to have kidney failure or kidney disease", and then,

question 3, "How long has it been that they've been waiting to get in to see a nephrologist" - if that was something that you were reporting --

MS L BELLEAR: Exactly, and I would think the rural area people would be hard done by trying to get into a specialist.

MR MUSTON: But if the KPIs, as burdensome as they might be, if they were at least identifying systemic failures rather than just saying, "Look, these are the number of people we've checked", that at least would be providing some potential benefit; would that be right?

MS L BELLEAR: Yes, because I just wonder why they want - they're pulling all the - extracting the data but to no avail. Like, are they going to put in better resources in Dubbo or Tamworth, or whatever, if every second person has got --

THE COMMISSIONER: Just before we go to you, Jamie, I did cut Cecil off. He was going to say --

MR LESTER: "Close the Gap" closes in 2030. What happens after that?

MS L BELLEAR: We'll either be all dead or we'll be racing in the wheelchairs.

MR MUSTON: You hopefully won't be sitting here with us having this quandary.

MR LESTER: I brought it up two years ago with Tom Calma and that was his response, "2030, it finishes". We still aren't anywhere near the goals that we're supposed to be getting.

THE COMMISSIONER: Yes.

MR NEWMAN: I think it comes down to, from my perspective, we have no idea what your acute systems KPIs are, and they have no idea what ours are, so we can't work collectively together. Government fund output, not outcome.

Years ago, the big push was being able to get every Aboriginal person a health check. It made some money for you, but if you found prevalence or incidence of kidney

disease, what happens? What is the perfect model of care for somebody with kidney failure? If you look at all those steps, what are the gaps that we see between us and mainstream?

We can reduce duplication by having joint clinical services plans between each AMS, if there's one in that town, and the hospital or the LHD. For Western LHD, you've got 12 AMSs. They should have joint clinical services plans between us, so where we see a shortage in workforce, we work together to fill that workforce. Where we see lack of materials, we work together to address that. Health outcome. You're still funding output. Change the old narrative. Make it so that the LHDs work with us and we work with them.

Patient reported outcome measures are done by acute, not by us. What you fund us for is different to what our people need. The outcome for an elderly person and for a young person is completely different, has completely different economic value as well.

So how do we get the key players together, if we're going to defund this, if you're running off three-year contracts - the most amazing thing to me is that for the last 20-odd years we've had 10-year Aboriginal health plans, but we fund three years.

We're not constant enough, we're not consistent. We're having a floating workforce. How do you attract a specialist to work with you, saying, "Oh, we've only got 12 months funding"? That's wasting their time, but if we said we're here for 10 years of change, that's going to be more attractive to get somebody to relocate.

THE COMMISSIONER: What's the level of engagement between your organisation and - you mentioned Western NSW LHD? Is there much?

MR NEWMAN: There's a partnership agreement at a state level and then hopefully applicable at a local level, but for years we've just talked about promoting stuff and sharing support. It's usually we get lumbered with all the people ending up at the LHD, say, in Orange, who have come from other places that need support, so rather than getting supports from the LHD, they ring us. That's the level of engagement we have. We need to change that old dynamic.

We're doing a lot more productive things now, but the ultimate, if we want outcomes for our people, is that we should be doing a joint clinical services plan, so that we talk about the patient journey, which is one of the indicators of "Close the Gap", our people at some point are going to go into hospital. The maximum we do now for the acute setting is that we, in some places, might get a copy of a discharge summary. What happens when our people come from further west into Orange for cancer care or any other specialist care, but there is no coordination of the health care from when they leave out there and they come to Orange spend a week or two weeks, and then they go back home. The clinical service plan could be around how we're supporting the navigation of our people's journey in health care. But if you don't have that connection under a contract, then we're always going to be doing things in silos.

I think that we haven't learnt anything in 19 years of "Close the Gap", we're still doing siloed, output-driven funding agreements. In our contracts, and every AMS knows this, there are so many you've got to get done. There's so many you've got to do. So we're chasing people to have health checks every nine months. Our people live day-to-day. Why are we worried about having a health check every nine months? Put in a model of care. If someone's got a particular - the prevalence of illness and incidence of disease should determine what we do and what is the best model of care for that. That should get us to the table with the specialist working at the hospital.

If we need to recruit somebody, a nephrologist, then why aren't we sharing that responsibility, because a lot of our people are on dialysis? How do we prevent getting to the dialysis level? If we find incidence earlier, that could be prevented. That's where we work together. We don't work together.

I know Gerry and her team have been pushing for this to happen. We're doing step by step, but I don't see you shutting down hospitals. If you shut us down, then you're still going to be dealing with illness and disease. If we don't get funded, if we don't have those pathways, we don't have a clinical plan for our own community. I would love to see that we have a clinical services plan jointly between Orange Aboriginal Medical Service and Orange Health Service that enables a patient journey before hospital,

after hospital, and who are the players in that.

Some of our people don't come to us, they go to a general practice, and that's their call. We don't challenge that. But if they want all these wrap-around services for a health outcome, then they would come to us. That's how we work with the hospital to say to our community, "If you've got this, if this is an incident or prevalence in your family, this is what we can do for you", because this is what the model of care should be. If our people don't know what their patient journey should be, then they only come for one thing.

That's what we were doing for years at Orange, people just wanted to access dental or people wanted to see a psychologist, and now we've got to change. We've got to change what is health to our people so they understand what they are going to get when they come to us. That's where - it's not trust, it's confidence. So if they're confident to say, "This is what we'll get health outcomes for. If you've got prevalence of type 2 diabetes, and you've got all these diabetes programs that we can turn it around, then resource for that." We're not just coming up with it because we know our people, but there are models of care that have been researched for multiple years, so when we come to the Commonwealth or states, we say, "The model is there, fund it." It's all about the budget.

MS L BELLEAR: But you know what I think, just to interject, I think what you should look at is not funding body parts, because that's what you're doing. Body parts or chronic disease, and then it filters in, we get bits of, pockets of money, here, there, everywhere.

In our constitution, we've defined "Aboriginal health" as holistic. So instead of channelling money coming in wherever, for specific body parts or disease, then why can't we just get a bundle of money? And then it's up to the managers then to decide what are really the needs of our community and then we can work out what activity and service we need to provide

But until you get rid of these body parts, mate, we will always remain subservient to the government. That's probably what they want, I suppose. But I would think, in a unique manner, if you gave us a lump sum rather than body parts, it would be so different and we would be able to

be - we're very creative in different programs, you know? Then it could be more sustainable as well.

THE COMMISSIONER: So instead of funding, "Here's this money, you must do this with it" --

MS L BELLEAR: That's right.

THE COMMISSIONER: -- funding, "We know our community, we know the services they need, and this is what we think we should do with that"?

MS L BELLEAR: Yes, and in your contract you will determine between the two what those outcomes are. Very easily, identifiably, you know, evaluated, and you know, for a longer term. But until we get that, you know, if you're going to fund - "Let's fund diabetes", or "Let's fund", you know, whatever disease - but we look at it as holistic, you know? People come in with a sore toe and next minute they're having a heart attack, but that wasn't important when they got out of bed that morning. So we have to deal with that. You know, even though they might have come in for exercise or something like that, and then, you know, we end up treating them for all these other things that don't count, you know, because they might be a mental health - that social and emotional wellbeing is a great one, I tell you. They come in for a clinic or consult and we've got to look around and try and get them in to a social and emotional wellbeing program. But really, they need the psychology, but, you know, they've been funded that they've got to provide a - we've got to provide a wellbeing program.

That's the difference and that's the juggling act that we've got to do. You know? If we take away that psychology consult, then old mate might, you know, go and do something. You know, they've got a zero suicide, whatever it is. I don't think half the AMSs participate in that because how are we going to get to zero suicides, you know, when we haven't got the human resource, the resources, it's impossible. But that was another baseline from a research project.

So, you know, they put millions and millions of dollars into research and we get to play with them for a couple of years, but we can't deviate from that because they've got to - they're doing their research, they need

that data, and that's what they're paying us for.

So that's why I'm a little bit mixed with the research, you know: why should our funding, main funding money, be part of research? So that's it from me. I'm going back to work now.

MR LESTER: We're funded as single persons and addressing single persons and their issues. It's a holistic approach. You aim everything at the family, because a lot of the diseases are inherited from year to year. It's no good addressing one person if you've got a lot of those diseases existing in the family. If you've got a young guy who comes in and he's got diabetes, you look at mum, look at dad, you look at the brothers and sisters, they've probably got the same thing too.

So taking it individual and singly, it's not going to close the gap - never. But, you know, that's the way we're funded. That's the way we've been funded for years.

MR RAUDINO: I just want to tack on about the funding and the buckets of money and stuff, just quickly. We did our job listings, we've got over 40 buckets of money sitting there. So you can imagine how much reporting we've got to do, you know, even for little buckets. We've got a men's shed, applied for a little - I think it was, like, just a $5,000 tool grant. Everyone thought I was going for a million dollars, you know, just for $5,000. It's just so tedious about applying for funding. And then I've got to go and report on that, don't I?

You know, they are going to want to know how many people come in - this is a two-day a week funded program, mind you. So what happens the other three days when men want to come into the men's shed, have a yarn? "Oh, no, sorry, you can't come, you've got to come Wednesdays and Thursdays".

If you've got some issues and you want a yarn at the men's shed, "Oh, no, come back next week." Just little things like that, you know. Yeah, I just wanted to add on to yours about it would be nice to have longer funding and buckets - I know there are reasons why we've got to report so much, there's different streams and LGAs and federal state, what-not, it would be nice if it was just five buckets of money not 40.

MS L BELLEAR: I've actually refused funding, because it was too horrific, the reporting, for a little bit of money. I thought, "No, stuff it", you know? And usually when they do throw out money, it's at the end of the financial year and then you've got to, you know, apply for it to roll over and, then you know, you jump through all the hoops, then they give it to you, then you've got six months to spend it.

MR RAUDINO: And you get it straightaway and then by the time they roll it out, it's September, and you've got to report on the first quarter and you haven't even started the program because it has taken them six to eight weeks to release the money.

MS L BELLEAR: Exactly. But we're fairly desperate in the AMSs. You know, people need that thing. But, yeah, that's a real issue of how and when we receive it, if you are lucky to get it.

And then some AMSs may not have submission writers, you know, and all that, so they are behind the eight ball. They will never grow. And people - I don't think there's anyone that really cares whether they are - you know, they could have a huge need and have - you know, that could impact on their community. So I don't think - you know, there's a demand, needs, and who's looking at that? So we all get the same money, depending on, you know, the population or how many numbers you've got. It all comes back down to about numbers. So, you know, we may be big, but a smaller organisation may be desperate for that, you know? I believe in sharing the love, too. But, you know, when it comes to dog eat dog, then, you know, we've got to survive in all this as well.

I think the government departments have a lot to do with that from the timeliness, and you know, if you're chatty chatty with one of the people in there, well, you will probably get the crumbs, if there's anything left over.

So rather than really looking at those communities that need that support or extra resource - you know? Like your men's shed and all that type of thing, you know, if they could run it five days in a rural country town, I would think, you know, that would help - that would help

with your domestic violence and mental health and suicide.

MR RAUDINO: Mental health, yes.

MS L BELLEAR: It's a whole stack of area that you could capitalise on, just by running a service, you know, five or six days a week. It's not asking for much when, you know, big hospitals are getting, you know, half a billion dollars worth of resources - "We could do some dot art here and then, mate, that'll make everyone welcome." You know, if that's all that it takes. So, you know, I just think that no-one's looking at the needs of the community.

MR MUSTON: I assume, accepting that more funding would obviously be of real benefit, but even if you were confined to the existing funding that you each have available to you at the moment, if all of that funding was broken down into a single pool, which you each were able to determine how best to spend it and prioritise that spend to meet the individual needs of your respective communities, you would be doing things quite differently; would that be right?

MS L BELLEAR: Exactly. Instead of giving $5 for a reading program, whereas you could actually hold up, you know, people having to go on renal dialysis by looking after your diabetic patients, so put your $5 in there, perhaps, or if you've got the numbers, you might be able to afford a renal chair. So it's what you've got in your community, and that's not what we're looking at.

MR C LAYER: It just means we could be more targeted to the actual needs that are developing there and then as opposed to reacting to someone later.

MS L BELLEAR: Yes, and that's how we do get funding, too: it is a reaction because someone's got - you know, there's a big case of diabetes or HIV somewhere and then, boom, there's money, all of a sudden, available.

MR ROXBURGH: It comes back to flexible funding. I think most AMSs have more than one funder, one funding stream, grants and everything else. But who funds them? It comes from one place.

MR RAUDINO: Or it's bowel awareness month so we'll give you a couple of grand, like, just because it's an agenda item. You know, it doesn't go away; like bowel cancer or

bowel issues don't stop the other 11 months of the year.

MS L BELLEAR: It's all about that screening, you know? They push screening down our face, so we've got bowel cancer, you know, we're more likely to have bowel cancer at a younger age, and that could have big ramifications if you've got a young family. You know, this is a disease that old people get in the mainstream.

But, you know, with us, we get it younger. It doesn't matter whether it's breast cancer, bowel cancer, cervical cancer, we get it all, but at a younger age. And that's the difference. You know? And we're hard done by, sometimes, targeting that group, that young group. Whereas the money may come out for the older ones. God forbid, they need it too, but that's where our concentration level is.

Breast screening - that was 50 years, and we'd say, "No, we've got to drop it to 40", and it took that long, because they were hell-bent, "No", and "It will cost too much money", but the money kicks in when you're diagnosed, I tell you. Some people don't even follow up with the oncologists and surgeons and all that, because they can't afford it, and you've got to go and have an ultrasound, it costs 1,000 bucks straight up after you're diagnosed from your free mammogram. So there are all those types of things.

You know, people are hard bent putting bread and butter on the table. So that's the difference. And there's no bucket of money for them to go to, "Oh, I need $1,000 to see a surgeon", it might be even more for the surgeon. And ultrasound, that ultrasound is expensive. So good luck with that. And people make a choice whether they're going to have it or not.

MR RAUDINO: I think talking about early intervention and prevention, it starts at conception. We have a child and family health team, which is great, one little room, we're squished in there, you know, mat on the floor because that's where they do all the work

We want to prevent and we want to try to put things in place for the five-, six-year-olds. That's really important, it's what they say is the most important time of a child's development, but yet they don't give us more

paediatricians. Our wait list is 12 or 18 months for paeds, you know? The amount of young people that we see, and youse would be the same, kids having high needs and stuff is growing immensely. It's not going away. But yet that's the same, it's the target age, we've got to get all these services in place, it's really important to get, but that's a big gap. That's a real big gap.

I know we are trying to service everyone and everyone is important, age groups are important, but the kids seem to be - not left behind but they - yeah, it's a big gap that we see, anyway, in our service, especially around the paeds. We've got a couple of paediatricians that come in, but still, it is a long wait list. Long.

MR MUSTON: I assume you would not be troubled by KPIs that measured the extent to which you were engaging in screening programs if you felt that the public health --

MS L BELLEAR: Well, if you pay me for it, I'll give it to you.

MR MUSTON: If you're paid for it and you were being held to account by KPIs in terms of an amount of screening, if you felt that, on the other side of that coin, there were KPIs that you were able to hold the public health system to in terms of picking up the consequences of that screening - that is to say, whether it be paediatrics, if you were funded to engage in screening programs to pick up a need for paediatric care in small children, there might be KPIs that require you to screen a particular number of children over a period to detect need, but then, on the other side of the coin, you'd probably like to see some KPIs on the part of the public health system which say how long is it taking you to get paediatricians to see these kids and deliver them the care that you have now found, through this wonderful program, that they need.

MR RAUDINO: They drop off because mum didn't wait that long and, you know, "Oh, I'm not waiting 12 months", or you can go, "I want to go somewhere else", you can't even go anywhere else. Well, they can't, they can't get there travel-wise, they can't afford it.

MS T LAYER: That impacts not just on primary health but NDIS, so you're waiting for a paediatrician for an assessment, you know, for an NDIS plan, and sometimes that

can be a couple of years. But I think it's not just the KPIs; it again comes back to that partnership with local health districts and the model of care that Uncle was talking about, in the sense that a tangible thing would be having the partnership around their specialists, that they have to service part of their KPIs, as the AMSs do, around that sort of stuff.

So when we're talking about this initiative that we have with Professor Kelvin Kong and just trying to reduce the ENT waits, that might be sometimes physically being there, but he's only one person, doing more telehealth and things like that, providing those just to close that gap in the specialist services, but instead of LHD trying to duplicate what AMSs do in primary health care, let AMSs do what they do best, but to have a partnership where there's actually that referral pathway right up to the specialist services would be amazing.

MR NEWMAN: Back to the clinical services plan. You can prevent all of this siloed rubbish. Let us do primary health care. They do acute care. Pathways. You maximise your dollar. You'd have better - we wouldn't be competing trying to get access to paediatricians because they're part of that care plan. So if our kids need paediatrics and someone is at the hospital, they see them, no ifs, buts or maybes, or "the books are full", "No, no, you're in a partnership with us". The state partnership agreement is fine, but it is does not impact us in the delivery of care to our people. That's why - it's not rocket science, mate. They need to know about our clinical services plan, we need to know theirs and see where the alignments are so that we've got pathways in and pathways out.

Saves us trying to compete with them for a paediatrician or an exercise physiologist or a dietician. Share that under a pathway. Right throughout the whole "Close the Gap", it's pathways and journey of our people in health care. Somewhere in this planning we forgot about acute and what their responsibilities are to us. It's all "This is our responsibility", half the money, maximum load. How do we make this work so that we're all responsible for the health and wellbeing of Aboriginal and Torres Strait Islander people, not just the AMS sector, because there's not 40 million? What are you doing in mainstream that enables us to work better together, where ALOs will feel more secure knowing they're working with an Aboriginal

medical service or Aboriginal group, that ensures that our pathways for our people are established and practised.

This is why you have those advisory groups that say, "No, you're not doing this", and crack the whip with them with the two board members, and then report back to this partnership, to say, "They are failing". It comes to us all the time, "You're failing here". Well, if we can't get pathways for our people for specialist care, whether it's through RDN or with our local service, even better, because we're not rushing our people down to Sydney because they can't get it in Orange - we don't even know if it exists in Orange - we're not maximising what wealth of resources, physical and material, that are available, because we don't know.

That's never happened, where we've had joint clinical services planning around the health needs of our people in Orange or in any of the mob here. That has never even been approached. They fund hospitals for this, they fund us for this, yet we are the two main providers where there is an AMS in the town, especially for our people and non-Aboriginal people, but we don't even know what each other is doing. It's reactive. Competition, duplication, minimal resources and maximum health impact. It's not hard. You have to do that. It's not based on character or personality. Based on the contract, "You will do this, no ifs, buts or maybes", because if it isn't in there, we're going to keep doing the same old thing, yet we're expected to look at multiple ways of trying to get our people - we can sit down at the table and talk to the general manager, but if the NUM or specialist in the room is saying, "Well, I'm full", we're not going to get anywhere.

It can be a beautiful way, because our people in the community still see the hospital as separate to what we do. We talk about pathways. If our people need dialysis and we're not going to be established at the AMS, then we need to support them going into the hospital. We've been fighting for years for our staff to go and work within the hospital to support the hospital staff. Still that policy hasn't been changed.

MR MUSTON: But even to use that example that you raise of dialysis, if there is perceived to be a need in the community for dialysis and it's First Nations people in that particular town or community that are the predominant

user of the dialysis service, presumably what you have in mind is part of this might include a discussion between the local health service and the AMS about where that dialysis service should be located.

MR NEWMAN: Absolutely, yes.

MR MUSTON: Should it be in the AMS, where people come and maybe a whole lot of collateral benefits associated with younger people bringing someone with kidney disease in and getting some other care while they're there - that is, the young person getting some other care - or in a particular setting, would it, in fact, be better to have the renal service at the hospital, because we're doing other things in the AMS?

MR NEWMAN: But those people who are in the know make that decision, so we're not competing with one another trying to get something, especially in our Central West and Far West, we don't know who is doing what.

So if we don't know who's doing what in the health sector, how do we expect our mob in community to know, whether they are black, white, yellow or pink or blue? But yet we have all this, "Let's navigate our people through health systems." Even GPs can't navigate health systems.

So it's fractured - the system is fractured. If we don't fix it the best way we know how, at a local level, working with our key partners, then we're still going to be competing, we're still going to be dealing with people, and we can do all the screenings under the sun, but if there's identified risk here or identification of potential illness, disease, how do we prevent it if we need the local hospital who has got the resources, physical and material, to work with us to do it?

MR MUSTON: That's probably a good spot to break for lunch.

MS L BELLEAR: Or you can give him an amount money to be able to buy in those services. So if that local hospital won't provide it, then he can take it somewhere else. But you've got to make sure he's got the funds to be able to compete and take his business elsewhere, and they won't like that, I tell you. They're happy to take all the money the hospitals, and they do with it whatever, and we just

have to wait.

But if you actually funded Orange AMS, you know, for that specific service, then he can buy in that service or, you know, maybe go to the next town. And then, I tell you, they will be servicing his patients because they don't want to miss out on any money. That's my assumption.

And that's the whole thing, underlying thing, is racism. You know, while they're getting black fellas' money, they don't care. But if we had it to manage, you know, and we went, "Oh, no, we could get a better service down the road", I tell you, it would change the ball game. And it's putting us in the driver's seat. That's just food for thought, anyway.

But I think you should have a look at funding an entire service, rather than body parts, because that's where we're losing out. We can negotiate the KPIs, whatever outcomes they want, we can negotiate that, and it would be dependent upon the needs and the demands in our local communities, or the communities that we serve.

Easy. I've got the solutions, I tell you. I've just got no money, no authority, I've got nothing. But we can't go forward like we are now, because that's just ludicrous, it's not working. It's not working. It mustn't be working for the government and it's certainly not working for us.

MS T LAYER: And it's not smart. When you think about if we've got 30 contracts, 30 acquittals, imagine the administration of 30 different organisations, if you pooled that administration cost, you'd pay three GPs. Like, you know, it's just not working smart. So I think from a monetary point of view, I think there is a much better way you can do it and just straight to the AMSs.

THE COMMISSIONER: Okay. Let's have a break for lunch, and for those of you - we're here as long as you want to talk to us, but for those of you who can stay, we will reconvene at 2.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: All right. We might recommence.

I think, Ed, we were going to discuss relationships

with LHDs.

MR MUSTON: I just wanted to ask Kevin one question. It's something that he had told the Inquiry team or discussed with the Inquiry team in Tamworth around the connection between funding and census data and some issues that that has caused for you. Do you want to just --

MR DUROUX: Yeah. In Tamworth I've experienced it a couple of times. When doing funding applications, we will need to collate the census data, and we're purely allocated funds on what that data looks like and presents. We have had several occasions where they've come back and said, "Hey, that's not what we see, the data's different", or "Your data doesn't represent the population that you're servicing", and I said, "What can we really do about that? We don't control the census", and the ultimate outcome is that assessment is made on the data that is available, so I've crossed that a couple of times and just thought I'd put it out there and see if anyone else has come across it.

MR MUSTON: Is that an experience anyone else has had, dealing with assumptions about the size of the population that you're service is notionally providing being totally disconnected from what your experience suggests that the population size that you're meeting the needs of is?

MR NEWMAN: We know that a lot of our people don't participate in census, because it's seen as a tool against us, not a tool for us. So we always - it's common, a given, you know, that we add 15 per cent to what the census says - because it's mismatched, when you look at the census data plus our data of access and utilisation of our service, it's completely out. So we have this position that we add 15 per cent or more.

An example is the census says there's about 3,200 Aboriginal people in Orange. We have over 4,000. So it's always going to be out because of the issue around census. So if government want to fund need, then our data is a true and accurate reflection of what we're dealing with.

MR MacQUEEN: I was going to say the same thing. I mean, we have a very transient population up and down the coast, and, you know, the night that they take the census, the next day, there could be another dozen in the house. So we don't think that census is really accurate at all on our

platform.

MR MUSTON: Moving to the issue about the relationship with the LHD, we've heard it suggested that in circumstances where there's a strong relationship between the AMS and the chief executive of an LHD or the AMS and the manager of a particular health facility, things can work really well and collaboratively; but without that good relationship, equally, things can work or not work at all.

What sorts of structural changes do you think could be made to the system? We touched a bit on this before lunch, but what sort of structural changes do you think could be made to the system to try and make good collaboration between Aboriginal medical services and local health districts more "business as usual" rather than just a serendipitous coincidence of two like-minded people?

MR DUROUX: From experience with our AMS dealing with the LHD, we have a fairly good working relationship there and an MOU that is current and that we review.

Although our CEO sits with their CEO and they have good conversations, and, you know, agree to service the same people and have a good vision, at the end of the day, we find a lot of red tape around policies that are governed by the LHD.

They come to us with good intentions and they want to do good work with us, but at the end of the day they'll say, "Oh, no, we can't do that", or "You can't use that pool for your patients in your cardiac rehab program", because there are all these rules and policies around it. So for us, policies higher up govern what we can do on the ground with the LHD.

MR MUSTON: Do others have that experience?

MR NEWMAN: A clinical services plan, a joint clinical services plan, would eradicate that, because they have to be binding. The MOUs, partnership arrangements, SLAs come and go. It usually goes with the character or the personality. You've got to provide - the whole entity has to buy in. It's like us; when we buy in, we buy in. We're all in. We're not one foot and then the arm comes later; we're in, all in. That's what has to change. I was chatting to Gerry at lunchtime about it.

We're healthcare providers. AMSs provide clinical care, hospitals provide clinical care; there is the connecting element. Don't worry about community controlled or government run. What brings us together is clinical care of our people. Aboriginal people, non-Aboriginal people, whoever comes to us, right? That is our connecting point. How do we maximise that element of what joins us? That's what we have to do.

MR MUSTON: And that doesn't involve one-off agreements or relationships that might be documented as between one AMS and a particular local health district but, rather, a more embedded, systemic, co-planning process?

MR NEWMAN: It has to be right across the board. If we don't have the specialist program - all of New South Wales or all of Australia, you want consistency, because our people move from place to place. We hear that, "Oh, they don't do that up there but you it do here", or "You don't do this but they did this". You want consistency in health care. That's what our ultimate goal is, because if we have that point, then we're going to get health outcomes.

So you guys, the people that control the contracts, control relationships. I have a good relationship with the general manager, have a good relationship with the Aboriginal health director for the LHD but that doesn't mean we're going to have pathways in to acute clinical services, if that plan isn't in place and adopted right across the whole country.

If you're going to focus on New South Wales, we've got 52 to 53 AMSs, then that should be a consistent, non-negotiable element of providing health outcomes for our community. They are the things that would bring us together. If you've got a good relationship, you might get an MOU or SLA, but we've been working 19, 20 years, and still haven't got a pathway and referral process for mental health, yet we have the biggest mental health facility in the region at Orange. Madness.

MR MUSTON: What about clinical handovers between the AMS sector and the acute care sector? How is that working?

MR NEWMAN: It's based on relationship. We might get a discharge summary. Sometimes we don't even know that our

people are in hospital. So if that's not working and the ALO doesn't have authority to say, "Oh, this needs to happen" - you have 24-hour or 48-hour follow-up on chronic care within most hospitals with their provider, sometimes that's AMS, sometimes it's general practice, but it's not consistent enough. It has to be where our people feel connected before they go into hospital and when they're in hospital and when they get out of hospital. That's the patient journey. There's no stops in that. It's got to be consistent so that the policy of allowing our staff to go in there - and not to question what the hospital's doing; it's to be there so that our clients, who are patients in the hospital, see that our doctor or our nurse or our AHP or our dietician can visit them in the hospital.

I don't think the mainstream system should be afraid of that. I think it's about continuum of care so we reduce - the whole idea is reducing discharge against medical advice, because our people don't want to be talking to 10 different people about what their health issues are.

That creates a better relationship between us and the mainstream sector so that our people see us working together. The policy negates that, "Oh, no, I'm not going to go in there and read the chart of somebody laying in bed and say, 'That's not right, they should not be doing that'". No, it's just our people need to be visible within the acute setting that says to our people and community, "We're close with the hospital".

We can promote that we work with the hospital under an SLA or MOU, but if our people don't see it physically, they don't believe us. So they need to see it so that they have confidence in our systems of working together. That's the difference. My view only.

MR MUSTON: Well, let's test it. Do others share that view?

MS T LAYER: Yes, I totally agree and I think that could be a different model for each different community, you know? For example, we've been trying to partner in an agreement with our local health district, but it was just a piece of paper. You know, we had someone from AH&MRC come and sit in in the meeting but it was more about how our AMS can help the LHD achieve their outcomes; you know, it had nothing to do with supporting.

We've gone around that and we've just created a partnership with a maternal and perinatal Aboriginal unit, maternity unit, themselves. We're just offering a space and they are coming in fortnightly to see some of our clients.

Where it did work, we set up a COVID vaccine hub, which turned out to be for all of community, and I had to go to a higher level to see if we can get some nurses from the LHD to help support, that were immunisers. That worked really well.

There could be opportunities around - you know, we've got a partnership with Western Sydney University about the placements for GPs. Is there a way that we can have - or allied therapies that are within the community health section of the LHD, that they can provide clinical supervision for placements of OTs or psychs or things like that?

There are so many different ways that the partnership could be mutually beneficial, but it's just nonexistent. So I think it's something that there just have to be tangible benefits for both parties, but I think it could work.

MR MUSTON: Presumably, that process, the clinical services plan, the joint clinical services plan, for it to work, it's got to be a genuine attempt at laying out that patchwork of services and identifying who is meeting what, rather than, "Let's tick that joint clinical services plan box, make sure it is populated with the language that some other policy tells it has to be populated with and move on"?

MR NEWMAN: Absolutely. It's going to be a little bit - we can bring resources to the table as well. I think the impression is that if we're going to have this - even if it's never been mentioned around clinical care of our people, they're talking more about pathways, so that, "Oh, you know, we'll do a discharge summary and we've got ALOs there and we've got some other Aboriginal people working in the hospital, and we've got paintings around everywhere, you know, we celebrate that."

But we've got to get beyond that. We're after

outcomes. So we are in a very strong position that if you want to partner with us, you bring your resources and financial material to the table, because if we bring that together, then we will be a lot closer to getting health outcomes and not outputs. Hospital fails in a lot of ways. We're not here to highlight their failures. We're saying, "Let's address failures and get good outcomes here so people can see us working together." Even the workforce can work together and not be fearful of one another.

MR MUSTON: Not fearful of one another in what sense?

MR NEWMAN: Well, my staff aren't going to go into the hospital and read the charts and say, "No, they should not be doing this", or questioning what an ALO is doing. No, we're there to support. Now, two ALOs at a $300 million facility, they're going to go on leave, so who is liaising with our people when they're not there? So there's gaps in that service that we've identified, and how can we help them, rather than being reactive, saying, "Oh, we've got somebody out here, their partner or family is here, they need somewhere to stay." That's the biggest insult ever. Don't ring us for the social determinants, mate, we're a clinical provider.

We should be able to - we make the call on what we can do, not you ringing us in front of the clients at the hospital, and then when we say, "No, we can't help out", we take a slap, "Oh, Orange AMS doesn't worry about people in hospital that come from Bourke or Brewarrina or Walgett", or whatever, right? Load of rubbish. If we were part of it, then we could identify those needs and address them so they're not even ringing us; it's just a given. It's not hard.

MR MUSTON: That's something else that has been raised with us in our travels, is a perception that any challenge that a First Nations person who presents at a hospital might have, they're told sometimes, "Well, just go down to Orange AMS", or "Go down to the local AMS. They'll sort out that problem, getting you transport to the specialist appointment, getting you some food security," whatever the challenge might be that has cropped up during the course of the discussion around a health problem. Is that --

MR BINGE: That's always happened.

MS T LAYER: That's always happened.

MR BINGE: That's not just cropped up. That's a - well, I can say 25, 30-odd years that's existed. It hasn't changed.

MR MUSTON: Yes.

MR BINGE: If anything, it's probably increased. You get people in A&E all the time and there's an assumption that they're a client of ours, which they aren't, they still get sent there. Sorry, but that's not something that has just popped up. It's an ongoing issue and it will be for a long time until we get to the space that we just talked about.

MR MUSTON: And so to the extent you're not funded to provide all of that extra care, that's obviously a massive challenge.

MR BINGE: Well, it is a huge challenge. I mean, an example of that is probably two years ago, there was a coroner's inquiry because that exact thing happened, and someone died. They were sent from A&E to the AMS and between the space of that trip, someone passed away. And that's just one example. I reckon that's happened for an extended period of time, because it's not a conversation that happens just for us.

If I go back out west, out to where my other family component is from, it's the same thing out there. You mentioned one of the hospitals, Moree, I was a patient out there. So, you know, it's just - I think we've got to be careful sometimes when we say these things have just popped up. They are not just popping up, they are ongoing issues, have been identified time and time again.

Pathways of, you know, fixing some of this stuff and working better together have been put forward time and time again, just nothing happens. It's just a conversation. When it comes to, you know, executive managers of, you know, local LHDs, it's about the relationship, but they come and go like a boat in the night. They're there this week and not next, or they're there for the next two years and then you don't see them again because they have progressed their way somewhere else, so how many times do you have to build a relationship? If there's something that's embedded as a practice, that's going to be sustained

regardless of who, you know, the executive officer is.

MR MUSTON: Something embedded as a practice also requires involvement of more people --

MR BINGE: I totally agree. It doesn't matter whether it is the health services, whether it's, you know, working in a child and family history, whether it is working with you. When we buy in, as Indigenous people, we buy in. Because we see the vested interests of our people. And we know what some of those outcomes could deliver.

MR MUSTON: In terms of those clinical pathways or the pathways through health, one that we have heard some evidence about is the delivery of health care to people in corrective facilities through justice health. We all know the statistics, we don't need to lay them out, they're appalling. But to the extent that there are First Nations people who are receiving health care through justice health whilst in a corrective setting, do you see benefit to some sort of more structured arrangement where there is a clinical handover of some description between justice health, on the one hand, and an AMS that the person might already have been receiving care through, or it might be the AMS that covers the footprint that that person might be moving into once they are discharged from the corrective setting? And if so, what sort of structure do you think might work and what might be some of the challenges from your end if we said, hypothetically, "There should be adequate funding to enable someone at justice health, in the lead-up to someone's release from custodial setting, to work out where they're going, work out with where the local AMS is and actually reach out to that local AMS, 'Here's the person, here are their clinical records', if they're happy to share those records, and make sure that there is that seamless transition from one place of care to another"? It seems like a good idea at one level but I recognise it might create all manner of pandemonium at your end.

MR RAUDINO: Who picks that up? Who picks those clients up, if you haven't got a justice program or justice - yeah. You know, all they do is they get out - "Oh, I just got out of gaol", they send through the medical records, that's all they do. There is no worker linked to them, on our end, anyway. We've got no funding. So they get out, they've just got to get into a GP, because that's how it is. If

you're a new patient or you've been in the system for two or three years, you have got to go through the new patient process - that's what our policy is anyway. So if they're in gaol for five years, they've come out as a new person, technically. They've got to get a GP, they've got to get all their referrals so they can start all over again.

So that's the gap that we have. So we have no worker either to link in with them. The hardest part is reintegration back into community, isn't it. So how do they make that - how do we make it smoother if we've got no pathway?

MR DUROUX: I'd like to just jump in there real quick and say, you know, talking about the justice health stuff, and that program and the prisoner release and that handover of information, for us in Tamworth, it wasn't happening. A huge, huge gap. People were just going out for a week, reoffending, going back in because they had no supports upon release.

What we've had to do is we've created our own private entity partnership with the prison in Tamworth, and the AMS actually goes in there. Justice health don't do it any more in Tamworth, for us, it's the AMS. We're not funded for it - I'm putting that out there. But we can then ensure that patient journey upon release, back to the AMS, back to the GPs, back to community, back to family. So that is a model that I can say works.

MR LESTER: Every LHD has an Aboriginal health worker - sorry, an Aboriginal health manager. They look after a specific area and it is making workers accountable to come under that Aboriginal health manager. So if any issues are lodged you go back to your Aboriginal health manager, not to other staff. That's the way you address it.

MR MUSTON: In what sense? Give us a hypothetical example.

MR LESTER: You're setting up your own Aboriginal health unit within your LHD. So you've got a person there accountable for any of the issues that happen within your area. Twenty years ago, I worked down at Queanbeyan. I was the manager for Aboriginal health. I had eight Aboriginal health workers ranging from Bega up to Batemans

Bay, out to Yass and out to Young. We set up our unit, they had vehicles, they had all the resources they needed to address the issues within the community. We set up numerous programs. One of them was an otitis media outreach, which we did at Goulburn. All the Aboriginal health workers with this program would set up a time with the school. They'd go out to the schools and they'd do the screening for the kids. The kids that passed the first time, fine, they'd leave them till next year; the kids that failed, they were kept on the program.

We talked to Westmead Children's Hospital and they provided us with a surgeon and he came down four times a year, he had a clinic. He did theatre in the morning, he had clinic in the afternoon. Theatre was up to six kids, clinic was up to 20 kids, and all the Aboriginal health workers - the kids who failed in the area, the workers would bring them and their family up to Goulburn to see the ENT specialist. We had an audiologist up there in Goulburn where we did all the screening for the surgeon and it just went on and on and on. It was a very successful program. It cost $15,000 to run.

The surgeon from Westmead took all the staff from Goulburn up to Westmead, trained them in theatre operations. It's a very easy, simple program, yet otitis media is supposedly one of the worst things around, but there are a lot of kids out there who don't get access to it.

If you make your staff accountable to your manager, your manager for Aboriginal health for that area, then an AMS can go back to that manager and say, "This is happening in your area. What can we do about it?" It's no good going to the hospital manager, it's no good going to the LHD, you're not going to get any satisfaction. It's a very simple program.

MR MUSTON: But it ties in with the service planning piece that we've been discussing - you can have that level of responsibility, but if you don't actually have a service plan built around it which identifies need and works out, as across the AMS setting and the LHD setting, how is that need going to be met, from which particular service are we going to be accessing particular things, then it's all very - it's a bit hard to hold people to account to a failure, if there's not an existing arrangement that

says, "We understand the problem. We understand this is how we're going to deal with it, and if it's not being dealt with in accordance with that plan. Then --

MR LESTER: You get rid of those people who won't conform. You know, what do you pay them good money for? To sit around and do nothing? We're not here to play games. We're here to get the job done to look after community, and if people can't understand that, that's their problem, that's their issue.

We don't deal with a lot of organisations out at Condobolin because they don't do their job, and we're left picking up the straws at the end of the day. But I've got incredibly good workers there.

MR MUSTON: The organisations out at Condobolin - are you talking about other NGOs who have received funding to provide the particular services?

MR LESTER: Yes, and they don't do their work, so it comes back onto my workers to pick up the pieces and run with it, and they do an incredible job with it, even though it's not within their duty statements, they still do it. Because they've got a job to the community.

We set up a breakfast program years ago, and how that came about is at the high school, one of the non-Aboriginal girls finished lunch and this Aboriginal girl who was there with them said, "What are you going to do with your crusts". She said, "I'm going to throw them out". She said, "Can we have them - can I have them?" So from that we set up a breakfast program, we set up a cooking program for the students twice a week up at our facilities, and that worked very well. There's no excuse for not doing anything; there is an excuse for failure.

MR MUSTON: I think they're the topics I wanted to cover.

THE COMMISSIONER: Does anyone feel as though there's anything that you want to raise that's of importance that we haven't raised as a topic or something important that you want to add to the discussion we've had?

MR RAUDINO: Dental, not on Medicare. Pretty simple. Why? It would be lovely to bill. We've got two dental chairs. We get funding, it's good, but it would be nice to

be able to bill it. Everyone knows dental's quite - you know, it's really expensive in the mainstream, and we're not immune to dental issues. There's no partners to help streamline the process, but wait lists are long. Long. Yes.

MR NEWMAN: I think that's across the state. It may not have the incidence or prevalence, but for most of our health issues, oral health is in there, but it's probably the least funded. And if we're ever going to get outcomes, we need to have equitable funding. The bucket has to increase that we're getting currently from the ministry. Not a budget, it has to be actual. Some have two chairs, we have three, but our people deserve to have access to orthodontics, to other oral surgeries to deal with cancers, but that's out of our control because it's not available to us.

Pathways might be, but then you've got to move them from regions or remote and rural areas down to Sydney, if it's available. The Commonwealth don't want to touch it or refuse to touch it. So we are relying on the ministry, which funds us as best they can based on the budget they have, but if that budget overall isn't enhanced, then we're still going to be missing out.

And even looking at regional capability building so that our people can come to Orange, if we've got a vision to expand our dental space, our oral health space, to have access to orthodontics, implants for our people that are cost effective, cost manageable, having oral surgery, cancers, and the cosmetic stuff as well - right? Young people don't want to have dentures, but if we're offering extractions, bridges and crowns and all the other stuff, then why aren't we working with the LHD, the Centre for Oral Health, around access to orthodontics, whether that's regional - so, say for instance, yes, of course, I'm going to push my service, I would love to have an orthodontist that could come out and we could have referrals from other AMSs in our region. We won't be able to build capability of all the AMSs but if there is an AMS that wants to do it, has the ability and infrastructure to do it, why aren't we doing it?

So funding of this - this should not be focused on pulling our kids' teeth out or for young women who are victims of domestic violence or people who play sport

losing their teeth, just putting a denture or whatever they can put in there - why aren't we offering good dental care?

If we want change, then we've got the ambition to be able to do it, but we're lacking in costs. Once again, it comes back to our clinical services; right?

The LHD can't provide all of that either. They're not in a position to provide the other wrap-around support services that our sector can do. If we're talking about under the "Close the Gap", building capability or transition or capacity building, then you've got to start putting your money where your mouth is, because we won't touch it unless we know it's going to be available to our people on the long period.

Don't say, "Oh, we've got some trial funds in. We can probably set up a visiting orthodontist for 12 months". Don't bother us, mate. One thing that has to happen with our people is constant care, so we can have health outcomes. So dental, but all the services, not just a dentist and an oral health therapist, but having access to orthodontics, you know, oral surgeries. If we've got oral cancers out there, why aren't we availing our people of that?

It's what we did years ago with chronic care. If you had a particular issue around somebody's illness, if it's not just - if it's intervention, prevention, treatment, management, but also tertiary, then we're not going to provide good care to our people. For our organisation, it's is talking about birthing to dreaming, so when they come in and when they leave.

No AMS caps our books or discharges people. We discharge them when our people leave to move out of town or they leave this earth. So we have the whole of the lifecycle with our mob, the ones that choose us, and more and more are, even with the limitations of what we have now.

I would love to think that we could be able to provide all levels of health care to our people, in collaboration with our key partners, so that when we're talking and sitting down with our people, they are prepared for a health journey where there's no gaps. That's the ideal - so then we have connection with our people, that our

relationship, our doctors, nurses, specialists have with our people.

If they go and visit them in the hospital, without any fear from anybody else thinking they're going to look at the chart at the end of the bed, just to maintain contact, then I think we're going to reduce discharge against medical advice. Our people will get the care they require in the acute setting and it's followed up with us before they leave the hospital - not getting a summary and we're chasing them up two days later. Gaps are so important - that there isn't a gap. So if we're there as part of the discharge planning with our people, wouldn't that be a completely different approach?

MR LESTER: It's the same with oral health, we're only funded for 75 per cent of the actual dental bill, they won't fund you for the full amount. So, I mean, we started - we kicked off dental a number of years ago. Initially it was funded out of generated income and then the Centre for Aboriginal Health gave us funding for practice. But as I say, they only fund based on Veterans Affairs rates. So you've got to make that difference up. If people on low income come and they want dentures or whatever, we've got to ring the LHD and get a voucher for them for that to happen.

MR MUSTON: And then they have to find a dentist who will accept that voucher.

MR LESTER: Yes.

MS T LAYER: We had a program set up in our old premises. We were donated a van that had two dental chairs in it that was with the Newcastle University. We had oral therapists doing placement and we had a senior oral therapist with a provider number and one dentist that would come out two days per month, which means we could bill some of it.

However, when we moved into the new premises, we had all that arranged, we even had some of the mining industry wanting to pay per patient to it, but we just couldn't find the funds to pay 250,000 for the dental chairs. We tried everything but we just couldn't do it. So we had the model but we couldn't get the funds; because dentals sits so far out from health. We just couldn't get any of the funds to do it. Again, agreeing with Uncle, we provided something

to the community and then we had to take it away. We wouldn't start it again unless we knew that we could continue doing it.

THE COMMISSIONER: Does anyone else have something further they'd like to say?

MR RAUDINO: Training. Training of the mob, trying to get them upskilled. Specifically, you know, in our social and emotional wellbeing area, that mental health work that we've identified, AOD workers. We struggle to find quality. People apply and want to get into the field but they're coming in with no skill set. We know it's a really challenging field, so we need people to upskill, so we're struggling to find them. So how do we make it more affordable to train, more accessible to train up community? Perhaps a pathway sort of thing.

MR NEWMAN: We are dependent on externals, not building our own internal capability. In no contract is there workforce development funding, yet we've got to develop our people. So for an allocation in every actual - we don't like talking about budgets, because budgets are a pain - in an actual, is a workforce development budget allocation, so we're not reliant on Medicare. There should be - we've got a service, we have 140 staff working for us - an allocation to be able to access the development of our own people.

If we're going to bring in young Aboriginal people, or young non-Aboriginal people into our workforce, we've got to develop them without them having a debt, because nobody wants to have a debt when they come into the workplace, but that's what our people are looking at. If we want to train our people beyond one year so they go from an Aboriginal health worker to an Aboriginal health practitioner, 12 months of training, that's risky. We need to put our people so they're equivalent to anybody else that works in this health system, so they can be practising clinical care for our people, independently. But you need money to do that.

We've got to toss up whether we develop the workforce or provide clinical care to our people. So we're stuck between a rock and a hard place. We're reliant on externals. If you send them to be any training RTO it's going to cost you. So how do we manage that? So it's still outputs. Health outcomes, you develop your

workforce, everybody has plans around succession but we don't have the money to be able to apply it, so we're at the beck and call of others.

We say to anybody who works for our organisation, doctors included, that we would love you to learn this new procedure, but who is going to pay for it? If a nurse needs new trends and patterns in health care delivery, we want to be in front of that so it enables us to be the most professional that we can be. There's always dollars attached to it. That's what we're faced with. Yet we've got to run what we've got, expand the workforce, get health outcomes, but the budget hasn't changed. That's madness.

MS T LAYER: And it is also, from a business point of view, mitigating risk, it's like what Caine said about building resilience in the workforce and enabling, so they're properly skilled, otherwise, they're going on mental health claims and workers comp because they're so stressed. And we do everything we can, we've got wellbeing days, we provide EAP, everything that we can to support them culturally, so they are culturally safe, but also their emotional wellbeing. So the risk it's putting on business now because of all the increased workers comp, because, you know, it's just - it's grinding businesses into the ground, you know?

How do you mitigate against that, you know, when someone - it can be now - you know, if you go to a forum in icare and it's someone's perception of what they feel they're feeling at the time, how do we mitigate against that from a business point of view and build up the resilient workforce in that sense?

MR RAUDINO: We had an audit, we had VACCHO come down and undertake a wellbeing audit as such, because we had so much sorry business in the community, you know, and stuff with the staff, so there were recommendations, "Oh, you need this particular" - you know, so we employed a people and culture worker. Where is that funding coming from? Us. Medicare dollars.

We're forever propping up our back-of-house staff from our own - we generate Medicare dollars, we never get the opportunity to put them back into the community because you've got to pay HR, people and culture, you've got pay your quality workers and WHS coordinators and, you know --

MR NEWMAN: All the corporate stuff.

MR RAUDINO: Corporate stuff for us managers. We're not funded. It's great, you know, we need those positions, but my belief is you're either really small so you don't need any middle management and stuff like that, or you've got to be really large so that you've enough got overheads to cover. But most of us are stuck in the middle, fighting for survival and fighting for extra funding. But you'll never get money for back-of-house services.

But without the admin team, we wouldn't function. Without transport - I run a transport team as well. We've got 3.5 or 3 and a casual, but we've still got to pay the local taxi companies four or five grand a month because we can't keep up because, you know, you've got to run everyone around.

You know, everyone's needy. It's quite a large area and we've had to cap, you know, the area. So we've got a certain amount of kilometres. We haven't got services like these fellows that go up to Melbourne, as such. "Oh, yeah, I need to go there for a specialist," and you've got to, you know, twist the manager's arm to get a $10 train ticket. So these are all --

MS T LAYER: And accreditation.

MR RAUDINO: What did I tell you we've got? Seven accreditations. RACGP, NDIS, mental health, diagnostics, NSQHI, QIC, ChildSafe, Standards New South Wales and we're going for another one. One accreditation worker. Overworked to her eyeballs. Like, I know our managers, we do a lot of work as well, but it is a lot.

MR C LAYER: I think you have to look at, too, like the AMS, Aboriginal organisations, the business model is very different. For example, I might start a business selling pies on the side of the road, my aim is to sell as many pies as I can to make a profit and earn money. We're driven by the needs of the community. So there's a lot of this up and down and fluxes, it's a very flexible environment. So we don't actually - we don't exist to make a profit and build a new home or a new car or whatever.

An AMS or an Aboriginal organisation is purely and

simply there for the needs of the community, and those needs will grow and diminish at different times for different things. So we've got to be extremely flexible. But the funding models that we have to work against are very rigid, there's no flexibility. They don't take into account, you know, the business model that we work with, and, you know, we've got to be very creative. I think everyone here will agree, we've got to be extremely creative sometimes to make it work, and we do make it work, but, you know, those who provide us with the funding don't always get that; it's just, "Well, here it is, there's the guidelines", it's like that; it's just a square box. "Whatever you've got, squeeze it in there."

And we do make that work, but I think there needs to be acknowledgment of flexibility, the nature of what we do is really needs driven, and that will change all the time and constantly, and we've got to change with it, and having the ability to do that financially as well, so that we can sustain that model moving forward, you know, consistently.

MR MacQUEEN: I'd just like to agree with that. In all the funding we get, there is never any funding in there for training and education. We are really short of AHPs on our footprint. We've tried to work with TAFE and tried to work with AH&MRC, which was a waste of time. So we are now negotiating with Wollongong University to run a course in Bega, face to face for our staff. So I've got 15 to go into that program. Where the funding comes from, we're still trying to work that out. How we fund it, we're still trying to work that out, but we're going to do it.

MR DUROUX: A little bit off topic, but something that concerns a couple of AMSs that I work closely with, particularly in northern and western areas, we previously used to rely heavily on organisations such as RACGP and ACRRM to recruit our doctors and qualified medical staff that needed to be placed rurally for either a two-year or five-year stint, we would rely heavily and be a receiver and also feed that out further west to AMSs to have qualified doctors and staff for a term.

Those entities, however, have recently, in the last 12 months, declared Western Sydney suburbs rural, so now all of these trained GPs and health practitioners, to do their rural stints, they actually go to Western Sydney, they don't make it beyond Tamworth, they don't make it to

Moree, they don't make it to Walgett. For me, that's a real concern.

MR NEWMAN: Western Sydney is rural?

MR DUROUX: Western Sydney is considered rural when you do make those applications.

MR NEWMAN: We might have to start saying Western Orange is Sydney.

MR DUROUX: They don't even have to leave Sydney anymore.

MR MUSTON: We did get some evidence along the way in Broken Hill, I think, that said they have the same remoteness rating as Katoomba, from memory, and Byron Bay. So not to say that both Katoomba and Byron Bay have their own significant challenges, but from a remoteness point of view, I don't think they could really compete with Broken Hill, but, nevertheless, for the purposes of certain funding decisions, they are all the same.

THE COMMISSIONER: All right. No-one else? Anything further?

MR NEWMAN: I think, finally, we can't expect money to come from the ministry if the money isn't going to the ministry. So treasury, or whoever holds the vault, loosen the doors so they get it and they can disburse it, because it's not them - we know it's not them that can't give us money: they can't give what they haven't got. We've come up with ideas, suggestions, plans and proposals, they hear it all the time, but they don't have access to the vault.

They've got to work off what they've got and then what we get is what they have, so it just isn't us with NSW Health, it's who controls the funds. They don't get it, they're not going to get it, we're never going to get it.

THE COMMISSIONER: The vault's working on a historical model.

MR NEWMAN: We hear a lot of history. We hear a lot of history.

MR MUSTON: But accepting that that's an important

point --

THE COMMISSIONER: It is.

MR MUSTON: -- the amount of money that's currently travelling from the vault into the ministry is being distributed and prioritised in historical ways as well, potentially, which it ought not be assumed - and I invite you to disagree with me if you want to - that if no more money is coming into NSW Health, that we should continue to do business as usual without potentially changing our ways to distribute more of that money towards AMSs if, as part of the service planning, that would produce better health outcomes for communities.

MR NEWMAN: They are calling for innovation. Let's do innovation. We're innovative people. Open your door and these guys can - they've got their door open to us. But where the money is, that door's locked. But they still want innovation. You can't expect capability, innovation, capacity, without investment and funds. Eight knew targets on the existing targets for "Close the Gap" without additional money? Something's missing here, mate. Anyway.

MR LESTER: What I'd like to see is a list of all organisations who receive health funding for specific areas and what they receive it for, and I will give you a classic example. I went to Condobolin 18 years ago, the local Lachlan Shire Council had 175,000 to employ a doctor. I went back to them and said, "I've found a doctor, can I have the money", they turned around and said, "No, we're going to put that into our owned health service and renovate it." And that's the type of shit you've got to put up with these days.

So a list of all the organisations that receive funding for Aboriginal health, for your various categories - social and emotional wellbeing, mental health, whatever, a list of those, and I will bet you whatever you like to bet that you will not come up with the answer.

It just makes our job a hell of a lot harder out there when you are doing stuff with the limited amount of money that you have and you see other organisations who receive moneys that they're not really accountable for.

I'll give you another classic example. CatholicCare

are out there. They set up a DV place, they had it all refurbished, in the local Catholic school, and they lost the job. So you've got a completed DV area that is fully set up, security, whatever, and there is no-one running it. Yet we, at Condobolin, would be the fourth highest DV area in New South Wales. Anyhow, that does not go through NSW Health.

THE COMMISSIONER: Well, thank you all very much for coming and we really appreciate the fact that you have given us so much time. We really appreciate the assistance you have given the Inquiry today by sharing your thoughts. So thank you very much for coming, we're very grateful. Thanks.

AT 2.53PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED ACCORDINGLY

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