

**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

1 (Acknowledgement of country delivered by Mr Grant Cameron)

2
3 MR CAMERON: Yaama, everybody. Hello. My name is
4 Grant Cameron, a proud Gamilaroi man and chief executive
5 officer here at the NCIE.
6

7 First and foremost, I'd just like to kick off with an
8 acknowledgment to country, so acknowledging that we are
9 meeting here today on the beautiful lands of the Gadigal
10 people of the Eora Nation. I just always like to show my
11 sincere respects to Elders past, present and emerging.
12

13 Obviously lots of mob in the room, so acknowledging
14 everyone in the room and the lands where they come from,
15 and our non-First Nations brothers and sisters who are our
16 allies who help us to do all great the work that we do.
17

18 I just always also like to acknowledge that this
19 always was and always will be Aboriginal land. So welcome
20 to NCIE.
21

22 A little bit about the centre. We're a First Nations
23 not-for-profit charity. We've been here for 16 years.
24 Our whole purpose is to serve the community in many ways,
25 every way that we can. We have a strong focus on our kids,
26 our youth and also our Elders.
27

28 Lots of programs happening here that, you know, we
29 fund and that we seek grants for - after school programs,
30 school holiday programs, youth events on Friday evenings.
31 We collaborate with the local police and other key
32 stakeholders in the area to try to get kids off the street.
33 Due to us running those events we've seen crime rates drop
34 in the area. Kids are engaged in sport more, healthy
35 routines, healthy lifestyle. Lots of stuff with our
36 Elders, AMS and Wyanga, so, you know there's always Elders
37 here on site.
38

39 Obviously the fitness and aquatics is our main source
40 of revenue. We have over 1,000 members in the gym, 400 are
41 Aboriginal or Torres Strait Islander; about 450 members in
42 the pool, about 100 are Aboriginal or Torres Strait
43 Islander. So really for us, it is all about, you know,
44 health and wellbeing.
45

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

1 you continue?

2

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

5

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

14

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

33

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

45

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

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

4
5 I think that's it. Have I forgotten anything?
6

7 MR GRANT: No, that's a lot. That's great.
8

9 In the whole time that NCIE has existed, we've never
10 had that type of support here on site, so I think it's
11 crucial to have Cass join the team, as I said, trying to
12 offer that real holistic wrap-around support to our
13 community.
14

15 I would like to thank you for choosing NCIE as the
16 venue today. All the revenue that we get from the
17 conference base, from our membership, from the
18 accommodation and everything all goes into community to
19 help us keep running the programs that we do, so I would
20 like to say a huge thank you for choosing us.
21

22 I'm not sure if you notice but around the room we've
23 actually got an art roadshow here at the moment. The art
24 comes from a gallery up in Brisbane called the Birunga
25 Gallery. It runs a cultural creative development program
26 for emerging artists. This is, like, some of their artwork
27 around the room. So if anyone's interested to purchase
28 that, we get 20 per cent of the proceeds, which will go
29 straight to our children's services. So, you know, in the
30 lead-up to Christmas, if you know someone who is looking
31 for some art, there is some beautiful art around the room.
32 All the information is on the cards underneath.
33

34 Enjoy your stay here. Thank you for choosing NCIE and
35 thanks for having us this morning.
36

37 THE COMMISSIONER: Thank you, thanks very much.
38

39 Good morning, everyone. My name is Richard Beasley.
40 I'm the Commissioner of this Inquiry. This is Ed Muston,
41 who is senior counsel assisting, and there are other
42 members of the team here and also some representatives,
43 including legal representatives, from NSW Health.
44

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

1
2 This Inquiry has been going for about 14 months now
3 and we have travelled to every LHD in the state, including
4 the regional LHDs. We've spoken with some of you, and
5 we've certainly spoken to a lot of your colleagues.
6

7 Most of those meetings have been meetings like this,
8 where we sit around and discuss issues that are important
9 to you. We also had some roundtables yesterday with some
10 of your colleagues who weren't able to travel to Sydney,
11 and they were held remotely.
12

13 I don't want to set the agenda about anything you
14 might like to raise, but I will say a couple of things
15 about the themes that have been fairly consistent in our
16 travels, particularly our travels in regional New South
17 Wales.
18

19 We've got a good idea of the services you offer and we
20 have a good, I think, appreciation of how important your
21 entities are to your communities and your people. These
22 are some of the things your colleagues have raised with us
23 or you have raised with us: in relation to funding, often
24 there have been concerns raised about the short-term nature
25 of some funding and the impact that has on workforce and
26 retaining staff.
27

28 I also think there's been a common theme that money
29 allocated to Aboriginal people should be in the control of
30 Aboriginal people, and there is often not enough autonomy
31 or trust about where you see the money would be best spent
32 in relation to the services you provide.
33

34 There have been some general workforce issues that are
35 actually, in relation to regional New South Wales in
36 particular, fairly consistent, no matter who we're talking
37 to, whether it's the LHDs, whether it's an AMS or an ACCHO,
38 or whoever, about the difficulty of attracting and
39 retaining staff in rural areas.
40

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

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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

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

10
11 We'll only learn that from you speaking really
12 directly to us, as freely as you feel comfortable. So
13 I hope do you that, because one of the main aims of an
14 inquiry like this is to be an investigation into truth.

15
16 MR MUSTON: Those of you who I have spoken to in our
17 travels, I am pretty comfortable that you will be pretty
18 frank and forthright in the expression of your views.

19
20 Perhaps the best way to start, though, is for us to
21 just perhaps go around, identify who you are, the
22 organisation that you're from and the rough footprint of
23 the state that you provide services across and the sorts of
24 services that your organisation provides.

25
26 MR DUROUX: My name is Kevin Duroux. I'm the deputy CEO
27 of the Tamworth AMS. We provide GP services. We have nine
28 full-time GPs, 21 visiting specialist services and mental
29 health and social and emotional wrap-around services.

30
31 MR RAUDINO: Caine Raudino. Office manager, Albury
32 Wodonga Aboriginal Health Service in Albury. We cover
33 Albury Wodonga. We've actually got five offices, so we've
34 got quite a large footprint in that area, New South Wales
35 and Victoria. So it's a bit unique. We're able to tap
36 into both sides of the river, state funding, so that is
37 quite unique.

38
39 We started out as a clinic 15 years ago. Now we have
40 morphed into basically full wrap-around services,
41 everything you can think of barring child protection
42 services and housing, and that's only because it's too much
43 to sort of say. We've got about 4,000 patients on our
44 books, so it's quite extensive.

45
46 We've got a similar amount of GPs, a few registrars.
47 We're a bit lucky in that sense. Yeah, so very fortunate

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

5
6 MR MUSTON: While you've got the microphone, I might just
7 ask you a couple of questions. You say you have 4,000
8 patients on the books. To what extent do you think the
9 services that you are able to offer within the funding
10 constraints you currently have enable you to actually meet
11 the needs of the First Nations population in your
12 footprint?

13
14 THE COMMISSIONER: I remember you telling us about
15 increasing wait times just for primary care clients.

16
17 MR RAUDINO: Yes, if you take our lead GP, or any GP,
18 we've got a 10-week wait, you know. As much as we're
19 fortunate enough to have a few GPs, the service is only -
20 you know, it will come up, everyone talks about funding.
21 They give you funding, but where's the capital funding to
22 come with that to expand your service? We would love to
23 have more GPs. We would love to have more services to meet
24 the community needs, to cut down the wait times, however,
25 we've got nowhere to sit people, and that's the reality of
26 it.

27
28 You know, we can get the funding to get more GPs or
29 get more services in our SEWP team, however, we just
30 haven't got the space. Our wait times are quite extensive.
31 Then if a GP has a sick day, I mean, you know, the
32 community ring up, it's the end of the world. They are
33 human, they have sick days, they have families, but then
34 they've got another 10-week wait.

35
36 THE COMMISSIONER: What's driving the extension of those
37 wait times? First of all, 4,000 people, obviously over the
38 years there's been an increasing awareness of the services
39 you offer, but otherwise, is the GP market generally
40 thinning and the bulk-billing market generally thinning; is
41 it ageing; is it population increase; is it a combination
42 of all of those things?

43
44 MR RAUDINO: Bulk-billing, that's, you know, the elephant
45 in the room. We're one of the only services that
46 bulk-bills, so now everyone becomes Aboriginal. You know,
47 everyone wants to jump on board and get a free service.

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

5
6 Our lead GPs won't see any new community members. We
7 get a lot of registrars, so there's no continuum of care.
8 So, you know, the mob want to see someone and don't want to
9 tell their story to four different GPs or four different
10 SEWP workers; they want to tell their story to one person,
11 get that continuum of care so that they feel comfortable
12 and it's better to make connections. So that's a big
13 issue.

14
15 Registrars are good, yeah, great, but you only get
16 them for 12, 24 months. We might get a casual locum float
17 in, float out, and they're really good, they're really
18 friendly, but they're here for six weeks, you know? So
19 that's the issue.

20
21 And then GPs go - our lead GP recently reduced his
22 days from five days to three days and took a job with the
23 army, so - you know, that's for two days, because of the
24 remuneration. That will come up too, no doubt.

25
26 MR MUSTON: So I've noticed, Kevin, you have been nodding
27 enthusiastically through most of that. I gather your
28 experience in Tamworth is pretty similar; would that be
29 fair to say?

30
31 MR DUROUX: Yes, very, very similar to what's been
32 described there, particularly having to compete, you know,
33 for remuneration, to be able to secure GPs that can be
34 stable in the service to create that kinship, I guess, and
35 that friendship that we ask them to have with patients,
36 yeah.

37
38 We, in Tamworth, provide a lot of services that
39 Aboriginal people prefer to source from an AMS. We're not
40 entirely funded for everything that we provide.

41
42 MR MUSTON: What sorts of services, just in general, fit
43 into that category of things that your community is wanting
44 to get access through the AMS but you're not really funded
45 to deliver?

46
47 MR DUROUX: A classic example of ours is the transport

1 service we provide.

2

3 MS L BELLEAR: Tell us about it.

4

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

9

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

13

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

15

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

22

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

32

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

36

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

46

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

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

3
4 MR MacQUEEN: No, it's the first. We can't find someone -
5 when we have found somebody interested, they wanted us to
6 pay \$350 an hour, so we weren't interested.

7
8 At the moment, on that space, I'm working with
9 Coordinaire and ForHealth, who have dental rooms
10 nationally, and they're to work through, I guess,
11 a possibility of coming down south with our dental program
12 down there.

13
14 We have mental health services, chronic disease, eye
15 and ear health, women and men's health, drug and alcohol,
16 patient transport. We go up and down the coast taking all
17 our members, community, to appointments - to Canberra, to
18 Nowra, to Sydney. So we have 2.5 FTEs in that space.

19
20 Yes. Funding from our point of view, we like dealing
21 directly with the feds and the state government with the
22 funding, it's more direct and it all comes to us. It maybe
23 the same everywhere, but down on our footprint, there's
24 a whole lot of other organisations that get government
25 funding for Aboriginal services. They obviously take their
26 administration costs off the top and then either get us to
27 deliver the services or try and find them themselves. They
28 get resources. There's so much funding down there for
29 Aboriginal services --

30
31 THE COMMISSIONER: This is like NGOs are getting the money
32 but then --

33
34 MR MacQUEEN: Yes, they're very good at getting funding
35 particularly from the Federal Government, but they also
36 come to us for us to help them provide the services.

37
38 But their administration - I mean, finding Indigenous
39 workers down there is really difficult, because you've got
40 all these other players in the field, and they also offer
41 higher wages than us. I mean, we struggle to keep our
42 team. I think I have said enough.

43
44 MS T LAYER: Good morning. I'm Taasha, CEO of Ungooroo
45 Aboriginal Corporation. I'm based in Singleton, Hunter
46 Valley. Our traditional owners are the Wannaruah people in
47 the valley. Ungooroo is celebrating its 30-year

1 anniversary this year, which is amazing.

2
3 We're an ACCHO and I'd like to reiterate everybody
4 else's sentiments around the struggles with, you know, GPs,
5 and I think one of the things - we've got four GPs, we're
6 lucky to have two Indigenous GPs in that, so they are very,
7 very booked all the time.

8
9 I think the struggle is they're reducing their days
10 because they are getting burnt out. Mental health care
11 plans are now our predominant thing that they're dealing
12 with. They call it "heavy patients", so I think it's
13 putting a strain on the GPs in that sense.

14
15 We have a good SEWP team.

16
17 THE COMMISSIONER: "Heavy patient", I take it, is someone
18 with complex problems?

19
20 MS T LAYER: Yes, mental health.

21
22 THE COMMISSIONER: You can't address it in six minutes;
23 you've got to really --

24
25 MS T LAYER: Yes, and I think it is the balance, because
26 it is bulk-billing, however, we really pride ourselves on
27 taking the time in longer appointments so it's that quality
28 of care for mob and community as well.

29
30 THE COMMISSIONER: Someone was telling us yesterday, when
31 certain grants are looked at, you know, you've got to
32 report, you might say a certain number of patients, and the
33 bureaucrat is only looking at the statistic of the number,
34 whereas one of your colleagues was saying, "But hang on,
35 that patient, I know, took an hour", or "This patient
36 actually took six hours because it was such a difficult
37 issue", and there's an imbalance between just looking at
38 a stat and actually what you do is provide a service, not
39 try and create statistics.

40
41 MS T LAYER: Yes, exactly, you know. Then you've got the
42 admin team, because they're running so far behind, they're
43 struggling, and things like that. So it's not just as
44 easy, I think, as a commercial surgery where you would be
45 10 minutes, you know, 10, 15 minutes, and they're just sort
46 of pushing it out. We have a very different model, but it
47 is putting a strain on the GPs.

1
2 We've got a partnership with ACRRM and RACGP. We've
3 just had a placement for another registrar coming in, and,
4 you know, we're looking at that alternative. But again, fi
5 they're cutting their hours, part time, it reduces the
6 clinical supervision that they can provide, so it reduces
7 the days that we can offer for the registrar, particularly
8 if they're a T3. So there are those sorts of things that
9 they're very strict on on-site supervision in that
10 circumstance.

11
12 You know, we've got our AHP, registered nurse, the
13 clinical support team around that, and we're really trying
14 to build up our SEWP program, which is funded under the
15 ministry, for suicide prevention and to support those, you
16 know, internal referrals into those more non-clinical
17 programs.

18
19 We're a registered NDIS provider as well, so again,
20 there's a lot of internal referrals sort of happening.
21 We've got a contract with Rural Doctors Network so we
22 provide allied therapies.

23
24 We really struggle with psychology. You know, we have
25 psychologists who we're trying to interview, they're 300,
26 350 an hour, more than what the GPs are even charging. If
27 you combine NDIS and even the funding, we can't cover the
28 cost of that psychology service, you know? So it really
29 falls back again on the GPs and what they can provide.

30
31 We have OT and exercise physiology, so there's a lot
32 of internal referrals from NDIS for that. Then we've got
33 other contracts, a specialist homelessness service with DCJ
34 and we've got Barranggirra , and Craig is the contract
35 manager for that, but that area covers from the Hunter
36 Newcastle area, right up to the Tweed. So that's a massive
37 footprint. We've got remote workers from the mid north
38 coast and north coast that cover it.

39
40 We did have a PSP program, out of home care. We
41 actually terminated that contract - we had it for two
42 years - purely because we couldn't staff it. It was
43 putting the kids at risk. We could not staff qualified
44 caseworkers in that area, so the board made the decision to
45 terminate that in June.

46
47 MR C LAYER: My name is Craig. I'm the chief operational

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

5
6 So the other programs that Taasha mentioned, I look
7 after the management of those, which is mentoring
8 apprentices/trainees, but also trying to create other
9 business arms that we can utilise to generate income to
10 come in and service or support the ongoing sustainability
11 of the medical stuff and the range of medical services that
12 we do provide.

13
14 That, in itself, becomes a challenge, because any
15 small business, no matter what it is, is a challenge. It's
16 getting traction in those different things that we create
17 so that they actually don't become a burden to what we're
18 trying to achieve, but help support. So, you know, we're
19 trying to be proactive to create things ourselves, but
20 again, it comes back to the funding and whether it's
21 adequate, the way it is managed, the way it is, I guess,
22 given out to AMSs and other Aboriginal services, to ensure
23 that we don't have to keep, you know, trying to create all
24 these other things and, in a sense, creating extra burden
25 on the overall business itself.

26
27 When they work - you know, for example, at the moment
28 we do things like work-wear and PPE. Being in the Hunter
29 Valley, that's not a bad thing to be focused on because of
30 the mining and construction, civil construction and so
31 forth, but it's a very competitive thing as well. So we're
32 not just a small operator, we're a very small operator in
33 comparison to the competition, but it's all these little
34 things that we try and create to assist with the
35 sustainability.

36
37 But the core of it really is just how that funding is
38 farmed out, managed, so we can utilise it to its best
39 effect, so that our clients, our community and patients,
40 are being cared for effectively.

41
42 MR MUSTON: In terms of your operations, to the extent
43 you're able to earn that revenue through these other
44 businesses where they're working and effective, what does
45 that buffer of completely untied money allow you to do -
46 that is to say, it's not tied to any particular program,
47 that's money, I assume, that just goes in that you can use

1 at your discretion for the operations of the service. What
2 does that allow you to do that you couldn't do if you
3 didn't have that parcel of untied money?
4

5 MR C LAYER: I guess one of the things is staffing,
6 ensuring we have the right people, adequate staff, but even
7 resources, you know, like, just making sure we have
8 resources. It was mentioned before about transport.
9 Transport is an issue for everyone in the room when it
10 comes to ensuring we can get our mob to where they need to
11 be. So, you know, there's no real definitive answer to
12 that other than whatever we can do to support in regards to
13 keeping those core services bubbling along and building.
14

15 One of the things that we have done, Taasha's been the
16 main mover of this, of course, is we're currently in the
17 process of establishing a specialist unit within Ungooroo.
18 That will attract different specialist services,
19 cardiology, paediatrics, et cetera, ear/nose/throat, all
20 that sort of stuff, so it cuts that travel distance and
21 access to specialists for our mob as well.
22

23 So we're just always trying to improve what we've got
24 and find more things that the community needs to have
25 access to. So there are other little things that we try
26 and create and build around it. Again, it doesn't provide
27 a lot but it provides something that can just support what
28 we've trying to achieve.
29

30 MR LESTER: Cecil Lester from Condobolin Aboriginal Health
31 Service. We have our primary health care, which is funded
32 by the Commonwealth. We have a dentist, social and
33 emotional wellbeing, mental health, which are funded by
34 NSW Health. We have two full-time doctors, one who has
35 been with us for five years, and we have a female doctor
36 who does three days a week and she's funded out of
37 generated income.
38

39 Our dentist, we have a full-time dentist, we have
40 a full-time dental therapist. We have four social and
41 emotional wellbeing workers, they're all more recent.
42

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

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

2
3 An example is we needed a dentist out there, so we
4 bought the old Westpac bank, we converted that over to
5 two-chair dental, with accommodation upstairs for students
6 from Charles Sturt University who spend time with our
7 doctors and nurses and clinical staff. We've put over
8 \$1 million in generated income into setting up the dental.

9
10 Pretty much the same thing with social and emotional
11 wellbeing, we bought the old fire station and converted
12 that over. We got a funding grant from NSW Health to help
13 with the renovations.

14
15 We're on to our last building now, which we bought out
16 of generated income and we put in for a loan, funding from
17 the Commonwealth, for 270,000, they gave us 124,000, so
18 we've got to come up with the difference.

19
20 The Commonwealth funding hasn't changed. I've been
21 there 18 years, the Commonwealth funding hasn't changed,
22 except the CPI increases, and if it wasn't for NSW Health,
23 we wouldn't be able to do the other services that we do.

24
25 Another big problem we have is we're the only medical
26 service in town. The other council-run health service
27 folded a long time ago, and they don't have a doctor at the
28 Condobolin hospital. So a lot of it falls back on our
29 staff.

30
31 Also, other organisations are funded to run programs
32 in the area, CatholicCare is a prime example. We find that
33 a lot of the issues, they don't deal with, so my staff in
34 social and emotional wellbeing and mental health have got
35 to deal with those issues.

36
37 DV is another area we have taken on board. Mental
38 health, social and emotional wellbeing and DV is only going
39 to get worse over the years.

40
41 We run a program for school kids for breakfast five
42 days a week in which they can have a proper meal, and at
43 least I know for five days they've got something to eat.

44
45 Not long ago, one of the young girls turned up with
46 her brother and sister and we said, "What did you do on the
47 weekend?" She said, "We slept on the steps of the Catholic

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

3

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

6

7 MR LESTER: The primary health care, yeah.

8

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

11

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

17

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

28

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

30

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

33

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

38

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

41

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

45

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

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

7
8 THE COMMISSIONER: When you say, "they don't come out and
9 listen", is it that you've invited them to have
10 discussions --

11
12 MS L BELLEAR: No, they've invited themselves but never
13 turn up on the appointment day, which I think is very rude.
14 I've had several meetings over the years, pre-COVID, and
15 I'm yet to still meet up, you know, with the state
16 director, God bless their soul. But, you know, that -
17 because how do you listen? You know, I had a couple of
18 years back, there was someone coming out, reviewing the
19 mental health policy for NSW Health. I don't think they
20 even read the document. When I brought up a couple of
21 issues, they, you know, didn't want to listen, didn't want
22 to --

23
24 THE COMMISSIONER: This was at some particular meeting in
25 relation to --

26
27 MS L BELLEAR: No, they'd come to interview me. So, you
28 know, I quickly read the document and went hell for
29 leather, but, you know, that's no use to us, if the
30 recipient of that information hasn't read the document, so,
31 you know, that's just wasting my time, unfortunately.

32
33 But, as you said, "Do you have a long waiting list?",
34 we have the luxury of if our waiting list blows out to
35 three or four hours, we have complaints. So, you know, we
36 don't have an appointment system, which could be some of
37 the issues, even though our doctors do want an appointment
38 book rather than walk-ins, but that's not how the AMS was
39 established in the first instance, so it is historical that
40 we remain a walk-in. So we can see anything up to one to
41 two hundred patients a day.

42
43 You know, sometimes it does put a glitch in the system
44 if there is someone there that, you know, we have to spend,
45 you know, a couple of hours on. But it is what it is. You
46 know, we pay our GPs very well, so they just need to suck
47 it up and deal with it. You know, we manage with a kind

1 manner as well. I say that tongue in cheek. But, you
2 know, I think at the end of the day, where we can afford to
3 provide luxuries or thank yous, then we do that as well.
4

5 And that brings me to another issue, which is the
6 workforce. So we have a partnership, metropolitan local
7 health partnership, with three districts and two networks,
8 hospital networks.
9

10 Now, one of their KPIs is to increase Aboriginal
11 employment, and I think it's 3-point-something per cent, so
12 that's a burden on us because all our trained staff and our
13 staff that we've held on to end up going over to the local
14 health districts or the hospital networks, because they get
15 more money. We can't match what they're giving. You know,
16 our staff want to have a flexi-day and all that. We just
17 can't afford to do, that because if one person's off, then
18 that program or service doesn't run, and that's not fair to
19 the patients as well.
20

21 THE COMMISSIONER: Can I just explore something with you
22 in relation to your idea or suggestion that an Aboriginal
23 person should be on the board of the LHDs?
24

25 MS L BELLEAR: Yes.
26

27 THE COMMISSIONER: I was in a royal commission a few years
28 back - I wasn't the commissioner - but the commissioner in
29 that made a recommendation that there be two First Nations
30 people on the board of the Murray-Darling Basin Authority
31 for the basin plan.
32

33 The reason he made that recommendation was because he
34 felt - rightly or wrongly, but this was his finding - that
35 the Commonwealth bureaucrats were displaying a tokenistic
36 attitude towards First Nations people and not properly
37 considering Aboriginal water rights and not understanding
38 what proper consultation was and not understanding even
39 what was fully meant by cultural flows in relation to that.
40

41 I can see the advantages of a First Nations person
42 being on the board of LHDs, but I'd rather hear from you as
43 to why you think that would be a good idea, rather than
44 making my own assumptions. So tell me why you --
45

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

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

10
11 I think we've just bastardised community control along
12 the way. But, you know, we can review it, can look at it,
13 you know, and have some sort of model of care that's going
14 to be for all.

15
16 You know, especially out in the rural areas, where
17 they really need a say in what's happening and where the
18 services are going, you know, and it could be a way of
19 working together.

20
21 I know we've got a robust working relationship with
22 the three districts and two hospital networks, because
23 I co-chair it. Mate, there is nothing too small, too
24 little, that I don't bring it to the table, and those CEOs
25 sitting around that room have to come up with strategies,
26 or if it's not - and some things, you know, that I suggest
27 would go around statewide, you know? Like why reinvent the
28 wheel? What's happening with us and with our partnership
29 could benefit other people, you know? Like where the
30 resources are lacking, you know, the hospitals and the
31 districts can support that.

32
33 Going back a little bit further, we used to have
34 "Closing the Gap". There were several KPIs, I can't
35 remember them now, but it's just like the deaths in
36 custody: had they implemented some of those
37 recommendations, we wouldn't be in the position we are now,
38 as a people.

39
40 I think we need to relook at that and what's working,
41 because what's working now is not working, you know? If
42 you're collecting data, as you said, data, that's there -
43 everyone's great on data, mate, as long as the numbers are
44 there, everything's sweet, but they don't really look at
45 how we get there or how resourceful it has taken to provide
46 that, and so that's not looked at. And I think that's
47 where everyone's getting burnt out, you know?

1
2 We also had a couple of years ago, I think NSW Health
3 funded it, it was an executive services management program,
4 I forget the thing, but through the ACHSE, New South Wales
5 branch. That helped develop our up and coming executives,
6 and they had the opportunity to both do some training in a
7 New South Wales health system and also in an aboriginal
8 medical service as well, and it's just about developing and
9 growing our own.

10
11 But because the competition is so great, like, we're
12 vying for the same workforce, and whoever's going to win is
13 the one with the most money, you know, and that's where
14 we're going to fall over.

15
16 THE COMMISSIONER: Yes.

17
18 MS L BELLEAR: That's all we do, is train, recruit,
19 recruit. Have a look through the SEEK. We've got all the
20 ads up there, you know, because it is quite difficult to
21 secure professional clinicians.

22
23 THE COMMISSIONER: Can I just explore one more thing with
24 you, but before I do, does anyone in the room have
25 a different view than LaVerne about what might be the
26 benefits of having Aboriginal representation on the boards
27 of LHDs? Is everyone in agreement or does anyone have
28 a different view?

29
30 MS L BELLEAR: I sit on a board, too, by the way.

31
32 THE COMMISSIONER: Yes, I know.

33
34 MR NEWMAN: Jamie Newman, Orange Aboriginal Medical
35 Service. I support what LaVerne is saying, but two people.
36 Not one, two.

37
38 THE COMMISSIONER: I might have raised two. LaVerne was
39 on one.

40
41 MR NEWMAN: Two, because if you'd have such a - especially
42 for rural, it's such a large area.

43
44 I'd also like an Aboriginal advisory group. You know,
45 two people on the board - you can could have an academic,
46 you can have community people, but you need people who are
47 operating in the health sector on the ground. That can

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

7
8 That's how you have some buy-in at your local LHD
9 level. That's crucial if you want continuation. One
10 person is going to be seen tokenistic, two, we would have
11 a balance, great - hopefully male and female. But having
12 people that then can report to and be held accountable by
13 the advisory group.

14
15 MR MUSTON: Can I ask you a question? With the advisory
16 group, do you think there would be benefit in it having, as
17 essentially mandatory members, a nominee from each of the
18 AMSs or ACCHOs that provide care in community within the
19 footprint of the LHD?

20
21 MR NEWMAN: There's not an AMS in every town, so the LHD
22 has to - I'd ask the LHD to work with - if there isn't one,
23 AMS, if there's no AMS, you've got land councils, you've
24 got other Aboriginal organisations, you've got CAPOs, so
25 talk to those groups about how we have governance. That
26 will keep the LHD accountable and keep the CEO accountable.

27
28 I have a great relationship with the CEO back home,
29 but we need to have KPIs that are monitored by, not just
30 the two board members, the Aboriginal advisory group. That
31 would be the biggest change that we would see, where you'd
32 get a lot more buy-in and support of mainstream working
33 with our sector.

34
35 Where you don't have an AMS or an Aboriginal Land
36 Council, that's where you need to look broader, so I would
37 rest that with the LHD. This Inquiry can say, "This is one
38 of the strategies we're looking at moving forward." It
39 gets them thinking outside the square at the same time.

40
41 THE COMMISSIONER: Keep the microphone, because this is
42 a question for everyone, it's something that was raised by
43 LaVerne. The issue of racism in the public hospitals has
44 been raised before today. We obviously won't solve that
45 today, but yesterday at the roundtable someone said that at
46 Moree hospital recently an Aboriginal person had chest
47 pains and was sent home, an Aboriginal child was taken in

1 with breathing difficulties and sent home, when they
2 shouldn't have been. Obviously that's said to us at
3 a roundtable, it's untested, but that's what we were told,
4 but racism as an issue in public hospitals has been raised
5 with us.
6

7 The use of Aboriginal liaison officers in public
8 hospitals, do people think that's a good model? Some of
9 the - not criticisms of it, in fact, I think it's generally
10 felt to be a good thing, but one of the issues that is
11 raised with us is that, you know, the hospital might have
12 an Aboriginal liaison officer that's employed between 7 and
13 3 or 9 and 5 and then they're not there when Aboriginal
14 people are coming in after those hours, which makes it
15 useless at that time; and also, even if they're there, they
16 may not be in the ED when they're needed, they might be on
17 a ward, so it's sort of an insufficient resource. What do
18 people think about it as a model, if it was better
19 resourced, or is there something else that is a better
20 idea?
21

22 MR NEWMAN: My professional and personal view is that ALOs
23 are an ashtray on a motorbike.
24

25 THE COMMISSIONER: I didn't hear that, sorry.
26

27 MR NEWMAN: ALOs are an ashtray on a motorbike. They're
28 not getting support. We have had Aboriginal people working
29 in hospital systems for years. They are pulled from pillar
30 to post and expected to be everywhere in the hospital.
31

32 Our hospital is a \$300 million facility, multiple
33 units out there, and we've got two people. Now, they are
34 not equipped still or have the authority to be able to
35 challenge people around racism, so you can have all the EAP
36 and EEO principles under the sun, but if they don't have
37 the authority to be able to pull somebody up, then they're
38 an ashtray on a motorbike.
39

40 Racism has not just happened in the last 10 years, it
41 has been happening for generations, yet we've done
42 training, we've had resources, we've had promotions, we've
43 had policies and it still happens.
44

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

1
2 Unless there are ramifications for racism, people are
3 still going to do it. If you are called out as a racist,
4 you're, what - are they banned from the service? Are they
5 put on leave? What are the ramifications to somebody that
6 is a pure out and out racist in the system?
7

8 THE COMMISSIONER: Sometimes there are no ramifications.
9

10 MR NEWMAN: No ramifications. It's, "Well, you know, it's
11 unconscious bias". I challenge that. Our people are
12 leaving at 10 o'clock at night - if our people go to
13 hospital at 10 o'clock at night, they need help. If
14 they're not understanding of the systems and the wait
15 times - and it's us, an AMS, or any other ACCHO, to educate
16 our community on what they're going to expect when they get
17 out there - but if they get out there and they face racism,
18 they're going to leave, and yet it will be documented as
19 "Discharged against medical advice", or "just walked out".
20

21 We don't even look at that sort of data. If our
22 people say it's racism, deal with it. We've engaged with
23 Gerry and the team to have something different, and that's
24 in the works now, it's going to be up to us to practise
25 that. We don't know what that would look like, but it's
26 how it's going to be promoted, saying that we won't
27 tolerate racism.
28

29 Those things have happened over many generations,
30 they've done multiple things, and yet, as LaVerne says, we
31 still have racism in our system. Unless we get really
32 serious about it, people are still going to do it. Because
33 there's no ramification for it. Whilever it's kept
34 internally, our people will not go to the HCCC because of
35 the process of that and because they don't get responded
36 back to. Let's make it a local issue and then have it like
37 the circle sentencing, bring in people from community, say,
38 "This is the case of racism," and let the community, with
39 the systems, deal with it.
40

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

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

3
4 THE COMMISSIONER: Would anyone else care to comment?

5
6 MR RAUDINO: Can I just add from a different point of view
7 with the hospital. The hospital just got, I think,
8 a \$450 million redevelopment fund in Albury.

9
10 THE COMMISSIONER: I thought it was 558 but they forgot
11 the car park. It has to come off the 558.

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

19
20 So with that, this new redevelopment, what input did
21 we have in the design or the implementation of it - an
22 Aboriginal room, ward, whatever you want to call it -
23 nothing. So racism's not just yarning to someone and
24 making an incorrect diagnosis, it's in the background,
25 isn't it?

26
27 You know, we had no say at all. We have basically no
28 relationship at all - it will come up later in
29 partnerships, so forgive me - but we have no relationship
30 with the hospital at all, basically.

31
32 It would be nice, would have been nice, to have some
33 input into the redevelopment. Yeah. "We'll go and do an
34 acknowledgment and put a plaque on the wall to open the new
35 emergency department", which we got an invite to, you know?
36 Tokenistic.

37
38 Yeah, we had no input in anything, basically. So it's
39 disappointing. We're the only medical service in, like
40 I said, 200, 300Ks one way and 400 the other. It's a big
41 area, a big catchment, but we had no input. We're doing
42 something right, so it would have been nice to get a foot
43 at the table.

44
45 MS T LAYER: I was just going to say from a different
46 perspective, in our experience with the hospital liaison
47 officers, the Aboriginal liaison officers - and they are

1 lovely girls - where we find it really lacking, it's the
2 duplication of services, and they only do part roles. So
3 it's almost like they are competing with the AMS to deliver
4 on their KPIs, but it's actually causing frustrations in
5 community.
6

7 An example of that would be we went to Muswellbrook
8 for NAIDOC, so we took a full clinic team, we had a couple
9 of GPs, a couple of AHPs and a registered nurse. We did
10 about 38 715 Aboriginal health assessments on the day.
11

12 They pulled up next to us, set up a tent, and did part
13 715s. So we have Auntie Denise, every year she does an
14 Aboriginal design for the shirt that gets given to all the
15 patients that complete the 715. They didn't have that.
16 But the riot it caused in community, because then they come
17 to us, then we had to redo the whole thing again.
18

19 So there's just this constant duplication of what the
20 AMSs are delivering, but they're not actually doing it to
21 completion or full circle and that's just creating more
22 confusion and more - you know, it doesn't help the
23 relationship because it's almost a competitive stream,
24 which isn't good for, you know, collaboration and those
25 things.
26

27 MR C LAYER: I just go back to Caine's point about when
28 there's a new development proposed and constructed, where
29 we are in the Hunter, John Hunter Hospital's doing
30 a massive extension there at the moment.
31

32 THE COMMISSIONER: Yes.
33

34 MR C LAYER: Cessnock Hospital is another one, Maitland
35 Hospital, we had a brand new hospital built there a couple
36 of years ago, all these sorts of things are happening
37 around us, but the only sort of input from us they want,
38 from the community in the Hunter, is what kind of artwork
39 they want in the corridor and that sort of thing - which is
40 nice, the artists get recognised, you know, it's great,
41 but, you know, where's the input into the delivery of
42 service? Where's the input into, "Well, how do we as
43 a hospital connect to you as an AMS in the community and
44 improve our services when they come in?"
45

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

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

9
10 So bring us in, let us be a part of that system, part
11 of that redevelopment, so the service that's provided is
12 going to be efficient and effective.

13
14 MR LESTER: You have racism in hospital, you also have
15 factionalism in the hospital, where the ALO might be from
16 one faction in the community, another person, who is not
17 well, comes into the hospital, they're asked by the staff
18 if they want to see the ALO and they get the choice of
19 saying "yes" or "no". I mean, I could walk into Queanbeyan
20 Hospital, I can go to Canberra Hospital. Within an hour,
21 I've got the ALO there, irrespective of who he is and who
22 I am, and you know, that should be across the board,
23 otherwise a lot of people - when I worked down in
24 Queanbeyan, I had an ALO at Moruya Hospital. The
25 Aboriginal people down there used to go to her house and
26 say to her, "Glenda, will you come to the hospital with
27 me", and she would go with them, it didn't matter what time
28 of day it was.

29
30 MS K BELLEAR: I'm Karinya, clinical governance and
31 corporate services manager at AMS Redfern. I think LaVerne
32 has covered most of it for us.

33
34 MS L BELLEAR: We could go on and on.

35
36 MS K BELLEAR: Yeah.

37
38 MR ROXBURGH: I'm Josh. I look after mental health, drug
39 and alcohol and public health. Similar with the staffing,
40 we've also got the not-for-profit and the non-government
41 sector and the non-Aboriginal sector that gets Aboriginal
42 money, and we fight for the same staff in the city area.

43
44 Within Redfern there are five Aboriginal services and
45 a whole host of other services that are getting Aboriginal
46 money for Aboriginal people, and we're all fighting for the
47 same person, for our leadership positions and right down to

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

3
4 THE COMMISSIONER: What's your theory on why that happens?

5
6 MR ROXBURGH: We offer a training program, the health
7 worker training program. Once they are nearing completion,
8 they're scooped up. We do further education, trying to
9 retain them and stuff like that, but we can't fight the
10 wage. The ACCHO wage and the NSW Health wage for health
11 workers, there's a massive difference in even starting
12 wage, I think it's about 15 grand. So it is very
13 difficult.

14
15 THE COMMISSIONER: But why isn't the money going straight
16 to you if you are providing the services?

17
18 MR ROXBURGH: We employ them, recruit them, educate them,
19 do all the training, but then they will apply for a job or
20 get headhunted for NSW Health, because they've got
21 employment quotas of 3.5 per cent. So they do a lot more
22 active marketing, even through our partnership, we bring it
23 up at every meeting, you know, "You've stolen another one",
24 all that kind of stuff.

25
26 With the ALOs, you have got - I know when I used to
27 work in health there was one ALO that covered two hospitals
28 that are about 15Ks apart from each other. The ALOs are
29 expected to be across every discipline - maternity,
30 emergency, chronic care, aged care, you know? You've got
31 specialised services and staff in each of those units, but
32 an Aboriginal health worker has to be across everything.
33 So the burnout rates are really high there, too.

34
35 MR LESTER: Just in addition to what my brother said, when
36 you've got your ministers saying, "Less than 50 per cent of
37 Aboriginal people go to AMSs", that's why they fund
38 mainstream.

39
40 THE COMMISSIONER: When I've got who?

41
42 MR LESTER: Ministers. Ministers have been saying forever
43 and a day, "Aboriginal people - not all Aboriginal people
44 go to AMSs." We know that. But it's more than that; it's
45 not less than 50 per cent, come on. That's why they
46 justify equitable distribution of funding. That's why
47 we're in competition not only with each AMS, but with

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

3
4 When ministers continue to say, "Less than 50 per cent
5 of Aboriginal people in any population, where there's an
6 AMS, access that AMS", then we're fighting against that.

7
8 We can provide the data, we can provide models of
9 care, we can provide continuity of care, specialist care,
10 but we still are challenged by this "less than
11 50 per cent".

12
13 MR MUSTON: Can I test an aspect of that. I gather from
14 what you've all told us so far that none of you have
15 periods in the day when you're not treating patients; you
16 are treating as many patients as you possibly can within
17 the funding envelope that you've got and possibly more.
18 Let's accept the premise that that's less than 50 per cent
19 of First Nations people in the community - it might be
20 wrong or might be right, but just let's for argument's sake
21 accept it - is it your view, based on what you know about
22 your respective communities, that if you had more resources
23 and were able to treat more people, then you would have
24 more than that 50 per cent coming in to your --

25
26 MR NEWMAN: Absolutely. What we're saying here and what
27 all my colleagues have said before is, if you - state
28 health is great. We have a great relationship with Gerry
29 and her team and the ministry and other units, but every
30 AMS is funded on a budget - not our budget, government
31 budget. That's always going to be restrictive of how many
32 people we can see.

33
34 Every AMS here is on a waiting period with our staff,
35 for our staff, to get more people through the door. But
36 that's because we're struggling to budget. We're paid
37 1.5 million, some of us, or 2 million, for some of us, yet
38 it costs us 4 million a year to run it.

39
40 So we're very reliant on Medicare, and when there is
41 a GP shortage in this country and GPs - no GP, no Medicare,
42 so if we don't have that resource, then how are we supposed
43 to grow?

44
45 We've got a brother over here in Albury, got a
46 brilliant facility out there, and doesn't even - you know,
47 without any input into what that should look like so we

1 have acute focus on Aboriginal health.

2
3 It happened the same thing at Orange. We had some
4 input into it, but they established something that was
5 completely different to what we asked them to do, to have
6 an Aboriginal unit within the hospital so that our people
7 did not have to sit in the ED, they'd sit in that
8 Aboriginal room, where people are manned 24/7. I know that
9 might be difficult, but that's where we have to get to if
10 we want our people to feel safe out there.

11
12 Resource the AMS sector. It's not difficult. Even
13 when we had the roundtable with the Commonwealth this year
14 and we sat at the table with New South Wales, new strategy,
15 new targets, no new money. They're setting us up to fail.

16
17 Our people - I don't believe our people lose trust in
18 us, I think our people lose confidence when we're not able
19 to deliver. People in our community don't understand what
20 it costs or takes to run our services. I don't think
21 people in government understand it either. So when you
22 say, "This is what the budget is" - the Commonwealth do it
23 regularly, we know that New South Wales does it - for every
24 entity that we get funds off, there is always a budget. If
25 it was actual funding to our sector, we would be a lot
26 better off. We would reduce burden at a quicker rate.

27
28 Capital funding has to be major capital funding from
29 NSW Health, not just minor capital funding, because the
30 Commonwealth holds the tender for that and we're competing
31 with 140 other AMSs in Australia for capital works.

32
33 Fund us, as well, for those who see non-Aboriginal
34 people, fund us for that, because we're reducing the burden
35 on mainstream, but we don't get recognised for that.

36
37 Throughout the referendum we took all this crap about
38 \$40 billion in our sector. Not even 8 billion is in our
39 sector. So I don't know where someone pulled this
40 \$32 billion from. That's ridiculous. Yet we are seeing
41 everybody in our community. I know AMSs that choose only
42 Aboriginal people to be there, that's fine, that's their
43 call. Our call is to see whoever walks through the front
44 door.

45
46 But when we do our reporting, all the number-crunchers
47 only read "Aboriginal uptake". Thirty per cent who come to

1 us are non-Aboriginal people, but they are connected to our
2 community, they are either married or living with
3 Aboriginal people. How are we supposed to say to an
4 Aboriginal man, "Oh, your white wife can't come in,
5 brother"? We'd lose trust, confidence and everything in
6 our community by doing that sort of stuff. I think that
7 takes away from who we are as Aboriginal people about
8 community wellbeing.
9

10 You can't say cultural - a cultural focus on who we
11 are and then eliminate people in our community who need
12 health care. We found through COVID everybody's
13 struggling, through the cost of living, people are
14 struggling, we are the go-to. The AMS is probably the only
15 service now that bulk-bills and can provide a range of
16 wrap-around services that aren't dispersed within the
17 community. Siloed health care has never worked for us.
18

19 So we have the model about how we get health outcomes
20 for all people, but we're not recognised for it and
21 definitely not funded for it. We have to generate income
22 so we can say yes to non-Aboriginal people coming to our
23 services, rather than them going to hospital and waiting,
24 sometimes eight hours. My mother-in-law, a non-Aboriginal
25 woman, sat at hospital for 14 hours, 82 years of age, only
26 two weeks ago. Unacceptable. So if we're not funded what
27 we know it costs us to run our services, if we aren't
28 allowed to apply self-determination because process,
29 policy, procedure, access to funding is distributed within
30 all elements within our communities, then we seem to be the
31 one missing out.
32

33 Brother is right, racism doesn't just happen in
34 healthcare delivery, racism happens in systems. So we're
35 dealing with individual racism but we're also dealing with
36 systemic racism. That's been around for generations, yet
37 we have more people wanting to come to us, especially in
38 Orange. We're not going to say no. We employ eight GPs
39 part time. They don't want to work full time. We have
40 medical students, we have registrars who come to us. We're
41 a multi-disciplined service. We do out of home care, NDIS,
42 aged care and now more into child care, if we get funded
43 for it.
44

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

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

7
8 When the government says there's no more money, then
9 how come you've got tenders running out left right and
10 centre for services that we're already running?

11
12 Just fund the same service. Don't worry about putting
13 a tender up for chronic care, when the AMS is providing
14 chronic care or the LHD is providing chronic care. Get
15 these people to come together and work together, and where
16 you might have personality or character clashes, if you're
17 going to fund services in the community, say, "Okay, you
18 guys need to come together, under your funding contract",
19 because if there is character or personality that separates
20 us, the people who say, "We're going to fund this, and this
21 is what we expect", if it doesn't come from the contract
22 provider, if there's clashes of personality at a local
23 level, our people miss out.

24
25 So whether it's the CEO of an AMS or the CEO of an
26 LHD, if they don't get on, "Suck it up, big fellas, this is
27 what we're going to fund and you will have to work with
28 these people. No ifs, buts or maybes." You know how that
29 will happen? Two Aboriginal people on the board and an
30 Aboriginal advisory group making sure it happens, because
31 if you've got CEOs of LHDs who are not really sure about
32 the CEO KPIs, then we have to be accountable for it.

33
34 Every AMS in this room is held accountable for the
35 failure of "Close the Gap." Mainstream aren't. That's
36 from my perspective. When the "Close the Gap" reports came
37 out, all the negativity, everybody looks to us. "What are
38 you doing?"

39
40 Look at our national uptake, we're providing more
41 episodes of care and occasions of care than anybody and yet
42 we're funded way less than everybody. I don't think -
43 I don't see how that could work. That's certainly not
44 sustainable.

45
46 Fund us for what we know we need. It still won't be
47 anywhere the 40 billion, by the way. At the national

1 roundtable - Gerry was there - all you need is another
2 \$10 billion across the whole country, not just in New South
3 Wales. Still nowhere near 40 billion. But you are funding
4 AMSs to run what we know is the actual, not a budget.

5
6 We're always in competition. We train our people and
7 skill our people but if they get 15,000 or 20,000 more at
8 the hospital, they will go there. I don't blame them. We
9 can't hold them. If you say, "Well, you can go to the
10 hospital and get paid 15,000, 20,000 more", they are going
11 to go there, whether you like it or not. GPs will use us
12 as leverage to say, "Well, I'm getting \$50,000 up the
13 road", well, our position is, "Go up the road."

14
15 We've got to be able to say, if we're going to be
16 sustainable, we need that initial resourcing, finance and
17 material, to allow us to grow to what we know we need in
18 the community. It's not that difficult, from my
19 perspective. I'm not a politician. I don't want to be
20 a politician. But we know there are disparities when it
21 comes to health allocation, whether it's capital or whether
22 it's service. Issues of racism are going to be around
23 forever. Until we do something different, they're always
24 going to be there.

25
26 I said my name earlier, so I don't need to say it
27 again.

28
29 MR PITT: Thanks, firstly I would like to thank everyone
30 for sharing and being honest. My name is Fred and I'm from
31 Rekindling the Spirit organisation, based on Bundjalung
32 country. We've got a growing health service, we're looking
33 to transition into an AMS over the next 12 months or so.
34 You know, we face pretty much the same issues as everyone
35 here and, you know, with these advisory groups and putting
36 two people on the board, listen. We don't want to be
37 tokenistic or anything like that, they're the people who
38 are in a position to make a decision. Listen.

39
40 MR BINGE: Thanks, Fred. Chris Binge, I'm the CEO of
41 Rekindling the Spirit. I've been there probably about four
42 and a half months now, five months.

43
44 I think, basically now, going last, I think everyone's
45 said it, particularly the last conversation we just had
46 with brother. I think being in this, being here today,
47 having the conversation with you guys, I think the biggest

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

5
6 You know, brother just said, we can sit around here
7 and we can have these discussions - I think for me, when
8 you look at funding particularly and how that's going to be
9 administered on the ground, we have the answers, we've had
10 the answers for generations, but we just don't seem to be
11 listened to or our voices don't seem to be loud enough.

12
13 By having them on advisory committees, yeah, that's
14 great - and I agree with Fred, unless that's a tokenistic
15 opportunity, then what is that worth?

16
17 As for advisory committees, we all know, there's not
18 one person sitting in the room that probably couldn't tell
19 you that there's been advisory committee after advisory
20 committee after advisory committee. What are we advising
21 on? Health care to our people. If we can't adequately
22 meet the need for our mob on the ground by delivering the
23 most appropriate services that get all the measures in, the
24 wonderful thing called "Close the Gap", we will be coming
25 back here in 10 years having the same conversation.

26
27 So for me being here today, my component, I suppose,
28 from my people back where I come from, is what are we
29 willing to do to make a difference and what does this -
30 what are going to be the outcomes of something like this
31 that actually hits the ground so that I can actually go
32 back and say to my people, "We are going to try - we are
33 going to try and do better", but to do that, we all need to
34 be able to work better together.

35
36 I mean, I could sit here and probably raise the same
37 issues as everyone else, but I think everyone else has said
38 what needs to be said to this point. But my concern about
39 these sorts of, I suppose, opportunities is: what are the
40 actions and outcomes that are coming from these sorts of,
41 you know, conversations?

42
43 THE COMMISSIONER: We might just take a break now, because
44 everyone has had one say and Ed wants to move on to issues
45 concerning funding streams, which is a big topic. So we
46 might take a 20-minute break and start again. We will
47 break until 20 to 12.

1
2 **SHORT ADJOURNMENT**
3

4 THE COMMISSIONER: All right, we might recommence with
5 funding streams.
6

7 MR MUSTON: Some of you have touched on it already this
8 morning, and in our travels around the state and through
9 the roundtable hearings we had remotely yesterday, a couple
10 of common issues around funding: first, the reporting
11 obligations, having to report multiple times for multiple
12 different funding streams, often to the same organisation
13 using different platforms and different sorts of
14 measurements and different software, we're told, is
15 unnecessarily burdensome and eats up a lot of internal
16 resources that could be used to actually deliver care to
17 people. If that's your experience, feel free to tell us,
18 but equally, you could take it that we have heard that loud
19 and clear.
20

21 The other issue that has been raised a few times is
22 the tied nature of funding such that a grant that you might
23 apply for and obtain successfully is confined in a way that
24 means you're effectively forced to deliver a particular
25 program or a particular type of care with that grant which
26 might not necessarily be, viewed through the eyes of you
27 guys who are on the ground and know about the needs of your
28 respective communities, the best way of using that money to
29 produce good health outcomes for your communities.
30

31 Then, related to that, we've been told about some of
32 the challenges with the short-term nature of that funding
33 and the tied nature of that funding meaning you can't
34 necessarily easily employ someone to fill a role in
35 circumstances where you can't guarantee them anything more
36 than, say, a year or two years' worth of employment,
37 because if you don't get the funding to continue - and
38 these things seem to come and go - then the ability to
39 deliver that service is severely compromised.
40

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

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

3
4 Of course, like any health service or other service,
5 in fact, the needs will be slightly different from one
6 community to the next and they probably will change from
7 one year to the next, and it feels like that dynamic
8 ability to shape your service to meet those needs would be
9 useful.

10
11 Over to you, LaVerne.

12
13 MS L BELLEAR: I would like to make comment on that.
14 You've got a very soft voice, but I picked up bits and
15 pieces. It just reminds me of health promotion and
16 preventative medicine. You know, in my books, preventative
17 medicine is just as important as throwing a tablet down the
18 drain, and we don't get funded for that, per se.

19
20 You know, we have many diseases - and it may change as
21 you go from community to community, but we're across all
22 the different chronic diseases known to mankind; we've got
23 it. Just trying to promote, you know, awareness and, you
24 know, give people information about how you can change your
25 lifestyle and even having healthy lifestyle programs is
26 hard done by to get funding, but yet that is the most
27 important component to anyone's health going forward and
28 holding up disease.

29
30 Years ago, there used to be \$3 million, I think, from
31 the state for health promotion activities. I don't know
32 where that's gone or it's just slipped off, but there is
33 nothing specific there, funding, for health promotion, and
34 you know, that's a big part of providing our service to our
35 people, if we're going to look to stop disease or hold up
36 disease.

37
38 So, you know, they talk about closing the gap, well,
39 give us some health promotion money. It shouldn't be just,
40 you know, for 12 months. Like, the duration of these
41 programs is frustrating too, you know? It's not only the
42 workforce, but it's setting up the programs, getting and
43 buying in resources to provide those services, and it's all
44 about trying to hold up disease.

45
46 MR MUSTON: What sort of programs do you have in mind,
47 just as some examples?

1
2 MS L BELLEAR: We promote, you know, healthy living and
3 that type of thing. So we have a community day. We try to
4 provide healthy foods. You know, we promote healthy juices
5 for our kids, because in the inner city, we're in
6 competition with McDonald's and all of the fast-food
7 stores. If you would have walked down Redfern Street,
8 there's not one fresh shop there available for you. You
9 know, we've got Pizza Hut, we have, you know, those rolled
10 over flatbread things, kebabs. So that's what we're
11 contending with. It is easy for people to give their kids
12 \$5, you'll get five cents change and you have a complete
13 meal. Like, what the hell is that? So we try and, you
14 know, have cooking classes and all that, but it's very
15 ad hoc and inconsistent, because it's only when we have,
16 you know, money.

17
18 Because we are very good at diagnosing, you know, we
19 screen till the cows come in, but once those people have
20 been screened, we need to do an intervention. You know,
21 these people really need to change their lifestyle. If we
22 can't do that, you know, by way of encouragement,
23 information, you know, or sending them off to allied health
24 services, you know, for exercise and all that, then we're
25 lost. We're just going to be content to give them, "Here's
26 your medication. Go home." You know?

27
28 But there's a whole range of other things. Once you
29 have been diagnosed - you know, I had an argument once with
30 a doctor on this - it was a panel. She was saying, "Oh",
31 more or less, that "Aboriginal people, they celebrate when
32 they have been diagnosed with diabetes", and I thought,
33 "What the hell? I've never heard of anyone jumping up and
34 down that they've got diabetes." And I said to the doctor,
35 "How did you come to that?" And she reckoned - so she gave
36 all the information - see, health literacy is a big thing,
37 too. Giving people information, when people are challenged
38 for reading and writing, then, of course, you know, they're
39 going to have a problem there.

40
41 So she gave this person information, and I said,
42 "Well, you know" - and they never changed their diet,
43 I said, "Well, they've probably got 10 people in that house
44 and you are asking them to eat, you know, fillet steak",
45 and I said, "All they can afford is minced meat and not the
46 lean minced meat." So it was all those type of things, and
47 she just thought I was mean. But it was not knowing the

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

4
5 MR MUSTON: So in terms of that funding structure, though,
6 obviously one answer to that is more money to deliver more
7 programs. To the extent you've got money currently
8 available to you through a range of different funding
9 sources, is there anything about the way that that funding
10 is delivered that prevents you from using it in the areas
11 that you think are best?

12
13 MS L BELLEAR: We don't really get funding directly for
14 health promotion. It may come out of program money for -
15 you know, it could be for BBV, STI, we may have a couple of
16 thousand left at the end of the financial year. Then we'll
17 do a promotion. That's what we spend the money on.
18 Nothing's really dedicated, you know?

19
20 Then again, if we do have dedicated funding, then
21 you've got to count all the heads, you know, how many
22 people participated and all that. You've got to really
23 work with people that, when you're trying to change
24 ideology and the way that you're doing things, not only is
25 it going to challenge them at the bank, but it's going to
26 challenge their mindset as well. And so that's why we need
27 that intervention. But if it's not dedicated money going
28 into that, you know, it could be a pseudo service, but, you
29 know, prevention has got to be just as important as the
30 primary health care.

31
32 MR MUSTON: I think Craig?

33
34 MR C LAYER: Yes, often those preventative programs are
35 short-lived, they don't last very long. There isn't a lot
36 of money associated with them so they've got a very short
37 lifecycle, when they should be a lot better. They should
38 be the primary focus.

39
40 Obviously we've got to focus on people with health
41 issues, but if we prevent the health issues, we take a lot
42 of pressure off the other end of it, which is, at the
43 moment, almost crumbling into the ground because of the
44 pressure.

45
46 That's one issue with those sorts of preventative
47 measures, whether it be healthy eating, exercise,

1 et cetera, is the short term nature of the programs.
2 They're often very light on when it comes to the funding
3 that's associated with them.
4

5 In most cases, I just think the box is full of
6 resources, like posters and pamphlets and booklets, and
7 that's it. So you throw all those things out, but there's
8 nothing to follow up. There's no person on the ground that
9 actually can provide, for example, you know, some
10 professional advice on healthy eating, what to eat, how to
11 do it within a budget, that sort of thing.
12

13 As our sister mentioned, you know, a lot of our mob
14 can't go out and buy lean steak and that sort of stuff if
15 they have a family of six, seven, eight people. So it's
16 looking at what the alternatives are for a family with
17 a limited budget as well.
18

19 One of the things that we do as a social venture that
20 helps out NDIS, is we run a cafe on site called Wattake
21 Cafe. One of the biggest battles we had initially, and we
22 overcame it without any problems, was establishing
23 a healthy food option for the cafe. So it's not just, you
24 know, people coming in to get a big juicy hamburger, which
25 saying it makes me hungry, but anyway, you know, hot chips,
26 all that sort of stuff, which people love, but the options
27 are healthy options. So, yeah, have a hamburger, but the
28 hamburger is a healthy option, you know, salads, salad
29 sandwiches, salad rolls, that sort of thing.
30

31 But that venture is supported pure and simple by us as
32 an organisation. We get no outside help for it and it's
33 a perfect vehicle to really promote - and our community use
34 it. They come in to see the doctor or our other services,
35 they always go to the cafe and get a coffee, a juice, a
36 shake, a sandwich, whatever. So if it's there, our people
37 will use it, but they've got to be shown how to use it and
38 have that follow-up long-term process so that that support
39 is there for them when they need it the most.
40

41 MR MUSTON: Do you find, though, whilst that service is
42 great, LaVerne's point is that the day they come to see
43 you, they may make use of that service, but every other day
44 of the week they've got a range of other options, which, if
45 individuals haven't been given good healthy eating
46 education, then --
47

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

5
6 MR MUSTON: We might quickly come back to you, just to
7 save traipsing the microphone all the way across and back.

8
9 MS T LAYER: Just further to what Craig said, we've had
10 a similar situation, where you have a dietitian and their
11 methodology was to put everybody on a paleo diet, so again,
12 that's just not the answer. We've got to fund our diabetes
13 program. We actually just, out of good faith, the board
14 support with some meals for some of those kids that just
15 don't, you, know, get lunches and things like that. So we
16 make things work so that we can provide some out of the
17 cafe. We just send over fruit and things like that so we
18 can make it work.

19
20 But I think if you have dieticians/nutritionists, you
21 just have to understand their approach, that it's not
22 a costly approach, because community just cannot afford it.

23
24 MR NEWMAN: In the majority of plans, whether they're
25 strategic or action plans or activity work plans, every
26 government department puts in early intervention and
27 prevention, but they don't fund it.

28
29 At OAMS we built a facility. We got \$385,000 off the
30 ministry, but we invested 1.4 of our own, to build this
31 resource where we can do recovery, rehabilitation and
32 exercise, but every position in there is funded through our
33 Medicare.

34
35 We are still funded for illness and disease. We're
36 not funded for early intervention and prevention, but it's
37 in every plan. The only way we can help the outcomes is if
38 we intervene and prevent, which we're still dealing with at
39 the moment. To run our services it's based on Medicare,
40 our bigger ticket items are health checks, GPMPs, mental
41 healthcare plans. The individual allied health items don't
42 bring in a lot of money. It can if you get the volumes,
43 but in the smaller communities, you're not going to
44 maintain the service delivery.

45
46 Fund it. Put it in one of your key actions under the
47 strategies of NSW Health or Commonwealth health, but put

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

10
11 We see more people now not even exercising. So if you
12 want to do early intervention and prevention that engages
13 our people, what we push at our services is a medically led
14 wellbeing program. So people have to come in through our
15 GPs, so we generate income off that, but it still isn't
16 sustainable if we lose GPs.

17
18 MR MUSTON: So you said that's funded through Medicare
19 billings. Can you just explain how that works?

20
21 MR NEWMAN: So all of our clients who come to us have to
22 see our GPs. If they're Aboriginal people, they can get
23 health checks done; for non-Aboriginal people, a long
24 consult and a care plan is done for them. So in most of
25 those you'll find there are some points of intervention and
26 prevention. The majority of them are still dealing with
27 illness and disease, so either a general practice
28 management plan, or if there's a mental health issue, which
29 we found through COVID is increasing - they're going to get
30 you money into your organisation. Whether we like it or
31 not, that's what ticks our bank balance up, because we need
32 it. But if we don't do it, then we're not providing good
33 health care for our people at the same time. So if we do
34 all those methods of health check, GP and mental health
35 care plan, attach all the items that you can under the MBS
36 items under Medicare, we can make some money, but we are
37 reliant on it.

38
39 MR MUSTON: So you use that money that you make through
40 those activities to fund --

41
42 MR NEWMAN: To develop our intervention and prevention -
43 early intervention and prevention, because like everybody
44 said, if you said, "Here is your early intervention and
45 prevention funding for a dietician, a nutritionist,
46 exercise physiologist, physio", we'd be laughing. We have
47 to generate almost an extra 800,000 a year to cover that

1 wellbeing team.

2

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

6

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

12

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

21

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

32

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

39

40 But, for example, you know, you might have - we get
41 RDN funding for psychology. The wage they pay hourly is
42 \$68, but it's \$300 for a psych. So we have NDIS billing,
43 that's \$193 per hour for psychology, but that still doesn't
44 make up the hourly rate for those sorts of things. So
45 that's where - you know, that's the funding component.

46

47 But I think preventative is better than cure, and

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

4
5 MR MUSTON: You mentioned a moment ago that some of that
6 funding is short term. I gather that turning the corner
7 for individuals in terms of that healthy eating,
8 preventative health type work, that's not something you can
9 do within a one- or two-year funding cycle.

10
11 MS T LAYER: No.

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

20
21 But to that point Taasha made in regards to the
22 funding as opposed to the hourly rate of practitioners with
23 mental health and so on, there's a huge shortfall between
24 what we get and what we've got to give. So that really can
25 grind us to a halt when it comes to some of those
26 essentials around mental health and so forth.

27
28 MR MUSTON: How does that work in the context of, say,
29 a particular piece of program funding? If you receive some
30 program funding to deliver some psychological care, for
31 example, you're getting a particular amount of money, it's
32 not enough to meet the cost of delivering that service, how
33 does that play out?

34
35 MS T LAYER: Using our example of - yes, we get funded
36 from the PHN for a groups program, so it's more of
37 a clinical-based program, so that's to run three 12-week
38 programs, so 36 groups all up. But the amount of funding
39 that we get, you know, to cover the costs of specific
40 criteria that they have to have identified to run the
41 program and that they're trained in mental health, it is
42 hard to get that staffing. But covering the costs, the
43 group program, catering it, just barely covers what we have
44 to do.

45
46 It has significant improvement for community. A lot
47 of the GPs who have the patients on mental health care

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

5
6 MR MUSTON: Caine, I thought when we were in Albury, you -
7 I think it was you - told us about the experience you had
8 of services that had been funded through a particular
9 funding stream, had been well received by your community
10 and were providing benefit, but then the funding for that
11 particular program dried up and funding was diverted into
12 different areas by the funding bodies. Can you just tell
13 us --

14
15 MR RAUDINO: Oh, there's a couple. So we had a family
16 violence/domestic violence program, Victorian-based
17 funding - so we couldn't go to New South Wales; there's
18 a river there. That's finished up. So a three-year
19 funding agreement, the old "three years", you know?
20 Delivered a quality service, you know, with a coordinator
21 and three workers or three caseworkers, so, you know, quite
22 a substantial outlay. Just, you know, didn't give us the
23 funding ongoing.

24
25 It met all the KPIs, did everything that we could ask,
26 and then they basically put out the tender again and it
27 went to another - not an AMS but a local non-Aboriginal
28 organisation in New South Wales, so that was a bit weird.

29
30 Then they gave us one position in New South Wales, so
31 we lost four but we gained one. So we're just picking it
32 up - talking about Medicare dollars, we're picking it up
33 ourselves just for another six months to try to regenerate,
34 to try to get into the ears of the government to try to
35 give us some funding or generate some other streams.

36
37 The other one is through YAC Vic, we had a youth
38 program.

39
40 THE COMMISSIONER: That's what I remember, a youth
41 intervention one.

42
43 MR RAUDINO: That one's finishing up now, or in December.
44 That was similar, so based around youth. We put a lot of
45 time and effort into developing youth programs. They drive
46 it. So the whole agenda was they could have meetings and
47 they would run the meetings, so the youth would be the

1 voice and they would say what they want to do to keep them
2 off the streets and what-have-you. Same thing. Three
3 years. That's finished. Never had the opportunity to
4 apply or, you know, to reapply or to get that bucket back,
5 so those youth now, we're trying to think of ways of how we
6 can pick that up and keep them - even if it's 15 youths,
7 16 youths, whatever it was, how do we keep them engaged in
8 the community, because they'll get lost.

9
10 MR MUSTON: I gather from that, it was, at least as you
11 saw it, a good program, which was --

12
13 MR RAUDINO: Yes, most definitely.

14
15 MR MUSTON: -- delivering great wrap-around care.

16
17 MR RAUDINO: It is driven by youth, so we're not running
18 the agenda. The government tells us how to run the agenda
19 but we - you know, you put it on them so that the youth -
20 if they're developing a program themselves and if they are
21 leading it internally, you know, young teenagers, it's what
22 they want, and you think it'd be a continuum of care,
23 because - it's hard to say.

24
25 MS L BELLEAR: They're probably doing research about that
26 program, project. I know Go4Fun, NSW Health, when it
27 initially started, I had a lot of issues, because they were
28 just isolating the fat kid from the family and they could
29 go, but not the whole family. So I had big problems with
30 that. But they wouldn't listen, and that was because they
31 were - it was a research project initially.

32
33 I mean, they did make changes. I've had it presented
34 to me and it still, I think, fails, you know, fails
35 Aboriginal people. We still send people there because
36 we're desperate for programs like that. But because it's
37 mainstream, a lot of people may only go once or twice, you
38 know? We get a lot of letters back, "Did not attend", "Did
39 not attend", God bless their souls, for whatever reason.
40 I hope someone is actually evaluating why people don't turn
41 up to these programs.

42
43 But, yeah, there is a lot of money that NSW Health's
44 putting into and they're just merely research. And that
45 doesn't help us, because we can see what our needs are, but
46 they're not being met or they're skewed and trying to, you
47 know, get to their outcomes instead of ours, for our

1 clients or patients.

2

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

8

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

14

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

18

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

24

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

27

28 MS L BELLEAR: It was a weight loss program.

29

30 MR MUSTON: And how did work?

31

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

37

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

44

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

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

5
6 MR BINGE: I think the issue that I find in a lot of this
7 space, particularly coming from a different government
8 component where I used to work, to this space, is the
9 difference in relation to the way that health-specific
10 programs are funded and the streamlines that they're funded
11 in, and the short-term timeframes on that funding where
12 programs like - as have been mentioned already, have what
13 we would quantify as good results, but then, for some
14 reason, I'm not quite sure why, but from a government
15 perspective that seems to stop at given points

16
17 For me, unless government are realistic about trusting
18 Aboriginal people - the majority of people have got
19 significant health concerns, it's taken a lifetime to get
20 to that point, yet we're going to fund programs for
21 short-term timeframes with expected - I'm not quite sure
22 what the expectation is, but with the expected outcomes of
23 this wonderful, you know, health outcome that's going to
24 make the difference, but on that cycle, it finishes, and in
25 three years you're back in the battleground and you are
26 trying to compete with other AMSs, with other NGOs, you
27 know, in the sector, to be able to try to continue a
28 program that we would deem as worthwhile

29
30 So for one, the funding streams aren't aligned with
31 what our health outcomes should be, and it needs to be
32 looked at in that perspective, I think, because we can
33 continue the pathway that we're all heading down with
34 these - and I think everyone's got sort of - everything I'm
35 hearing right now is a common story, not just in the health
36 services, but it's a common story in community. Everyone
37 knows. Like, the first thing you get asked when a new
38 program comes in is, "So how long is this going to go for?"
39 It's a hard thing to answer, but you get the investment,
40 you get the buy-in, you do see some outcomes, but there's
41 no sustainability in those outcomes because the program is
42 cut short.

43
44 MR MUSTON: When you say the first question that you get
45 asked is "How long is this going to last for", is that
46 asked by community members or --

47

1 MR BINGE: That's community, yeah.

2

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

4

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

20

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

28

29 Then the KPIs that are reporting that - I think
30 everyone in this room would be reporting about, you know,
31 10 or 15 different reports for the same thing. Like, that,
32 in itself, is just ridiculous. We continually see the
33 trend and we raise these issues, but nothing happens.

34

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

42

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

44

45 MR MUSTON: What is it?

46

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

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

8
9 Then a year or two later, you'll say, "Oh, we've got
10 that funding back again, but it's just a different name.
11 We've now got to focus on this aspect of youth work." So
12 it's just - it's repetitive, it's frustrating. As I said,
13 there are a lot of people in this room that have been
14 around a lot longer than me - I come from a different
15 government space to where I am now - but the similarities
16 with what we do with funding is no different, particularly
17 when it comes to Indigenous-based specific funding for
18 community and community programs. We've got it so wrong
19 for so many years, and we'll be coming back here with you
20 guys in about another five years, I could say that, to
21 answer the same questions, sorry.

22
23 MR RAUDINO: We're so reliant on Medicare for funding.

24
25 MR C LAYER: Just on that point, what happens when
26 something stops, you know, when a program is pulled, for
27 whatever the reason might be, we don't just move on. We
28 become the target because we're part of the community. We
29 live there. We're part of the family. We're part of the
30 fabric of that community. We can't just move on and go on
31 to something new. We've still got to stand there and be
32 accountable for the fact that this service that was working
33 no longer exists. So they blame who they see and that's
34 us.

35
36 In some cases, it's the people we have working on our
37 front desk that get abused because one minute this is
38 available, next minute it's not. So again, the people who
39 make those decisions, the people looking at figures on a
40 piece of paper, don't live there, they don't feel the
41 community, they don't have that buy-in, but we do. We
42 can't go away. We've got to stay there. So we become the
43 focus of the frustration as well.

44
45 I think the other thing, too, is an AMS - if I go to
46 my local GP down the road, I walk in the door, it's a GP,
47 it's a clinic, it's a doctor, it's this, it's that. An AMS

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

9
10 MS T LAYER: And again just to the point that it's the
11 qualitative stuff not the quantitative, you know. For the
12 youth program that finishes in December, we had a whole lot
13 of young fellas come out of juvenile justice, they went
14 into the youth program.

15
16 There was one young fella, he's 16, and he had his
17 foot run over when he was about eight but never had really
18 any medical attention to it, so he came into the youth
19 program and went and saw Dr Joel Wentong and got a 715. He
20 booked in to the podiatrist, went in to the optometrist and
21 found out that he couldn't hardly see, so we got him some
22 glasses. He now has a job in a car dealership doing parts.
23 So the effect and impact that it has had on him and his
24 family in getting that job - but then to say that that
25 program is finished in December, you know, there's no words
26 to say that, the impact that it has on them and the next
27 generation of young people coming through.

28
29 THE COMMISSIONER: So what's the --

30
31 MR LESTER: "Close the Gap" was supposed to --

32
33 THE COMMISSIONER: Just let me ask you this, sorry to
34 interrupt. What's the big picture problem here? I mean,
35 if someone breaks their arm, an acute care issue, they get
36 seen for the broken arm; if they've got a skin rash, go and
37 get seen for the skin rash. But what we're talking about
38 is the gradual development of things like chronic disease,
39 or where children that might have a particular paediatric
40 issue that needs an early intervention and then constant
41 monitoring and work to assist with whatever that issue is,
42 whether it's an illness issue or a developmental issue or
43 whatever, but both of those things, the gradual development
44 of the chronic disease or an intervention that's required
45 in a child that needs ongoing work and services is like
46 a long-term generational thing, but the investments that
47 have been put in are just constantly on short-term cycles.

1 Is that the fundamental problem or is it something --

2

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

12

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

19

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

23

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

34

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

39

40 MS L BELLEAR: Yes.

41

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

45

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

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

10
11 There was one mum that came to me and said she can't
12 get her child out of bed Monday to Friday, "but Saturday
13 morning, boom, we're there at 8 o'clock." So, you know,
14 it's those little things, and it was, for us, an
15 opportunity to teach them to eat healthily. You know? We
16 thought we did that, didn't we? These two used to come,
17 too. But it was not funded, you know? That's not
18 sustainable. I can't expect, you know, after working
19 a five-day week, then the staff - we would be there at
20 8 o'clock in the morning and we wouldn't come back until 3.
21 So it was a big day, a big day out.

22
23 But those programs, there's nowhere where we can apply
24 for funding or, you know, if they're going to give it to us
25 for 12 months, we're in the same position, we may as well
26 just do it volunteer, then we don't have to acquit either.
27 The acquitting is just brutal, sometimes, for a little
28 amount of money and, you know, they're only after numbers
29 and, you know, nothing quantitative - quality. So, you
30 know, that's the difference in thinking. You know, what's
31 your success doesn't necessarily mean that it's mine, or
32 for my community.

33
34 THE COMMISSIONER: Yes.

35
36 MS L BELLEAR: That's where the two don't meet sometimes.

37
38 MR MUSTON: That also gets us into another issue, which
39 maybe is if you've got someone centrally within a funding
40 body, be it a government body or some other agency, who is
41 deciding what the program is and what the funds are for,
42 built into that assumption is that that's what's going to
43 work in every single community, as opposed to maybe what's
44 going to work in your community, which will be quite
45 different to what will work in another one of your
46 communities.

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

8
9 MR MUSTON: What do you mean by that? So that in terms
10 of --

11
12 MS L BELLEAR: Well, it's clinical data that they're
13 pulling. You know, it could be how many times you've
14 measured HbA1c. I'm more interested, as a manager, in how
15 many new diagnoses do we have for diabetes, you know? That
16 would tell me things are working, things aren't. But we're
17 just stuck, hell-bent on numbers, you know, counting heads
18 on seats, and that's it. Not really an outcome. You know,
19 "How many times did you do a kidney check?" But what does
20 that really mean, you know? And do the people asking for
21 that data really understand what that means and what the
22 results are?

23
24 MR MUSTON: So to take that example, the sort of question
25 might be, "How many times have you done a kidney check" but
26 if there's not that second question, "And what were the
27 outcomes?" --

28
29 MS L BELLEAR: Yes, "What were the outcomes?" You know?
30 And, "What have you done about it?" You know, "Why isn't
31 this person referred to a nephrologist for dialysis?" None
32 of that.

33
34 MR MUSTON: How long have they had to wait for that
35 nephrologist?

36
37 MS L BELLEAR: Yeah. None of that comes around, but they
38 just continually pull the data and, you know, some of it
39 could be very well meaningful, as managers, but --

40
41 MR MUSTON: Just using that example, accepting that
42 reporting is a burden, would you feel differently about
43 some of these reporting obligations if you did feel that
44 there was some consequence, just to use your example, "How
45 many times have you done a kidney check", and if there was
46 then a follow-up question, "How many of those people were
47 found to have kidney failure or kidney disease", and then,

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

4
5 MS L BELLEAR: Exactly, and I would think the rural area
6 people would be hard done by trying to get into
7 a specialist.

8
9 MR MUSTON: But if the KPIs, as burdensome as they might
10 be, if they were at least identifying systemic failures
11 rather than just saying, "Look, these are the number of
12 people we've checked", that at least would be providing
13 some potential benefit; would that be right?

14
15 MS L BELLEAR: Yes, because I just wonder why they want -
16 they're pulling all the - extracting the data but to no
17 avail. Like, are they going to put in better resources in
18 Dubbo or Tamworth, or whatever, if every second person has
19 got --

20
21 THE COMMISSIONER: Just before we go to you, Jamie, I did
22 cut Cecil off. He was going to say --

23
24 MR LESTER: "Close the Gap" closes in 2030. What happens
25 after that?

26
27 MS L BELLEAR: We'll either be all dead or we'll be racing
28 in the wheelchairs.

29
30 MR MUSTON: You hopefully won't be sitting here with us
31 having this quandary.

32
33 MR LESTER: I brought it up two years ago with Tom Calma
34 and that was his response, "2030, it finishes". We still
35 aren't anywhere near the goals that we're supposed to be
36 getting.

37
38 THE COMMISSIONER: Yes.

39
40 MR NEWMAN: I think it comes down to, from my perspective,
41 we have no idea what your acute systems KPIs are, and they
42 have no idea what ours are, so we can't work collectively
43 together. Government fund output, not outcome.

44
45 Years ago, the big push was being able to get every
46 Aboriginal person a health check. It made some money for
47 you, but if you found prevalence or incidence of kidney

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

5
6 We can reduce duplication by having joint clinical
7 services plans between each AMS, if there's one in that
8 town, and the hospital or the LHD. For Western LHD, you've
9 got 12 AMSs. They should have joint clinical services
10 plans between us, so where we see a shortage in workforce,
11 we work together to fill that workforce. Where we see lack
12 of materials, we work together to address that. Health
13 outcome. You're still funding output. Change the old
14 narrative. Make it so that the LHDs work with us and we
15 work with them.

16
17 Patient reported outcome measures are done by acute,
18 not by us. What you fund us for is different to what our
19 people need. The outcome for an elderly person and for
20 a young person is completely different, has completely
21 different economic value as well.

22
23 So how do we get the key players together, if we're
24 going to defund this, if you're running off three-year
25 contracts - the most amazing thing to me is that for the
26 last 20-odd years we've had 10-year Aboriginal health
27 plans, but we fund three years.

28
29 We're not constant enough, we're not consistent.
30 We're having a floating workforce. How do you attract
31 a specialist to work with you, saying, "Oh, we've only got
32 12 months funding"? That's wasting their time, but if we
33 said we're here for 10 years of change, that's going to be
34 more attractive to get somebody to relocate.

35
36 THE COMMISSIONER: What's the level of engagement between
37 your organisation and - you mentioned Western NSW LHD? Is
38 there much?

39
40 MR NEWMAN: There's a partnership agreement at a state
41 level and then hopefully applicable at a local level, but
42 for years we've just talked about promoting stuff and
43 sharing support. It's usually we get lumbered with all the
44 people ending up at the LHD, say, in Orange, who have come
45 from other places that need support, so rather than getting
46 supports from the LHD, they ring us. That's the level of
47 engagement we have. We need to change that old dynamic.

1
2 We're doing a lot more productive things now, but the
3 ultimate, if we want outcomes for our people, is that we
4 should be doing a joint clinical services plan, so that we
5 talk about the patient journey, which is one of the
6 indicators of "Close the Gap", our people at some point are
7 going to go into hospital. The maximum we do now for the
8 acute setting is that we, in some places, might get a copy
9 of a discharge summary. What happens when our people come
10 from further west into Orange for cancer care or any other
11 specialist care, but there is no coordination of the health
12 care from when they leave out there and they come to Orange
13 spend a week or two weeks, and then they go back home. The
14 clinical service plan could be around how we're supporting
15 the navigation of our people's journey in health care. But
16 if you don't have that connection under a contract, then
17 we're always going to be doing things in silos.

18
19 I think that we haven't learnt anything in 19 years of
20 "Close the Gap", we're still doing siloed, output-driven
21 funding agreements. In our contracts, and every AMS knows
22 this, there are so many you've got to get done. There's so
23 many you've got to do. So we're chasing people to have
24 health checks every nine months. Our people live
25 day-to-day. Why are we worried about having a health check
26 every nine months? Put in a model of care. If someone's
27 got a particular - the prevalence of illness and incidence
28 of disease should determine what we do and what is the best
29 model of care for that. That should get us to the table
30 with the specialist working at the hospital.

31
32 If we need to recruit somebody, a nephrologist, then
33 why aren't we sharing that responsibility, because a lot of
34 our people are on dialysis? How do we prevent getting to
35 the dialysis level? If we find incidence earlier, that
36 could be prevented. That's where we work together. We
37 don't work together.

38
39 I know Gerry and her team have been pushing for this
40 to happen. We're doing step by step, but I don't see you
41 shutting down hospitals. If you shut us down, then you're
42 still going to be dealing with illness and disease. If we
43 don't get funded, if we don't have those pathways, we don't
44 have a clinical plan for our own community. I would love
45 to see that we have a clinical services plan jointly
46 between Orange Aboriginal Medical Service and Orange Health
47 Service that enables a patient journey before hospital,

1 after hospital, and who are the players in that.

2
3 Some of our people don't come to us, they go to a
4 general practice, and that's their call. We don't
5 challenge that. But if they want all these wrap-around
6 services for a health outcome, then they would come to us.
7 That's how we work with the hospital to say to our
8 community, "If you've got this, if this is an incident or
9 prevalence in your family, this is what we can do for you",
10 because this is what the model of care should be. If our
11 people don't know what their patient journey should be,
12 then they only come for one thing.

13
14 That's what we were doing for years at Orange, people
15 just wanted to access dental or people wanted to see
16 a psychologist, and now we've got to change. We've got to
17 change what is health to our people so they understand what
18 they are going to get when they come to us. That's where -
19 it's not trust, it's confidence. So if they're confident
20 to say, "This is what we'll get health outcomes for. If
21 you've got prevalence of type 2 diabetes, and you've got
22 all these diabetes programs that we can turn it around,
23 then resource for that." We're not just coming up with it
24 because we know our people, but there are models of care
25 that have been researched for multiple years, so when we
26 come to the Commonwealth or states, we say, "The model is
27 there, fund it." It's all about the budget.

28
29 MS L BELLEAR: But you know what I think, just to
30 interject, I think what you should look at is not funding
31 body parts, because that's what you're doing. Body parts
32 or chronic disease, and then it filters in, we get bits of,
33 pockets of money, here, there, everywhere.

34
35 In our constitution, we've defined "Aboriginal health"
36 as holistic. So instead of channelling money coming in
37 wherever, for specific body parts or disease, then why
38 can't we just get a bundle of money? And then it's up to
39 the managers then to decide what are really the needs of
40 our community and then we can work out what activity and
41 service we need to provide

42
43 But until you get rid of these body parts, mate, we
44 will always remain subservient to the government. That's
45 probably what they want, I suppose. But I would think, in
46 a unique manner, if you gave us a lump sum rather than body
47 parts, it would be so different and we would be able to

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

3

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

6

7 MS L BELLEAR: That's right.

8

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

12

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

33

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

43

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

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

2
3 So that's why I'm a little bit mixed with the
4 research, you know: why should our funding, main funding
5 money, be part of research? So that's it from me. I'm
6 going back to work now.

7
8 MR LESTER: We're funded as single persons and addressing
9 single persons and their issues. It's a holistic approach.
10 You aim everything at the family, because a lot of the
11 diseases are inherited from year to year. It's no good
12 addressing one person if you've got a lot of those diseases
13 existing in the family. If you've got a young guy who
14 comes in and he's got diabetes, you look at mum, look at
15 dad, you look at the brothers and sisters, they've probably
16 got the same thing too.

17
18 So taking it individual and singly, it's not going to
19 close the gap - never. But, you know, that's the way we're
20 funded. That's the way we've been funded for years.

21
22 MR RAUDINO: I just want to tack on about the funding and
23 the buckets of money and stuff, just quickly. We did our
24 job listings, we've got over 40 buckets of money sitting
25 there. So you can imagine how much reporting we've got to
26 do, you know, even for little buckets. We've got a men's
27 shed, applied for a little - I think it was, like, just
28 a \$5,000 tool grant. Everyone thought I was going for a
29 million dollars, you know, just for \$5,000. It's just so
30 tedious about applying for funding. And then I've got to
31 go and report on that, don't I?

32
33 You know, they are going to want to know how many
34 people come in - this is a two-day a week funded program,
35 mind you. So what happens the other three days when men
36 want to come into the men's shed, have a yarn? "Oh, no,
37 sorry, you can't come, you've got to come Wednesdays and
38 Thursdays".

39
40 If you've got some issues and you want a yarn at the
41 men's shed, "Oh, no, come back next week." Just little
42 things like that, you know. Yeah, I just wanted to add on
43 to yours about it would be nice to have longer funding and
44 buckets - I know there are reasons why we've got to report
45 so much, there's different streams and LGAs and federal
46 state, what-not, it would be nice if it was just five
47 buckets of money not 40.

1
2 MS L BELLEAR: I've actually refused funding, because it
3 was too horrific, the reporting, for a little bit of money.
4 I thought, "No, stuff it", you know? And usually when they
5 do throw out money, it's at the end of the financial year
6 and then you've got to, you know, apply for it to roll over
7 and, then you know, you jump through all the hoops, then
8 they give it to you, then you've got six months to spend
9 it.

10
11 MR RAUDINO: And you get it straightaway and then by the
12 time they roll it out, it's September, and you've got to
13 report on the first quarter and you haven't even started
14 the program because it has taken them six to eight weeks to
15 release the money.

16
17 MS L BELLEAR: Exactly. But we're fairly desperate in the
18 AMSs. You know, people need that thing. But, yeah, that's
19 a real issue of how and when we receive it, if you are
20 lucky to get it.

21
22 And then some AMSs may not have submission writers,
23 you know, and all that, so they are behind the eight ball.
24 They will never grow. And people - I don't think there's
25 anyone that really cares whether they are - you know, they
26 could have a huge need and have - you know, that could
27 impact on their community. So I don't think - you know,
28 there's a demand, needs, and who's looking at that? So we
29 all get the same money, depending on, you know, the
30 population or how many numbers you've got. It all comes
31 back down to about numbers. So, you know, we may be big,
32 but a smaller organisation may be desperate for that, you
33 know? I believe in sharing the love, too. But, you know,
34 when it comes to dog eat dog, then, you know, we've got to
35 survive in all this as well.

36
37 I think the government departments have a lot to do
38 with that from the timeliness, and you know, if you're
39 chatty chatty with one of the people in there, well, you
40 will probably get the crumbs, if there's anything left
41 over.

42
43 So rather than really looking at those communities
44 that need that support or extra resource - you know? Like
45 your men's shed and all that type of thing, you know, if
46 they could run it five days in a rural country town,
47 I would think, you know, that would help - that would help

1 with your domestic violence and mental health and suicide.

2

3 MR RAUDINO: Mental health, yes.

4

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

13

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

22

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

30

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

34

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

39

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

44

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

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

2
3 MS L BELLEAR: It's all about that screening, you know?
4 They push screening down our face, so we've got bowel
5 cancer, you know, we're more likely to have bowel cancer at
6 a younger age, and that could have big ramifications if
7 you've got a young family. You know, this is a disease
8 that old people get in the mainstream.

9
10 But, you know, with us, we get it younger. It doesn't
11 matter whether it's breast cancer, bowel cancer, cervical
12 cancer, we get it all, but at a younger age. And that's
13 the difference. You know? And we're hard done by,
14 sometimes, targeting that group, that young group. Whereas
15 the money may come out for the older ones. God forbid,
16 they need it too, but that's where our concentration level
17 is.

18
19 Breast screening - that was 50 years, and we'd say,
20 "No, we've got to drop it to 40", and it took that long,
21 because they were hell-bent, "No", and "It will cost too
22 much money", but the money kicks in when you're diagnosed,
23 I tell you. Some people don't even follow up with the
24 oncologists and surgeons and all that, because they can't
25 afford it, and you've got to go and have an ultrasound, it
26 costs 1,000 bucks straight up after you're diagnosed from
27 your free mammogram. So there are all those types of
28 things.

29
30 You know, people are hard bent putting bread and
31 butter on the table. So that's the difference. And
32 there's no bucket of money for them to go to, "Oh, I need
33 \$1,000 to see a surgeon", it might be even more for the
34 surgeon. And ultrasound, that ultrasound is expensive. So
35 good luck with that. And people make a choice whether
36 they're going to have it or not.

37
38 MR RAUDINO: I think talking about early intervention and
39 prevention, it starts at conception. We have a child and
40 family health team, which is great, one little room, we're
41 squished in there, you know, mat on the floor because
42 that's where they do all the work

43
44 We want to prevent and we want to try to put things in
45 place for the five-, six-year-olds. That's really
46 important, it's what they say is the most important time of
47 a child's development, but yet they don't give us more

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

8
9 I know we are trying to service everyone and everyone
10 is important, age groups are important, but the kids seem
11 to be - not left behind but they - yeah, it's a big gap
12 that we see, anyway, in our service, especially around the
13 paeds. We've got a couple of paediatricians that come in,
14 but still, it is a long wait list. Long.

15
16 MR MUSTON: I assume you would not be troubled by KPIs
17 that measured the extent to which you were engaging in
18 screening programs if you felt that the public health --

19
20 MS L BELLEAR: Well, if you pay me for it, I'll give it to
21 you.

22
23 MR MUSTON: If you're paid for it and you were being held
24 to account by KPIs in terms of an amount of screening, if
25 you felt that, on the other side of that coin, there were
26 KPIs that you were able to hold the public health system to
27 in terms of picking up the consequences of that screening -
28 that is to say, whether it be paediatrics, if you were
29 funded to engage in screening programs to pick up a need
30 for paediatric care in small children, there might be KPIs
31 that require you to screen a particular number of children
32 over a period to detect need, but then, on the other side
33 of the coin, you'd probably like to see some KPIs on the
34 part of the public health system which say how long is it
35 taking you to get paediatricians to see these kids and
36 deliver them the care that you have now found, through this
37 wonderful program, that they need.

38
39 MR RAUDINO: They drop off because mum didn't wait that
40 long and, you know, "Oh, I'm not waiting 12 months", or you
41 can go, "I want to go somewhere else", you can't even go
42 anywhere else. Well, they can't, they can't get there
43 travel-wise, they can't afford it.

44
45 MS T LAYER: That impacts not just on primary health but
46 NDIS, so you're waiting for a paediatrician for an
47 assessment, you know, for an NDIS plan, and sometimes that

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

8
9 So when we're talking about this initiative that we
10 have with Professor Kelvin Kong and just trying to reduce
11 the ENT waits, that might be sometimes physically being
12 there, but he's only one person, doing more telehealth and
13 things like that, providing those just to close that gap in
14 the specialist services, but instead of LHD trying to
15 duplicate what AMSs do in primary health care, let AMSs do
16 what they do best, but to have a partnership where there's
17 actually that referral pathway right up to the specialist
18 services would be amazing.

19
20 MR NEWMAN: Back to the clinical services plan. You can
21 prevent all of this siloed rubbish. Let us do primary
22 health care. They do acute care. Pathways. You maximise
23 your dollar. You'd have better - we wouldn't be competing
24 trying to get access to paediatricians because they're part
25 of that care plan. So if our kids need paediatrics and
26 someone is at the hospital, they see them, no ifs, buts or
27 maybes, or "the books are full", "No, no, you're in a
28 partnership with us". The state partnership agreement is
29 fine, but it does not impact us in the delivery of care
30 to our people. That's why - it's not rocket science, mate.
31 They need to know about our clinical services plan, we need
32 to know theirs and see where the alignments are so that
33 we've got pathways in and pathways out.

34
35 Saves us trying to compete with them for
36 a paediatrician or an exercise physiologist or a dietician.
37 Share that under a pathway. Right throughout the whole
38 "Close the Gap", it's pathways and journey of our people in
39 health care. Somewhere in this planning we forgot about
40 acute and what their responsibilities are to us. It's all
41 "This is our responsibility", half the money, maximum load.
42 How do we make this work so that we're all responsible for
43 the health and wellbeing of Aboriginal and Torres Strait
44 Islander people, not just the AMS sector, because there's
45 not 40 million? What are you doing in mainstream that
46 enables us to work better together, where ALOs will feel
47 more secure knowing they're working with an Aboriginal

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

3
4 This is why you have those advisory groups that say,
5 "No, you're not doing this", and crack the whip with them
6 with the two board members, and then report back to this
7 partnership, to say, "They are failing". It comes to us
8 all the time, "You're failing here". Well, if we can't get
9 pathways for our people for specialist care, whether it's
10 through RDN or with our local service, even better, because
11 we're not rushing our people down to Sydney because they
12 can't get it in Orange - we don't even know if it exists in
13 Orange - we're not maximising what wealth of resources,
14 physical and material, that are available, because we don't
15 know.

16
17 That's never happened, where we've had joint clinical
18 services planning around the health needs of our people in
19 Orange or in any of the mob here. That has never even been
20 approached. They fund hospitals for this, they fund us for
21 this, yet we are the two main providers where there is an
22 AMS in the town, especially for our people and
23 non-Aboriginal people, but we don't even know what each
24 other is doing. It's reactive. Competition, duplication,
25 minimal resources and maximum health impact. It's not
26 hard. You have to do that. It's not based on character or
27 personality. Based on the contract, "You will do this, no
28 ifs, buts or maybes", because if it isn't in there, we're
29 going to keep doing the same old thing, yet we're expected
30 to look at multiple ways of trying to get our people - we
31 can sit down at the table and talk to the general manager,
32 but if the NUM or specialist in the room is saying, "Well,
33 I'm full", we're not going to get anywhere.

34
35 It can be a beautiful way, because our people in the
36 community still see the hospital as separate to what we do.
37 We talk about pathways. If our people need dialysis and
38 we're not going to be established at the AMS, then we need
39 to support them going into the hospital. We've been
40 fighting for years for our staff to go and work within the
41 hospital to support the hospital staff. Still that policy
42 hasn't been changed.

43
44 MR MUSTON: But even to use that example that you raise of
45 dialysis, if there is perceived to be a need in the
46 community for dialysis and it's First Nations people in
47 that particular town or community that are the predominant

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

5
6 MR NEWMAN: Absolutely, yes.

7
8 MR MUSTON: Should it be in the AMS, where people come
9 and maybe a whole lot of collateral benefits associated
10 with younger people bringing someone with kidney disease in
11 and getting some other care while they're there - that is,
12 the young person getting some other care - or in a
13 particular setting, would it, in fact, be better to have
14 the renal service at the hospital, because we're doing
15 other things in the AMS?
16

17 MR NEWMAN: But those people who are in the know make that
18 decision, so we're not competing with one another trying to
19 get something, especially in our Central West and Far West,
20 we don't know who is doing what.
21

22 So if we don't know who's doing what in the health
23 sector, how do we expect our mob in community to know,
24 whether they are black, white, yellow or pink or blue? But
25 yet we have all this, "Let's navigate our people through
26 health systems." Even GPs can't navigate health systems.
27

28 So it's fractured - the system is fractured. If we
29 don't fix it the best way we know how, at a local level,
30 working with our key partners, then we're still going to be
31 competing, we're still going to be dealing with people, and
32 we can do all the screenings under the sun, but if there's
33 identified risk here or identification of potential
34 illness, disease, how do we prevent it if we need the local
35 hospital who has got the resources, physical and material,
36 to work with us to do it?
37

38 MR MUSTON: That's probably a good spot to break for
39 lunch.
40

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

1 have to wait.

2

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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

1 with LHDs.

2

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

8

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

21

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

27

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

36

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

42

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

1 platform.

2

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

10

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

18

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

22

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

28

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

36

37 MR MUSTON: Do others have that experience?

38

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

1
2 We're healthcare providers. AMSs provide clinical
3 care, hospitals provide clinical care; there is the
4 connecting element. Don't worry about community controlled
5 or government run. What brings us together is clinical
6 care of our people. Aboriginal people, non-Aboriginal
7 people, whoever comes to us, right? That is our connecting
8 point. How do we maximise that element of what joins us?
9 That's what we have to do.

10
11 MR MUSTON: And that doesn't involve one-off agreements or
12 relationships that might be documented as between one AMS
13 and a particular local health district but, rather, a more
14 embedded, systemic, co-planning process?

15
16 MR NEWMAN: It has to be right across the board. If we
17 don't have the specialist program - all of New South Wales
18 or all of Australia, you want consistency, because our
19 people move from place to place. We hear that, "Oh, they
20 don't do that up there but you do it here", or "You don't
21 do this but they did this". You want consistency in health
22 care. That's what our ultimate goal is, because if we have
23 that point, then we're going to get health outcomes.

24
25 So you guys, the people that control the contracts,
26 control relationships. I have a good relationship with the
27 general manager, have a good relationship with the
28 Aboriginal health director for the LHD but that doesn't
29 mean we're going to have pathways in to acute clinical
30 services, if that plan isn't in place and adopted right
31 across the whole country.

32
33 If you're going to focus on New South Wales, we've got
34 52 to 53 AMSs, then that should be a consistent,
35 non-negotiable element of providing health outcomes for our
36 community. They are the things that would bring us
37 together. If you've got a good relationship, you might get
38 an MOU or SLA, but we've been working 19, 20 years, and
39 still haven't got a pathway and referral process for mental
40 health, yet we have the biggest mental health facility in
41 the region at Orange. Madness.

42
43 MR MUSTON: What about clinical handovers between the AMS
44 sector and the acute care sector? How is that working?

45
46 MR NEWMAN: It's based on relationship. We might get
47 a discharge summary. Sometimes we don't even know that our

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

15
16 I don't think the mainstream system should be afraid
17 of that. I think it's about continuum of care so we
18 reduce - the whole idea is reducing discharge against
19 medical advice, because our people don't want to be talking
20 to 10 different people about what their health issues are.

21
22 That creates a better relationship between us and the
23 mainstream sector so that our people see us working
24 together. The policy negates that, "Oh, no, I'm not going
25 to go in there and read the chart of somebody laying in bed
26 and say, 'That's not right, they should not be doing
27 that'". No, it's just our people need to be visible within
28 the acute setting that says to our people and community,
29 "We're close with the hospital".

30
31 We can promote that we work with the hospital under an
32 SLA or MOU, but if our people don't see it physically, they
33 don't believe us. So they need to see it so that they have
34 confidence in our systems of working together. That's the
35 difference. My view only.

36
37 MR MUSTON: Well, let's test it. Do others share that
38 view?

39
40 MS T LAYER: Yes, I totally agree and I think that could
41 be a different model for each different community, you
42 know? For example, we've been trying to partner in an
43 agreement with our local health district, but it was just
44 a piece of paper. You know, we had someone from AH&MRC
45 come and sit in in the meeting but it was more about how
46 our AMS can help the LHD achieve their outcomes; you know,
47 it had nothing to do with supporting.

1
2 We've gone around that and we've just created
3 a partnership with a maternal and perinatal Aboriginal
4 unit, maternity unit, themselves. We're just offering
5 a space and they are coming in fortnightly to see some of
6 our clients.

7
8 Where it did work, we set up a COVID vaccine hub,
9 which turned out to be for all of community, and I had to
10 go to a higher level to see if we can get some nurses from
11 the LHD to help support, that were immunisers. That worked
12 really well.

13
14 There could be opportunities around - you know, we've
15 got a partnership with Western Sydney University about the
16 placements for GPs. Is there a way that we can have - or
17 allied therapies that are within the community health
18 section of the LHD, that they can provide clinical
19 supervision for placements of OTs or psychs or things like
20 that?

21
22 There are so many different ways that the partnership
23 could be mutually beneficial, but it's just nonexistent.
24 So I think it's something that there just have to be
25 tangible benefits for both parties, but I think it could
26 work.

27
28 MR MUSTON: Presumably, that process, the clinical
29 services plan, the joint clinical services plan, for it to
30 work, it's got to be a genuine attempt at laying out that
31 patchwork of services and identifying who is meeting what,
32 rather than, "Let's tick that joint clinical services plan
33 box, make sure it is populated with the language that some
34 other policy tells it has to be populated with and move
35 on"?

36
37 MR NEWMAN: Absolutely. It's going to be a little bit -
38 we can bring resources to the table as well. I think the
39 impression is that if we're going to have this - even if
40 it's never been mentioned around clinical care of our
41 people, they're talking more about pathways, so that, "Oh,
42 you know, we'll do a discharge summary and we've got ALOs
43 there and we've got some other Aboriginal people working in
44 the hospital, and we've got paintings around everywhere,
45 you know, we celebrate that."

46
47 But we've got to get beyond that. We're after

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

10
11 MR MUSTON: Not fearful of one another in what sense?

12
13 MR NEWMAN: Well, my staff aren't going to go into the
14 hospital and read the charts and say, "No, they should not
15 be doing this", or questioning what an ALO is doing. No,
16 we're there to support. Now, two ALOs at a \$300 million
17 facility, they're going to go on leave, so who is liaising
18 with our people when they're not there? So there's gaps in
19 that service that we've identified, and how can we help
20 them, rather than being reactive, saying, "Oh, we've got
21 somebody out here, their partner or family is here, they
22 need somewhere to stay." That's the biggest insult ever.
23 Don't ring us for the social determinants, mate, we're
24 a clinical provider.

25
26 We should be able to - we make the call on what we can
27 do, not you ringing us in front of the clients at the
28 hospital, and then when we say, "No, we can't help out", we
29 take a slap, "Oh, Orange AMS doesn't worry about people in
30 hospital that come from Bourke or Brewarrina or Walgett",
31 or whatever, right? Load of rubbish. If we were part of
32 it, then we could identify those needs and address them so
33 they're not even ringing us; it's just a given. It's not
34 hard.

35
36 MR MUSTON: That's something else that has been raised
37 with us in our travels, is a perception that any challenge
38 that a First Nations person who presents at a hospital
39 might have, they're told sometimes, "Well, just go down to
40 Orange AMS", or "Go down to the local AMS. They'll sort
41 out that problem, getting you transport to the specialist
42 appointment, getting you some food security," whatever the
43 challenge might be that has cropped up during the course of
44 the discussion around a health problem. Is that --

45
46 MR BINGE: That's always happened.

47

1 MS T LAYER: That's always happened.

2

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

6

7 MR MUSTON: Yes.

8

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

15

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

19

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

28

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

36

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

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

2

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

5

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

12

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

40

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

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

7
8 So that's the gap that we have. So we have no worker
9 either to link in with them. The hardest part is
10 reintegration back into community, isn't it. So how do
11 they make that - how do we make it smoother if we've got no
12 pathway?

13
14 MR DUROUX: I'd like to just jump in there real quick and
15 say, you know, talking about the justice health stuff, and
16 that program and the prisoner release and that handover of
17 information, for us in Tamworth, it wasn't happening.
18 A huge, huge gap. People were just going out for a week,
19 reoffending, going back in because they had no supports
20 upon release.

21
22 What we've had to do is we've created our own private
23 entity partnership with the prison in Tamworth, and the AMS
24 actually goes in there. Justice health don't do it any
25 more in Tamworth, for us, it's the AMS. We're not funded
26 for it - I'm putting that out there. But we can then
27 ensure that patient journey upon release, back to the AMS,
28 back to the GPs, back to community, back to family. So
29 that is a model that I can say works.

30
31 MR LESTER: Every LHD has an Aboriginal health worker -
32 sorry, an Aboriginal health manager. They look after
33 a specific area and it is making workers accountable to
34 come under that Aboriginal health manager. So if any
35 issues are lodged you go back to your Aboriginal health
36 manager, not to other staff. That's the way you address
37 it.

38
39 MR MUSTON: In what sense? Give us a hypothetical
40 example.

41
42 MR LESTER: You're setting up your own Aboriginal health
43 unit within your LHD. So you've got a person there
44 accountable for any of the issues that happen within your
45 area. Twenty years ago, I worked down at Queanbeyan.
46 I was the manager for Aboriginal health. I had eight
47 Aboriginal health workers ranging from Bega up to Batemans

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

11
12 We talked to Westmead Children's Hospital and they
13 provided us with a surgeon and he came down four times
14 a year, he had a clinic. He did theatre in the morning, he
15 had clinic in the afternoon. Theatre was up to six kids,
16 clinic was up to 20 kids, and all the Aboriginal
17 health workers - the kids who failed in the area, the
18 workers would bring them and their family up to Goulburn to
19 see the ENT specialist. We had an audiologist up there in
20 Goulburn where we did all the screening for the surgeon and
21 it just went on and on and on. It was a very successful
22 program. It cost \$15,000 to run.

23
24 The surgeon from Westmead took all the staff from
25 Goulburn up to Westmead, trained them in theatre
26 operations. It's a very easy, simple program, yet otitis
27 media is supposedly one of the worst things around, but
28 there are a lot of kids out there who don't get access to
29 it.

30
31 If you make your staff accountable to your manager,
32 your manager for Aboriginal health for that area, then an
33 AMS can go back to that manager and say, "This is happening
34 in your area. What can we do about it?" It's no good
35 going to the hospital manager, it's no good going to the
36 LHD, you're not going to get any satisfaction. It's a very
37 simple program.

38
39 MR MUSTON: But it ties in with the service planning piece
40 that we've been discussing - you can have that level of
41 responsibility, but if you don't actually have a service
42 plan built around it which identifies need and works out,
43 as across the AMS setting and the LHD setting, how is that
44 need going to be met, from which particular service are we
45 going to be accessing particular things, then it's all
46 very - it's a bit hard to hold people to account to
47 a failure, if there's not an existing arrangement that

1 says, "We understand the problem. We understand this is
2 how we're going to deal with it, and if it's not being
3 dealt with in accordance with that plan. Then --
4

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

11
12 We don't deal with a lot of organisations out at
13 Condobolin because they don't do their job, and we're left
14 picking up the straws at the end of the day. But I've got
15 incredibly good workers there.

16
17 MR MUSTON: The organisations out at Condobolin - are you
18 talking about other NGOs who have received funding to
19 provide the particular services?
20

21 MR LESTER: Yes, and they don't do their work, so it comes
22 back onto my workers to pick up the pieces and run with it,
23 and they do an incredible job with it, even though it's not
24 within their duty statements, they still do it. Because
25 they've got a job to the community.
26

27 We set up a breakfast program years ago, and how that
28 came about is at the high school, one of the non-Aboriginal
29 girls finished lunch and this Aboriginal girl who was there
30 with them said, "What are you going to do with your
31 crusts". She said, "I'm going to throw them out". She
32 said, "Can we have them - can I have them?" So from that
33 we set up a breakfast program, we set up a cooking program
34 for the students twice a week up at our facilities, and
35 that worked very well. There's no excuse for not doing
36 anything; there is an excuse for failure.
37

38 MR MUSTON: I think they're the topics I wanted to cover.
39

40 THE COMMISSIONER: Does anyone feel as though there's
41 anything that you want to raise that's of importance that
42 we haven't raised as a topic or something important that
43 you want to add to the discussion we've had?
44

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

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

6
7 MR NEWMAN: I think that's across the state. It may not
8 have the incidence or prevalence, but for most of our
9 health issues, oral health is in there, but it's probably
10 the least funded. And if we're ever going to get outcomes,
11 we need to have equitable funding. The bucket has to
12 increase that we're getting currently from the ministry.
13 Not a budget, it has to be actual. Some have two chairs,
14 we have three, but our people deserve to have access to
15 orthodontics, to other oral surgeries to deal with cancers,
16 but that's out of our control because it's not available to
17 us.

18
19 Pathways might be, but then you've got to move them
20 from regions or remote and rural areas down to Sydney, if
21 it's available. The Commonwealth don't want to touch it or
22 refuse to touch it. So we are relying on the ministry,
23 which funds us as best they can based on the budget they
24 have, but if that budget overall isn't enhanced, then we're
25 still going to be missing out.

26
27 And even looking at regional capability building so
28 that our people can come to Orange, if we've got a vision
29 to expand our dental space, our oral health space, to have
30 access to orthodontics, implants for our people that are
31 cost effective, cost manageable, having oral surgery,
32 cancers, and the cosmetic stuff as well - right? Young
33 people don't want to have dentures, but if we're offering
34 extractions, bridges and crowns and all the other stuff,
35 then why aren't we working with the LHD, the Centre for
36 Oral Health, around access to orthodontics, whether that's
37 regional - so, say for instance, yes, of course, I'm going
38 to push my service, I would love to have an orthodontist
39 that could come out and we could have referrals from other
40 AMSs in our region. We won't be able to build capability
41 of all the AMSs but if there is an AMS that wants to do it,
42 has the ability and infrastructure to do it, why aren't we
43 doing it?

44
45 So funding of this - this should not be focused on
46 pulling our kids' teeth out or for young women who are
47 victims of domestic violence or people who play sport

1 losing their teeth, just putting a denture or whatever they
2 can put in there - why aren't we offering good dental care?
3

4 If we want change, then we've got the ambition to be
5 able to do it, but we're lacking in costs. Once again, it
6 comes back to our clinical services; right?
7

8 The LHD can't provide all of that either. They're not
9 in a position to provide the other wrap-around support
10 services that our sector can do. If we're talking about
11 under the "Close the Gap", building capability or
12 transition or capacity building, then you've got to start
13 putting your money where your mouth is, because we won't
14 touch it unless we know it's going to be available to our
15 people on the long period.
16

17 Don't say, "Oh, we've got some trial funds in. We can
18 probably set up a visiting orthodontist for 12 months".
19 Don't bother us, mate. One thing that has to happen with
20 our people is constant care, so we can have health
21 outcomes. So dental, but all the services, not just
22 a dentist and an oral health therapist, but having access
23 to orthodontics, you know, oral surgeries. If we've got
24 oral cancers out there, why aren't we availing our people
25 of that?
26

27 It's what we did years ago with chronic care. If you
28 had a particular issue around somebody's illness, if it's
29 not just - if it's intervention, prevention, treatment,
30 management, but also tertiary, then we're not going to
31 provide good care to our people. For our organisation,
32 it's is talking about birthing to dreaming, so when they
33 come in and when they leave.
34

35 No AMS caps our books or discharges people. We
36 discharge them when our people leave to move out of town or
37 they leave this earth. So we have the whole of the
38 lifecycle with our mob, the ones that choose us, and more
39 and more are, even with the limitations of what we have
40 now.
41

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

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

3
4 If they go and visit them in the hospital, without any
5 fear from anybody else thinking they're going to look at
6 the chart at the end of the bed, just to maintain contact,
7 then I think we're going to reduce discharge against
8 medical advice. Our people will get the care they require
9 in the acute setting and it's followed up with us before
10 they leave the hospital - not getting a summary and we're
11 chasing them up two days later. Gaps are so important -
12 that there isn't a gap. So if we're there as part of the
13 discharge planning with our people, wouldn't that be
14 a completely different approach?

15
16 MR LESTER: It's the same with oral health, we're only
17 funded for 75 per cent of the actual dental bill, they
18 won't fund you for the full amount. So, I mean, we
19 started - we kicked off dental a number of years ago.
20 Initially it was funded out of generated income and then
21 the Centre for Aboriginal Health gave us funding for
22 practice. But as I say, they only fund based on Veterans
23 Affairs rates. So you've got to make that difference up.
24 If people on low income come and they want dentures or
25 whatever, we've got to ring the LHD and get a voucher for
26 them for that to happen.

27
28 MR MUSTON: And then they have to find a dentist who will
29 accept that voucher.

30
31 MR LESTER: Yes.

32
33 MS T LAYER: We had a program set up in our old premises.
34 We were donated a van that had two dental chairs in it that
35 was with the Newcastle University. We had oral therapists
36 doing placement and we had a senior oral therapist with
37 a provider number and one dentist that would come out two
38 days per month, which means we could bill some of it.

39
40 However, when we moved into the new premises, we had
41 all that arranged, we even had some of the mining industry
42 wanting to pay per patient to it, but we just couldn't find
43 the funds to pay 250,000 for the dental chairs. We tried
44 everything but we just couldn't do it. So we had the model
45 but we couldn't get the funds; because dentals sits so far
46 out from health. We just couldn't get any of the funds to
47 do it. Again, agreeing with Uncle, we provided something

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

4
5 THE COMMISSIONER: Does anyone else have something further
6 they'd like to say?

7
8 MR RAUDINO: Training. Training of the mob, trying to get
9 them upskilled. Specifically, you know, in our social and
10 emotional wellbeing area, that mental health work that
11 we've identified, AOD workers. We struggle to find
12 quality. People apply and want to get into the field but
13 they're coming in with no skill set. We know it's a really
14 challenging field, so we need people to upskill, so we're
15 struggling to find them. So how do we make it more
16 affordable to train, more accessible to train up community?
17 Perhaps a pathway sort of thing.

18
19 MR NEWMAN: We are dependent on externals, not building
20 our own internal capability. In no contract is there
21 workforce development funding, yet we've got to develop our
22 people. So for an allocation in every actual - we don't
23 like talking about budgets, because budgets are a pain - in
24 an actual, is a workforce development budget allocation, so
25 we're not reliant on Medicare. There should be - we've got
26 a service, we have 140 staff working for us - an allocation
27 to be able to access the development of our own people.

28
29 If we're going to bring in young Aboriginal people, or
30 young non-Aboriginal people into our workforce, we've got
31 to develop them without them having a debt, because nobody
32 wants to have a debt when they come into the workplace, but
33 that's what our people are looking at. If we want to train
34 our people beyond one year so they go from an Aboriginal
35 health worker to an Aboriginal health practitioner,
36 12 months of training, that's risky. We need to put our
37 people so they're equivalent to anybody else that works in
38 this health system, so they can be practising clinical care
39 for our people, independently. But you need money to do
40 that.

41
42 We've got to toss up whether we develop the workforce
43 or provide clinical care to our people. So we're stuck
44 between a rock and a hard place. We're reliant on
45 externals. If you send them to be any training RTO it's
46 going to cost you. So how do we manage that? So it's
47 still outputs. Health outcomes, you develop your

1 workforce, everybody has plans around succession but we
2 don't have the money to be able to apply it, so we're at
3 the beck and call of others.
4

5 We say to anybody who works for our organisation,
6 doctors included, that we would love you to learn this new
7 procedure, but who is going to pay for it? If a nurse
8 needs new trends and patterns in health care delivery, we
9 want to be in front of that so it enables us to be the most
10 professional that we can be. There's always dollars
11 attached to it. That's what we're faced with. Yet we've
12 got to run what we've got, expand the workforce, get health
13 outcomes, but the budget hasn't changed. That's madness.
14

15 MS T LAYER: And it is also, from a business point of
16 view, mitigating risk, it's like what Caine said about
17 building resilience in the workforce and enabling, so
18 they're properly skilled, otherwise, they're going on
19 mental health claims and workers comp because they're so
20 stressed. And we do everything we can, we've got wellbeing
21 days, we provide EAP, everything that we can to support
22 them culturally, so they are culturally safe, but also
23 their emotional wellbeing. So the risk it's putting on
24 business now because of all the increased workers comp,
25 because, you know, it's just - it's grinding businesses
26 into the ground, you know?
27

28 How do you mitigate against that, you know, when
29 someone - it can be now - you know, if you go to a forum in
30 icare and it's someone's perception of what they feel
31 they're feeling at the time, how do we mitigate against
32 that from a business point of view and build up the
33 resilient workforce in that sense?
34

35 MR RAUDINO: We had an audit, we had VACCHO come down and
36 undertake a wellbeing audit as such, because we had so much
37 sorry business in the community, you know, and stuff with
38 the staff, so there were recommendations, "Oh, you need
39 this particular" - you know, so we employed a people and
40 culture worker. Where is that funding coming from? Us.
41 Medicare dollars.
42

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

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47

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

1 simply there for the needs of the community, and those
2 needs will grow and diminish at different times for
3 different things. So we've got to be extremely flexible.
4 But the funding models that we have to work against are
5 very rigid, there's no flexibility. They don't take into
6 account, you know, the business model that we work with,
7 and, you know, we've got to be very creative. I think
8 everyone here will agree, we've got to be extremely
9 creative sometimes to make it work, and we do make it work,
10 but, you know, those who provide us with the funding don't
11 always get that; it's just, "Well, here it is, there's the
12 guidelines", it's like that; it's just a square box.
13 "Whatever you've got, squeeze it in there."
14

15 And we do make that work, but I think there needs to
16 be acknowledgment of flexibility, the nature of what we do
17 is really needs driven, and that will change all the time
18 and constantly, and we've got to change with it, and having
19 the ability to do that financially as well, so that we can
20 sustain that model moving forward, you know, consistently.
21

22 MR MacQUEEN: I'd just like to agree with that. In all
23 the funding we get, there is never any funding in there for
24 training and education. We are really short of AHPs on our
25 footprint. We've tried to work with TAFE and tried to work
26 with AH&MRC, which was a waste of time. So we are now
27 negotiating with Wollongong University to run a course in
28 Bega, face to face for our staff. So I've got 15 to go
29 into that program. Where the funding comes from, we're
30 still trying to work that out. How we fund it, we're still
31 trying to work that out, but we're going to do it.
32

33 MR DUROUX: A little bit off topic, but something that
34 concerns a couple of AMSs that I work closely with,
35 particularly in northern and western areas, we previously
36 used to rely heavily on organisations such as RACGP and
37 ACCRRM to recruit our doctors and qualified medical staff
38 that needed to be placed rurally for either a two-year or
39 five-year stint, we would rely heavily and be a receiver
40 and also feed that out further west to AMSs to have
41 qualified doctors and staff for a term.
42

43 Those entities, however, have recently, in the last
44 12 months, declared Western Sydney suburbs rural, so now
45 all of these trained GPs and health practitioners, to do
46 their rural stints, they actually go to Western Sydney,
47 they don't make it beyond Tamworth, they don't make it to

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

3
4 MR NEWMAN: Western Sydney is rural?

5
6 MR DUROUX: Western Sydney is considered rural when you do
7 make those applications.

8
9 MR NEWMAN: We might have to start saying Western Orange
10 is Sydney.

11
12 MR DUROUX: They don't even have to leave Sydney anymore.

13
14 MR MUSTON: We did get some evidence along the way in
15 Broken Hill, I think, that said they have the same
16 remoteness rating as Katoomba, from memory, and Byron Bay.
17 So not to say that both Katoomba and Byron Bay have their
18 own significant challenges, but from a remoteness point of
19 view, I don't think they could really compete with Broken
20 Hill, but, nevertheless, for the purposes of certain
21 funding decisions, they are all the same.

22
23 THE COMMISSIONER: All right. No-one else? Anything
24 further?

25
26 MR NEWMAN: I think, finally, we can't expect money to
27 come from the ministry if the money isn't going to the
28 ministry. So treasury, or whoever holds the vault, loosen
29 the doors so they get it and they can disburse it, because
30 it's not them - we know it's not them that can't give us
31 money: they can't give what they haven't got. We've come
32 up with ideas, suggestions, plans and proposals, they hear
33 it all the time, but they don't have access to the vault.

34
35 They've got to work off what they've got and then what
36 we get is what they have, so it just isn't us with
37 NSW Health, it's who controls the funds. They don't get
38 it, they're not going to get it, we're never going to get
39 it.

40
41 THE COMMISSIONER: The vault's working on a historical
42 model.

43
44 MR NEWMAN: We hear a lot of history. We hear a lot of
45 history.

46
47 MR MUSTON: But accepting that that's an important

1 point --

2

3 THE COMMISSIONER: It is.

4

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

15

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

24

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

35

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

41

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

46

47 I'll give you another classic example. CatholicCare

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

8
9 THE COMMISSIONER: Well, thank you all very much for
10 coming and we really appreciate the fact that you have
11 given us so much time. We really appreciate the assistance
12 you have given the Inquiry today by sharing your thoughts.
13 So thank you very much for coming, we're very grateful.
14 Thanks.

15
16 **AT 2.53PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
17 **ACCORDINGLY**

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