FIRST PEOPLES'
HEALTH AND WELLBEING

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TO: Yoorrook Justice Commission

RE: First Peoples' Health and Wellbeing's Submission to Yoorrook's Health and Healthcare Inquiry

First Peoples' Health and Wellbeing (FPHW) is grateful for the opportunity to provide a submission to the Yoorrook Justice Commission's (Yoorrook's) Inquiry into Health and Healthcare.

About FPHW

FPHW is a dynamic Aboriginal community-controlled health organisation (ACCHO) providing affordable primary healthcare services to Aboriginal and/or Torres Strait Islander People and their families in urban Melbourne.

Our clinics are fully bulk-billing. We offer:

- General Practice
- Family Medicine
- Aboriginal Health Checks
- Childhood Hearing checks
- Mental Health Care
- Asthma Care and Visiting Spirometry
- Chronic Disease Management
- Women's Health
- Men's Health
- Immunisations
- Pathology
- Sexual and Reproductive Health
- Weight Loss Management
- Psychology
- Social and Emotional Wellbeing and Alcohol and other Drug Services

The Frankston Clinic also offers Physiotherapy and Skin Checks.

Our clinics offer trauma-informed care in environments that are culturally-safe, calm and healing.

FPHW was previously known as Access Services for Koories, which was set up to improve primary health care access for First Peoples in the northwest of Melbourne. In 2018 the organisation expanded to set up a clinic in Thomastown – an area with unmet primary health care needs. To reflect this development, the organisation changed its name to First Peoples' Health and Wellbeing. In 2019, we expanded again, opening the first Aboriginal health service on the Mornington Peninsula in Frankston. We remain the only ACCHO located on the Bayside Peninsula, despite the area being forecast to have the largest population of First Peoples in Victoria by 2028. The health needs of First Nations people living in and around Frankston are significant, complex and long-standing and require comprehensive, multidisciplinary care from a highly-skilled workforce that is both trauma-informed and strengths-based.

In 2024, FPHW will relocate its Frankston services to a brand new facility that will also accommodate Baluk Balert Barring – Victoria's first Aboriginal Early Parenting Centre. Baluk Balert Barring – many strong footprints – will provide First Nations families with a culturally-safe model of early parenting care that builds on the strengths of Aboriginal families, culture and community.

First Peoples' Health and Wellbeing understands that health is about balance between the physical, emotional, mental, cultural and spiritual and is committed to achieving health equity for Aboriginal and/or Torres Strait Islander peoples.

FPHW's submission

As an ACCHO, FPHW is well-placed to provide evidence and information on a range of health and healthcare-related issues impacting First Peoples. Given the vast amount of evidence that we anticipate will be submitted on systemic injustices experienced by individuals in health and healthcare, FPHW has chosen to focus its submission on a number of key themes that relate to our experience as an organisation (ACCHO). Systemic injustice in the healthcare sector impacts FPHW as an organisation, which has direct flow on effects to Aboriginal people as staff members, and Aboriginal people as Community members (who may or may not be patients or clients of FPHW).

As an ACCHO, some of the key differences between ourselves and a mainstream primary healthcare provider include:

- The high level of accountability we have to Aboriginal Communities and to our all-Aboriginal Board of Management who represent our members.
- Our unique service delivery model that is both trauma-informed and culturally-responsive, offering a multi-disciplinary, team-based approach. We centre our approach on Aboriginal-healing practices that enable Aboriginal people to engage with our services and remain engaged throughout their care and treatment.
- Prioritising Aboriginal workforce development to ensure we continue to meet the health, social and emotional wellbeing needs of our communities.
- Having to work harder to improve access to care through programs and models that reduce the physical, cultural and service barriers for clients and patients.
- Of the 13 General Practitioners and Psychologists currently employed across our two clinics, none are Aboriginal people. The reality is, that for some years to come, it will continue to be difficult to recruit Aboriginal people into these highly-qualified clinical roles. This means, in order for us to deliver culturally-safe care, we need to employ a range of Aboriginal Health Practitioners, Aboriginal Nurses and Aboriginal Alcohol and other Drug Workers to work alongside the GPs and other Clinicians to deliver our model of care. The funding does not adequately cover the costs of the multidisciplinary team that is required to deliver Aboriginal-led care. Without Aboriginal people as part of the care team, the job of educating non-Aboriginal clinicians about trauma and culture falls to patients, who are already over-burdened.

The key themes of our submission are:

1. **Inequities in the Medicare and My Medicare systems**
2. **Inequities faced by those under the ACCHO Award**
3. **Inherent mistrust of ACCHOs by funders and the associated excessive administrative burdens**
4. **Data sovereignty**
5. **Interactions with mainstream providers**

Our recommendations for change are highlighted in grey

1. Inequities in the Medicare and My Medicare systems

There are significant differences between FPHW and private practice in the way General Practitioners (GPs) consult. This section has been developed by FPHW's Clinical Director, who also works as a GP at FPHW, and has had previous experience in private general practice (including working in and owning his own medical practices).

Despite increased morbidity, Indigenous Australians access primary care less than non-Indigenous Australians, even though access is recognised as a key determinant of Indigenous health outcomes. Services such as FPHW have been created to help meet this need.

At FPHW, general practice work diverges significantly from private practice due to the complexity of patient cases, psychosocial and cultural factors and negative experiences of most patients of previous engagement with health services. FPHW relies heavily on community partnerships and adopts a multidisciplinary approach. Preventative health, health promotion, and public health initiatives are also major focuses at FPHW. Consults themselves are trauma-informed and narrative based. These priorities impact the delivery of primary health care in several ways, requiring significantly more time and resources per patient compared to private practice settings.

Patients at FPHW typically present with multiple chronic conditions and a high burden of moderate to severe psychological and psychiatric issues. Additionally, there are elevated rates of substance misuse, interactions with the forensic system, homelessness, food insecurity, family breakdown, removal of children, domestic abuse and violence, non-compliance with treatment recommendations, high rates of non-attendance to booked appointments, crisis presentations and more.

For FPHW, there are considerably higher costs and relatively less access to the Medicare Benefit Schedule (MBS -a listing of the Medicare services subsidised by the Australian Government), compared to private practice.

On a typical day in private practice, a GP could bill Medicare approximately $2,400 and bill patients approximately $600 in gap payments. 30% of these total earnings (i.e. $900) would go to the practice as a service fee to cover the costs of nursing, medical administration, management and other expenses such as rent and consumables. The practice can earn additional income through Practice Incentive Program payments and rental to pathology services among other income-generating activities. The doctor bares the costs of insurance, holiday/sick leave and superannuation.

On a typical day at FPHW, the GP spends significantly more time with fewer patients. Medicare billing per Full Time Equivalent GP generates less than $1,000 per day. This covers approximately 70% of the doctor's wage including superannuation and leave entitlements, leaving 30% of the doctor's wages to be funded by FPHW. There are also other significant additional costs to FPHW (higher than in private practice) due to, for example, the ratio of nursing staff to doctor being triple and only a small part of the wage of psychology being funded through the Better Access Program. The heavy burden of reporting and auditing adds significantly to the administrative cost of running the clinic.

The costs to government are offset by reduced presentations to emergency departments, hospital stays, access to crisis services and such.

Each of FPHW's two clinics are funded through the Indigenous Australians' Health Programme (IAHP) for one FTE doctor, nurse and medical administration officer and small administration fee for overheads. At present, FPHW employs 45 staff members (clinical and administrative) across the organisation. IAHP funding, combined with Medicare rebates does not go anywhere close to funding the current services provided, let alone the need. Therefore, the current funding model is unsustainable and FPHW will inevitably need to reduce services or identify additional funding to continue current services, much less expand them to meet the current and growing additional need.

Despite the funding scenario described, FPHW received a letter from the Hon Mark Butler MP, Federal Minister for Health and Aged Care in May 2024 in relation to IAHP that revealed a lack of understanding at the highest level, of the inadequacies of Medicare as a source of funding for ACCHOs. The MP (or his department) wrote “there is no limit to the Medicare income that FPHW can generate to support comprehensive primary healthcare (CPHC) service delivery”. This level of ignorance at the highest level deflates our hopes for any change to the funding model to suitably fund ACCHO activity.

From 1 November, the ACCHO sector will face further disadvantage with the introduction of MyMedicare. This will put additional barriers put in place for First Peoples to accessing healthcare. For example:

- No culturally appropriate materials exist to explain MyMedicare to First Peoples and to overcome the mistrust of government that many First Nations people have. FPHW is currently directing resources away from service delivery, to develop written and video materials to ensure all our patients are informed and empowered to register with MyMedicare. This is a huge administrative undertaking.
- At present, many of our patients are willing to see any of the GPs within our practice and prefer the flexibility this affords to get appointments at short notice, or to see a GP with a particular specialty interest as needed e.g. for Women’s Business. Under MyMedicare, patients will not only have to select their preferred practice, but also their preferred GP. If this does not occur, clinics can not bill for GP management plans, mental healthcare plans, additional telehealth for a patient. This will create significant additional financial hardship for FPHW as it is the bulk of the income we receive from Medicare.
- Registering for MyMedicare, nominating a particular GP and having reduced flexibility to see another GP are all additional access barriers for First Peoples at a time when we should be doing everything we can, as a system, to reduce barriers.
- MyMedicare disproportionately impacts First Peoples, but we were not part of the decision-making, and had no voice in the process of developing MyMedicare. It has been developed to advantage non-Aboriginal GPs in private practice, and will only lead to greater access barriers for First Peoples.

ACCHOs are best-placed to provide the care needed to overcome inter-generational trauma and to support the deep healing that is needed to close the health gap. Government has a choice – either to fund Aboriginal health adequately, or concede that the aim of the current models is to create an impression of, rather than a genuine commitment to, Closing the Gap.

The Australian Government Department of Health and Aged Care needs to make an exemption from MyMedicare for ACCHOs and/or First Nations people, to eliminate the financial risk and disadvantage to ACCHOs, and barriers to access for First Peoples, that MyMedicare creates.

2. Inequities faced by those under the ACCHO Award

The ACCHO Award, (which is the Award that the majority of our staff – particularly our Aboriginal, lower-qualified staff are currently under) is not included in the Portable Long Service Benefits Scheme. This means employees commencing work at FPHW from other parts of the health, social or community services sectors or leaving employment with FPHW to take up roles in these sectors are not eligible to carry their long service leave entitlements with them. As an ACCHO, when it comes to portable long service leave, we are not recognised as a health service, or a community or

social service. If a nurse working in a hospital, wants to move to another hospital, they are eligible to take their long service leave entitlements with them. We do not have access to such a scheme, limiting movement for employees between organisations for career opportunities, pay rises, lifestyle reasons etc.

This limits recruitment opportunities for FPHW but also significantly disadvantages people (predominantly Aboriginal people) who are employed under the ACCHO Award, in terms of economic and career development.

The ACCHO Award also does not have any paid parental leave. Again, the generational disadvantage this perpetuates falls mostly to Aboriginal people and their families. As an organisation, FPHW foots the bill for paid parental leave (paying the gap between the Government's scheme and a person's usual salary). This is yet another additional cost of operating an ACCHO that is not faced by similar mainstream community services.

The Victorian State Government needs to ensure the ACCHO Award is equitable, by being part of a suitable Portable Long Service Benefits Scheme and including Paid Parental Leave for employees covered by the Award.

3. Inherent mistrust of ACCHOs by funders and the associated excessive administrative burdens

FPHW, like all ACCHOs has multiple reporting requirements connected to various funding streams. Program grants from two different areas within one government department can result in us having to report the same performance information and narrative multiple times per year, and year after year.

We also have all the usual accreditation and compliance processes (for example AGPAL accreditation against the Royal Australian College of General Practitioners Standards and Department of Health Child Safe Standards) as other healthcare organisations, but without the economies of scale of larger organisations. Whether you are a 45-staff organisation, or a 200-staff organisation, the level of compliance against National Standards remains the same.

Finding a suitable skill-base to oversee, manage and deliver on these complex and onerous reporting and compliance requirements has meant recruiting additional non-Aboriginal staff members into the organisation. This adds additional costs and complexities: ensuring non-Indigenous staff are culturally safe (ongoing cultural awareness training), ensuring Aboriginal staff are not burdened with an additional cultural load, that the workplace remains Aboriginal-led, culturally safe and with a balance of power when those in higher-paid management positions are increasingly non-Aboriginal. Succession planning to ensure a pipeline of Aboriginal staff within our organisation that can move into more senior clinical and administrative roles is an ongoing priority and task.

We are working every day to achieve generational change, yet we're constrained to working within election cycles. These two things to do not marry up.

Streamlining and simplifying reporting (for example, reporting by exception) would reduce the administrative burden and cost to our ACCHO. The onus should be on Government Departments to share information so that ACCHOs are not required to recreate the same reports multiple times per year.

We're aware of the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031, but feel no impact of its implementation on the ground. As an ACCHO we should be informed of how the Strategy can support our workforce development and how funding through the Strategy can be accessed.

4. Data sovereignty

Funding ACCHOs to conduct our own research does not appear to be deemed a high priority for Government and other funding bodies. Research into Aboriginal primary healthcare continues to be led and conducted by non-Aboriginal organisations, government departments and universities.

First Peoples health and wellbeing data belongs to First Peoples – it is our story to tell and we should be funded and supported to develop the research infrastructure needed to lead this work.

Fund the ACCHO sector as a matter of priority, to develop an Aboriginal Outcomes Framework. This will ensure that, rather than reporting on the 'what' – i.e. activity, we can move to reporting on the impacts, benefits and outcomes of our services. We need robust, evidence-based Aboriginal health data, developed, collected and owned by Aboriginal people and organisations.

5. Interactions with mainstream providers

We have many interactions on a daily basis with mainstream providers such as other local primary healthcare services, the Primary Healthcare Networks, tertiary services such as hospitals, specialist services and others.

These interactions are important to improve pathways for Aboriginal people as patients and clients, reduce barriers to services and increase cultural safety of mainstream providers.

However, much of the work (e.g. enhancing the cultural safety of mainstream organisations) is unpaid work conducted by Aboriginal employees of FPHW. It does not recognise the financial cost to FPHW and the cultural load it adds to FPHW staff. For example, a local mainstream primary healthcare provider engaged with FPHW for support in developing their reconciliation action plan (RAP). They set up several meetings with our Thomastown Site Manager who was asked to advise on what should go into the RAP. This was unpaid work, with no assurance of cultural safety for the Site Manager going into those meetings as the only Aboriginal person, and did not recognise the cultural burden placed on the Site Manager when sharing her cultural expertise.

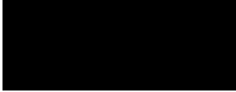
Improved cultural safety of mainstream organisations is a positive and necessary endeavour, and increases the genuine choice of providers available to Aboriginal people. However, the number of mainstream providers wanting to enhance the cultural safety of their organisation has the potential to grow exponentially. This is not matched by growth in the number of Aboriginal organisations, with Aboriginal employees who can provide the expertise, guidance, support and advice the mainstream organisations are seeking. The work of eliminating racism (individual and systemic) and improving the cultural awareness and safety of mainstream organisations and sectors can not fall to Aboriginal people and organisations alone, and certainly not without adequate supports, recognition and reimbursement of Aboriginal people who are doing the work.

When specific Aboriginal program dollars are put into the mainstream sector, the first thing the funded mainstream organisation does is knock on the door of the ACCHO looking to 'partner'.

We've even had a mainstream organisation ask us to 'house' their Aboriginal staff with 'out-reach' capacity so that they could gain access to the patients within our services for their program.

I wish every success to the Yoorrook Justice Commission with the finds and recommendations on improved health and wellbeing to come shortly.

Kind Regards



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