COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

Reference: Long-term strategies to address the ageing of the Australian population over the next 40 years

MONDAY, 2 FEBRUARY 2004

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

Monday, 2 February 2004

Members: Mr John Cobb *(Chair)*, Ms Hall (Deputy Chair), Ms Corcoran, Ms Ellis, Ms Gambaro, Mr Hartsuyker, Mr Hunt, Mrs May, Mr Mossfield and Mr Tony Smith

Members in attendance: Mr John Cobb, Ms Corcoran, Ms Hall, Mr Hartsuyker and Mr Mossfield

Terms of reference for the inquiry:

Long-term strategies to address ageing of the Australian population over the next 40 years.

WITNESSES

BELL, Ms Stephanie, Director, Central Australian Aboriginal Congress 721

BOFFA, Dr John, Public Health Medical Officer, Central Australian Aboriginal Congress................ 721

DE DECKER, Dr Koen Paula Karel, Acting Medical Officer Coordinator, Central Australian Aboriginal Congress... 721

DENNIS, Ms Louise, Aboriginal Healthworker, Frail, Aged and Disabled Program, Central Australian Aboriginal Congress 721

KUNOTH-MONKS, Mrs Rosalie Lynette, (Private capacity).. 734

LUSTY, Ms Ellie, Coordinator, Frontier Services Carer Respite Centre 713

MILES, Mrs Mary Anne, Director of Nursing, Frontier Services Old Timers Aged Care.................... 713

NOBLE, Mrs June Hartley, (Private capacity) 705

SMITH, Ms Maxine Kay, Aged Care Project Officer, Yuendumu Old People's Program, Mampu Maninja-kurlangu Jarlu Patu-ku Aboriginal Corporation.. 741

Committee met at 9.02 a.m.

NOBLE, Mrs June Hartley, (Private capacity)

CHAIR—I declare open today's public hearing of the House of Representatives Standing Committee on Ageing, which is focused on remote, rural and Indigenous aspects of ageing. Today we will hear from six witnesses from aged and respite care services, workers and advisers to the Northern Territory government on ageing matters, all of whom are accustomed to working in rural and remote areas. Each witness has been allotted 35 minutes, but we can vary that as necessary. Preferably, if the witnesses choose to do so, they can make a short statement at the start and then the committee will ask questions as necessary. I ask witnesses to remember that this is a formal hearing of the parliament and that you must not try to mislead or detract from the truth because you can be held in contempt of parliament if you do so. That is not a warning; that is just information. I would ask you all to relax and tell us what we need to know.

I now welcome our first witness, Mrs Noble. I invite you to make an opening statement.

Mrs Noble—I will introduce myself first. I was not born here but I am allowed to call myself a Territorian because I have lived here for 40 years—25 years and then you are allowed to be called a Territorian. I grew up in Melbourne. My husband and I came to settle here in Central Australia in January 1964. We have seen it grow from 5,000 people, when it was a beautiful place. It is still a beautiful place, but now we have 26,000. My profession was preschool teaching. I had three years at an Aboriginal community when we first lived up here. Then we moved into town and went into our own plumbing business. We had four beautiful children, and I had 14 years at home with them, which I thoroughly enjoyed. I loved my preschool work so much that I went back to it and was in charge of a preschool for the next 19 years. Unfortunately we had not done away with our compulsory retirement law then, so 65 came along and I had to retire. I have now been retired for nearly five years, and I am busier than when I was working. Before I retired I was elected to the Alice Springs Town Council, and I did eight years there. I have grandchildren in Victoria, so I needed to have time to travel, so I did not stand again. But I manage to keep very busy with community work and lots of committees.

I am not absolutely sure what you need from me. I am also—and I have been for 12 months—a member of the Seniors Advisory Council to the Chief Minister. This was established last year. We have four meetings during the year. Every three months I travel to Darwin. There are 11 of us on the council representing senior Territorians—three from Alice Springs, one from Tennant Creek and the rest from the Darwin area. It is a very new council, as I said.

The Territory government looks after senior Territorians very well. I do not know if you have all been given a copy of this—I did not have any to give you. It is the Northern Territory Pensioner Concession Scheme *Guidelines and application booklet*. But you do not have to be a pensioner; you just need to be 60 if you are a woman and 65 if you are a man. The concessions are quite considerable. There is a rebate on your rates, a dollar a day off your electricity, a rebate on your drivers licence, spectacles every two years and return travel every four years. So there is a lot in there that makes life a lot easier for senior people in the Territory.

Our committee are looking not so much at financial things but at the quality of life of Territorians. The government has established a few seniors villages for tenants of government

houses, but we really do not have anything in the Territory for people like me, a self-funded retiree. You cannot sell the big house you have been living in and move into a village, as you can down south. That is something that has been identified by just about everybody I have talked to who is over 60. The other things we have been looking at are keeping seniors in the work force, and the safety of seniors. They might be encouraged to have very secure dwellings, but when something happens they might not be able to get out or ring up, or people might not be able to get in to help them because they are so secure. That is something else that a lot of people on the committee have identified as quite a high priority. Also, in the Territory we do not have a mental health facility anywhere, and that is another big problem.

I have read about nine reports, which of course you have all got. Certainly every area has been covered about the problems over the next 40 years and what has to be addressed. I certainly could not add anything to that. I think the COTA National Seniors policy document is incredibly thorough and covers every possible aspect of problems of ageing. I am sure you have that. It is probably not the most recent one—it was written last year.

There are two things I would be very concerned about, as a person of my age. The Pharmaceutical Benefits Scheme is critical for older people. If you need medication, it is going to take a big bit out of your budget. It would be very sad to see the PBS disappear. I think young people are not really aware of the importance of the superannuation side of things. I feel that there needs to be much more public education about the need for superannuation and some sort of savings scheme for the future. I totally agree that it is going to be a big burden on the government unless people are far more self-sufficient when they get to retirement age. I do not think young people really have got the idea, from what I have seen. I have probably said all I have thought about saying, and I welcome your questions.

CHAIR—Thank you very much, Mrs Noble. Are there any things that struck you as you read the report that would be different for a place like Alice Springs as opposed to where that information has been compiled thus far? Are there any things that have not been put in the report that strike you as making a remote place like Alice Springs different in an obvious way?

Mrs Noble—In the COTA report, or in any of the reports?

CHAIR—In the ones you have read.

Mrs Noble—They started in 2000 and each one that has been written has certainly covered more avenues. Reading the COTA national policy document, I just felt that it covers everything that would apply to anybody living anywhere. I cannot see that living here is that different to anywhere else.

CHAIR—Have you had anything to do with aged care as such?

Mrs Noble—No.

CHAIR—I will not go there then. Is retirement something that people do in this area?

Mrs Noble—I should have said this, actually. The main task the Chief Minister gave us when we were established as the Seniors Advisory Council was to ascertain why so many people leave

the Territory after they retire. That does happen. People do leave, and one of the reasons is the lack of accommodation for people like self-funded retirees to move into. There is only government accommodation. The other reason is that most of our children seem to go and live somewhere else, so we follow grandchildren. There is probably a need for more emphasis on quality of life for senior Territorians to keep them here.

CHAIR—Quality of retirement life or quality of life in general?

Mrs Noble—Quality of retirement life. There are a lot of avenues for education, carrying on long-term learning, and there are certainly plenty of avenues for volunteer work, but I guess it is the recreational side of things that is a bit limited in the Territory.

CHAIR—I only know this because I have read it recently: all rural communities tend to age more than metropolitan ones. In the committee that you have worked on for the Chief Minister, which is one year old now, have you formed any opinion as to how to address the issues of ageing in rural communities or as to why ageing is faster in rural communities than it is in other areas?

Mrs Noble—What do you mean by 'faster'?

CHAIR—If people age faster in remote communities than they do in capital cities—

Mrs Noble—Do they?

CHAIR—They certainly do. We are older communities. The Indigenous population age faster than white people but, quite apart from that, the population is getting older on average in rural areas to quite a marked degree. Have you dealt with that one?

Mrs Noble—No. I still do not quite know what you mean. Do you mean they feel older than they are or the average age of the population—

CHAIR—The average age is older, and that is obviously because young people tend to leave.

Ms CORCORAN—I think maybe what John is trying to say is that there is evidence around that the illnesses and diseases that some communities experience at perhaps 60 or 70 are being experienced in other communities at an earlier age, that the things that happen to our bodies or our health happen earlier in some communities than in others.

Ms HALL—John was probably referring more to the factors existing in Indigenous communities, and I think we are going to receive a little bit of information on that later. Also, I think that rural communities that are not remote are getting older; in remote communities it is a little different. You are probably a remote community here. I am sorry if we confused you.

Mrs Noble—That is all right. All the reports say that people are ageing more healthily than they used to. That is why I could not quite follow you. I am nearly 70 but I feel 30—

CHAIR—What you say is correct but the average age is getting higher in country areas.

Mrs Noble—I do not know why.

CHAIR—One reason is that a lot of the young people leave. I just wondered if you had tried to address that on your committee.

Mrs Noble—You are saying that the children leave and live somewhere else?

CHAIR—That is one reason, yes.

Mrs Noble—No, we have not even thought of that.

Mr HARTSUYKER—Is the distance from families and the family support base becoming a big problem in the Territory for ageing retirees who decide to stay?

Mrs Noble—I think they leave when it becomes difficult. It does not become a problem because people relocate quite easily.

Mr HARTSUYKER—A large proportion of the Territory's population is spread very thinly over a large area. Are you working on issues relating to remoteness and isolation for older Territorians? What are your thoughts on that? How can we improve the lives of older people in remote areas?

Mrs Noble—We are certainly addressing that. We have not come up with any concrete solutions as yet. As in every state now, we have a seniors card and we publicise and circulate information to everybody who has a card and is on that list. That is our main way of contacting people. That is then their avenue for contacting us.

Mr HARTSUYKER—Do community groups and non-government authorities in the Territory perhaps fill a void that might be filled commercially in larger centres by CWAs, service clubs and so forth bringing seniors together and providing services for them?

Mrs Noble—I am sorry; who fills a void?

Mr HARTSUYKER—Do community charities and community groups fill the voids that might be filled commercially in larger centres, such as the CWA organising a function for seniors or something of that nature?

Mrs Noble—Most definitely; the service clubs are very active, working right throughout the Territory. Yes, there is a lot of volunteer work happening in the Territory.

Mr MOSSFIELD—In your capacity as a member of the Seniors Advisory Council, what issues affecting Indigenous people do you feel are important and what issues have you raised at that level concerning older Indigenous people and their needs?

Mrs Noble—The chairman of our committee is an Indigenous lady and we have a couple of other members who are Indigenous. The debate is very balanced. There is not a lot of difference in the needs of the two groups. As John was alluding to earlier, there is probably a need earlier with the Indigenous people but there have not been any specific needs that we can address. As I

said, we are an advisory committee to the Chief Minister, so if there are areas that need to be investigated and looked at more closely that is where we come into the picture.

Ms HALL—Thank you very much, Mrs Noble. Your contribution was excellent and I am sure that the work that you are doing on the Chief Minister's council must be really exciting and setting the groundwork for the future direction that the Territory will take when it is looking at older people living in the Territory. I would like to ask you a little bit about some of the things that you mentioned. You are looking at quality of life issues for seniors. Are you putting together a plan or a strategy to address that? If so, could you tell us a little about it or could you identify for us the issues that are impacting on the quality of life of seniors in the Northern Territory?

Mrs Noble—I think the main problem in respect of quality of life, especially in Alice Springs, is the small population base—26,000. The economy always drives opportunities, and the opportunities that you might have in a bigger city are limited in Alice Springs. When I talked about quality of life I guess I meant outlets that are different and challenging.

Ms HALL—What type of things would you like to see here?

Mrs Noble—I have never identified exactly what. I would just like to see more opportunities for social get-togethers. We have a seniors club and we have a Probus club. I guess it is often the case that people on committees look at what they think might be needed, and people have individual requests, but when it comes to the big picture it is very hard to introduce something that everybody is actually going to take part in. I am sorry I am very vague in that answer, but it is a difficult thing to identify.

Ms HALL—That is fine.

Mrs Noble—I quite like the idea, in one of the reports, of an institute of the ageing to be established federally with centres in different states. I think you probably need something like that before you can really get down to the nitty-gritty of doing something about the quality of life. A committee like ours is a very general committee identifying needs without being able to establish anything, whereas an institute of the ageing with centres in different places would be so specialised that it would achieve more.

CHAIR—Your answer is what we want because the inquiry is very much about the quality of life and what people expect out of ageing over the next few decades; it is not just about aged care. I do think those things have to be addressed.

Ms HALL—The next area I would like to explore a little bit more is seniors in the work force. You identified that on the ministerial council you were looking at seniors in the work force. Could you share with us some of the barriers for seniors or older or more mature workers in the work force here with respect to obtaining and maintaining work? Could you share with us whether or not it is more difficult for mature workers to obtain employment here?

Mrs Noble—The reports talk about a culture of early retirement in Australia. I guess it has something to do with the big bulge of baby boomers when there is so much opportunity to have younger people in employment. I think what has happened is this. In my experience, when I was determined to hang onto my job until I was 65, there were a lot of little pushes here and there—

you know: ‘You’re not going to wait until you’re 65, are you?’ It seems that the culture is not so much the ordinary person thinking, ‘I should retire at 55 because everybody else is retiring at 55;’ it is something that is put down by the employers. That is just my personal opinion. They give you the feeling that youth is more productive and efficient than age.

Ms HALL—So it is a subtle form of discrimination—is that what you are saying?

Mrs Noble—That is how I felt in my last 10 years in the work force.

Ms HALL—You would say that that is something government needs to address?

Mrs Noble—That is just for me, yes.

Ms HALL—You would know!

Mrs Noble—I really feel that that has been a big influence on people feeling that they are not as capable. You do not have the same energy level, but I was still running a very good preschool at 65 and I know I could have kept going another four years. But there was that feeling from up above that you really should be thinking about retiring. There is also that loophole in the government pension system where, if you retired the day before you were 55, you got a lot more money than if you waited until after you were 55. That was tempting to people not realising they still had a long time to be occupied. I think that culture is hard to get rid of. In the Territory we are very fortunate; we have very little unemployment and there are jobs for everybody. But it is still hard for an older person to get a job over a younger person because of that idea that they are not going to work as hard or be as productive as a younger person.

Ms HALL—Is there a youth culture in the Territory? I see in the background some heads nodding.

Mrs Noble—You could say that, although there are plenty of jobs. Depending on what you are prepared to do, you can get work but not necessarily the work you might choose because no doubt a young person will be chosen over you. The first part of your question was on what the council was doing. We have talked a lot about it. There probably need to be incentives given to employers to retain people with skills and knowledge in a different role to what they have been working in. When somebody in a trade who is so experienced and so full of knowledge and skills gets to 60, they are probably a bit slower than a young lad of 25 but they have the ability to be an assessor. This is where we are going at the moment: talking about the possibilities of keeping people in the work force in a different role. But employers need a bit of encouragement to do that and there might be some retraining needed, so we have been talking about the possibility of encouraging employers to retrain these very skilled workers to work in a different role.

Ms HALL—I have a question on health. Are there issues and difficulties in accessing the kind of health care that you need as an older Territorian? If you become very ill, can you receive the treatment that you need within the Territory or do you need to travel to obtain that sort of treatment?

Mrs Noble—I think Mary Miles is going to be a good person to answer that question. We have enough doctors for basic health needs. From a community perspective, for a person needing health care we do have visiting specialists for some areas, so there are some operations for which we need to be flown to Adelaide, but that is always taken care of. Sometimes there is a waiting list at the doctors' surgery. There is not a really good after-hours service—we have just established one but it is very expensive. I guess that, for a town of 26,000 people, we have a very efficient and a very good hospital. I cannot put a finger on anything that is seriously lacking, from my point of view. The private health fund cost is going up and I do not know how long my husband and I will be able to afford that. That is something else that is quite a serious concern.

Ms HALL—You identified safety of seniors. You started talking about a program that was operating in the Territory for visiting and checking up on people. Would you go into that a little bit more for us? I think that sounds very interesting.

Mrs Noble—It is not happening here but it is happening in Darwin. It is a local council initiative. Somebody makes an early morning call to people who might be considered at risk to make sure that they are up and about. There is quite a lot of debate with people on the council because older people are at risk and are encouraged to have deadlocks and things on their units but when something happens nobody can get in, so there needs to be a key arrangement. That is all being looked into. One local council up there is starting to do something like that.

Ms HALL—Would you be able to organise for us to get information on that? Would you talk to the secretariat afterwards to see if there is a way we can get some written information on the scheme and also copies of the booklet that you referred to on the Northern Territory Pensioner Concession Scheme? It would be worth while for us to have a look at that. Thank you very much for answering my questions.

Mrs Noble—Jill, you will get that when you get back to Darwin, and you will probably have somebody in Darwin who can definitely give you the information on what is happening with the safety issue.

Ms CORCORAN—I will be very quick; I am aware of time. I want to go back to this business of old people being compulsorily retired. Is compulsory retirement still in place?

Mrs Noble—It finished last year. We were the last part of Australia to get rid of that 65 thing. I know that one report thought it was all abolished in 1999, but we have taken a long time to get rid of it here.

Ms CORCORAN—That leads me to the second part of my question. You talked before about the need for employers to be encouraged to continue to hang on to their older employees. In other parts of Australia on this inquiry we have heard people say that, even once someone has retired, they have still got a lot of skills, knowledge and experience that can be used in the community. Has your committee given any thought to ways of using those experiences and skills outside the workplace, perhaps in mentor programs or through volunteering in different places? Is it seen as an issue up here?

Mrs Noble—As I said, we are not there to initiate things; we are there to just advise the minister on things that should be taken further or investigated. I guess that gets me back to the

institute for the ageing. To me, that is where that sort of thing could be all pulled together and where something really constructive could be done.

Ms CORCORAN—Is there legislation in the Northern Territory to prevent discrimination on the grounds of age?

Mrs Noble—I do not know.

CHAIR—Mrs Noble, on your comments about having to retire at 65, I think sheer logistics are going to take care of that problem because it has become obvious that there is a very great shortage of skilled people in Australia. It seems probable that people might start going back to work at 65 in the future, having taken early retirement, rather than the other way around. Thank you very much for appearing before us.

Mrs Noble—Thank you for listening to me.

[9.37 a.m.]

LUSTY, Ms Ellie, Coordinator, Frontier Services Carer Respite Centre

MILES, Mrs Mary Anne, Director of Nursing, Frontier Services Old Timers Aged Care

CHAIR—Welcome. I do not think you were here before, so I will just repeat that you must understand that this is a formal hearing of parliament and, as such, by misleading or giving incorrect information you could possibly be held in contempt of parliament. That is not a warning; it is just for information. We would be very interested in hearing a five-minute statement from you on what you believe we should hear from your area.

Mrs Miles—I have been a nurse in Alice Springs for the past 33 years and I have been involved in aged care in Central Australia for the previous 18 years. I have been a director of nursing for 11 years in Central Australia.

I believe that the state of operating aged care facilities in Central Australia is reaching almost crisis proportions with regard to two major issues. The first of those two major issues is capital upgrade. We are in a situation in Central Australia where 87.1 per cent of residents of our 56-bed high-care nursing home are concessional residents. As you are probably aware, the ability to recoup money for capital upgrade depends on acquiring accommodation charges and bonds. There is a high proportion in Central Australia of poor retirees—that is, poor and frail aged. Of the high-care residents in the nursing home, 47 per cent are traditional Aboriginal aged folk from all of the remote areas of Central Australia, ranging from the South Australian border to the Western Australian border up to the Barkly Tableland.

Old Timers aged care facility also has 47 self-care, independent units, which are pensioner flats. The only criteria for admission to the pensioner units are that you have a housing need and are a pensioner. John Flynn of the Inland Mission started Old Timers 52 years ago purely as a vision for the aged in the outback. We have the oldest retirement village in the Northern Territory, and it has very aged buildings. In the next three years we are required to do a $3 million upgrade to the nursing home. The oldest of the self-care, independent units is 52 years old. We rely on the Uniting Church, which is the operator of the facility, to top up the financing of the pensioner units and on fundraising within the community. I should say the community support the Old Timers village in a most heroic manner. We usually raise up to $50,000 a year at one fundraising event.

One of the major issues of the past three years has been, and I think will be into the future, the recruitment and retention of skilled staff. There have been times in the past 12 months when 23 per cent of the payroll has been taken up by agency staff wages. I am currently in the process of sponsoring a South African registered nurse, who I hope will be here in three weeks time. There have been times in the past 12 months when I have had four agency registered nurses from South Australia on my books, and I have to fly them in and out as well as pay for return airfares, pay casual rates and provide free accommodation. It is unsustainable to continue to operate in that manner, which is why we have looked into importing registered nurses—professional staff—from abroad. I have also had to fly in direct care workers in the past 12 months.

There is a shortage of trained and skilled aged care workers. The face of aged care in the last two years has changed hugely. People do not live as long once they enter a high-care facility. They have multiple medical conditions and there is a huge amount of palliative care and palliation, and you need skilled clinical staff to deliver excellent care. Since the Aged Care Act was introduced—and all nursing homes must be accredited and meet the requirements of accreditation—we are required to provide a higher, more excellent level of care with fewer resources and fewer skilled staff. I cannot see any improvement in the future for our lot as far as retaining and recruiting staff when the disparity of wages in the public sector in Central Australia is so huge. An experienced registered nurse—a level 1, year 8—working for Territory Health at the hospital would be earning approximately $10,000 more than a registered nurse with the same experience working in an aged care facility.

I think the networking between, and the support for, the agencies that deal with the frail aged and the disabled in Alice Springs is very good. We communicate well and meet frequently. I think overall a lot of the services that I deal with—remote and urban—work above and beyond to try to deliver the best for individuals. Frontier Services Old Timers Nursing Home is quite unique in the fact that 47 per cent of the 56 high-care residents are traditional Aboriginal. We offer 1,700 respite bed days per year. So it is very busy.

CHAIR—How many beds have you got altogether?

Mrs Miles—Fifty-six high-care beds.

Ms Lusty—I work for Frontier Services as well, but I am the coordinator of the carer respite centre. We work in the community as far north as Elliott, and out to the WA and Queensland borders. There are two people who work at the carer respite centre—me and an outreach work. We try to work with carers to support them and ensure that they receive respite so that they can continue in their caring role. My focus in relation to older people is both as recipients of care and as carers themselves. We have quite a large number of older carers looking after younger disabled people.

Older people are encouraged to remain in their own homes for as long as possible rather than be admitted inappropriately into residential care. Informal carers take on the main impact of that care in the community. They provide an invaluable service to the community, with very little recognition. In Central Australia there are also older Aboriginal people who want to remain on their homelands. There are greater health problems, such as high instances of high blood pressure, diabetes and renal disease. Allied health in that area is particularly lacking. Covering that remote area we have one physio, half an OT and half an Aged Care Assessment Team position. Most of the services are centred in town, and most of the residential respite facilities are centred in Alice Springs and Tennant Creek. So people have very little choice about accessing residential respite facilities. Although people are being encouraged to remain in their own homes for as long as possible, from what I have observed there are very few resources for them to do that. A community aged care package provides a very limited amount of support to people, and we do not have any of the EACH packages in Central Australia.

In relation to respite, the quality of everyday care services is paramount. If we can support carers appropriately on a daily basis then the demand on respite is not as great. Particularly in remote communities, the aged care services are fairly inadequate. We are often asked to provide

respite as a general day-to-day service for people. We are very limited in the residential respite we have for younger people with disabilities and for people with mental health problems, who often have older carers. There is a general lack of support for carers of those people, I feel, in a respite capacity. Generally, for older people living out in remote communities life is extremely hard. There are huge health problems, poverty, heat—although it is not hot here today—and a lack of resources. There are other familial obligations. Carers are finding it extremely difficult to look after older people, although they are looking after older people. There are also older people out in the communities who I feel are being neglected, through no choice of the family.

Employment for local people out on communities is very difficult because it is hard to pay people a proper wage out on a community—CDEP is very limited. For older people accessing health and allied health services there need to be very clear processes. Here in Central Australia there are a lot of services. The services that are provided are fairly arbitrary and quite ad hoc, there are not clear processes for people, and there are a lot of organisations involved, so one older person might have seven or eight people coming to see them asking the same questions. There needs to be some streamlining of that.

Another area is hospital discharge. People are quite often placed in respite beds when they are discharged from hospital before they return home, and I question whether some of those situations are ones where people need to be rehabilitated in a more appropriate setting than a nursing home. The discharge planning is definitely health led rather than being led by social care. It would be good to see a development of pre-admission to hospital that supports people in the community, so that people do not have to enter hospital unnecessarily. Also, at discharge it would be good to have a plan to support people for a limited amount of time so that they can return home rather than fill up respite beds that we then cannot access. To improve aged care services in the future I would see more early intervention services for people, and issues around hospital admission and discharge need to be resolved.

There needs to be a greater acknowledgment of the role of carers in keeping people out of institutional care. Another area that needs to be reflected in the workplace is where people are expected to provide care for their elderly parents but who do not have any employee entitlements through their organisations. There needs to be flexibility in the workplace for people looking after their parents. There also needs to be more resources in the community to prevent inappropriate admission to residential care.

CHAIR—Thank you. You said you had 57 high-care beds. Do you have low-care beds as well?

Mrs Miles—There are 56 high-care beds and 20 low-care beds, which I do not manage but our organisation does—it is on site—and there are 47 self-care independent units.

CHAIR—So most people come in directly as high care, do they?

Mrs Miles—No. The majority of admissions to the high-care facility would come directly from the acute care sector at the hospital. The care needs of people in the pensioner units may increase and community services may not be able to support them safely, so they may go into the low-care facility before they come to the high-care facility. Theoretically, there are three stages of care.

CHAIR—You mentioned bonds and what have you for people who come in on low care, and I know we will find out that Broken Hill is exactly the same. Obviously people do not have the resources because their homes are worth nothing like they are in other places. Did you say that almost half your people in the home are of Aboriginal background?

Mrs Miles—Yes, 47 per cent, and it has always been at that level.

CHAIR—Do they come in at similar or different ages? Are they younger when they come in?

Mrs Miles—You have to understand that traditional Aboriginal people in Central Australia, in my experience, age at a younger stage due to chronic illness. We are also finding demand for admission for what I call younger aged people who have chronic illnesses and disabilities as a result of substance abuse and alcohol related violence. Quite a few of the frail aged traditional Aboriginal people who come into the nursing home have a need for a secure and caring environment, and they usually have very high care needs. Chronic renal failure is quite common. We have several people currently who are on haemodialysis and we also had Aboriginal people in the previous year on peritoneal dialysis, which we do at the nursing home.

CHAIR—Could you hazard a guess as to how young most of them would be who come in? How much younger would they be than the rest of the population?

Mrs Miles—They would be in their late fifties, early sixties. Some of the remote communities, depending on the strength of the family groups, provide incredibly good care to quite dependent non-mobile family members in Third World situations. It is quite spectacular. However, it is usually the last option for a traditional Aboriginal person to be admitted into a residential facility. Usually the discharge planner and the ACAT team go through quite a long process to try to return them to their community. But a lot of the willing carers in the remote communities have a lot of responsibilities. They may have children; they may have families. In my experience, they may have other family members who are not their children but for whom they have responsibilities.

CHAIR—Because of where we are here in Central Australia, what you are saying is that the 2008 standards that have to be met, combined with the lack of resources of the people coming into the homes and the expense of getting good staff, is making it very hard to run a home.

Mrs Miles—Yes. It is the most difficult situation that I have experienced in 18 years.

CHAIR—How long have you been here?

Mrs Miles—I have been living in Alice Springs for 33 years, and it is the most difficult situation I have experienced in my entire career in aged care. Do not forget that our Frontier Services Old Timers Nursing Home is fully accredited. We had our second accreditation round in January last year and, since we have never had any suggestions or requirements for improvement, I consider we run a good service, but it is in very difficult circumstances.

Ms HALL—Thank you for sharing that with us. It really shows us what a challenge it is to deliver not only quality aged care but any kind of service in the Territory. What would be the

average age of somebody in the nursing home and hostel? You have given us an idea with the Indigenous population.

Mrs Miles—As an absolute guess I would say mid-70s. We have a couple of young disabled Aboriginal people in the nursing home, and if I accept a young disabled person into the nursing home it is usually as a stage to being relocated to their community. They may have been involved in a motor vehicle accident and be in rehabilitation in Adelaide for up to 12 months. We discharged one back to their home country in Hermannsburg last year, and we are planning hopefully to discharge someone into a house in the community with the family in the middle of this year.

Ms HALL—We hear in other places of the difficulties associated with the RCS. I am wondering how you find that in the Territory. Forgive my ignorance, but do you get any sort of weighting? Do you get a greater amount, having to deliver services in the Territory?

Mrs Miles—No.

Ms HALL—You do not?

Mrs Miles—We get a viability subsidy, but it is a pittance in the real costs. I was just looking back at the last couple of months, and our viability subsidy was between $6,500 and $7,000 per month.

Ms HALL—So the RCS is a problem for you?

Mrs Miles—It is. I could not see the nursing industry tolerating it. I think the aged care industry has undergone huge changes in the last six years and has coped with it in an amazing way. Those changes have been very good changes. I would be the first to say that the changes that have been imposed on the aged care industry have been for the betterment of it. However, the cumbersome, unwieldy, time-consuming documentation requirements in the aged care industry are a scandal. I have to pay an enrolled nurse for usually two days a week full time to ensure that we keep on top of our assessments and our claims, because our money comes with our claims. If we do not do proper assessments, we do not make a high enough claim and we do not recruit the money to pay for the interventions we are delivering. It is scandalous.

Ms HALL—Are there greater costs in having to deliver culturally appropriated aged care to Aboriginal people that you have in your high care and low care, and how do you cope with problems such as language?

Mrs Miles—That is a very good question; communication is a huge issue. There would be at least four language groups and people for whom English is a second language. We are able to tap into interpreter services locally if we need to. We have only one Aboriginal person on staff who can interpret at times. Traditional Aboriginal people who come in for respite care or for permanent care usually have no personal effects at all. We usually do not have any of the required numbers—for example, pensioner numbers, Medicare numbers and all of those things—so extra time is spent by our administration in chasing up and ensuring that the names and the pension numbers are correct. That takes a lot of time. They have no personal effects at all, and there is a settling-in period usually. I could say that most of the Aboriginal people in the

nursing home would rather be living on the land, but they are safe in the nursing home and they are usually happy there. If someone is really unhappy, we try to relocate them home. Everyone has to understand that no-one really wants to live in a nursing home; it is not their home. If you are not Aboriginal you probably would rather be living at home too.

Ms HALL—My next question is directed to you, Ellie, and it is about carers and delivering services to remote communities. What sort of support is there for carers and what sort of support is needed? I noticed you made quite a point of saying that carers were under stress.

Ms Lusty—Yes. Particularly out in remote communities—but also in towns—carers are under enormous stress. As I said before, part of it is in the services that already exist out in the communities. Some communities do not have functioning aged care programs, so there is not an ongoing daily—

Ms HALL—How should it be addressed?

Ms Lusty—I think a lot of communities need a lot of support in being able to establish and set up aged care services and for ongoing, continued support.

Ms HALL—What sorts of recommendations would you like to see government make to improve the situation?

Ms Lusty—I think there needs to be a way of looking at employing local people to work in communities in an effective way, and that is a huge issue in itself. We do employ people in a couple of communities through a dementia pilot project. That is only for a limited number of hours per week, but it provides additional support to that aged care program and, as an organisation, we can support the infrastructure for that program.

Ms HALL—Take the scenario of an aged person living in a remote community who needs dialysis and a quite large amount of health services. How do you cope with that? What sort of cost does that impose?

Ms Lusty—Somebody having to access dialysis would not necessarily be carer respite. I guess they would have to access that in town. They cannot access that out in the community.

Ms HALL—So that involves extra costs?

Mrs Miles—Yes. One of the points is that it is difficult to recruit for and continue to staff a specialist service in remote areas in the communities. Getting dialysis units running in some of the larger communities has been mooted quite a lot. It is difficult to recruit and retain skilled staff.

Mr MOSSFIELD—Are there any remote communities that you are not in contact with at all to supply aged care? Is there unmet demand out there?

Ms Lusty—I would say there are communities that would not have received a visit by an allied health professional for a very long time.

Mrs Miles—Further to your question, Mr Mossfield, I am finding that those services with established aged care services—those with home and community care services or aged care support services—tend to tap into more services available than those communities that do not have any services. Do you know what I am trying to say? It is basically that I am finding that the people who already have a fair amount of support are a bit more in the know.

Mr MOSSFIELD—Yes, I see. Isolation is obviously a big factor there. Is it that the further away and more remote that people and communities are there is less likelihood that they are going to have these aged services?

Mrs Miles—It depends on the community, from my experience. It depends on the structure and on the strength of the people in the community.

Ms Lusty—Yes; and, quite often, attached to a lot of funding is the need for reporting. That can be quite difficult for some communities where there might not be a particularly well-established infrastructure to handle that.

Mrs Miles—When people are booked to come in for respite, my respite beds are usually booked back to back, fortnightly in and out. It is not unusual for people not to turn up on the booked day because of transport problems—aircraft ones or because it might have rained or there might not have been a car or the car may have come in three days in a row but still not come to where they were meant to come. I lose money on those down days. This is a small country town, in my eyes, really with lots of services. Some are not as effective as they could be.

Mr MOSSFIELD—Do you have services such as Meals on Wheels? If so, what area do they cover?

Mrs Miles—In the urban area the Red Cross provides Meal on Wheels. It provides a fine service in town. I think one of the Aboriginal organisations also provides Meals on Wheels in the urban area. There is here a representative of one of the remote communities who will talk more about Meals on Wheels in remote communities, but it depends on the community and what is available at the particular time.

Mr MOSSFIELD—What about other services for aged people living in their own home, such as shopping, laundry, banking and meeting the need to take medication at appropriate times?

Mrs Miles—There is one service provider in Central Australia who has provided approximately 24 community aged care packages over the past few years. There are several funded services providing community aged care packages in the urban area, as well as the Red Cross providing HACC services, which help people with shopping, prompting for medications and going to appointments with the doctor.

Ms Lusty—Those services, especially the HACC services, seem to be very limited for people. They provide the bare minimum.

Mrs Miles—Although they are limited, I know that they are much easier to access than those in a capital city.

Mr HARTSUYKER—Is there a strong reluctance by, particularly, people in remote communities to actually go into care and would that reluctance be causing some very adverse health outcomes?

Ms Lusty—My experience recently is of carers who are asking for an aged person to go into respite and residential care but the person does not want to go. There is then a conflict in the community. You want to try and meet the needs of the carer but, at the same time, the care recipient does not want to come into town. So we are trying to find ways to take care out to the community and look after people there so the carer can still have a break but the elder person be looked after.

Mrs Miles—It is not unusual for these old people to not have a house. It could be just a shelter with no access to water or a bathroom. It is not unusual at all.

Mr HARTSUYKER—Is it a big cultural change—I presume it must be for people to go from that sort of situation—and how do they blend in with those residents who are already there in the existing facility?

Mrs Miles—It is a big cultural change for the individual, because they always want to see family. However, if you have not had food, warmth and shelter, you are pretty happy when you have got it, and we make big efforts to try to have the family visit as frequently as possible. Security is another thing. Security for Aboriginal and non-Aboriginal people is quite an issue in Central Australia, I believe.

CHAIR—Is safety a bigger issue for older people?

Mrs Miles—Yes, because they are vulnerable.

CHAIR—Thank you very much indeed for coming forward. You have given us a mile of information, and we do appreciate it very much. Thank you both.

[10.13 a.m.]

BELL, Ms Stephanie, Director, Central Australian Aboriginal Congress

BOFFA, Dr John, Public Health Medical Officer, Central Australian Aboriginal Congress

DE DECKER, Dr Koen Paula Karel, Acting Medical Officer Coordinator, Central Australian Aboriginal Congress

DENNIS, Ms Louise, Aboriginal Healthworker, Frail, Aged and Disabled Program, Central Australian Aboriginal Congress

CHAIR—I welcome representatives from the Central Australian Aboriginal Congress to our public hearing today. This is a formal hearing of the parliament, so any misleading statements or otherwise can be held in contempt, which I am sure will not happen. Thank you very much for your submission. If you would like to give a very brief statement, we would be very pleased to hear it.

Ms Bell—I thought we would start by each of us having five minutes to present something, if that is okay.

CHAIR—I do not know if we can give you all five minutes. Perhaps you could take 10 minutes amongst the lot of you. I think we can do that. Then we will ask you questions. Okay?

Ms Bell—Okay. The main thing I wanted to do was let you mob know what congress do and what our role is here in the community. We provide a comprehensive primary health care service to about 7,500 people per annum. That population consists of about 5,500 Aboriginal people in the town and the other 2,000 we see are visitors from other remote communities. Within that population base there are 3,500 people who live in the town area and 1,000 people who live on the town camps. As well, we service a population of 1,000 people within a 100-kilometre radius of Alice Springs itself. We have in the front page tried to break down the population of the area that you are doing a review on. About 900 of our clients are above the age of 55 and 330 are above the age of 65, so we do not really have a big population of people who are over 65—the age at which most of the Commonwealth's aged care programs are targeted. They are the main points we wanted to bring to your attention.

Congress are the only bulk-billing service in Alice Springs itself. We are open between 8.30 a.m. and 8.30 p.m. and on weekends we open until lunchtime. We deliver a range of programs. Koen and Louise work on the program that deals mainly with frail aged and disabled people, and they have statistics that Koen will advise you about.

The other main point I want to raise is that the demographics of Aboriginal people are not similar to those of the mainstream, as you are probably aware. We do not have a very long life expectancy; it is 20 years less than that of most other citizens. More than half the population we see is under the age of 25. We also have generations of people who are having families and children much younger, so they are important statistics for this government's long-term planning

over a 40-year span. They need to be considered with respect to access to services and other needs of the Aboriginal population. In today's society we have Aboriginal people who are grandparents in their forties. That is another important component in planning for long-term ageing services.

The other main thing we are trying to advise the committee about is that access to services and funding needs to be reflected around that environment and that population. What we mean by that is that currently aged care services do an injustice to Aboriginal people because they do not target that level of population that I just described. Access to services is a major issue. How those services are provided and targeted to that population's needs is another major issue, which we talk about throughout the submission. For the next part I will hand over to John.

CHAIR—We are quite happy to give you all five minutes each; we are going to restrict ourselves on questions. Over to you, John.

Dr Boffa—I will just talk about the importance of primary health care, work force and quality service delivery, and then Koen and Louise will talk about aged care specific services within congress. The burden of illness that older Aboriginal people are suffering from mainly now is complex chronic diseases—that is, heart disease, kidney disease, high blood pressure, diabetes and those sorts of things. The international evidence, which we quote in our submission, is very clear: comprehensive primary health care can make a major contribution to reducing the burden of those diseases and enhancing life expectancy amongst groups of populations such as Aboriginal people. Unfortunately, Aboriginal people throughout the Northern Territory and Australia have not had good access to primary health care, unlike indigenous people in the US, Canada and New Zealand.

The Commonwealth government has a major initiative called the Primary Health Care Access Program, which is attempting to address that inequitable access to health care. One of the major points we want to make to this inquiry is that the full funding of that program will make a very substantive difference to the quality of life and life expectancy of older Aboriginal people. In Central Australia, for instance, at the moment there exists an inequity in that there are 11 health zones and in terms of per capita funding the worst zone is $330 per person and the highest funded zone is $1,500 per person, so there is a big difference. The benchmark under the Primary Health Care Access Program is $2,000 per person plus Medicare plus PBS. So there is a severe inequity out there. In Alice Springs, congress's funds are at a level of about $1,000 per person, the benchmark for remote areas being, as I said, $2,000 per person. With that sort of funding, properly distributed, supporting comprehensive primary health care, we can expect to see a very significant improvement, particularly in those chronic disease conditions that Aboriginal people suffer from.

The second point I want to make is that, once you have the funding, you then have to be able to recruit and retain a quality work force, and you have to be able to deliver quality services. Certainly, in remote areas, relying on competition and consumer choice to determine quality does not work. There are not enough providers and the reality is that, if consumers do not get a quality service, they cannot easily move to another provider. In the case of congress, we are the only bulk-billing medical service in Alice Springs and we are the only service that provides access to free pharmaceuticals. So, if someone does not like our service, it is pretty difficult to go elsewhere. It is the same with HACC service providers. It is very difficult for consumers to

suddenly say, 'I'm not getting my service from this organisation; I'll take my CAP P money and go elsewhere.' It does not happen. So there need to be quality assurance systems that are contractually required and in place and accreditation systems as a protection for consumers in terms of quality of service delivery. Congress has had an accredited quality assurance program since 1994 which we think is very effective. It reports regularly to management and to our governing committee, and that provides some safeguards to our consumers about the standards of our services. But not all services have that, particularly the HACC services—they have nothing like that.

In terms of the recruitment and retention of the work force, in the last 10 years congress has gone from having three full-time GPs in 1995 to having 11, which means we now have a full quota of general practitioners. That is one example of the ability to recruit and retain professional staff. In the last three years the staff turnover amongst the professional staff at congress has gone from 20 per cent in 2000-01 down to 0.9 per cent last financial year. So we have been able not only to recruit but to retain professional staff.

The things that have made a difference in that are, firstly, offering adequate pay and conditions, PBI status and getting extra resources through Medicare, MBS, PBS, allowing part-time GPs to work and the cessation of the 24-hour on-call service. We used to provide an overnight on-call service but two years ago that was stopped. We are open only to 10.30 at night now, so doctors do not have to get out of bed overnight and then have to come to work the next morning. So a range of things have happened to improve the pay and conditions for GPs. Secondly, congress offers work beyond the traditional fee-for-service role of GPs. At congress GPs work in our clinic in a fee-for-service capacity but they also choose from a whole range of public health programs, depending on their interests. Dr Koen works on the frail aged and disabled program, another doctor services the nursing home, some work on the youth program, some work on male health and some work with children. There is a whole range of areas that they get involved in outside of the clinic which provides an interesting and challenging work environment. Thirdly, the organisation is large enough to have effective internal support systems: human resources, management, locum support—a range of things that are essential in terms of recruiting and retaining staff.

Translating that into what generically makes a difference, we think that in remote areas organisations that get funded to deliver programs and services need to be large enough to have economies of scale, to have the internal support systems that are necessary. They also need to be large enough to have a multidisciplinary team environment. We should not set up and fund small organisations that have only a few staff; there needs to be larger organisations that have multidisciplinary teams, and staff in various programs can be integrated into those team environments. That is not really what has happened. In aged care there has tended to be an atomisation of funding through CAP P packages and potentially many organisations getting a little funding. That needs to be looked at, as we said before, because consumers are not in a strong position to suddenly take their funding and go elsewhere. With that, I will hand over to Koen and Louise to talk about the need for aged care specific services within comprehensive primary health care services.

Dr De Decker—I would like to explain a little about the FAAD program, which is an acronym standing for frail aged and disabled patients. It is a specialist clinical program within the congress structure. The eligibility criteria for patients are actually patients who have a great

difficulty to access congress or who are even unable to do so because of frailty, age and/or disability. In general, these are often patients with complex chronic medical diseases who require more intensive monitoring on a more regular review, and often home visiting on a regular time scale is very important. Staff on the program consist of one doctor—me—who is doing four sessions a week whilst trying to be flexibly available at other times in the week whenever problems arise, and a 1.5 full-time equivalent Aboriginal health worker.

Why do we have a FAAD program and why do we actually need it? I think health outcomes are likely to be better for Aboriginal patients because of triple facilitators—which is one working within an Aboriginal medical service, having a program within that service and being able to work as a team of health workers and doctors. As an Aboriginal medical service, it obviously has appropriate policies and an appropriate infrastructure—for instance, programs in place in order to make sure that the best possible medical and social services can be delivered to Aboriginal patients. Apart from just caring for people, it is an organisation that can also advocate for Aboriginal interests and rights. Within the structure, there is an opportunity to actually create multiple medical services, allied health services, where people can access all those services within the one building as far as possible.

As a doctor on the program, I think it is extremely good to have a program. It gives me the ability to look after the same patients day after day so that there is continuity of care, unlike in a general clinic where patients usually walk in—rather than having an appointments system. Equally important from my point of view is the fact that I have sufficient time. Being on a program, I have time to actually manage the patients. It is not unusual for me to take a couple of hours to actually browse through a patient's file to start a management plan, time which I would never have in a general clinic.

It is extremely important to have Aboriginal health workers on the program. For obvious reasons, they have a greater understanding of Aboriginal culture, lifestyle, problems, needs, social determinants of health, social risk factors et cetera. At the same time they have knowledge of Western concepts of health and diseases, and therefore they are the ideal people to bridge the gap between patients and doctors and between patients and other services. They are important because they are a point of reference for the patients to trust and they empathetically support them emotionally and practically.

The FAAD program works with a team of a doctor and one or two health workers. I think this program actually gives us the opportunity to give good care because it creates time and it facilitates guidance, close monitoring and follow-up of patients. We also have the experience to deal with specific medical and social problems, issues and obstacles that arise time and again because we are exposed to them on a daily basis. For all these reasons, there are numerous examples of good outcomes where care for the patients has improved just because of having a program and a team and being able to work from within congress.

As John was mentioning, there is a huge burden of chronic diseases. They are more prevalent in Aboriginal patients, and their onset is often at a much younger age. They are more likely to be complicated—again, complications are prevalent at a younger age—and there are significantly worse outcomes at younger ages. Chronic diseases are especially prevalent, and synergistically they make it worse for the patient—not to forget the social determinants and risk factors which are basically a breeding ground for acute and chronic diseases. Most, if not all, patients on the

FAAD program have a range of chronic diseases and disabilities which have a significant impact on their health status and their quality of life. It makes us realise that we are basically dealing with the tip of the iceberg, that there is such a burden within the program. It really suggests and proves that there is a much greater burden of pathologies which we cannot even take on board.

We have a bit of information on FAAD statistics. We have 50 patients currently on the program—18 males and 32 females. The average age is 57 years and the mean age is 59.5 years, which means that half of the patients are younger than that.

I would like to say a bit about disability. By definition, FAAD patients are frail, aged and/or disabled. So, in a way, being on the program means that 100 per cent of them are disabled. But if we were to be a bit harsher and have a stricter criteria for major disabilities in order to be present some statistics—if, for instance, for visual loss we talked about blindness; for hearing loss, we talked about deafness; for osteoarthritis, we talked about not being able to walk, needing a walking stick or a wheelchair—then we would have 1.2 major disabilities per patient on our program.

I have a few statistics here and I want to highlight some of them. I would be happy to submit this paper as well later on. We have 50 patients on the program, so the percentage is double the figure. We have 24 diabetics. We have 31 hypertensive patients. I am just mentioning the main ones. We have 28 patients—which is more than half—with chronic renal disease, and half of them have a grade 3 or grade 4 chronic renal disease, which means it is pretty much advanced—grade 4 is predialysis, including dialysis itself. We have five patients with bronchiectasis, a condition which is not frequently encountered, definitely not to that extent in mainstream practice. Two of them are on home oxygen.

We have five patients with chronic liver disease. We have 11 patients, which is 22 per cent, with symptomatic anaemia. Their blood is that weak it affects their daily life. We have six patients with hearing loss. We have a very large number of patients with visual loss. Thirteen, which is 26 per cent, are basically blind. There is a lot of trachoma. Ten patients have trachoma which, again, is a disease which is more common amongst Aborigines. We have three palliative patients. We have a huge range of social problems which make the chronic diseases more likely to happen. We have lots of patients with poor housing problems and alcohol and smoking dependence. Importantly, we have 15 patients with moderate problems when using English as a language to communicate and 20 patients with severe problems. This is important because it affects the health outcome, obviously. The same applies to the level of education. Ten patients have only moderate education. Twenty-two have poor education.

To give some more statistics in general, summarising the above, we could say that the average number of chronic complicated conditions, plus significant events, per patient would be four—and that is excluding the cardiovascular risk factors as such. The average number of cardiovascular risk factors, excluding Aboriginality, is three. The average number of patients on the program with common chronic conditions, as mentioned in the chronic diseases projects—hypertension, diabetes, asthma and heart disease—is two.

Ms Dennis—I am an Aboriginal health worker who works with the frail and aged disabled program. We have 50 clients but, overall, there would be many other people who would be in need of our service. Apart from all the medical work that we do on the program, we are also

responsible for coordinating care and home help for people. A big problem that we have is organising home help and home care, especially for people on the town camps. There have been problems in the past with getting trained people to go and work and deliver that service and also with respect to a bit of teamwork amongst people providing the care for those people. I guess that in working and looking after the aged there are great problems for us in getting support for carers and accessing that care. There are also lots of problems in terms of people who maybe need nursing home care but often cannot access it or there are long waiting times for those people to access those services.

Ms HALL—What would the waiting time be?

Mrs Miles—It is very variable. Right now there are at least 13 people on the waiting list for permanent admissions but at this time last year I was running about eight respites because we did not have a vacancy. It is very variable.

Ms Dennis—There is such a lack of support for carers that it puts pressure on us doing the work that we need to do. Then there are all the gaps and the social needs of the patients who cannot get support. There is just no support for those people. That is all that I would like to say about that.

CHAIR—Are you involved in delivering the aged care packages?

Ms Dennis—No.

Dr Boffa—We have to try to coordinate with other service providers that deliver HACC services. That is what Louise is talking about: the HACC services and the quality and extent of those services.

Ms Bell—The liaison between HACC providers and the health service is quite difficult. We think that there have to be some quality components put in there so that the relationship between HACC and health services happens in a coordinated way to maximise the quality of life for people.

Dr Boffa—We actually think the contracts for HACC services should require providers to liaise, integrate and work with health services. It should not be left to the discretion of individual service providers to do that; it should be a contractual thing—and it is not at the moment.

CHAIR—It is not a condition, in other words.

Ms Bell—You need that coordination.

Ms HALL—So that would be a very strong recommendation for us as a committee.

Ms Bell—There should be quality assurance systems for HACC programs. There is no quality assurance for the way programs are provided and who monitors them. The quality is determined by the relationship between the provider and the client.

CHAIR—All the figures and everything you have given us today involve about 5,500 people plus whoever travels through. Is that right?

Dr Boffa—Yes, there are 5,500 permanent client, and 16 per cent of those are over 55 and six per cent of those are over 65. And we see 2,000 visitors a year; they change.

Ms Bell—But the capacity of our program is only 50 patients. There are only two health workers on it.

CHAIR—We have heard a few times today that the Aboriginal population seems to age at a younger age, if I can put it that way. I think you have very graphically described the causes. Do you want to have a go at describing some of the ways we can address it. Is it diet from a very young age that is causing it? Could you have a go at telling us why, physically, it is happening?

Dr Boffa—I might start with what we told an interdepartmental committee that is currently inquiring into Aboriginal health. The congress thinks there are five major determinants of the poor health status of Aboriginal people. The first is lack of access to health care, especially primary health care but secondary and tertiary as well. That is a big problem compared to the situation in other countries. The second is poor education. The third is substance abuse. The fourth is employment and income support. The fifth is individual responsibility versus welfareism—that issue. There are other determinants that people talk about, like housing and various other things, but for various reasons we think those five determinants are the key things that need to be addressed if we are going to improve Aboriginal life expectancy.

CHAIR—Can you come down off that broad descriptive level and say whether it is bad diet when they are young going through into middle age? Can you be a little more earthy about it?

Dr Boffa—The reason I went out to that level is because diet, to a very large extent, is determined in a social context: what people eat, what foods they can access, the price of food, what they learn to eat is embedded in a social environment and social context. So of course if you have a poorly educated population, an unemployed population and people living in poverty what they will tend to eat is very different from what another population will eat.

CHAIR—I do realise that, but I would like you to be graphic about it.

Dr Boffa—There is an issue of individual responsibility in all of our choices, obviously, but there is a continuum between our own responsibility to choose effective food, to choose healthy lifestyles, that is embedded in the social environment in which we live.

Ms Bell—The problem with most of the communities we are talking about is that access is an issue, whether it is to good healthy food in stores, to transport, to good health care. All we can do in the current epidemic of chronic disease is have a system that helps manage that, because we cannot go back 50 years to find out why someone has a chronic disease—we have missed the boat. I suppose the other determinant that we are trying to express is that governments do have a level of responsibility to Aboriginal citizens in terms of access to education as a really important determinant so they can then take responsibility to engage with systems to be able to get what they can out them.

Education is a really important component that all of us need to take on board as being the thing that contributes to health gain. If you are living in poverty, if you are living in an environment where access to most services that all of us have access to is not there, it makes it very difficult until people get into environments of really chronic disease, including renal disease, which is quite an epidemic. That puts a person's lifestyle into a whole spin so then they have to adjust a whole level of their lifestyle to have access to a service that is predominantly not there in their community. There is a really huge epidemic of renal disease and therefore all the social issues that impact on people's lives become secondary, because if you are going to die you need to be on machines, and there is a whole range of survival issues that people have to deal with.

There are some important issues that the committee can advocate, beyond just dealing with ageing, in terms of the current population and planning for 40 years. There is the fact that teenagers are having children at a much younger age, so you have now got grandparents in their 40s. There is the epidemic of chronic disease, heart disease and a whole range of other things. You have to plan and target services around that particular population.

CHAIR—Horses for courses.

Ms Bell—Education is another critical component. If we do not start addressing the level of access, of young kids getting into school, and address education in that context, the epidemic will go on for generations, which is what you are seeing now.

Mr MOSSFIELD—There is a point in your submission, on page 5, that interests me, where it says:

… some HACC workers believe that certain family members should be providing care to their old people in accordance with traditional law. This may lead to reluctance on the part of some HACC workers to provide services that old people are entitled to under the HACC program.

Could you expand on that statement to give us a broader idea of what you are getting at?

Ms Bell—We are trying to articulate that Aboriginal people have a culture and a tradition and their society in which they are living and that they relate to, and that is the basis for their whole identity and their being. There is a relationship within that for people in that family group or that clan to play a role with old people. There is a struggle happening in relation to that in their society and, on top of that, if you have a range of services that people need to enhance their own health care and they are not getting those services it becomes a double-barrelled issue for communities to manage for their older people and people with disabilities. It is a combination of what Aboriginal society feels it can do for its own community and the level of services that people need to make the quality of someone's life much better. For Aboriginal people there is a boundary around both of those things, and trying to manage those boundaries within their own society puts a lot of pressure on people.

Dr Boffa—Also, in the recruitment and training of HACC workers, it is important that you recruit and train workers who are going to accept that their role is to provide these services even though they might be providing services that they think the family member should be providing. That can be a tension. If people who are employed as HACC workers do not understand that

completely, they can actually not provide a service while they are attempting to get family members to provide it, which is how it should have been. In our system these HACC services are essential and they are provided to people as a matter of right, irrespective of what families do. There is an issue there.

Mr MOSSFIELD—So there is a bit of a conflict here between Aboriginal culture and what the HACC workers feel as far as the service that should be provided, is there?

CHAIR—Can't that sort of problem be resolved locally?

Ms Bell—Not really.

Dr Boffa—Like we said, there are no quality assurance systems looking at this issue. If there is a situation where individual service providers make a decision to not provide a service because they think family members should, that is something that really gets worked out between clients, who often are quite disempowered, and service providers. There are not good systems for monitoring and making sure that those services are provided when they are funded. One of the main points we are making is that there needs to be accreditation systems and quality assurance systems applied to these really fundamental community based services in aged care that have not been applied in the past. As I said, in big cities, where consumers move their service elsewhere, maybe it works, but that does not work in remote areas. There needs to be assistance.

Ms Bell—I suppose we are trying to say it is a work force issue. If Aboriginal people do have particular family members that they want to nominate as their carer, that is all well and good, because it makes that client comfortable about who is providing the service. But the person providing the service needs to have some training and understanding about the quality way in which it is provided. You cannot just have a service reliant on traditional Aboriginal relationships, because the person who is quite sick needs more than that. That is what we are trying to say. It is a work force training issue. It is okay to provide a nomination of Aboriginal people—it is an employment component—but the prospects are that that person needs proper care and they need good, trained people to deliver that care.

Mr HARTSUYKER—Louise, you mentioned support for carers. Apart from respite, what do you see as the key needs for carers in isolated areas?

Ms Dennis—I think we need more people trained to be able to deliver those services, especially like home help and hygiene. We have people who have lived with no housing and are very sick who have not been able to access anybody to come into that community and into that setting to deliver care and support for carers, even just with food and shopping. Often you have one old lady who is looking after a number of really sick and old people. I think we just need more people who are trained and more workers to deliver those services. I think there need to be more meetings amongst service providers to work out how we can do that and on just knowing what each group of people does.

I find that working on the frail, aged and disabled program we are really consumed with the sickness and the illnesses and trying to manage that, and all the social issues just go around in a circle with no solutions. If you live in a flat or a house in town you have a better chance of

getting someone to come into your house and provide care. But if you live in a town camp it is almost impossible to get help at home. I think that is very unfair for Aboriginal people. There is not enough housing. Houses are overcrowded. The old people often do not want to go into respite care or nursing home care, so maybe within the town camps or the town itself there needs to be alternative respite for them somehow.

Ms Bell—Community based.

Ms Dennis—Yes, community based respite.

Ms CORCORAN—I would like to ask a different sort of question. I am interested in how the congress physically looks after itself. You have painted a picture of a very successful provider of services. Despite all the existing problems, you are actually making a difference. You have been talking about PBI status and all that sort of stuff. I do not know how many employees congress has. Is it an organisation that has salaried people on staff, including doctors? I am interested in how you operate financially. Are you financed purely through Medicare rebates and HACC programs? Can you tell me a little bit about that?

Ms Bell—We have over 100 people. There are over 50 staff working in the services branch alone. We run a generalist clinic, and that is purely funded by the Commonwealth as well as by Medicare funding, which is generated as a part of that.

Ms CORCORAN—It is funded by the Commonwealth?

Ms Bell—Yes, the Commonwealth health department funds us. The other generation of income comes through Medicare, and that is applied back into the services area. We have 100 staff and 50 in the services area. We get some funding out of the Territory government, but most of it, the majority of it, is Commonwealth funding.

Dr Boffa—It is important to note that we do not get any aged care specific money. We never have, so we have to use our core grant to provide it. All the programs we provide are, by and large, coming out of our core grant, which is about $1,000 per head. We need specialist programs like the ones that we have got. The FAAD program provides palliative care. Yet when there was new money for palliative care that did not come into comprehensive primary health care services; that set up separate services. When there was money for dementia workers, that did not come into services like ours. Dementia workers were set up outside the health system and health services. So often there has not been a willingness to apply aged care specific funding and integrate that into comprehensive primary health care, which has been a weakness. There is obviously a need for funding to go to separate organisations for some services, but I think there could be better planning and better use of resources by putting some of the funding, some of the aged care specific money, into comprehensive primary health care services. That program needs a social worker and it needs an occupational therapist—we have not got those. We do not get that sort of funding at the moment. As Stephanie said, it is largely health department money and Medicare and PBS money, and it is from that core grant that we run the clinic and have these public health programs of which aged care is one. We service the nursing homes through Medicare. But if you look at the cost recovery from the service we provide to the nursing homes, you see that Medicare would not cover it all, so our core grant is important for doing that as well.

Ms HALL—I have been lucky enough to visit you at the congress and see some of the things that you do. I know what a great job you do not only in Alice Springs but out in communities in the more remote areas. I have two questions that I would like to ask. One goes back to the HACC programs, the competitive tendering process, the fact that they do not operate on an economy of scale and the lack of networking between those HACC programs. Put very simply, as a recommendation that we as a committee could make would you like to put forward that there needs to be an overarching body that looks at that and can enforce some sort of cooperative approach? What would your solution to that problem be so that we could take it up as a recommendation?

Ms Bell—The establishment of quality assurance systems as an attachment to HACC programs would address some of those—and there would be a category of quality assurance within that—as well as training and support for employees. There are the criteria on which HACC programs are delivered. Work force is a major one, and that would encompass training and the role of carers and what systems need to be there to support carers. They would be the main things.

Dr Boffa—And accreditation too. To get accreditation under a part of health services, you have to do a consumer survey. So if HACC service providers had to be accredited, and as part of that accreditation an independent team of accreditors went and talked to some of the recipients of the services, you would probably then get better information about what services are actually being delivered and what consumers actually think of the services. What we are saying is that competitive tendering alone is not sufficient to safeguard the quality of service delivery and to ensure that all the services that are meant to be provided are being provided.

There have also been some unrealistic expectations in some of the contracts about HACC service providers in some ways being meant to deliver domiciliary nursing. Their staff are nowhere near trained to that level. There was a withdrawal of domiciliary nursing services as the HACC program came in. It is a Commonwealth funded program and states withdrew their domiciliary nursing services such that, at the more demanding end of the spectrum where people need assistance with lifting, showering and bathing—those sorts of things—there is a gap. The HACC workers often do not want to do that—they do not feel that that is their job. The contracts might say they are meant to do that but their level of training is not sufficient, and it is very difficult to get domiciliary nursing services going back to provide those services which they used to provide.

Ms HALL—There should be some form of accreditation attached to Community Aged Care Packages, too.

Dr Boffa—Yes, absolutely.

Ms Bell—I think that would be good, Jill, because that actually provides capacity building alongside service provision rather than just having this program that is supposed to be out there doing things. You have got to build capacity both at a community level and at a work force level.

Ms HALL—I think that is a very good recommendation for us to look at. I had another issue I wanted to pick up on. You identified employment as a health issue. Could you expand on that? Earlier I asked about mature age employment in the Territory. I do not think that is the question

here; I think the question is employment and its relationship with health outcomes and ageing issues.

Ms Bell—We were talking about employment being a key determinant and a factor in enhancing your quality of life, your life choices and access to a whole range of services. But education becomes the first plank that people have to get on to get to that level. Employment is a critical factor determining people's health outcomes.

Ms HALL—What is the unemployment level for Aboriginal people in the Territory?

Ms Bell—I could not tell you the figure on that.

Dr Boffa—If you include CDEP, it is very high.

Ms HALL—No, not including CDEP.

Dr Boffa—The actual official figures are nothing like the reality on the ground. In the official figures, it is only 10 or 12 per cent unemployment—something like that. The rates of unemployment are much, much higher, depending on which figures you look at and whether you include CDEP as being employed or not employed.

Ms HALL—What about as workers on the ground here?

Dr Boffa—It is 40 per cent, at least, unemployment. The *Australian* and the *Age* a couple of weeks ago published a study which showed that the relationship between education and employment is much stronger in Indigenous communities than it is in the mainstream. Even though the relationship is strong in the mainstream, the chance of getting employed if you are an Aboriginal person are much, much more enhanced by educational level—any sort of certificate or training—compared to non-Aboriginal people. The two things do go together, as Stephanie said.

CHAIR—Thank you very much. You have mentioned the need for support for carers and better qualified people. Ms Bell, has the congress involved itself in trying to get local people into courses? There are very substantial scholarships to become an aged care provider through to the registered nurse stage. Have you involved yourselves in trying to find candidates for those courses?

Ms Bell—No, we have not. That is not our core business. I guess that is where the burden for us becomes quite difficult. The ability to roll out and provide quality services becomes an issue for us once we employ staff and need to enhance skills and knowledge as a means of providing best quality services. But we did have a lot of input into the AHMAC inquiry that happened two years ago on Aboriginal health and the Aboriginal health work force and approaches and strategies to ensure that institutions that get funding to provide us with a work force do their job. We cannot do it for them. That is the key message.

CHAIR—Do local organisations in general make an effort to try to find people to get them into those courses?

Ms Bell—We run a health worker course, which is a part of our core business. That has an intake of 20 students a year. We are starting to assist remote communities in that. We have had students from Mutitjulu who were part of our course last year. We have had some students from the Pit lands who have enrolled in our course, because they also work in our clinic as a part of their training. People have found that quite useful. But in terms of the broader recruitment and training of a work force, no.

CHAIR—I do not mean you should do it; I was just asking whether you try to find people and guide them towards where it exists.

Ms Bell—We try to.

Dr Boffa—There are people who have trained in nursing and we are always looking for people to go into medicine. We have assisted various Aboriginal people to get into nursing, and one of those has come back. We are always looking, and there are scholarships and that sort of thing. Many years ago some of the health services submitted for the HACC program when it first started but there was a decision in the Northern Territory not to give HACC funding to health services. That was a deliberate decision. None of the health services in the early years got funded, so the health services by and large have not involved themselves in aged care specific training. We do not employ HACC workers. We have not been in that area of work, not because historically the whole service did not think it was a good idea but because there was a decision not to fund health services to deliver those programs.

Ms Bell—We are part of an in-service postgraduate institution called CARHDS. Their core role is to upskill and enhance the primary health care work force with respect to gaps.

CHAIR—Thank you very much indeed.

Proceedings suspended from 11.01 a.m. to 11.24 a.m.

KUNOTH-MONKS, Mrs Rosalie Lynette, (Private capacity)

CHAIR—Welcome. This is a formal hearing of the parliament and any misleading statements or otherwise can be held in contempt of the parliament, although I know there will not be any. Would you like to make an opening statement?

Mrs Kunoth-Monks—Yes. I come from the Utopia community, north-east of Alice Springs. Utopia is a unique community and is steeped in Aboriginal culture, which I guess is like an adhesive that holds the community together. It also holds its customs, practices and ceremonial activities. So I am saying that we live in Aboriginal culture. English and the dominant culture to us at Utopia are secondary. We are able to access all the good things from the dominant culture, which is the European culture. We have a group of elders who to us are priceless. I am happy to say that I am included as one of them. These elders hold together the age-old songs, the land and the ceremonies through their continuing knowledge, which was handed to them verbally and not in written form. It always amazes me that 80-year-olds can remember very detailed history that was handed to them by their grandparents.

Coming from that background, living it and practising it, and coming into the white man's world is indeed a very difficult time. We realise that we are not isolated to such an extent that we live like our forebears, like our grandfathers and grandmothers; although, in my living history I can remember that. I am not quite a hundred years old but I am in my late 60s. We have a clinic that is manned by a doctor and nurses and run by an Aboriginal council or committee. At the moment we have an Aboriginal person as the administrator trying to cater to the Indigenous customary needs as well as the illnesses that I think congress and the Old Timers facility people have already eloquently explained.

In living it and observing it, I believe we need all the assistance we possibly can get, without the destruction that comes with that. By 'destruction' I mean my being removed from Utopia to the Old Timers facility, for instance, or even to the Hetti Perkins hostel. I am an Indigenous person who is involved in my ceremonies and in the continuation of caring for my land. In our philosophy the land owns me. It is not very easy or healthy for me to even contemplate the thought of being removed from my home and being put somewhere foreign, because Alice Springs is foreign for the majority of the Alyawerre group of people that inhabit Utopia.

We have aged care, although it is not really formalised. There are eight positions at Utopia for aged care workers. The people who run aged care are not really formally trained in taking care of the aged outside of their customary practice. Therefore, I would say that aged care at Utopia needs to be addressed formally by way of assisting people to be trained. I am sure they are in the process of linking in with people such as the Central Australian Aboriginal Congress and maybe Batchelor Institute of Tertiary Education for further training.

At Utopia there are approximately 15 aged people who are given a meal once a day. These 15 people have demonstrated needs. The rest of the aged, whether they are 70 or 80—it does not make any difference, as long as they are standing and as long as they can shower themselves and maybe cook a meal for themselves—are not really categorised as being elderly. As long as they are able to look after themselves and are not incapacitated—where they can go to the toilet and

shower themselves or gather some wood for themselves—they are not really under a formal aged care scheme. Members of the community have the custom of taking care of each other, and that is still very apparent, I am glad to say.

Utopia is also unique in that we do not live in a congregate setting—'congregate setting' meaning that we do not have buildings where there are streets and people are living as neighbours. I live about 70 or 80 kilometres away from the clinic on an out-station at the southern end of Utopia, and other people live in other scattered areas. To give you the picture, Utopia is approximately 1,500 square kilometres with 17 out-stations. That is where we live. We do have a service centre and a community store at a place called Arlparra. We also have community learning centres for primary schools at five or six out-stations where Northern Territory teachers are in charge. We have the presence of Batchelor Institute there, but we are always having difficulties, of course, retaining staff out on these communities because it is a remote area and people want to have their social life as well as caring for us.

One of the difficulties that I perceive, one that is already evident in the community, is that the younger people are now mobile: they have vehicles, they have access to this town and they come into this town. One of our biggest hurdles is substance abuse. That has already been spoken about not only for this town but for many other towns. Because people have not really had education in how to limit, how to control, their abuses, we have not as much now but an increasing number of people who are drinking and taking drink home, although it is a dry area. We have no way of enforcing the safeguard which the community has put in place. We just do not have a way of policing that.

This brings a tremendous number of problems as the aged are the ones who are not mobile, who are not moving to and fro from Mount Isa or here, because we are between Mount Isa and Alice Springs and Tennant Creek. We tend to have our younger people, who have got our grandchildren, drinking and getting rid of their fortnightly Centrelink cheque. They do not have any food from fortnight to fortnight because they drink it in one or two or three days in these towns. The older people are then expected to look after the grandchildren on their pension. We cannot cope; I can tell you that we cannot cope. I am lucky that my grandchildren are well cared for because I have only got one daughter who does not drink. So that is the thing that we see as being the breakdown out in the communities, and the people who are going to be the next people in charge of our cultural inheritance will no longer be there taking that responsibility.

The data was taken in 1998. I am not quite sure who it was done by; I had better not say it was done by the Menzies School of Health. The male population of Utopia live maybe 11 to 12 years longer than those in the Aboriginal communities around Central Australia. To me that is something to be proud of. When I was speaking with the doctor, Hugh Hegyi, he informed me that depression and aimlessness can be a triggering thing for mental illness and also heart attacks. I believe this. The Utopia elders are an active group of people because we are made to carry and be responsible for our cultural activities, and this is why we feel that reaching the age of 65 does not mean that we retire. I think this helps us to be a healthy, happy, effective people in our community.

I guess what I am trying to say is that the Utopia community has its identity. It also still has its vision, and this vision and identity at this stage in our history is driven by the elders, unlike other communities. The aimless men and women that we have at the moment are around 30 and 40

years of age, and they are the ones I am saying are going out and drinking. If you are looking at 40 years from now and you are addressing the issue of ageing, I would hate to think of the catastrophe that will hit, that is starting to hit, the Indigenous people around Central Australia. You talk about petrol-sniffing and what damage that does. What is the future of those elders?

You are talking about relocating Aboriginal people, but you are taking away the very fabric of that community and its continuing health—spiritual, mental and physical. There are ceremonies: if a murder takes place on a community, there are ceremonies of atonement so that that murder does not affect people where it has become an unanswered question, where you are suffering, because the grieving process takes place within a formalised ceremony and that is then put to rest, not forgotten, because the grieving has been done. This enhances your health, your mental health and your relationship with those around you.

When we lose people in death—my husband and I were only last week at a ceremony because we lost one of our elders. That elder was fairly close in family bloodline to me. Going through the grieving process in the normal sense of losing someone because of age was done so beautifully that I could put him to rest on that day, because you have done it as a collective. This is the background from where Aboriginal people are coming. Putting an Aboriginal person from Utopia or Yuendumu or Santa Teresa into the Old Timers facility takes them away because they are no longer a part of the community, nor can you carry out the ceremonies and put that person back to rest from where they came. Yesterday, coming into Alice Springs, I said to my husband, 'We've made it so far.' The only place that held us captive for half an hour was Alan Creek, which is a creek that runs across, and it was flooding. I know that place, because it is the place of my conception. That is where my spirit will go back to when I die, and I want it to go back. I do not want it to stray around in Alice Springs; I want it to be there. That is the psychology of the Aboriginal person.

For us, it is very hard indeed to come into this world; even for me to sit under this thing and not speak my first language is extremely difficult. I should actually say that I am going to talk in Alyawerre and that, if you cannot understand me, you will have to get yourselves an interpreter. It should be that way to understand each other. Do not get me wrong: I enjoy the dominant culture. I enjoy the freedom that it gives me and I have enjoyed the journey of learning in your world. I have been one of the lucky people who have not had it destroy me. But it could so easily have done so. I have been lucky.

I am saying all this so that you know where I am coming from and where my people are at. There are 800 to 900 people on Utopia. Adjoining us is Ampilatwatja, which is Ammaroo, and I think there are 500 or 600 people there. Another lot of people not far from there are at Harts Range. I am not quite sure of their numbers, but there are quite a lot of people. In running into Ti Tree, into the Anmatjere people, I would say that there are probably 1,500 to 1,600 or more people—I think I can safely say about 2,000 people—living under traditional customary law. Traditional customary law takes care of you physically, mentally and spiritually, which takes in your emotional needs, and we would not like to see that disintegrate without some formal safeguard as we journey into your world. We are a willing party to journey into your world and to cope in this world but we do need assistance, not only within Australia but globally. We are a global people now; we are not isolated just because we live down-under.

I am involved with Batchelor Institute, which is a VET and tertiary education training centre, in trying to help people cope and feel empowered, but I can tell you that it is a hard job. It is a very hard job. I am also involved with the Centre for Appropriate Technology, which tries to help people out in the bush live a more sustainable life. I am also involved in the Desert Peoples Centre, which we are going to set up so that the Indigenous people can access education and training. We have a bit of a catalyst for change, but we are the driving force.

When I went to school, I went to school under the assimilationist program. I had to sink or swim. I think I have swum. I thank the education system and my father and mother for making me do that, because it has enabled me to cope with living and in understanding what it is to have a quality of life. A lot of my people from Utopia have not had that opportunity. That is all I want to say. If you have gleaned something out of that, I am open to questions.

CHAIR—Thank you very much, Mrs Kunoth-Monks. You certainly did say a lot that I have not heard said quite like that. I have trouble reconciling the community that you described so very eloquently with the higher education system that you have at the Batchelor Institute, but perhaps you might expand on that a little and, in particular, on a question I raised earlier today: does the culture of your people make it hard for them to leave that, even when you find somebody who is willing to go to higher education, as in nursing, or some other very necessary formal education?

Mrs Kunoth-Monks—I do not believe it does. From my experience, I think people from Utopia are thirsty to access what is out there. But, to access higher ed and a deeper knowledge, it has to be a culturally safe place. If I can perhaps put it in terms of our recent history, even here in Alice Springs when I was a young girl we had to be off the streets before sunset because of the colour of our skin and our racial background. Coming from that background, within living memory—it was not that long ago—people are still scared about being broken, being told that they are second class and that they are inferior. We now have in place in the Northern Territory—the Northern Territory is a fascinating place—institutions such as Batchelor that make people feel they have a worthwhile, wonderful culture of their own which is still alive but that there are programs whereby they can enhance their existence, and that is how we do it. Is that what you are asking me?

CHAIR—Yes. When you talked about aged care, you were talking about eight people involved in aged care who were not trained. Is that something you just do locally—something the community does for itself—or does that involve the formal Commonwealth aged care program? Is that something that is just peculiar to Utopia?

Mrs Kunoth-Monks—Utopia has an autonomous medical clinic which is run by an Aboriginal committee, but they have funding through the formal channels. They have eight positions, and they have also identified 15 people with demonstrated incapacitation, I guess, who need care. So what they are doing is very rudimentary. It is not formalised in that the aged get together and hunt together or things like that. It is just that these people are unable to take care of themselves. That is all we have. But if you go a bit deeper than that you will find—I probably touched on it in a funny way—that the people who also need support and care are the grandmothers and grandfathers who are taking care of the 30- to 40-year-old aimless people who have nothing to do and who come in and drink and do whatever they want to do here. They also buy blue movies and things like that, and that brings a change. We do not know what blue

movies are—nobody has ever seen those things before—but they are starting to come into the community and the sacredness of the Aboriginal woman is being exploited. It brings in a lot of awful social things, maybe even paedophiles.

I was a court interpreter for two to three years almost, and in that I was not aware of all the awful things that were happening in the communities—child abuse. We have had one in our community, and that is a shock to our area. It is because they have access to all these things. The situation of aged people is probably an internal community business and we will come to some terms on how to address it, but, by the same token, I feel that we need help before it gets out of control.

Mr MOSSFIELD—We are all rather impressed, and taken aback, by your presentation. You have said today a lot that we will all have to think about. Education is obviously a big thing. You have said that the people in the Batchelor Institute are in the 30 to 45 age group. Is there any possibility of expanding that age profile to younger and older people?

Mrs Kunoth-Monks—Absolutely.

Mr MOSSFIELD—Would that obviously be a step in the right direction?

Mrs Kunoth-Monks—The Batchelor Institute takes people from 18 years on. It is extremely difficult for us to try to pick up students who left just after doing primary school and bring them up to tertiary level, to educate them further. Nevertheless, we are doing it. I think Batchelor has done it fairly effectively. It is, of course, the same old thing about funding and things like that, but we are doing it very well.

Mr MOSSFIELD—How is the institute funded?

Mrs Kunoth-Monks—Through the formal channels such as DETYA, the Northern Territory government and also the federal education department. We have had a lot to do with Brendan Nelson in trying to obtain funding at such a level that it makes us effective.

Mr MOSSFIELD—What about getting more men involved in that system? You have said that 70 per cent of those involved are women. And your students are women?

Mrs Kunoth-Monks—That is right. I have not got the magic ingredient or formula for that, but we would like men to take part. But, again, that is about Indigenous people talking and saying: 'Listen, we've got to get going. We've got to be a bit more clever about how we maintain the two cultures in the learning experience journey while also retaining our culture in its completeness so that it means something to us.'

Mr MOSSFIELD—I am interested in your background. You have said that your mother and father encouraged you to continue your education. What was the culture and what were the circumstances? Are they not so much available now, or are people not following them through to the same extent?

Mrs Kunoth-Monks—As for my circumstances, my father was the only shearer—believe it or not—in Central Australia. We had sheep stations then; they have since seen the light and those

have gone on to be cattle stations. There were four or five stations here that ran 2,000 or 3,000 sheep and my father was the shearer. One day Dad just said, ‘You kids are going to school.’ Up to that stage I had just had the traditional upbringing. My first language was that of the Alyawerre, which I am glad to say I am still very fluent in. Sometimes I revert to thinking in Alyawerre before I answer you people, and this is probably why I am talking differently from everyone else, because I do not come from the dominant culture background. Dad just said we had to go to school. By that time I was about nine years of age and I did not speak one word of English. He brought us in to St Mary’s. It is St Mary’s children’s village now but at that stage it was St Mary’s children’s hostel. Bush children went there from all over the Territory. That is my background. I went to school from there. I went up to only grade 7. From there it has been a process of adult education and accessing whatever has been there. At 18 I went from here down to Adelaide, and from Adelaide to Melbourne. I came back here in 1977. I got a culture shock because I was probably the old-time blackfella, whereas the younger generation in Alice Springs had moved on. My identity with my land and my cultural practices are old because I left here in 1957 and did not come back until 1977, so that probably was the gap.

Ms HALL—I actually do not want to ask you a question; I just want to thank you for your presentation and for putting forward to us a positive image of ageing within an Indigenous community—the role that older people have within a community and the respect that is given to them, which probably contrasts with some things in the wider Australian society. Thank you.

Ms CORCORAN—I have just two questions for you. I want to follow up on the question that Frank asked. I am intrigued with why the student population of Batchelor is 70 per cent female. It is a slightly different question to the one about what you are doing about getting more men into it. I am just interested in why it is so: why is it 70 per cent female?

Mrs Kunoth-Monks—There have been a lot of things bandied around about that amongst our group of people, but looking at recent history I am not really surprised. Our men were made to feel that they were of no consequence. They were made to feel that they were second-class and had nothing to offer. Coming from that kind of background a lot of our people, especially the men, still feel a bit that way. Another thing I have noticed is that my two grand-nephews—my sister’s grandchildren—were put through the ceremonies and now are just finishing off. I think they are about 15 years old. They are in year 10 at school. To try and keep up their customary obligations plus continue at school the old people need to get those boys steeped in their future responsibilities, and their ceremonial duties disrupt the European school system.

Old people are aware of this: they talk about it and they try and have the ceremonies during that big Christmas break. These two young men—they are now men because they have gone through the ceremonies, which are fairly intensive—are coming back into year 11. They will feel different with their classmates back in Alice Springs because they have gone through fairly potent, sometimes mind-bending, ceremonies out bush in a different culture. To come back and fit in with their peer group—white and Jewish and whatever—back in Alice Springs is going to take an act of will. It will take absolute willpower to say, ‘I want to finish my year 11 and year 12 and have the option of going on to university.’ They have a dual role to play. The ceremonies are not just all dancing and fun; a lot of it is absolute physical pain and endurance. They have gone through three weeks of absolute high-level military like training. For our Aboriginal men to bounce back and say, ‘Right, I’m going to pursue this now,’ is very hard because they have the two responsibilities.

The old people are saying, 'You must access as much education as you possibly can in the white man's system,' but, by the same token: 'You've got to listen and your psychology is different from the white man's psychology. This is what you have to do back here.' Sometimes I think it is insidious, but I have coped and I am sure the younger people can. Those are the two things that I am saying. Recent history said that the Aboriginal men were really nothing. If you look at the leadership structure that has been in place, I suppose everybody knew Uncle Charlie Perkins; he was really up there. But you look at Lois O'Donoghue, at the Pat O'Shanes and all of those people: they are women. The women have contributed in some way to making the men feel they are less. The women have been able to achieve a lot more. I do not even belong to the women's league or whatever, but I think women are capable in many ways of achieving a lot of things.

Ms CORCORAN—We have been charged with the responsibility of making recommendations to the government about strategies to put in place for how we live in 2040, for instance. Is there one thing you would like to see come forward out of this inquiry? If you had one recommendation to make, what would it be?

Mrs Kunoth-Monks—My recommendation is that the communities must be helped in a culturally sensitive way. The communities in many cases still have their own identity, and the communities also have an ongoing vision of where they are going. Those things are driven by the elders. I think I said somewhere along here that the elders in the Aboriginal social structure are priceless. Please help us take care of them with some sensitive, formal structures. Now is the time to do that, not 20 years down the track, because we will be on a fast, self-destructive road if we are not assisted with coming to terms with where we are at.

CHAIR—Thank you very much for that, Mrs Kunoth-Monks. If I understood you correctly, you said amongst other things that communities like yours, and certainly the very remote ones that retain all their cultural links, need the ability to work out for themselves how to run things like aged care—but not just aged care; also ageing. It is not just about care; it is about quality of life and enjoying it as well as living it. I think that is what you are telling us. I thank you very much for your time.

[12.08 p.m.]

SMITH, Ms Maxine Kay, Aged Care Project Officer, Yuendumu Old People's Program, Mampu Maninja-kurlangu Jarlu Patu-ku Aboriginal Corporation

CHAIR—Welcome. You have probably heard me say this before, but please remember that this is a formal proceeding of the parliament with all that that means, which is that wayward statements can lead to contempt—but obviously that will not happen. Please make a statement.

Ms Smith—I have been in the aged care scene for maybe 13 years. I was initially a HACC training officer for the region Elliott south. I have been at Yuendumu for 10½ years developing an aged care program. Yuendumu is a Warlpiri community 300 kilometres north-west of here, on the edge of the Tanami Desert. There are about 1,000 highly mobile people living in the community. It is a very traditional community with a history of being a government reserve but self-determining since the late seventies. Like Mrs Kunoth-Monks was saying, cultural life is very strong out there also. The language and the cultural mores are the predominant thing in the life of the people. About 10 per cent of the population is over the age of 50. We have about 70 people in the client group and two-thirds of those are female, so the men are just not making it to old age.

We were initially just a HACC funded project, then we became a pilot project under the Aboriginal aged care strategy, and now we are called a flexible project. We have a really nice architect designed facility out there. We have been in that building for about three years, but we are not fully functioning yet due to a range of issues that I will address as I go through my notes. It is intended that we will run short-term residential respite in the community so that people will not have to go into Old Timers or Hetti Perkins as frequently as they do now. Currently we run Meals on Wheels, laundry support and personal care, with the occasional day care service. We have a local Aboriginal management group, which is made up of a member of every skin group. We have eight women and four men on that, reflecting the gender make-up of our client group. We intermittently provide day care at the moment, as I said, and we provide emergency accommodation for people if they have family carers, but at the moment we are not providing residential respite care.

I have had a brief discussion with our chairman, who is a senior man in the community. The first issue that he wanted me to raise with you is that the relationship between the federal government department—the Department of Health and Ageing—and Aboriginal community organisations, such as ours, needs serious attention. There needs to be more trust and respect for the community organisations in remote communities and for the people involved in undertaking this work on behalf of the people. The pace of development is necessarily slow for a range of issues to do with health, ceremonial and cross-cultural constraints, and the government needs to accept the pace of development and not come in and take over the running of organisations for the sake of the expediency of the funding programs.

We need the government to support Aboriginal control and hands-on service provision instead of undermining that by pushing mainstream standards, bureaucratic requirements and impossibly short time frames. We need government officers who have cross-cultural orientation provided by

the department and who are serious about listening to and working with community organisations. We have a problem that has been getting worse over time, with government officers not really listening to our management committee and the issues of the community. We have found that the department has become more dictatorial in the relationship and less flexible with regard to what the organisation sees as its priorities.

We are working in really difficult circumstances: it is a very harsh environment, there are many social problems, and there are a lot of political issues internally and in terms of the mainstream, not to mention the health and mortality issues that have been raised by several people today. We do not want to see the flexible services being pushed towards accreditation, like the mainstream nursing homes, or towards mainstream standards because that will take the care out of the community's control and repeat the institutionalisation of the past, where people were coming through the medical system and ending up in the Alice Springs nursing homes.

We need the government to work with community people in a genuine and realistic way rather than make demands that are impossible for the community to meet. This can result, as has happened in other communities, in Aboriginal people being determined not to be capable of running these services and non-Aboriginal people coming in and dominating the work force. In line with that, we need to be mindful of 'overmedicalising' the process of ageing. Whilst there are chronic health issues amongst the aged population it is not necessarily a medical problem that requires medical staff in all the communities. Services need to be funded at a level where local people can have real jobs and be employed in such a way that their cultural concerns can be accommodated. We do that at Yuendumu by people sharing positions and by having large pools of casual workers to accommodate the different family groups and the different responsibilities that people have culturally within their families. HACC services are notorious for being underfunded and for people receiving very poor pays. There are great expectations on what poorly funded services can deliver.

My experience is that Aboriginal people are quite capable of solving their own problems and determining how things can best be run, but we really need government to appreciate this and to work with Aboriginal management and staff and the employees of the organisations in true partnership. That is a very important issue for the management committee of this organisation: a lot of our time and energy is taken up in dealing with government issues when we feel our energies might be better put into developing the service and working with our people.

Housing is a very serious issue. It is an issue for old people in communities who continue to be the last housed, and in the scramble for resources it means that they continually miss out. Aged care services cannot manage the housing because it has a very serious infrastructure problem, and many old people are left living in the yards of families or still in humpies or in the most derelict houses in the community. Staff housing in communities is very limited and this contributes to the serious problems that we have with recruiting mainstream professional support staff. Infrastructure for services also needs to be provided, and not just the funds for service delivery without capital funds. We are lucky at Yuendumu because we are a big community and we do have infrastructure, but we are very aware of the smaller communities perhaps operating out of women's centres or the backrooms of clinics or what have you.

Training has been raised as an issue. That is really important if local people are going to be employed to provide care to their own elderly people. It is still not addressed adequately in

remote areas and, even though there is a HACC training project in the Northern Territory, the training needs to be ongoing and cyclic and delivered on the job in the community. We are lucky at Yuendumu that we have enough people that Batchelor College is able to do that for us, and we have several people completing certificate 2 training in community services. We have one person who has completed certificate 3 in community services and aged care, and we have a non-Aboriginal support staff going this term to Centralian College to do certificate 3 in aged care. That is a really serious matter that has been raised in Central Australia since 1985, when the HACC program first came in: the need for training on the job in the community to skill people up to provide services to their own mob.

We also feel that media campaigns and general community education about the value and contribution of older people is important to lessen the marginalisation that people face in the new settlement conditions in which Aboriginal people now live in the communities. It is particularly important for young people and substance abusers, who often exploit old people in the community. In our experience, exploitation is a significant problem in terms of financial abuse and physical neglect.

The bush needs better specialised services, particularly in dementia care, palliative support, physiotherapy and occupational therapy. We have not had a visit to Yuendumu from any specialist for at least two years. In relation to that, I also want to speak about the issue of aged care services and medical clinics, as raised by the Central Australian Aboriginal Congress earlier. That has been an issue for us in the community. What we have done is negotiate a service-level agreement between our organisation and the clinic—it is a Territory health services clinic. Their town management has signed off on it, as has our management committee, which means that it is no longer down to personalities or the whims and special interests of people employed in both positions. There are a quite a few aged care services in the bush that have done similarly to us in that regard.

In terms of the future, more respite beds are needed throughout the region. They are needed in small communities as well as big communities like ours. More beds are also needed in Alice Springs because there will always be a need for people to get out of the environment of the community. Yuendumu has been asked many times to provide respite care for people from other communities, but that creates cultural concerns of responsibility. So even though a facility in a place like Yuendumu sounds like it might be very helpful for the entire region, cultural constraints and family responsibilities mean that that may not always be the case. As has also been mentioned, transition beds between the hospital and a return to the community are sorely needed. Community conditions are very harsh. People very often do not have housing. People who return very quickly from hospitalisation never get the chance to properly recover.

Recruitment of professional support staff is a serious issue. We have been trying for nearly three years now to get a development worker to come in and work with local people on developing the respite care services. As Mrs Kunoth-Monks said, it needs to be culturally appropriate. It will be a challenge for someone with an aged care or community development background to work with local people to find a sustainable way of providing that service. I do not know whether it is because aged care is just not groovy or Aboriginal affairs are just not groovy, or whatever, but it is not that easy to recruit people these days.

Our final concern is that there may not be many Aboriginal people in the future, given that there is such an incredible death rate of young people and people in their middle years because, as other people have said, there is such a very poor health status. The people in their 80s and 90s that we are currently looking after are people who grew up before settlement. We believe one of the problems is diet. We see lots of young people buying Coca-cola and iceblocks for breakfast—it is not at all uncommon in the community. The cost of food and the quality of the food is very exorbitant in community stores and so people continue to live on flour and tea and sugar. Things like fruit and fresh vegetables are often beyond what people can afford. We think it is an urgent matter if something is to be done about the life expectancy of the young people that we now see. That is all we have to say.

Mr HARTSUYKER—You mentioned that the Department of Health and Ageing were not listening to the needs of the local community. Can you expand on that?

Ms Smith—There was an instance last year where we were given 24 hours to sign off on over $100,000 in capital moneys to do repairs on our infrastructure for a report that had been done by a national reviewer, but we had not seen the report and nor were we given any opportunity to put forward what our priorities would be for capital expenditure. There have also been requests for meetings at inappropriate times, when there have been deaths in the community, and an unwillingness to accept that the meetings were not possible. It is really a different world once you get off the Stuart Highway. It is a real world for the people who live it, and we just need government to work with us more on that.

Mr MOSSFIELD—You raised the question of the relationships between the governments and the communities. Do you have any positive suggestions as to how those relationships can be improved?

Ms Smith—Some cross-cultural orientation would be really useful for people. I am not sure what the department does at the moment. It would be really useful, too, if people were able to get across the history of the communities and organisations that they work with. I appreciate that people have very big workloads, but a lot of hard work is being done at the community level that we need the ever-changing government officers to appreciate and work with. I guess it is a matter of orientation and maybe recruitment of people who view the Aboriginal community effort positively.

Mr MOSSFIELD—You have raised the diet issues, particularly of young people. How do they get access to these iceblocks and Coke? Is there a store of some description?

Ms Smith—Yes, all the communities have stores.

Mr MOSSFIELD—Are they run by the communities?

Ms Smith—They are mostly run by the community or some sort of community organisation. There may be other motivators, like profits or something. It is really a problem. There is also a problem in that people get used to sweets and fats. For example, we have many diabetics in the community. I happen to know that strawberries are a fruit that any diabetic person can eat freely—they can eat as many of them as they like—and a punnet of strawberries cost $7 in the community store recently.

Mr MOSSFIELD—Could there be a more proactive approach by the community stores to stock only those items that would be healthier for people?

Ms Smith—I believe Nganampa Health on the Pitjantjatjara lands has done a healthy store project. I am not sure how that has gone. It needs to be an ongoing thing. I have been in the community for 10½ years and, in the past, they have had a policy where fresh food was cheaper than it was in Alice Springs. That worked really well and people's intake stepped up, but that has reverted again to those foods being very expensive. That is an ongoing matter and I do not know whose business that is.

Mr MOSSFIELD—It is a suggestion that could be looked at by both the government and the communities.

Ms HALL—Thank you very much, Kay. Your presentation to the committee today was quite enlightening. It gives us a different perspective from somebody who is working in a remote area. Firstly, following up on what Frank asked, a lot of the stores, whilst they may be owned by the community, are actually run by someone outside the community. The stores return a percentage to the community and whoever runs the stores gets a profit out of selling the Coca-Cola and iceblocks. Is that correct?

Ms Smith—I am not sure. In Yuendumu, where I am, there are two stores and both are run by community organisations and have local management committees. Sometimes some profits are returned to the community in various ways and at other times there is a lot of distrust about it. I do not know how other communities operate their stores.

Ms HALL—For the *Hansard* record, I noted a number of people at the back of the room nodding as I was saying that. One of the main points that you seem to be making is about this conflict between actually delivering the services needed by the community and, on the other hand, meeting the requirements of bureaucracies. What recommendation would you make to this committee for government to adopt in dealing with the delivery of aged services to remote communities? What does government need to do to make sure that they meet the needs of the community, not the needs of the system or the bureaucracy?

Ms Smith—I think it would be really good if government supported the community's efforts. It is not at all helpful to be pushing mainstream standards in the community. It would be good if government looked at some other mechanism for ensuring that there is good quality of care and standards of work practices et cetera in Aboriginal communities so that we could continue to empower people to work in their own communities.

Ms HALL—Is there conflict between various bureaucracies? What sort of an impact does the piloting of programs and funding for a period of time and then not funding for other periods of time have upon the delivery of services?

Ms Smith—I can only speak of our experience. We had three years of a pilot project, and then there was just a name change and the re-signing of a contract for a further 12 months. But with that has come more talk about mainstream standards and more fears within the flexible services in the Northern Territory—of which there are 12—that it will be taken out of the hands of the community.

Ms HALL—Do conflicts between Commonwealth, state and local bureaucracies exist and do they impact on the communities?

Ms Smith—We only receive two lots of funding: the HACC funding and the flexible aged care funding. HACC funding is managed by the Territory and that relationship is fine—the reporting mechanisms and all that have been refined over the years and there are HACC support officers and so forth. That relationship is fine. It is just with the Commonwealth one, with going from a pilot project, and I believe the Aboriginal aged care strategy term ended and my impression is that there is a bit of uncertainty as to what to do now with these special programs on Aboriginal communities. I would appeal for people to consider the special nature of the communities and the difficulties of the communities, and support mechanisms that enable communities to stay in control.

Ms HALL—Does Batchelor College outreach training programs in the communities? Is it possible to do part of the training or study in the community?

Ms Smith—It is possible at Yuendumu because we are big and we have enough students to warrant them coming out and delivering an on-the-job program in the community, which is working well—except that I do not know how well it is working for Batchelor: with our pool of casual workers we seem to be dealing with different people. But from our point of view it is really good, and our committee has said that they do not want people to go to town anymore because we have had people run off from training sessions, and families have had to come in and get them, and there are all sorts of problems when people leave the community. Our Batchelor course is delivered entirely in the community, except for first aid.

Ms HALL—So, basically, the way of the future would be to try and deliver courses within the community rather than take people away from the community?

Ms Smith—Yes, absolutely. All Aboriginal services will say that repeatedly—and have been doing so since 1985.

Ms HALL—Once again, I note people at the back of the room are in agreement.

CHAIR—I thank everybody very much. We are going to take a short break and then have the community forum, where anybody can stand up and make a statement, and you will not be subject to parliamentary proceedings at all. Thank you very much.

Resolved (on motion by **Ms Hall**, seconded by **Mr Hartsuyker**):

That this committee authorises publication, including publication on the parliamentary database, of the proof transcript of the evidence given before it at public hearing this day.

Committee adjourned at 12.35 p.m.