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1. Central Australian Aboriginal Congress and the Aboriginal population of Alice Springs.

Central Australian Aboriginal Congress is a large Aboriginal community controlled comprehensive primary health care services situated in Alice Springs. We service the Aboriginal population of the Alice Springs town and town camps and the surrounding outstations within about a 100km radius of Alice Springs.

We service a permanent client population of about 5500 Aboriginal clients of whom approximately 3500 live in town houses, 1000 live in town camps and 1000 live on outstations within a 100 km radius of Alice Springs. We see a further 2000 visitors each year. Of our permanent client population 900 clients are above the age of 55 (16%) and 330 (6%) are above the age of 65. The permanent clients access Congress on average more than 5 times a year each which is higher then the national average for a RAMA 6 remote centre.

Because of the continued low life expectancy of Aboriginal people the community consider people to be "old" at an earlier age than the mainstream. This fact has been recognised recently by a number of programs from the DoHA. In particular when the Medicare items was introduced for health assessments for Aged Australians the Age was 65 years for non Aboriginal Australians and 55 years for Aboriginal Australians. Congress believes that all government programs, including the aged pension, should commence from the age of 55.

Congress provides a bulk billing medical service from 8.30am until 8.00pm Monday to Friday with an on call GP service until 10.30pm and from 8.30am until 12.30pm Saturday, Sunday and Public Holidays with an on call GP service until 10.30pm at night. We have a transport service and employ our own pharmacist who works in an on site pharmacy with access to PBS drugs through the Section 100 program. We have a number of public health programs including:

- Frail Aged and Disabled Program
- GP service to the Nursing Homes

- Male Health program
- Youth Program
- Early Childhood Program
- Social and Emotional Well Being Program
- Aboriginal Health Worker Training and GP Registrar training
- Chronic Disease Program
- Hearing program
- Bush Mobile Program
- Women's health and birthing service

2. The high burden of illness amongst older Aboriginal people

Older Aboriginal people are suffering from an epidemic of chronic disease at much higher rates than the non Aboriginal population of Australia. Many older Aboriginal people have multiple chronic diseases at the one time especially the so called "syndrome X" – the combination of diabetes, hypertension, heart disease and high blood cholesterol. In addition to this Aboriginal people in Alice Sprigs suffer kidney disease at 8 times the national average rate and in remote Central Australian Communities at 27 times the national average rate. Cancer is also becoming an increasingly common cause of death and the rates are much higher again amongst older Aboriginal people (see the attachment on the FAAD program for further details about the illness profile of the Aged population).

3. The need for comprehensive primary health care: the Primary Health Care Access Program (PHCAP)

There is now substantial evidence that comprehensive PHC services reduce morbidity and mortality:

- Caldwell 1986: the low road to health in third world conditions
- Kunitz 1994: evidence in USA, Canada, & NZ that improved PHC services to Indigenous people has led to substantial declines in mortality and improvements in life expectancy
- Evans et al 1994 Why are some people healthy and others not?
- Starfield et al 1999: the ratio of primary care physicians to population is a key determinant of population health
- WHO: World Health Report 2000 – 50% of health gain since the second world war is due to health systems
- Evaluation of Aboriginal Co-ordinated Care Trails 2001

Comprehensive primary health care can make a real impact on the burden of chronic disease that is now affecting older Aboriginal people. Heart disease, renal disease, and diabetes have been shown to be amenable to interventions through early detection, and treatment within primary health care services.

The Primary Health Care Access Program (PHCAP) is the major initiative from the DoHA that aims to address the lack of access to comprehensive primary health care for Aboriginal people in the Northern Territory and other parts of Australia. Under this program Aboriginal people will access about $2000 per person in funding as well as MBS and PBS funds. PHCAP has the capacity if fully implemented to ensure the older Aboriginal people have access to multidisciplinary health care which will provide essential services in critical areas. Aboriginal health services will also provide critical community based infrastructure through which further Aged Care specific services can be administered and run. It is essential that this inquiry supports the full funding of the PHCAP.

The failure to make major improvements in health gain for Aboriginal people cannot be blamed on a failure of PHC to make a difference – the Primary Health Care Access Program is not fully funded and implemented. Unlike indigenous people in other countries most Aboriginal people still do not have access to adequately resources comprehensive primary health care services. Katherine West Health Board is fully funded and is making a difference.

4. Workforce and Quality service provision

There is a critical link between the ability to be able to recruit and retain a quality workforce and the quality of service provision. Congress has been very successful in the last few years in recruiting and retaining a quality professional workforce and we will outline this success using GPs as an example.

In 1995 there were only 3 Full Time Equivalent (FTE) GPs at Congress now there are 10 FTE GPs and 1 remote GP (plus 3 rural pathway registrars). The average length of stay for GPs is 6 years with a median of 3 years. 5 FTE's are Australian graduates and 6 FTE's are Overseas Trained Doctors (OTDs). Staff turnover in 2000/01 was 20%, 2001/02 was 14.6% and 2002/03 was 1.9%. What's has made the difference in the recruitment and retention of GPs at Congress?

Firstly adequate pay and conditions including:

- Attractive salary packaging through PBI status and better levels of funding (MBS and PBS).
- Better working conditions including the cessation of 24 hour on call service 2 years ago, little overtime and 1 in 8 roster for after hours clinics
- The inclusion of Part time GPs (7)
- Multidisciplinary teamwork and professional support with AHW's, nurses, pharmacist, psychologists, social workers, dentist, visiting medical specialists and others.
- Remote Area Grants: RAMA 7 (Hermannsburg).
- Retention payments

Secondly Congress is able to provide an interesting, challenging autonomous work environment and GPs are not tied to Fee for Service medicine. GPs get involved in the

range of public health programs mentioned earlier depending on their areas of interest, qualifications and experience. In aged care services one GP services the nursing homes while another is involved in community based aged care service delivery on the Frail Aged and Disabled Program (see attached outline of the FAAD program)

Thirdly, Congress is able to provide or access effective support services for GPs including:

- Effective Management, including HR and active engagement in shaping the policy environment.
- Effective Orientation program.
- Locum support program
- Family support program
- Recruitment support
- QA and CME program
- OTD training program
- Involvement in health policy and public health activities

In order to achieve these successes it is essential in remote areas that organizations are large enough to be able to utilise economies of scale and have adequate internal support systems. It is also essential that professional staff are part of a multidisciplinary team in order for quality services to be provided.

In addition to his consumers are not in a very strong position to be able to ensure that they receive quality services because they have limited choice in providers. It is not easy for them to choose to go to another provider if they are concerned about lack of quality because there are few other providers in Alice Springs and there are no other bulk billing service providers who provide access to free medicines. This puts a great onus on Congress to ensure that it has an effective internal quality assurance system that reports regular to our elected governing board. In fact Congress has had a RACGP accredited quality assurance program since 1994 which provides continuous feedback of individual and collective data to practitioners Management and our governing board on a regular basis.

Congress believes that some Aged Care specific funding in remote areas must be integrated into Comprehensive primary health care services to build on economies of scale and existing quality service delivery. In addition to this, when Aged Care funding is given to other organisations, government needs to ensure that there are effective quality assurance systems to protect consumers from poor quality service delivery. It is not enough to rely on competition and consumer choice in remote areas as currently seems to be the case. We will return to this point when we discuss the problems with HACC service delivery.

5. The need for specialist services and programs within comprehensive primary health care services

Historically, Aged Care specific funding has not flowed into primary health care services. Congress receives no aged care specific funding to support the services that we provide. WE have had to use our core funding to establish our Frail Aged and Disabled program which employs a part time doctor and 2 Aboriginal Health Workers. This program provides specialist aged care services and attempts to coordinates care for aged clients with HACC service providers, the Aged care Assessment team and others. It provides specialist clinical care, palliative care, rehabilitation services, dementia assessment and support and other services (see attachment for further details).

It is important that funding in these areas is made available to primary health care services such as Congress so that we can expand on the range of services and recruit the specialist workforce that is required. The FAAD program needs to be able to obtain the services of a social worker and an occupational therapist but funding for these types of allied health professionals has never been available to Congress. Although in recent years there has been additional funding put into palliative care services this has not been within the primary health care sector either.

6. The need for specialist services and programs within the secondary health system

It is also important that specialist services are available within the secondary health system in palliative care, rehabilitation services, gerontology and others. Such services have not been adequate in the past and have been inconsistent in their funding base.

7. Home and Community Care (HACC) services and domiciliary nursing – the need for effective QA systems.

Congress has been concerned for many years about the adequacy and quality of HACC service provision and the lack of effective integration between HACC services and health services. The demands placed on HACC service providers seem to be above the level of training and skill of many of the HACC workers and the traditional role of domiciliary nursing seems to have largely disappeared – this has left a gap in service delivery in many cases. Such gaps occur when clients need supervision of medications at home, assistance with bathing and dressing at home and other needs. Such assistance for short periods of time can keep people out of nursing homes and hostels but in the current system such assistance is very hard to find.

There is a particular problem in Aboriginal communities where 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 get under the HACC program.

The effective care of older people requires close liaison between health services and HACC services who are often servicing the same client group. There has been great difficulty over the years in getting HACC service providers to attend meetings with health services and clients to develop joint care plans for clients. Congress believes that such interaction should be a contractual requirement on any HACC service provider and not something that can be considered optional.

There also need to be a greater acceptance that HACC workers have not taken over all of the functions of domiciliary nurses and such specialist nurses need to be available form within the primary health care sector. The funding for these positions have been largely restructured over the years rather than outsourced into the primary health care sector. This has meant that primary health care services have had to pick up these functions without any additional resources.

Finally, it is largely fanciful to believe that consumers in a remote area will turn to another provider if they are not receiving a quality service. Aboriginal consumers are by and large not empowered to this extent and even those that are find their choice of provider is very limited. As mentioned earlier Congress believe that government have an obligation to ensure that there are effective quality assurance systems in place perhaps through an accreditation system for HACC providers to ensure that there is additional protection built into the system for consumers.

8. Respite services

The respite beds available in the nursing homes are nearly always full and difficult to access – there is a need for more nursing home respite beds. In addition there needs to be other respite options such as community based respite houses run by community organisations.

9. Nursing Homes / Hostels and retirement villages

There are insufficient nursing home and hostel beds in Alice Springs to meet the needs of the community. If the ratio is adequate according to the current formula then the formula is not adequate. If the age limit that was used in the formula for Aboriginal people was 55 instead of 65 then this may go some way in allowing for the increased need per capita for nursing home and hostel beds for Aboriginal people.

In addition to nursing home and hostels beds there are no retirement villages in Alice Springs. Given the small number of non Aboriginal old people who stay in Alice Springs and the level of poverty in the Aboriginal community it is unlikely that private capital alone will build such a village. It may be appropriate for government funding to support such a development in Alice Springs to provide another alternative for older Aboriginal people.

10.Income support

In view of the demographics of the Aboriginal population, the poor life expectancy and the high burden of multiple chronic diseases amongst older Aboriginal people Congress believes that the Age of 55 should become the universally accepted entry point for eligibility all Aged Care programs and the pension.

11.Carers

There needs to be better training and wages for carers along with accreditation and quality assurance systems.

12.Transport

Service providers need to be resourced to provide transport otherwise this becomes a major role for health professionals working in aged care programs.

13. Social determinants of health / social risk factors

It is important to realise that unfortunately these social determinants are very often a chronic reality for Aboriginal patients. This equally applies for patients on the FAAD-program.

a) Poor housing: (overcrowding, poor maintenance). There is not enough public housing. It is difficult for Aboriginal people to obtain private sector housing. Overcrowding and poorly maintained dwellings are common problems: these cause skin conditions with potentially serious complications (acute rheumatic fever, with resulting rheumatic heart disease) and worm infestations with equally potentially serious complications (anaemia, respiratory problems). It is also very difficult to find vacancies for patients who need temporary (respite) or permanent placement in a nursing home.

b) Employment / Income support / financial problems: there is a lack of employment opportunities for Aboriginal people and many older people are not able to access adequate income support.

c) Alcohol- & nicotine-dependence

d) Communication. Most Aboriginal people appear to understand English reasonably well, but especially amongst the older patients (FAAD), there are definitely communication-barriers, especially with regard to medico-technical jargon and colloquial medical English.

e) Poor education is another barrier.

f) Poor (self-)care / (self-) management is a problem for approximately half of the FAAD-patients. It is important to realise the importance of cultural obligations and the fact that many patients suffer from a breakdown of their traditional way of living.

g) The impact of emotional stress and grief, as a result of poverty, cultural dissimilation & detachment, accumulation of medical and social problems, death of relatives, ... is not to be underestimated.

h) Underweight / Malnutrition: this is one of the possible outcomes of some of the above-mentioned social determinants / social risk factors, for some of the FAAD-patients.