Central Australian
**Aboriginal Congress**
ABORIGINAL CORPORATION | ICN 7823

# Submission to the
Senate Community Affairs Reference Committee
*Inquiry into the Purpose, intent and adequacy of the Disability Support Pension*
**July 2021**

## Background

### About Us

Central Australian Aboriginal Congress (Congress) is a large Aboriginal Community Controlled Health Service (ACCHS) based in Alice Springs. We are one of the most experienced organisations in the country in Aboriginal health, a national leader in primary health care, and a strong advocate for the health of our people.

Congress delivers services to more than 17,000 Aboriginal people living in Alice Springs and remote communities across Central Australia including Ltyentye Apurte (Santa Teresa), Ntaria (Hermannsburg), Wallace Rockhole, Utju (Areyonga), Mutitjulu and Amoonguna.

In recent years, led by our community-elected Board of Directors, we have developed extensive expertise on approaches to health service policy and delivery that take account of the social, cultural, economic and political determinants of health, including poverty, housing, and early childhood development.

### Input into this Inquiry

We understand that the Aboriginal Medical Services Alliance Northern Territory (AMSANT) and Danila Dilba Health Service are making submissions to this Senate Inquiry. Congress supports the recommendations made by these organisations.

Congress is available to provide further input to this Inquiry through appearing as a witness at a public hearing, at which time we could provide further case studies to illustrate the complexities and challenges faced by Aboriginal people in Central Australia in applying for the Disability Support Pension.

*Note that in this document we use the term 'Aboriginal' as the most appropriate term in the Central Australian context to refer to Australia's First Peoples.*

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*Aboriginal health in Aboriginal hands.*

# Recommendations

**Recommendation 1. Congress recommends that the Australian Government focus on reducing poverty and inequality as a key way to increase the health and wellbeing of Aboriginal people and meet 'Close the Gap' targets, including by increasing the JobSeeker payment rate for all participants by at least $50 per week, and providing an additional loading on JobSeeker payments for those in remote or very remote areas to address significantly higher costs of living.**

**Recommendation 2. That instead of the Independent Assessments being provided by a doctor, often from intestate, local allied health professionals provide an independent assessment from the referring GP to ensure that functional impairment is adequately assessed.**

**Recommendation 3. Independent Assessments need to be independent, i.e. not directly contracted by Centrelink/DSS.**

**Recommendation 4. Governments fund ACCHSs for a position dedicated to supporting clients and services through the DSP application process, including advocacy for clients, coordination of supporting evidence, and training for health workforce on accessing and understanding the impairment tables.**

**Recommendation 5. Rejected DSP applications should provide more information and greater detail as to the reasons for being rejected.**

**Recommendation 6. Impairment Tables should include end stage kidney disease and haemodialysis to reflect the significant burden of disability and the very limited capacity for people with this condition to engage in employment.**

**Recommendation 7. A culturally validated assessment tool is considered for development co-designed with and for Aboriginal people/organisations for assessing DSP applications made by Aboriginal people.**

**Recommendation 8. That the requirement of an IQ test for developmentally acquired neurocognitive impairments is removed.**

**Recommendation 9. Centrelink should establish or increase the number of social work positions within their service centres to support high needs clients with DSP applications, with a particular focus on ensuring these positions are equitably distributed within remote and very remote regions. Some of these positions would be best outsourced to ACCHS.**

**Recommendation 10. Telecommunications services to provide free access/unmetered access to Government websites and other essential activities in mobile phone and data plans most likely to be used by low-income households.**

**Recommendation 11. Government should implement a system that adjusts the evidence requirements depending on remoteness and other factors to ensure there is greater equity in the DSP eligibility, application and assessment process for priority and high needs populations.**

**Recommendation 12. Strengthen Aboriginal community control and empowerment to develop place-based employment and training, based on community-identified needs and priorities.**

**Recommendation 13. Following the death of a DSP recipient, payments should continue to be made to provide funds for their families to cover funeral costs, with up to 12 weeks provided for the most disadvantaged recipients based on means testing.**

**Recommendation 14. That focus is given to addressing gaps and inconsistencies in data related to disability in Australia, so that comprehensive data on priority populations—including Aboriginal and Torres Strait Islander and remote populations— is available and accessible at a regional level.**

# Context

*Aboriginal concepts of health and disability*

Aboriginal health is best understood in a holistic context. Physical and mental health, cultural and spiritual health exist in synchronicity; while land, or country, is central to wellbeing. As stated in one of the foundational documents in Aboriginal health, the 1989 National Aboriginal Health Strategy:

> *"Health" to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity*.[1]

The concept of *disability* as something that is separate from other domains of health is therefore foreign to many Aboriginal people. For this reason, the identification and prevalence of disabilities is often misunderstood, under-represented and hidden.

> *There is no equivalent word for 'disability' in many Aboriginal and Torres Strait Islander languages … Consequently, some Aboriginal and Torres Strait Islander communities may not have a general concept of disability, resulting in underreporting of disability and underutilisation of disability services.*[2]

Disability for Aboriginal people occurs within a complex context; it does not occur in isolation for an individual or community, and is interrelated to intergenerational trauma, chronic and communicable disease, and complex and vulnerable family life.

> *Culturally, our people treat disability and impairment as a part of life, a part of our community and just get on with it. In other words, it is not always an obvious step to seek out help and support from outside family networks.*[3]

For these reasons, Congress considers 'disability' to be more than a diagnosed, overt and obvious physical or cognitive impairment of a person, and rather encompasses a range of 'impairments' that are deemed to be outside of normal functioning to Aboriginal people and the community. This is where the term *wellbeing* is best situated—being disabled can be understood as not experiencing wellbeing in the usual way.

*The experience of colonisation*

In traditional times, Aboriginal people's access to the land and its resources and their cultural practices ensured that they were healthy and that those who needed were cared for by networks of kin. However, the processes of colonisation including the dispossession and impoverishment of our communities; the forcible removal of children from their families and its intergenerational effects; the suppression of culture and language; and the ongoing experience of racism and discrimination have had profound effects on the health and wellbeing of our Nations. This includes high levels of disability.

The trauma and health impacts of these experiences often sees chaotic families, impacted by family violence, alcohol and other drugs which, in these circumstances can lead to cognitive disability in children.[4] For children, this means traits such as impulsivity, poor concentration, lack of self-control and self-discipline are more likely, leading to learning difficulties, inability to participate in school and poor educational attainment,[5] all of which have an impact on a person's outcomes into adulthood.

Chronic (or non-communicable) disease such as diabetes can also lead to a range of impairments, including sight impairment and amputation; impaired mobilisation and frailty due to chronic obstructive pulmonary disease, rheumatic heart disease or renal failure; chronic ear infections that impact on hearing, and can lead to long term hearing loss; and other common communicable disease such as trachoma which can lead to blindness.

For some people these illnesses can be self-managed effectively but, for many Aboriginal people who have experienced the impacts of intergenerational trauma, they do not have the same capacity and capability to self-manage.[1]

The inclusive nature of Aboriginal families and communities are a protective factor whereby family members with disability are included and supported within families. Disability is normalised and is absorbed into family and community life, rather than reduced to an individual responsibility for the person and their carer. This means actual service need is often masked, even though the need may be there. There is still a need for capacity-building for individuals, though this must include family and community.

> *It's also part of our culture to principally lean on family for care and support. It's been noted by researchers that Aboriginal and Torres Strait Islander people with disability are mostly cared for within their extended family, rather than by professional service providers. This is the same across remote, rural and urban areas of Australia.*[6]

*The Congress approach to supporting people with disability*

In the context of colonisation described above, Aboriginal people in Central Australia have very high levels of disability. Families provide much of the care needed, with 19% of Aboriginal people in the region reporting that they provide unpaid care to family members, while their capacity to do so is challenged by poverty, isolation and lack of services.[7]

[1] This reality was once thought to be so profound that the *Commonwealth Disability Act* (1988) suggested that Aboriginal people suffered a double disability because of this history of trauma. The concept of a 'double disability' goes too far and tends to normalise disability, but relying only on a diagnosis is too far in the other extreme as this does not recognise the underlying issues that create a functional impairment that is akin to a disability.

As a comprehensive primary health care service, Congress operates from the core principle of providing multidisciplinary 'sick' care to make people well, whilst also working to promote health and address the underlying determinants of ill-health.[8]

Congress does not have a dedicated working-age disability service in the same way that mainstream health services are arranged. Rather, adult clients with disability are distributed throughout several Congress services including our health clinics and allied health services, Frail Aged and Disabled outreach program, Social and Emotional Wellbeing service, and our NDIS service. Clients with disability may access Congress services and programs through one or a combination of these areas.

*A human rights approach*

Given this context, any approach to addressing the needs of Aboriginal people with disability must recognise, in addition to the rights under the *United Nations Convention on the Rights of Persons with Disabilities*, the rights to self-determination of Aboriginal peoples established under international agreements to which Australia is a signatory, including the *United Nations Declaration on the Rights of Indigenous Peoples*[9], which states:

> *Article 22: Particular attention shall be paid to the rights and special needs of … persons with disabilities in the implementation of this Declaration.*
>
> *Article 23: Indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.*

Additionally, structural reform is needed for Australia's first sovereign Nations to claim their rights of self-determination, as called for in the *Uluru Statement of the Heart*[10].

# Addressing the Terms of Reference

## a. the purpose of the DSP

*Citizenship entitlements in the context of poverty and inequality*

Australia is a wealthy country with a Gross Domestic Product well above the OECD average, but income and wealth are not distributed evenly. On average, Aboriginal and Torres Strait Islander people receive a personal income that is only two-thirds that of the non-Indigenous population.[11] The situation is considerably worse in Central Australia where the median weekly personal income for Aboriginal people is $281: barely more than a quarter of that for non-Indigenous people in the region (at $1,080).[12] Unfortunately, both absolute poverty and relative inequality are worsening. Nationally, in very remote areas – and this covers almost all of Central Australia – Aboriginal and Torres Strait Islander incomes are falling in real terms, and the income gap is widening.[13]

The purpose of the Disability Support Pension (DSP), as outlined by the Australian National Audit Office[14], is to provide financial support to Australians with a permanent physical, intellectual or psychiatric impairment that prevents or limits their capacity to work.

An alternative citizenship entitlement for working age people is JobSeeker, which provides financial help for people who are unemployed and looking for work, or taking part in approved job-seeking activities. Broadly speaking, prevention of poverty is the main purpose for government income support payments.[15] However, despite the recent increase by $25 a week to the JobSeeker rate[16], these income support payments still fall below the poverty line.

Therefore, in the context of Central Australia where Aboriginal people experience both absolute poverty and relative inequality at disproportionate rates, *as well as* experiencing disproportionately high rates of disability, the DSP can make a considerable difference to a person's financial circumstances. Additionally, this is also within the context of a labour market where opportunities for alternative employment for people with disability is limited. This is discussed in more detail under terms of reference (d).

The COVID-19 pandemic has shown that government can have both the ability *and* the political will to increase the rate of JobSeeker so that it surpasses the poverty line. The doubling of this rate during 2020 and early 2021 meant that people receiving citizenship entitlements were provided with greater ability to meet their basic needs. Congress continues to advocate for an increase to the JobSeeker payment which would reduce the level of poverty and inequality amongst Aboriginal people in Central Australia. The flow-on effect of this to families and communities would help to reduce income stress; furthermore, it would reduce the pressure placed on people with disability to seek the DSP as a way to ease their families' financial stress and meet basic needs.

**Recommendation 1. Congress recommends that the Australian Government focus in reducing poverty and inequality as a key way to increase health and wellbeing of Aboriginal people and meet 'Close the Gap' targets, including by increasing the JobSeeker payment rate for all participants by at least $50 per week, and providing an additional loading on JobSeeker payments for those in remote or very remote areas to address significantly higher costs of living.**

## b. the DSP eligibility criteria, assessment and determination, including the need for health assessments and medical evidence and the right to review and appeal

*Application process – burden of time*

Supporting our clients through the DSP assessment and application process requires significant time and intensive advocacy.

Outside of an appointment with a general medical practitioner, much of the work involved in undertaking eligibility assessments by other health professionals (including but not limited to psychologists and neuropsychologists, occupational therapists and physiotherapists, as well as social workers) is largely not funded through Medicare rebates. Whilst there may be opportunity to claim a small amount of Medicare for an initial appointment, it takes substantially longer than one appointment to complete a DSP assessment.

In addition to the significant workload required to provide the medical documentation and supporting evidence for a DSP application is the intensive advocacy that is necessary to support clients in managing the Centrelink component of the process. This is work that organisations like Congress are not explicitly funded for.

*Application process – training and support*

There is also the challenge that medical practitioners must become familiar with the DSP application process and the associated Impairment Tables. For an organisation like Congress with a large number of GP Registrars (doctors undergoing specialist GP training), this is a significant body of documentation to learn especially when considering everything else a registrar is required to learn in a short period of time. Congress believes it would be valuable for Centrelink to provide training to support doctors and health professionals to better understand the assessment and application process.

*Accessibility of allied health services*

Generally speaking, allied health services are not as accessible as general medical practitioner services, especially in remote and very remote regions[17]. Australia's allied health workforce is unequally distributed and the rate of allied health professionals is the lowest in remote and very remote areas compared with major cities.[18] This creates an additional barrier for someone to receive the level of assessment required for an application. There is often a mismatch between a medical assessment of disability, and the detailed understanding of the impact of the disability on a person's day-to-day functioning. This highlights the importance of multidisciplinary input into a DSP application which—for already time-pressured health professionals—requires significant time to provide.

**CASE STUDY**

*A client who has had a stroke seeks support from their GP for a DSP application. The GP refers them to an occupational therapist to provide more supporting evidence. The OT must use the Impairment Tables to provide evidence as to what constitutes active rehabilitation. The OT finds that the Impairment Tables don't really go far enough in capturing the reality of living with disability caused by stroke that this client experiences. Since their stroke, the client now finds it takes a considerable amount of time to do routine tasks that would previously not have been an issue, for example 2-3 hours to shower and get dressed to leave the house, 2-3 hours to cook dinner, time taken attending medical appointments as well as being expected to engage in employment or job seeking activities. Therefore there is a gap in the information captured by the DSP application process that doesn't go far enough in providing an accurate overview of the client's lived experience of their disability.*

*Requirement for Disability Medical Assessments*

It is Congress' view that the Disability Medical Assessment, which is provided by a government-contracted doctor or clinical psychologist, is unnecessary and the requirement for it to be carried out should be removed, for the following reasons:

- it duplicates the medical assessment that is already provided by the client's treating doctor, who generally has a greater understanding of the person's history and abilities in their social and cultural context. This is especially the case as the doctor

providing the independent assessment often lives in a capital city and has real issues in giving a culturally safe response;

- it can lead to inequitable outcomes if an overriding decision is made by the contracted doctor/psychologist who is not the client's treating clinician, and who has limited experience in providing assessments for Aboriginal people and people in remote areas; and
- the true independence of a government-contracted doctor or psychologist is dubious as there is always the perception that they are being asked to reduce the spend on the public purse as much as possible by setting a higher threshold for acceptance than other peers would accept.

If it is not considered that the Disability Medical Assessment can be removed from the DSP process, Congress then proposes that:

- the provider of the Assessment must be made truly independent i.e. not directly contracted by the Department of Social Security / Centrelink; and
- that to provide greater value, this additional layer of assessment should be provided by allied health practitioners in response to the need for multidisciplinary assessments that complements the medical assessment already provided by the client's treating doctor. Wherever possible these should be local allied health practitioners who understand the cross-cultural context they are working in and are preferably employed by ACCHS.

*Impact of rejected applications*

The process of making a DSP application in itself can cause distress to people who already experience multiple stressors in their everyday lives. Communication with and correspondence from Centrelink is often difficult for people to understand, especially as many of them speak English as a second or third language and may have limited English literacy.

For clients whose applications are rejected, the impact can be devastating. Further, when applications are rejected there is frequently scant explanation as to the reasons for the rejection (for example, was it because the client didn't meet eligibility requirements? was the application missing information? did it contain mistakes?). When the reasons for rejection are not made clear, it is difficult for organisations like Congress to support a client through any appeals process.

*Inclusion of end stage kidney disease and haemodialysis in the Impairment Tables*

In the past, renal disease and haemodialysis were included in the Impairment Tables, meaning that there were points able to be accumulated by clients with end stage kidney disease and receiving haemodialysis that would support their DSP application.

Haemodialysis is extremely time intensive requiring patients to spend five hours per session, three times per week, every week of the year undergoing the treatment. This continues indefinitely, unless the patient is able receive kidney transplant surgery and the transplant is successful.

Key points to note include:

- A person with end stage kidney disease is usually already significantly unwell and unlikely to be able to hold employment
- Employment or job seeking activities would need to be flexible enough to be able to happen on days where the patient is not having dialysis
- End stage kidney disease disproportionately affects Aboriginal people, who experience the condition at a rate of almost seven times the rate for non-Indigenous Australians (63 per 100,000 and 9 per 100,000 respectively)[19]
- Remoteness and socio-economic disadvantage also increase the incidence rates of end stage kidney disease.[20]

It is Congress' view that the Impairment Tables should include end stage kidney disease and haemodialysis to reflect the significant burden of disability and the very limited capacity for people with this condition to engage in employment.

**Recommendation 2. That instead of the Independent Assessments being provided by a doctor, often from intestate, local allied health professionals provide an independent assessment from the referring GP to ensure that functional impairment is adequately assessed.**

**Recommendation 3. Independent Assessments need to be independent, i.e. not directly contracted by Centrelink/DSS.**

**Recommendation 4. Governments fund ACCHSs for a position dedicated to supporting clients and services through the DSP application process, including advocacy for clients, coordination of supporting evidence, and training for health workforce on accessing and understanding the impairment tables.**

**Recommendation 5. Rejected DSP applications should provide more information and greater detail as to the reasons for being rejected.**

**Recommendation 6. Impairment Tables should include end stage kidney disease and haemodialysis to reflect the significant burden of disability and the very limited capacity for people with this condition to engage in employment.**

*Deficit approach of the DSP application process*

As noted earlier in this submission, Aboriginal health is a holistic concept. This focus on holistic wellbeing from a strengths-based perspective is incongruent to the DSP assessment process which takes a deficit perspective. For an Aboriginal person with disability, they may still have capacity to contribute to and fulfil, to some extent, their cultural, spiritual and familial obligations to their community, in which sense disability may be seen as a difference, not a deficit. Congress proposes that further investigation should occur into the development of culturally validated DSP assessment tools specifically co-designed with and for Aboriginal people/organisations, that centres Aboriginal peoples' views of health and wellbeing.

**Recommendation 7. A culturally validated assessment tool is considered for development co-designed with and for Aboriginal people/organisations for assessing DSP applications made by Aboriginal people.**

*IQ testing requirements*

A particular anomaly is the inconsistent requirement for an IQ test to form part of a DSP application. For a person whose impairment arises from an acquired neurocognitive disorder, an IQ test is not required as part of their DSP application. However, for a person whose cognitive dysfunction arises from a developmental disorder (that is, a disorder that was present at birth), an IQ test is required as part of the DSP application process. Note that an IQ score is not required to make the same diagnosis under DSM-5.

The process of undertaking an IQ test is degrading and stigmatising, and disproportionately impacts Aboriginal people where there is a higher prevalence of neurocognitive impairments.[21] Further, consideration must be made as to how meaningful Western cognitive tests, such as IQ tests, are for assessing remote Aboriginal people. Tests such as these have strong links to Western education[22] and in a context where there is often limited uptake and attainment in Western education and lower levels of English literacy, it is highly unlikely that such tests give an accurate appraisal of cognitive ability. Therefore there is an important question about whether it is morally right to have to provide an IQ score for the DSP application process, when it is not required for other purposes related to the same diagnoses.

**Recommendation 8. That the requirement of an IQ test for developmentally acquired neurocognitive impairments is removed.**

## c. the impact of geography, age and other characteristics on the number of people receiving the DSP

*Higher rates of disability in Aboriginal communities*

As noted above, for Aboriginal people in Central Australia, there are a range of compounding factors, including remoteness and socio-economic disadvantage that intersect to increase the vulnerability of the Aboriginal population to experience higher rates of developmental vulnerabilities, chronic disease and disability than the non-Indigenous population. For example, rates of fetal alcohol spectrum disorder (FASD) and other neurocognitive developmental disorders are estimated to be disproportionately higher in Aboriginal communities.[23] As also noted above, rates of renal and end stage kidney disease are disproportionately higher in Aboriginal people in remote areas, including Central Australia.

*Reduction of Centrelink resources*

Nationally, Centrelink staff resources have been significantly eroded over at least the last decade,[24] [25] and the impact of these reductions has been sharply felt across the Northern Territory where remote services provided by Centrelink have been considerably pared back.[26]

Congress clients report lengthy waiting times at the Centrelink Service Centre and that local Centrelink staff did not have the skills or knowledge to provide the level of support required to assist Aboriginal clients with DSP applications. Frequently, clients are directed to use the computers or the phones to progress their applications although clients living

in remote communities, who speak English as a second or third language and with limited digital literacy, are unable to effectively do so without assistance.

**Recommendation 9. Centrelink should establish or increase the number of social work positions within their service centres to support high needs clients with DSP applications, with a particular focus on ensuring these positions are equitably distributed within remote and very remote regions. Some of these positions would be best outsourced to ACCHS.**

*Digital inequity*

Centrelink and many other government services are moving away from face-to-face and towards online service delivery. Whilst this may be convenient for large population groups living in cities and areas where there are well established telecommunications and internet infrastructure, and a range of service providers, this increases the digital divide experienced by people in remote and very remote locations.

In their latest *Cost of Living Report* focused on Telecommunications[27], the NT Council of Social Services (NTCOSS) highlighted the increasing inequity experienced by lower income families and people in remote areas of the NT in accessing affordable telecommunications services. Additional challenges faced by remote communities include frequent interruptions to power supply leading to regular disconnection of remote Wi-Fi hotspots; challenges in maintaining charge to a mobile phones in housing where there is only metered power; and the likelihood that families on low incomes use prepaid mobile phone services often meaning people have limited ability to access mobile data.

The NTCOSS report describes the 'poverty premium' faced by low-income consumers of mobile phone plans, particularly those people for whom prepaid phones are the only available option. Prepaid mobile phone plans generally include lower levels of data, meaning that when people run out of phone credit, they also lose access to internet data. Better value deals for data and phone calls are more expensive and therefore less accessible for people with low income.

In the context of the DSP, these challenges add additional barriers for Aboriginal people living in Central Australia and remote parts of the NT. Alongside a DSP applications, there may be additional processes that a client must also undertake such as opening a bank account that require use of a device with a reliable internet connection to access online systems. Significant challenges arise for people who do not have identification documents such as a birth certificate or driver's licence, who must then tackle these hurdles that are required as part of the complex DSP application process.

**Recommendation 10. Telecommunications services to provide free access/unmetered access to Government websites and other essential activities in mobile phone and data plans most likely to be used by low-income households.**[28]

*Challenges of a thin market environment*

Remote areas such as Central Australia experience a thin market with limited access to services. This includes employment support service options generally, with fewer options

available still for Aboriginal people with disability. For people in remote communities, there are additional challenges in accessing services, compounded by the extra costs that people must cover to travel into town to and back to community. It is in this context that Congress suggests that expecting people who already face limited choice to be held to the same standards of proof as those in large cities and regional areas, where there is greater choice, greater access to services and lower costs of living, is inequitable. It is vital that any assessment is culturally safe and at times this means if the only option is for an independent assessor who lives in a capital city this requirement should be waived.

**Recommendation 11. Government should implement a system that adjusts the evidence requirements depending on remoteness and other factors to ensure there is greater equity in the DSP eligibility, application and assessment process for priority and high needs populations.**

## d. the impact of the DSP on a disabled person's ability to find long term, sustainable and appropriate, employment within the open labour market

*Support for APO NT's Fair Work and Strong Communities proposal for economic empowerment*

Meaningful employment is empowering and people should have the opportunity to do work that is valued and be properly remunerated for that work. However, remote Aboriginal communities continue to carry the burden of the impacts of successive government policies that have been top-down, punitive and have seen little improvement in health and social conditions.[29] For people with disability, opportunities for employment are even more limited and employment support programs tend to be provided by mainstream, non-Indigenous service providers based outside the service region.[30]

Congress supports the *Fair Work and Strong Communities: Proposal for a Remote Development and Employment Scheme*[31] developed by the Aboriginal Peak Organisations Northern Territory (APO NT) and the solutions it proposes as they relate to strengthening economic and employment opportunities in remote Aboriginal communities. The Remote Development and Employment Scheme proposed by APO NT has the following high level aims:

- Expand community control and engagement in remote employment programs
- Increase the number of jobs in communities
- Drive community participation and development
- Reduce the role that the welfare system plays in peoples' lives
- Realign government investment to maximise outcomes for Aboriginal people in remote communities.[32]

**Recommendation 12. Strengthen Aboriginal community control and empowerment to develop place-based employment and training, based on community-identified needs and priorities.**

## k. any related matters

*DSP payments for funeral costs*

Previously, people on the DSP continued to receive payments following their death which allowed families to cover some or all of the costs of their funeral. For people who are socio-economically disadvantaged, this provided significant financial assurance at a time when families were more vulnerable. Congress proposes that these payments should be once again be continued following the death of a DSP recipient. The frequency of payments could be assessed based on means testing so that the most disadvantaged are supported at a greater rate, up to 12 weeks following the recipient's death.

**Recommendation 13. Following the death of a DSP recipient, payments should continue to be made to provide funds for their families to cover funeral costs, with up to 12 weeks provided for the most disadvantaged recipients based on means testing.**

*Addressing gaps in data*

The availability of and access to reliable data and information is essential to support Aboriginal community controlled organisations to be empowered and equipped to exercise their rights to self-determination. This is a key focus of the National Agreement on Closing the Gap, which includes Priority Reform Four: *Shared access to data and information at a regional level*.[33] The AIHW report, *People with disability in Australia*, draws attention to the critical gaps in data that limit the ability for a comprehensive understanding of what life is like for people with disability in Australia, particularly those with intersecting characteristics such as Indigenous status and remoteness.[34]

**Recommendation 14. That focus is given to addressing gaps and inconsistencies in data related to disability in Australia, so that comprehensive data on priority populations—including Aboriginal and Torres Strait Islander and remote populations—is available and accessible at a regional level.**

## NOTES

[1] National Aboriginal Health Strategy Working Party, *A National Aboriginal Health Strategy*. 1989, Department of Aboriginal Affairs: Canberra. See also P. Dudgeon, H. Milroy, & R. Walker (Eds.), (2014). *Working Together: Aboriginal and Torres Strait Islander Mental Health and Well-being Principles and Practice* (2 ed.). Commonwealth Government of Australia.

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[9] United Nations. *United Nations Declaration on the Rights of Indigenous Peoples*. 2007; Available from: http://www.un.org/esa/socdev/unpfii/en/drip.html.

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[14] Commonwealth of Australia (2016). *The Auditor-General ANAO Report No. 18 2015-16 Performance Audit: Qualifying for the Disability Support Pension*. Accessed from: https://www.anao.gov.au/work/performance-audit/qualifying-disability-support-pension

[15] Davidson, P., Saunders, P., Bradbury, B. and Wong, M. (2020). *Poverty in Australia 2020: Part 1, Overview*. ACOSS/UNSW Poverty and Inequality Partnership Report No. 3, Sydney: ACOSS.

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