



Central Australian
Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

Submission to the

Standing Committee on Health, Aged Care and Sport: Inquiry Into Diabetes

August 2023

**Central Australian Aboriginal Congress
Aboriginal Corporation**

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***Aboriginal health
in Aboriginal hands.***

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Note

* 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.

Recommendations

1. The causes of diabetes (type 1, type 2 and gestational) in Australia, including risk factors such as genetics, family history, age, physical inactivity, other medical conditions and medications used;

Recommendation 1: That the Australian Government develop a sugar tax, hypothecated to fund a healthy food subsidy model designed to increase the consumption of healthy foods, and decrease consumption of high sugar, nutrient-poor foods, with particular consideration for remote Aboriginal communities.

Recommendation 2: That the Australian Government, through the Joint Council on Closing the Gap, develop and adequately fund coordinated actions to address the social determinants of health that contribute to the unequal burden of diabetes (including poverty, inequality, education and housing) in disadvantaged communities, especially remote Aboriginal communities.

Recommendation 3: That all levels of government implement evidence-based population-level strategies and reforms to reduce alcohol related harm that can include low birth weight, obesity, reduced capacity to optimally self-manage diabetes, and post-pancreatitis diabetes mellitus.

Recommendation 4: That the Australian Government provide universal access to evidence-based early childhood development and intervention programs, as a key strategy for the primary prevention of type 2 diabetes.

2. New evidence-based advances in the prevention, diagnosis and management of diabetes, in Australia and internationally;

Recommendation 5: That the Australian Government expand eligibility for continuous glucose monitoring devices to all Aboriginal people with youth onset type 2 diabetes, diabetes in pregnancy, or those at risk of hypoglycaemia

Recommendation 6: That the Australian Government ensure that all Aboriginal people have affordable access to GLP-1 receptor agonist medication, including by listing them on the PBS and in Section 100, for both diabetes and obesity formulations. Additionally, in times of shortage, prioritise access to GLP-1 receptor agonist medications for Aboriginal people and those living in MM6 and MM7 locations.

Recommendation 7: That the Australian Government provide adequate funding for research through Aboriginal Community Controlled Health Services (ACCHSs) (in partnership with universities and research institutes) to find new ways to effectively prevent and manage diabetes and obesity, especially in children, young people and pregnancy.

3. The broader impacts of diabetes on Australia's health system and economy;

Recommendation 8: All levels of government to address the maldistribution of the primary health care workforce so that Aboriginal people with diabetes and other chronic conditions have equitable access to primary health care.

Recommendation 9: All levels of government take action to address the crisis in primary health care workforce needed to detect, manage and treat diabetes in rural and remote Australia including reversing the decision to allow overseas trained and non-vocationally-registered doctors to work in MM1 and MM2 (urban) areas; developing an international migration campaign with streamlined approval processes specifically for remote primary health care; introducing Commonwealth-funded retention payments for remote area nurses; implementing tax relief for all essential workers (including health professionals, teachers and police) in remote and very remote areas; establishing an NT Medical School at Charles Darwin University.

Recommendation 10: All levels of government to fund traineeships, scholarships, and cadetships to enable Aboriginal people to enter, develop, and progress within the primary health care workforce, including diabetes services.

4. Any interrelated health issues between diabetes and obesity in Australia, including the relationship between type 2 and gestational diabetes and obesity, the causes of obesity and the evidence-base in the prevention, diagnosis and management of obesity;

Recommendation 11: All levels of government develop a clear and consistent campaign that promotes the benefits of two years of breastfeeding, including the full legislation of the *International Code of Marketing of Breastmilk Substitutes* (the WHO Code), as a strategy to reduce risk of child obesity.

Recommendation 12: That the Australian Government implement nation-wide strategies to reduce exposure and access to hyper-palatable, ultra-processed foods through a ban on marketing and digital advertising campaigns, as well as mandating, monitoring, and enforcing childcare and school-based nutrition programs and policies.

Recommendation 13: That the Australian government develop and implement clear and consistent mandated food labelling (such as the 'traffic light' system) for all packaged and processed foods to enable people to make informed health choices when purchasing food, and to incentivise the food industry to reformulate their products.

Recommendation 14: That the NT Government implement and mandate all recommendations made by the Coalition for Healthy Remote Stores for the NT Food Security Program, including restrictions on promotion, placement and volume of unhealthy food and beverages sold for all community food retail businesses, inclusive of stand-alone takeaways. This could be extended to major supermarkets with particular emphasis on restrictions on product placement.

Recommendation 15: That the Australian government appropriately fund and increase access to evidence-based, culturally-appropriate, and age-appropriate diabetes prevention, weight loss and diabetes remission interventions, such as lifestyle programs, low energy diet programs, pharmaceuticals, and bariatric surgery for priority groups.

5. The effectiveness of current Australian Government policies and programs to prevent, diagnose and manage diabetes.

Recommendation 16: All levels of government to ensure that any approach to addressing the high prevalence of diabetes in Aboriginal communities is based upon the rights to self-determination of Aboriginal peoples as established under international agreements to which Australia is a signatory, including the *United Nations Declaration on the Rights of Indigenous Peoples*.

Recommendation 17: All levels of government to provide dedicated funding for targeted, strengths-based, and culturally responsive diabetes health promotion and prevention strategies, such as school-based education programs and community-driven initiatives, led by ACCHS.

Recommendation 18: That the Australian Government develop a capacity strengthening package for use in schools that supports early risk factor identification as well as early diabetes identification (including screening), support and referral for young people living with type 2 diabetes.

Recommendation 19: That the Australian Government appropriately resource and recognise ACCHS as preferred providers of primary health care including diabetes services (that includes health screening, brief interventions, and multidisciplinary diabetes management) for Aboriginal and Torres Strait Islander communities.

Recommendation 20: Strengthen utilisation of the National Diabetes Services Scheme (NDSS) and promote the utilisation of NDSS registration by multidisciplinary teams, to ensure that it meets the needs of Aboriginal people.

Central Australian Aboriginal Congress

1. Central Australian Aboriginal Congress (Congress) is a large Aboriginal Community Controlled Health Service (ACCHS) based in Mparntwe (Alice Springs). Established 50 years ago, Congress is 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 Mparntwe and remote communities across Central Australia including Ltyentye Apurte (Santa Teresa), Ntaria (Hermannsburg), Wallace Rockhole, Utju (Areyonga), Mutitjulu, Amoonguna, Imanpa, Kaltukatjara (Docker River), and Yulara.
2. Our submission to the Inquiry into Diabetes is based on our experience of delivering comprehensive primary health care including multidisciplinary clinical care; health promotion and disease prevention programs; and action on the social, cultural, economic, and political determinants of health and wellbeing.
3. Congress provides comprehensive primary health care, which includes diabetes services, to the Central Australian Aboriginal community. Our primary health care workforce consists of a multidisciplinary team of general practitioners, Aboriginal Health Practitioners, nurses, allied health staff, health promotion staff, and Aboriginal Liaison Officers. This team works collaboratively to provide culturally responsive diabetes management support for clients within Mparntwe, and in the remote communities Congress serves.

The Inquiry into Diabetes

4. Congress welcomes the Inquiry into Diabetes by the Standing Committee on Health, Aged Care and Sport. As an ACCHS, Congress has a long history of working with and for our community in the struggle for justice and equity. Therefore, within the Terms of Reference, we wish to highlight the importance of the Inquiry specifically considering the substantial impact that diabetes is having for Aboriginal people of all ages, across Australia.

Why it is important to specifically consider Aboriginal Australians in this Inquiry

- As a result of the processes of colonisation, intergenerational trauma and the other social determinants of health, diabetes disproportionately impacts Aboriginal Australians, particularly those living in remote locations.
- We are seeing concerning increases in the number of young Aboriginal people diagnosed with type 2 diabetes in Central Australia.
- Central Australian Aboriginal people have among the highest documented rates of diabetes, renal dialysis requirements, and lower limb amputation in the world.
- The specific needs of Aboriginal people must be recognised by providers and funding bodies to ensure that services are effective, appropriate and accessible for Aboriginal people.
- There is a need for a high-quality, culturally responsive diabetes services workforce, including particularly Aboriginal staff, to meet the needs of the Aboriginal community.

Addressing the Terms of Reference

1. The causes of diabetes (type 1, type 2 and gestational) in Australia, including risk factors such as genetics, family history, age, physical inactivity, other medical conditions and medications used

Recommendation 1: That the Australian Government develop a sugar tax, hypothecated to fund a healthy food subsidy model designed to increase the consumption of healthy foods, and decrease consumption of high sugar, nutrient-poor foods, with particular consideration for remote Aboriginal communities.

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Recommendation 4: That the Australian Government provide universal access to evidence-based early childhood development and intervention programs, as a key strategy for the primary prevention of type 2 diabetes.

5. In traditional times, the diverse Aboriginal peoples of the Northern Territory had active lifestyles and a healthy diet low in sugar and free of processed foods. While specific records on diabetes are not available, it is highly likely that diabetes was very rare, if not unknown.
6. However, contemporary Aboriginal people have been deeply affected by the processes of colonisation, including dispossession and impoverishment; the forcible removal of children and its intergenerational effects; the suppression of culture and language; and the experience of racism and discrimination. Aboriginal families continue to live with these effects of colonisation which challenge their capacity to live healthy lives, and provide care for, and nurture, their families. It is in this context that the high and increasing rates of diabetes should be seen, with **40% of Aboriginal adults in Central Australia now living with a diagnosis of type 2 diabetes [1], and prevalence increasing by 2.5% each year in remote communities.**

Poverty, inequality and food insecurity

7. Despite improvements in health outcomes, including increased life expectancy and reduction in diabetes-associated mortality for Aboriginal people in this region over the past 20 years [2], there has not been the same improvement in the gap associated with the social determinants of health. It is well documented that diabetes is strongly correlated with poverty and inequality [3,4]. In the Central Australian region, food security and affordability has declined between 2006 and 2021 [5], exacerbated by inflation and inadequate increases to citizenship entitlement payments. Aboriginal people use income support at disproportionately

higher rates than non-Indigenous people and in remote areas across Australia both poverty and inequality are worsening for Aboriginal people, with Aboriginal incomes falling and the income gap to non-Indigenous people widening [6]. In Alice Springs, the weekly median personal income for Aboriginal people is only 40% of that of non-Indigenous residents, and in remote locations in Central Australia, it is only 25% [5]. Action to reduce Aboriginal poverty is needed to reduce levels of community violence. This should include:

- (a) an increase in JobSeeker and similar citizenship entitlements with an additional loading on such payments for those in remote or very remote areas to address significantly higher costs of living in those places; and
- (b) redesign citizenship entitlement administrative systems to ensure they are socially and culturally appropriate for Aboriginal people, especially those in remote areas.

8. People living in remote communities need to spend more on food than other Australians. Prices for healthy, fresh foods, particularly fresh fruit, vegetables and dairy foods, are higher in remote areas for a number of reasons, including the cost of freight over long distances, and the high cost of storing perishable food. [7,8]. On average, a healthy food basket (i.e. foods that meet the average energy and recommended nutrient needs of a family of six for a fortnight) is 41% higher in remote NT communities than in Darwin [9]. Poor access to reasonably priced healthy food drives high rates of highly-processed, sugar rich food consumption which increases the risk of developing type 2 diabetes [10]. A direct to consumer, point of sale subsidy is required to address financial barriers and increase affordability of essential food, including fruit and vegetables, in remote areas funded by at least a 20% hypothecated tax on sugar, including all sugar-sweetened beverages, to rebalance the high cost of healthy foods against the relative affordability of unhealthy foods [11,12].

Education

9. Parental – and particularly maternal – educational attainment and literacy is an important protective factor for strengthening families and improving outcomes for children, including prevention of future health complications [13]. Additionally, educational attainment has been shown to empower people to take control of their health, reduces risk of type 2 diabetes, and contributes to lower levels of morbidity and mortality [14]. Educational attainment rates for Aboriginal people, particularly in remote Australia, are low: only 39% of Aboriginal people over 15 in Alice Springs have completed year 11/12, and in remote Central Australia it is only 21% [5]. Without an education system that delivers results for its Aboriginal citizens, Australia will fail to 'close the gap' in health (measured by life expectancy), as committed to in *National Agreement on Closing the Gap*.

Housing and homelessness

10. The Northern Territory has 12 times the national average rate of homelessness and many Aboriginal Australians in Central Australia who are considered homeless reside in severely overcrowded dwellings [15]. In 2021 in the Northern Territory, 57% of Aboriginal people reported living in overcrowded homes [15]. Overcrowded and poor-quality housing have been associated with both negative physical and mental health outcomes among residents [16]. Maintaining an open household, and connecting and sharing with visiting family members is a core element of many Aboriginal Australian households, however, persistent overcrowding places additional pressure on facilities and infrastructure. This can limit the ability of residents to employ healthy living practices, with 19% of Aboriginal people reporting that they do not have access to functional facilities for preparing food [17]. This contributes to the high consumption of processed or take-away food. Significant increases in culturally appropriate and well-maintained housing for

Aboriginal communities is required, to ensure that Aboriginal families have access to appropriate food storage, preparation and cooking facilities.

Alcohol

11. The individual and community harms of alcohol are well documented [18]. Excess alcohol consumption can lead to obesity, may adversely impact glycaemic levels, and reduces an individual's capacity to self-manage their diabetes [19]. Sustained alcohol consumption can also contribute to the development of pancreatitis where inflammation and cell dysfunction/loss and can lead to deficiencies in insulin production. This disease of the exocrine pancreas may result in hyperglycaemia and is known as post-pancreatitis diabetes mellitus (PPDM). In Central Australia, alcohol is the leading aetiology of both acute and chronic pancreatitis, and 29% of those diagnosed with pancreatitis went on to be diagnosed with diabetes [20]. With people having a two-fold higher lifetime risk of developing diabetes after pancreatitis, diabetes secondary to disease of the exocrine pancreas is being increasingly recognised as a significant cause of diabetes. Evidence suggests that PPDM is now the second most common form of new-onset diabetes, however, at present the true prevalence of PPDM is likely to be underestimated. [21,22].
12. Evidence-based, whole of population-level strategies and reforms are required to limit the significant and wide-reaching impact of alcohol-related harms. There is now an internationally established evidence-base as to what works to reduce alcohol-related harm, as well as a great deal of data and experience specific to the Northern Territory demonstrating how healthy public policy on alcohol has achieved harm reduction. This evidence and contextualized policies are important guides for future action.

Diabetes in pregnancy

13. Gestational diabetes mellitus (GDM) is characterised by glucose intolerance of varying severity, which develops or is first recognised during pregnancy, predominantly in the second or third trimester. GDM is an important health issue associated with pregnancy which has implications for the immediate and longer-term health of both the mother and baby, including increasing both of their risk of developing type 2 diabetes in the future. [23]. In a sample of Central Australian communities, 19% of pregnancies were associated with GDM or type 2 diabetes (where the mother had a diagnosis of type 2 diabetes prior to pregnancy). There are increasing documented rates of pre-existing type 2 diabetes and pregnancy in our region which is of concern due to the higher severity of metabolic changes seen in type 2 diabetes (compared to GDM), and the potential presence of hyperglycaemia in the pre-conception and early stages of pregnancy [24]. It is clear that children exposed to hyperglycaemia in utero are at significantly higher risk of experiencing obesity or type 2 diabetes earlier in life [25] and this is being evidenced in our region.

Diabetes and young people

14. In Central Australia, we are seeing significantly increasing rates of young people (<25 years) being diagnosed with type 2 diabetes, with the highest reported prevalence of any population of youth internationally [26]. Median HbA1c for young Aboriginal people in this region, along with other regions in Northern Australia, has been shown to be high (9.7%), with only 14% of young people with type 2 diabetes achieving glucose levels within target range (which is <6.5%) [26]. A diagnosis of diabetes at this young age presents as a particularly malignant disease and has been associated with a 23 times higher risk of kidney failure and 39 times higher risk of dialysis requirement within 20 years after diagnosis, compared to those with type 1 diabetes [27]. Weaver et al [28], found that young Aboriginal people in Northern and Central Australia may experience a normalisation-shame paradox in

response to receiving a diagnosis of diabetes (such that “everyone has diabetes” (in this region), is coupled with the stigma of a diagnosis). In addition, young Aboriginal people had suboptimal understanding of type 2 diabetes and experienced significant and numerous barriers to optimal diabetes management. It is common for young people to have sporadic and uncoordinated diabetes care, and targeted, age-appropriate and culturally responsive programs are required to support the prevention and management of diabetes for young people.

Early childhood

15. There is strong evidence that well-designed and sustained early childhood health and development programs are highly cost-effective and lead to health gains across the lifespan. The experience of a child, including in the months before birth, is critical for a healthy life, and deficits at this time are powerfully linked to the development of chronic conditions later in life. [29,30]. Early childhood is therefore a key intervention point for the prevention of chronic conditions, including type 2 diabetes. Examples of evidence-based preventative programs include the Australian Nurse-Family Partnership Program and the Abecedarian model of educational day care. Overseas, children who have been through the Abecedarian program are four times more likely to report living a healthy and active lifestyle when they are young adults [31]. These programs work with children before health and developmental problems arise, supporting children and their families to develop the stimulation, relationships and access to services needed for healthy development now, and into the future.
16. **We are facing an epidemic of diabetes in this region, with diabetes in pregnancy and youth onset type 2 diabetes being of significant concern.** Prompt and dramatic action on modifiable risk factors, including the social determinants of health listed above, is required to halt the tsunami of diabetes-related complications that will otherwise be faced in Australia.

2. New evidence-based advances in the prevention, diagnosis and management of diabetes, in Australia and internationally

Recommendation 5: That the Australian Government expand eligibility for continuous glucose monitoring devices to all Aboriginal people with youth onset type 2 diabetes, diabetes in pregnancy, or those at risk of hypoglycaemia

Recommendation 6: That the Australian Government ensure that all Aboriginal people have affordable access to GLP-1 receptor agonist medication, including by listing them on the PBS and in Section 100, for both diabetes and obesity formulations. Additionally, in times of shortage, prioritise access to GLP-1 receptor agonist medications for Aboriginal people and those living in MM6 and MM7 locations.

Recommendation 7: That the Australian Government provide adequate funding for research through Aboriginal Community Controlled Health Services (ACCHSs) (in partnership with universities and research institutes) to find new ways to effectively prevent and manage diabetes and obesity, especially in children, young people and pregnancy.

Continuous Glucose Monitoring (CGM) devices

17. Technologies that support blood glucose monitoring, including flash continuous glucose monitoring (CGM) devices, are associated with optimised blood glucose levels, and reduced incidence of hypoglycaemic exposure, compared to traditional blood glucose monitoring for some groups of people with type 2 diabetes [32,33,34]. Currently in Australia, only those with a diagnosis of type 1 diabetes are eligible for subsidised CGM, however, there is a growing number of these technologies emerging for diabetes management and studies have shown the cost effectiveness of expanding access of these to those with type 2 diabetes on insulin therapy [32,35]. While not appropriate for everyone, CGMs can act as an empowering tool for diabetes self-management and have shown merit in increasing self-reported frequency of glucose testing, compared to finger prick measurements, for Aboriginal women living with type 2 diabetes in pregnancy ($p=0.001$) [36].

GLP-1 receptor agonist medications

18. A number of pharmaceuticals have been developed to support diabetes management. Recently, the introduction of glucagon-like peptide 1 (GLP-1) receptor agonist medications have brought great interest from clinicians, the media, and the wider community. Its benefits include achieving clinically significant reductions in HbA1c, suppressing appetite, and facilitating weight loss [37]. The weekly injection has since seen severe shortages across the country which has significantly impacted diabetes management for our community members. Trials have demonstrated a 15% mean reduction in body weight for participants who are overweight or obese and utilising a higher dose formulation of weekly GLP-1 injections plus a lifestyle intervention [38]. This reduction in body weight reduces risk of insulin resistance, dyslipidaemia, and diabetes-related complications [39]. Currently in Australia, this higher dose formulation, which specifically targets weight loss, is not available on the PBS.

19. With the development and future rollout of dual and triple glucose-dependent insulinotropic polypeptide (GIP) and GLP-1 receptor agonist medications, which show significant promise for diabetes and weight loss [40], equitable access and affordability must also be considered. Given the significant and unequal burden of type 2 diabetes experienced in this region, and the very high median HbA1c recorded among our young people [26], priority access to these gold standard medications in times of shortage is extremely important for Aboriginal people, particularly those living in remote communities. As accessibility increases, GLP-1 receptor agonist medication formulations that are suitable for diabetes and obesity management should be made affordable and available for all Aboriginal people, through listing on the PBS and in Section 100.

Research

20. At both a strategic and operational level, Congress is committed to research that benefits the health and wellbeing outcomes of Aboriginal people. In addition to undertaking internally driven research, Congress' dedicated research team partners with institutions across Australia to conduct research in the areas of clinical care, health promotion and disease prevention, and actions on the social, cultural, economic and political determinants of health.

21. Congress adheres to the *Aremella Arratyenye-ileme: Doing It Right* guide for research in Central Australia [41] that ensures Aboriginal community expectations and cultural protocols are followed, fostering quality, culturally responsive and trauma-informed research. As an ACCHS, Congress is well placed to work alongside universities and research institutes to develop new ways of preventing and

managing diabetes. This will ensure that local communities have control of issues that directly affect their community, and will see greater gains in health and wellbeing outcomes for those living with diabetes. It is imperative that adequate funding is provided to strengthen research development and translation activities, to enable Aboriginal people to equitably access latest evidence-based advances in the prevention, diagnosis and management of diabetes in a culturally appropriate manner.

3. The broader impacts of diabetes on Australia's health system and economy;

Recommendation 8: All levels of government to address the maldistribution of the primary health care workforce so that Aboriginal people with diabetes and other chronic conditions have equitable access to primary health care.

Recommendation 9: All levels of government take action to address the crisis in primary health care workforce needed to detect, manage and treat diabetes in rural and remote Australia including reversing the decision to allow overseas trained and non-vocationally-registered doctors to work in MM1 and MM2 (urban) areas; developing an international migration campaign with streamlined approval processes specifically for remote primary health care; introducing Commonwealth-funded retention payments for remote area nurses; implementing tax relief for all essential workers (including health professionals, teachers and police) in remote and very remote areas; establishing an NT Medical School at Charles Darwin University.

Recommendation 10: All levels of government to fund traineeships, scholarships, and cadetships to enable Aboriginal people to enter, develop, and progress within the primary health care workforce, including diabetes services.

The importance of primary health care through ACCHSs

22. Diabetes mellitus has long been identified among Australia's National Health Priority Areas due to its substantial impact on morbidity and mortality, and subsequent high financial expenditure [42]. The estimated total annual health expenditure attributable to diabetes was \$3.1 billion in 2019-20, representing 2.2% of total disease costs [43] and, with rates of diabetes rising, this monetary value is only expected to significantly increase.

23. The Australian Institute of Health and Welfare outlines 22 conditions for which hospitalisation is potentially preventable, of which 'Diabetes Complications' is one. These potentially preventable hospitalisations (PPH) are hospital admissions that could have been prevented by timely and adequate health care in the community [44]. In Central Australia in 2017-18, 'Diabetes Complications' resulted in an aged-standardised rate of 393 per 100,000 PPH admissions in the Alice Springs region, and 1,636 per 100,000 PPH admissions in the Barkly, compared to 187 per 100,000 nationally. The Alice Springs region had an average length of stay of 6.6 days (995 total bed days) attributable to diabetes, with the Barkly demonstrating an average of 8.3 days (688 total bed days). [44]. This represents a significant burden to the acute health system in this region.

24. As already outlined, the greatest burden of diabetes continues to impact Aboriginal people in Central Australia, where there is among the highest documented rates of diabetes-related complications worldwide, including end stage renal failure and lower limb amputations [45,46]. This has particular impact for Aboriginal people who are more likely to be diagnosed with these complications at a younger age, when they are at their most active in their working and family life [45,46].
25. Higher attendance at ACCHSs have been found to reduce the likelihood of hospital admission for Aboriginal Australians [47]. Supporting and expanding ACCHSs as critical primary health care service providers is therefore important to drive reductions in PPH, diabetes complications and avoidable deaths. Investing \$1 in primary care in remote Aboriginal and Torres Strait Islander communities was found to save \$3.95–\$11.75 in hospital costs, in addition to benefits for individual community members [48]. Despite this, a significant proportion of healthcare expenditure on diabetes is attributed to mainstream services such as public hospital admissions and public hospital outpatient services.

Figure 1: Health care expenditure on diabetes, by diabetes type and area of expenditure, 2019–20

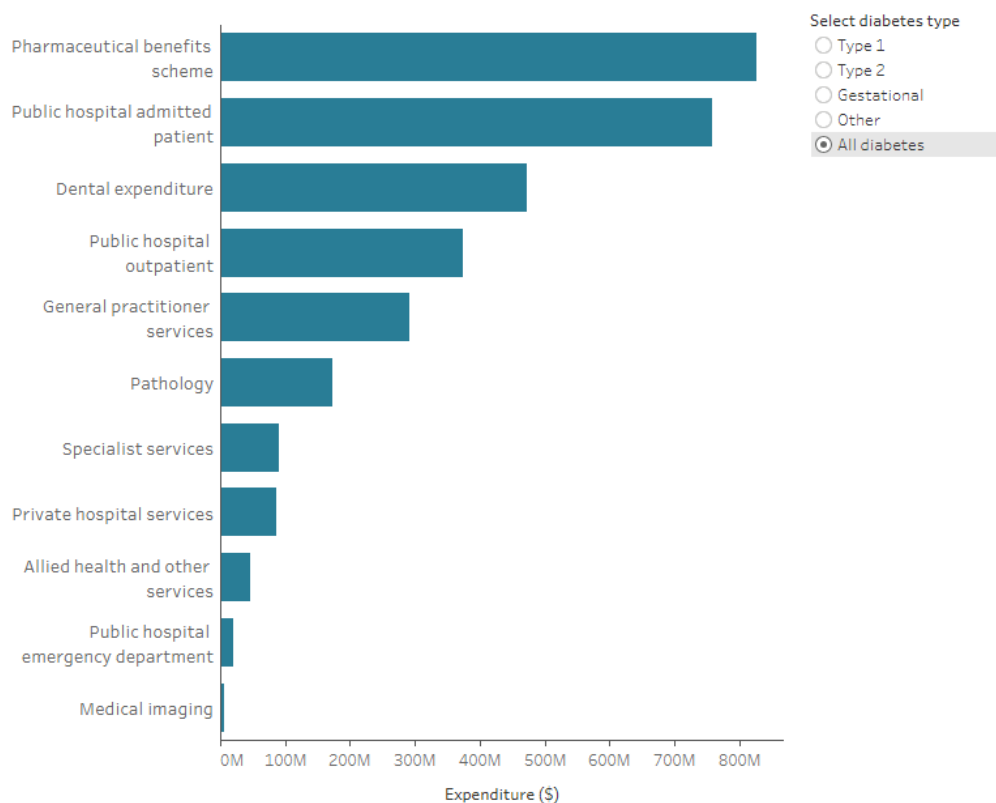


Chart: AIHW. Source: AIHW Disease Expenditure Database [43]

Addressing remote primary health care workforce challenges

26. Congress has recorded a 67% increase in prevalence of type 2 diabetes across the Central Australian region since 2010 and, with over a third of our clients living with diabetes this is extremely resource intensive. This is now generating an enormous burden on our stretched primary health care services.
27. A primary health care workforce is critical for the continued success of the ACCHS sector to meet the health needs of the Aboriginal peoples of Australia. Today, especially in remote and very remote areas, the availability of staff to fill key roles in the primary health care multidisciplinary team is a key limiting factor in meeting the healthcare needs of our community. Maintaining a workforce in remote areas is challenging, and attracting and retaining suitable permanent diabetes-services

team members is no different [49]. Failure to address this current workforce crisis will undermine further attempts to 'close the gap' in health outcomes for Aboriginal people. Workforce shortages, staff turnover and high service demand contribute to impaired relationships and partnerships with the community. Congress has identified a range of practical short-, medium-, and long-term strategies to address remote primary health care workforce shortages. The actions requiring immediate attention are:

- a) the Australian Government to immediately reverse its July 2022 decision to allow overseas trained and non-vocationally-registered doctors to work in MM1 and MM2 (urban) areas
- b) the Australian Government to develop an international migration campaign with streamlined approval processes specifically for remote primary health care
- c) the introduction of Commonwealth-funded retention payments for remote area nurses
- d) the Australian Government to develop, cost and implement tax relief for all essential workers (including health professionals, teachers and police) in remote and very remote areas
- e) the allocation of 40 Commonwealth Supported places or CSPs to establish an NT Medical School at Charles Darwin University.

28. Ensuring that the primary health care workforce includes Aboriginal people to deliver and lead services is essential to providing culturally responsive services. Dedicated funding for Aboriginal people to enter, develop, and progress within a primary health care profession, through scholarships, traineeships and cadetships, will strengthen workforce capacity in remote and regional areas. Strategies to increase the number and proportion of Aboriginal people in the primary health care workforce specifically may include:

- a) Establishing a skills-based Aboriginal Health Worker training program to provide a pathway for Aboriginal community members into the health professions
- b) Establishing a national scheme of scholarships and cadetships directed especially through ACCHSs to support the training and mentorship of the Aboriginal primary health care workforce
- c) Expanding Aboriginal leadership at all levels of the health system, including as managers, administrators, and health professionals, through cadetship and scholarship programs
- d) Longer term efforts to address education levels, poverty, inequality, poor housing and intergenerational trauma has the potential to unlock Aboriginal participation and contribution in the primary health care, and wider, workforce.

4. Any interrelated health issues between diabetes and obesity in Australia, including the relationship between type 2 and gestational diabetes and obesity, the causes of obesity and the evidence-base in the prevention, diagnosis and management of obesity;

Recommendation 11: All levels of government develop a clear and consistent campaign that promotes the benefits of two years of breastfeeding, including the full legislation of the *International Code of Marketing of Breastmilk Substitutes* (the WHO Code), as a strategy to reduce risk of child obesity.

Recommendation 12: That the Australian Government implement nation-wide strategies to reduce exposure and access to hyper-palatable, ultra-processed foods through a ban on marketing and digital advertising campaigns, as well as mandating, monitoring, and enforcing childcare and school-based nutrition programs and policies.

Recommendation 13: That the Australian government develop and implement clear and consistent mandated food labelling (such as the 'traffic light' system) for all packaged and processed foods to enable people to make informed health choices when purchasing food, and to incentivise the food industry to reformulate their products.

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Recommendation 15: That the Australian government appropriately fund and increase access to evidence-based, culturally-appropriate, and age-appropriate diabetes prevention, weight loss and diabetes remission interventions, such as lifestyle programs, low energy diet programs, pharmaceuticals, and bariatric surgery for priority groups.

Breastfeeding

29. There is an expanding body of evidence that highlights that breastfeeding has a protective effect against obesity in children, and that mothers who breastfeed have decreased risk of developing type 2 diabetes and cardiovascular disease [50]. Where possible, the WHO recommends exclusive breastfeeding for the first 6 months of life, and continued breastfeeding for at least the first 2 years of life, alongside complementary foods from 6 months of age [51].

30. The 2023 Lancet Series on Breastfeeding [52], provides commentary on the predatory tactics used by the commercial formula milk industry that has contributed to a reduction in breastfeeding rates across the world. Information about infant and young child feeding provided to women and families must be accurate and independent to ensure that informed decision making is possible. Improving breastfeeding education, training and skills of healthcare professionals is essential in order to provide culturally appropriate and woman-centred support

that will optimise breastfeeding rates. A clear and consistent campaign that supports ongoing efforts to increase breastfeeding rates and duration may have a significant impact on future rates of obesity. Additionally, fully adopting, legislating and monitoring compliance with the International Code of Marketing of Breastmilk Substitutes (the WHO Code) will protect and promote breastfeeding, and ensure the appropriate use of breastmilk substitutes when they are necessary [53]. To compliment this campaign, workplace policies and societal changes are required that includes adequate paid maternal and parental leave, paid breaks to facilitate breastfeeding or expressing milk upon return to work, flexible return-to-work options and suitable areas in public places to support breastfeeding [54].

Hyper-palatable, ultra-processed foods

31. Sugar sweetened drinks and ultra-processed foods are a severe threat to health, and are associated with a wide range of health problems across the life-course, including obesity and type 2 diabetes [55]. As outlined above, for many Aboriginal communities, the limited access and high cost of healthy foods, intergenerational poverty and educational disadvantage impact on the capacity of some families to make healthy choices.
32. These problems are compounded by advertising, branding and sponsorships of unhealthy foods and drinks, especially where it is aimed at young people. In line with the Food for Health Alliance's position (previously the Obesity Policy Coalition) [56], young people in particular should be able to access online content free from exposure to marketing that is harmful to their health, as their exposure to online marketing of unhealthy food has been shown to influence their food choices [57]. In these circumstances, **government regulation and mandatory standards are required to protect the health of the public, irrespective of whether their introduction threatens the profits of the producers of unhealthy foods and drinks.**
33. Developing healthy eating habits early in life has been shown to lay the foundations for life long practices that support the prevention of diet-related chronic conditions and obesity [58]. Childcare and school-based nutrition programs, that include food education and provided meals or canteens, are well placed to foster healthy eating habits. Mandating and monitoring compliance with nutritional standards for food provision in early childhood education and care as well as school settings is required to ensure that this is possible [59]. There are a number of barriers to implementing health and nutrition policies in these settings and include staff nutrition knowledge, perceived food acceptability, and organisational support [60]. Embedded nutrition training and professional development for existing staff is essential for successful food and nutrition programs [59].

Food labelling to support healthy choices

34. Many marketing strategies are utilised by manufacturing companies to increase the attractiveness of ultra-processed foods. This can lead to confusion among community members and it is important that everyone has access to clear and accurate information about the nutritional value of the food they buy. Mandating food labelling that is displayed on multi-ingredient packaged food products in a clear and consistent manner will support this. At present, interpretive front-of-pack labelling systems, including the Health Star Rating System and the Traffic Light System are voluntary for manufacturers in Australia, despite their recommended use by the WHO [61], and evidence that they contribute to increase consumption of healthy food choices [62]. Studies have outlined factors for success of nutritional rating systems include that they are mandatory, use colour and have an overall rating to provide understandable information [63]. This would not only support

people to purchase healthy options, but will encourage manufacturers to reformulate their products to improve nutritional quality of the food they supply [64].

35. The Coalition for Healthy Remote Stores is comprised of representatives from state/territory and national non-government retail, health and academic organisations. This Coalition, of which Congress is a member, has called for immediate action to improve the healthiness of all food retail stores (including stand-alone takeaways) in remote Aboriginal and Torres Strait Islander communities across Australia. Among these recommended actions includes mandating simple strategies to restrict promotion and placement of unhealthy food and beverages that have been demonstrated to reduce the consumption of these items. There are:

- a) no promotional activity on unhealthy food and beverages,
- b) no availability of unhealthy food and beverages in high traffic areas,
- c) no placement of sugary soft drinks of more than 600ml in refrigerators,
- d) less than 40% of refrigerator facings made up of sugar sweetened beverages

36. In 2018, evidence from the co-designed Healthy Stores 2020 study [65] demonstrated that the implementation of these strategies resulted in significant reductions in sugar purchased (i.e., a 2.8% reduction in free sugars; =1.8 tonnes less sugar from 10 stores in 12 weeks), while not impacting store profit. Modelling on this data suggests that these achievements could result in a 10% risk reduction in mortality from cardiovascular disease [65] and similar reductions in diabetes burden could also be hypothesised as a result of these strategies. Evidence-based strategies such as these play a critical role in reducing ease of access to unhealthy options, and such strategies may be extended into larger metropolitan supermarkets for wider reaching impact.

37. The current approaches to managing type 2 diabetes in Central Australia have encountered notable challenges. Although primary health care services are accessible in remote communities, they often face resource limitations that hinder their ability to deliver comprehensive care for individuals with type 2 diabetes. This situation underscores the requirement for innovative strategies that address type 2 diabetes management in a culturally responsive manner and integrated within the framework of primary healthcare services. The focus in primary health care to date has been on promoting healthy lifestyles to prevent or manage type 2 diabetes and on medical management.

38. However, a recent intervention in Glasgow, United Kingdom, has successfully pioneered a promising alternative approach to managing type 2 diabetes in a primary health care setting using a Very Low Calorie/Energy Diets (VLED) [66,67]. The use of VLEDs in the Diabetes Remission Clinical Trial (DiRECT) trial involved providing individuals with carefully formulated, nutritionally balanced, and low-calorie meal replacements for 3-5 months. This approach aims to induce rapid weight loss and address the underlying metabolic abnormalities associated with type 2 diabetes. By achieving substantial weight loss and improving metabolic control, the intervention resulted in a significant number of participants experiencing remission of their type 2 diabetes. Critical to the success of the program was professional support for the stepped transition back to a food-based diet. The study concluded that:

A low-calorie diet is extremely effective in reversing obesity and secondary type 2 diabetes [however] ... a low-calorie diet is not sufficient alone; for

long-term success, people need a composite forward-looking integrated programme directed at long-term maintenance [68].

39. Congress is currently negotiating for funding to extend a feasibility trial and evaluation of a culturally adapted VLED program that includes the low-calorie meal replacements and a lifestyle intervention program, with structured support throughout from an Exercise Physiologist and Dietitian, in remote communities in Central Australia. Outside of research or time-limited grants, funding for structured evidence-based, culturally-appropriate, and age-appropriate weight loss and diabetes remission interventions such as the VLED program is limited. Currently the Medicare Benefits Scheme provides inadequate access to subsidised Allied Health services to facilitate effective multi-disciplinary support for those living with a chronic condition such as diabetes (5 Allied Health sessions in total per calendar year). This makes it extremely challenging to secure funding for long term follow up, continuity, and potentially, results for our community members.
40. Person-centred interventions that move beyond diet and lifestyle are also warranted. As outlined in paragraph 17, pharmaceuticals will play an increasing role in obesity management and ensuring equitable supply of, and access to, these important medications will be essential. Another approach to support significant and sustained weight loss, and subsequently diabetes management, is bariatric surgery. This procedure is costly, has extremely long waiting periods, and is challenging to access for many. Expanding access to this procedure under the public system, including in regional hospitals (such as Alice Springs), will enable those at highest need to access this life-changing procedure that improves health outcomes and reduces mortality [69].

5. The effectiveness of current Australian Government policies and programs to prevent, diagnose and manage diabetes.

Recommendation 16: All levels of government to ensure that any approach to addressing the high prevalence of diabetes in Aboriginal communities is based upon the rights to self-determination of Aboriginal peoples as established under international agreements to which Australia is a signatory, including the United Nations Declaration on the Rights of Indigenous Peoples.

Recommendation 17: All levels of government to provide dedicated funding for targeted, strengths-based, and culturally responsive diabetes health promotion and prevention strategies, such as school-based education programs and community-driven initiatives, led by ACCHS.

Recommendation 18: That the Australian Government develop a capacity strengthening package for use in schools that supports early risk factor identification as well as early diabetes identification (including screening), support and referral for young people living with type 2 diabetes.

Recommendation 19: That the Australian Government appropriately resource and recognise ACCHS as preferred providers of primary health care including diabetes services (that includes health screening, brief interventions, and multidisciplinary diabetes management) for Aboriginal and Torres Strait Islander communities.

Recommendation 20: Strengthen utilisation of the National Diabetes Services Scheme (NDSS) and promote the utilisation of NDSS registration by multidisciplinary teams, to ensure that it meets the needs of Aboriginal people.

The right to self-determination

41. Self-determination, including both personal and community empowerment, is critical to effectively impacting the social determinants of health that contribute to the burden of diabetes for Aboriginal Australians. Any approach to addressing the high rates of diabetes in Aboriginal communities must recognise the continued impact of colonisation and its effects, and be founded on the rights of Aboriginal peoples as established under international agreements to which Australia is a signatory, including the United Nations Declaration on the Rights of Indigenous Peoples [70], which states:

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.

The strengths of Aboriginal self-determination were demonstrated in the response to the COVID-19 pandemic, with detailed social and cultural knowledge of local Aboriginal communities playing a key role in public health action. The same urgency shown in the COVID-19 response should now be mirrored to address the epidemic of diabetes across the nation.

Culturally-responsive health promotion

42. Recent studies have demonstrated that community understanding of diabetes is suboptimal as current resources are delivered with a biomedical lens and do not privilege Aboriginal languages or perspectives [28]. With 40% of Aboriginal adults in remote Central Australia living with a diagnosis of type 2 diabetes [1], it is important for health education and promotion in this region to be delivered community wide. Improving a person's understanding of a health condition can increase their agency and control over their life. Funding for health promotion, diabetes awareness, and type 2 diabetes prevention is currently unstructured and ad-hoc. Providing culturally relevant and contextualised information about type 2 diabetes that is co-designed and delivered in locations requested by communities will contribute to improving peoples true understanding of the significant impacts of this condition and raise awareness about lifestyle modifications and management. Dedicated funding for targeted, culturally responsive diabetes education that is led and facilitated by ACCHSs, in a similar way to the Tackling Indigenous Smoking program [71], will strengthen the reach of these activities.
43. Schools can play an important role in increasing awareness and de-stigmatising type 2 diabetes in the community. Through school nurse programs, and in partnership with primary health care providers, early identification of diabetes (including screening) and education may promote earlier lifestyle modification. A capacity strengthening package for school nurses and teachers that outlines evidence-based recommendations for type 2 diabetes prevention, detection and management would ensure that youth appropriate and diabetes friendly environments are provided to those living with diabetes. This would enable young people to attend to their diabetes management without stigma and with the support they require (such as a safe space to store and utilise their medication, pastoral care etc). They would also be able to be referred in a timely manner to primary health care services, for crucial early intervention and diabetes management.

Aboriginal community controlled health services

44. Aboriginal community-controlled health services are an extremely important delivery system for evidence-based, culturally appropriate services to address the health needs of Aboriginal communities. There are over 140 ACCHSs around Australia delivering almost 3 million episodes of care annually through over 300 clinics, and employ over 6,000 staff, most of whom are Aboriginal and Torres Strait Islander Australians [72]. ACCHSs have a range of inter-linked structural advantages in delivering services and hence have improved outcomes compared to non-Indigenous services (government or private). The key role of ACCHSs in primary health care delivery was confirmed by one major study which concluded that up to fifty percent more health gain or benefit can be achieved if health programs are delivered for the Aboriginal population via ACCHSs, compared to if the same programs are delivered via mainstream primary care services [73]. Appropriately resourcing ACCHSs, as preferred providers of primary health care, that includes diabetes support, for Aboriginal people will enable a spectrum of high-quality, culturally appropriate diabetes services to be reliably provided, ranging from prevention and screening to coordinated, client-centred, multi-disciplinary care.

Cultural safety in mainstream services

45. The new AHPRA and health professions' training accreditation standards, most of which are for implementation over the next five years, mandate the inclusion of Aboriginal and Torres Strait Islander cultural safety curriculum as a strategy for eliminating racism in the healthcare system [74]. Funding for resources and further training to support the existing health workforce to undertake cultural safety training and self-reflective practice to address assumptions, bias, and racism, is required to enhance accessibility of all diabetes services for Aboriginal people.

National Diabetes Services Scheme (NDSS)

46. The National Diabetes Services Scheme (NDSS) is a nation-wide scheme that is designed to support diabetes self-management. Providing a range of subsidised diabetes products and diabetes health information support, the NDSS is an Australian Government initiative administered by Diabetes Australia. Enrolment with NDSS requires certification from a doctor, endocrinologist, nurse practitioner, or credentialed diabetes educator. Clinical information, such as the incidence of insulin-treated diabetes, is determined using NDSS registration information, and is used in research and to guide policy development across Australia [75].

47. Congress is aware that the NDSS figures for those living with diabetes in the Central Australia are not accurate. Aboriginal Australians who access ACCHSs may not register for NDSS at all as programs operating under Section 100 of the National Health Act 1953 (which includes ACCHSs) provide clients access to free and subsidised products that are essential for their diabetes management. These factors result in under-representation of Aboriginal Australians and do not reflect the true rates of diabetes or medication utilisation. Strategies that support increased NDSS enrolment, such as increasing the number of health professionals who can certify enrolment (including Aboriginal Health Practitioners, Pharmacists and Remote Area Nurses) and ongoing promotion of the scheme through culturally appropriate resources will ensure that it improves in meeting the needs of the Aboriginal community.

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