Central Australian
Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

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Consultation Paper for the National Preventive Health Strategy

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Aboriginal health in Aboriginal hands.

Vision and Aims of the Strategy

Please review pages 13 & 14 of the Consultation Paper, which outlines the vision and aims of the Strategy, before completing this question.

Are the vision and aims appropriate for the next 10 years? Why or why not?

Providing a policy foundation

The preventive health strategy should be built upon solid policy foundations, and as such take account of the *Ottawa Charter for Health Promotion* [1] which remains the key international statement in the field. The Charter concludes that:

> *The fundamental conditions and resources for health are: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. Improvement in health requires a secure foundation in these basic prerequisites.*

It sets out five key areas for action: building healthy public policy, creating settings and environments that are supportive of good health, supporting community action, educating and informing the community, and reorienting health services towards these approaches. The Alma Ata declaration [2] is also key in describing the vital role of primary health care in preventing ill health (see below).

Other international agreements to which Australia is a signatory should also form underpinning policy guidance for a preventive health strategy, including in particular the *United Nations Declaration on the Rights of Indigenous Peoples* [3].

Goals of the Strategy

Please review page 15 of the Consultation Paper, which outlines the goals of the Strategy, before completing this question.

5. Are these the right goals to achieve the vision and aims of the Strategy. Why or why not? Is anything missing?

Reducing poverty and inequality must be included as key goals for a Preventive Health Strategy.

The Consultation Paper states that it aims to address the broader causes of health and wellbeing (page 13). It also acknowledges the powerful effects of poverty on health (page 3). However, it then ignores this evidence in its goals and actions. It also fails to address the evidence around inequality: as well as absolute deprivation (poverty), relative deprivation (inequality) is related to higher infant and adult mortality rates, to reduced life expectancy, and to higher rates of illness [4].

The powerful effects of poverty can be seen in the Northern Territory where between a half- and a third- of the gap in life expectancy between Aboriginal and non-Indigenous Territorians is due to socioeconomic disadvantage [5].

Australia is a wealthy country with a Gross Domestic Product well above the OECD average, but on average, Aboriginal and Torres Strait Islander people receive a personal income that is only two-thirds that of the non-Indigenous population [6]. 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 ($1,080) [7].

Unfortunately, both absolute poverty and relative inequality is worsening. Nationally, in very remote areas Aboriginal and Torres Strait Islander incomes are falling in real terms, and the income gap is widening [8].

Addressing both poverty and inequality as drivers of ill health must therefore be included as central actions for any national preventive health strategy.

Universal access to evidence-informed early childhood development programs is an essential goal

Another key primary prevention approach with strong evidence for health gain across the lifespan is evidence-based early childhood programs.

The experience of the child, including in the months before birth, is critical for a healthy life, and deficits at this time are powerfully linked to disadvantage and ill health later in life [9]. Early childhood is thus a key intervention point for the prevention of ill health.

The link between poor development in the early years and the subsequent development of life-long health, wellbeing and social problems has been demonstrated by many studies, including a recent major longitudinal study from Dunedin in New Zealand, which followed a cohort of more than one thousand children from birth to age thirty-two [10]. It found that poor early childhood experience was strongly linked to poorer physical health, greater substance dependence, lower income, and increased criminal offending outcomes as an adult.

Fortunately, there is an abundance of strong evidence that well-designed early childhood development programs are a key, cost-effective intervention to address and offset the effects of poor early childhood experience. Examples of such preventative programs include the Nurse Family Partnership (NFP) Program Home Visitation and the Abecedarian model of Educational Day care. These programs work with children before developmental problems arise, supporting support children and their families to develop the stimulation, relationships and access to services needed for healthy development.

Evidence from overseas, based on decades of study, show incontrovertibly that such early childhood programs can:

- significantly lower prevalence of risk factors for cardiovascular and metabolic diseases in adults (especially men) [11]
- reduce the use of alcohol and other substances by young adults [12];
- more than double school retention rates [13];
- dramatically reduce the youth incarceration rates [14]; and
- dramatically increase (by a factor of four) the likelihood that at age 18 young people will report having an active, healthy lifestyle [13].

Early childhood development programs are an essential contributor to raising children who are resilient and thus better equipped to meet challenges to their health and wellbeing. Healthy early childhood development through responsive care, stimulation and support are thus an essential part of the answer to preventing ill-health in both the Aboriginal and Torres Strait Islander and broader communities.

Addressing future infectious disease outbreaks must be included as a goal – and adequate housing is essential to this goal

The inadequacy and inequity of housing in Aboriginal Australia and amongst other disadvantaged and marginalised groups has been brought into sharp focus by the COVID-19 pandemic.

Fortunately at the time of writing, due to swift, evidence-driven action and the efforts of Aboriginal communities and organisations, there has been no community transmission of COVID-19 in a remote Aboriginal community in the Northern Territory. However, should there be an outbreak, overcrowded housing and poorly installed and maintained infrastructure will both ensure the rapid spread of disease with high exposure doses leading to more severe illness which will undermine conventional public health responses. Physical distancing, self-isolation and quarantine are very difficult to implement effectively in severely overcrowded houses with inadequate health hardware such as plumbing, cooling/heating, cooking and food storage, power supply.

Poor housing thus puts people at significantly greater risk during the current or future viral pandemics. Protecting communities from such pandemics must include addressing the high levels of overcrowding in houses, particularly in remote areas.

There are a range of other health risks posed by severely overcrowded housing including:

- *Communicable disease.* Overcrowded housing is a major factor in the transmission of other infectious diseases, including bacterial ear infections and scabies, Rheumatic Heart Disease, and bronchiectasis. For children, recurrent infections can undermine healthy childhood development and educational

outcomes and contribute to the development of chronic disease in later life [15].

- *Early childhood development*. A child's experience in the first few years of life is known to set the foundations for physical health and social and emotional wellbeing across the lifespan. A recent study that looked at the association between housing and child development in the Australian context is highly significant [16]. It finds that 'Indigenous children live in starkly inferior housing circumstances [compared to] non-Indigenous children' and that overcrowding and poor living conditions contribute to their poorer physical and socio-emotional outcomes, concluding that 'improvements in housing can be expected to translate into gains in child development outcomes for Indigenous children' (p52-3). This is consistent with an association between lower housing standards and decreased school attendance observed in Northern Territory remote Aboriginal communities [17].

- *Mental health and social and emotional wellbeing*. Insecure or overcrowded housing is associated with a range of mental health issues such as depression, anxiety and suicide [18]. The social stress associated with over-crowding may also be a contributor to family and sexual violence [15, 19]. In 2012-13, across Australia one in ten Aboriginal and Torres Strait Islander adults reported overcrowded housing as a stressor in their lives [20].

- *Exposure to tobacco smoke*. Poorly designed, overcrowded houses increase the exposure of the family to tobacco smoke, with increased risk of respiratory disease and (for children and babies), heightened risk of Sudden Infant Death Syndrome, asthma, and ear infections [21]. 12% of the burden of disease that the Australian Aboriginal and Torres Strait Islander population experienced in 2011 is caused by tobacco use [22].

- *Exposure to smoke and dust*. Particulates in dust and smoke (from bushfires, burning of rubbish, or cooking fires) are associated with a range of respiratory and other conditions, particularly in children. Poorly designed and maintained houses and lack of investment in community infrastructure (e.g. sealing of roads, vegetation of public spaces) contributes to increased exposure to such particulates [23].

Mobilising a Prevention System

Please review page 17 & 18 of the Consultation Paper, which outlines the seven enablers to create a more effective and integrated prevention system, before completing this question.

6. Are these the right actions to mobilise a prevention system?

The importance of comprehensive primary health care

The term 'primary health care' (PHC) gained widespread currency following the Alma-Ata Conference held by the World Health Organisation in 1978 [2]. The definition of PHC advanced by Alma Ata was comprehensive: as well as the provision of medical care, it also captures the ideal of 'wellness' as a goal, and prevention, health promotion, advocacy and community development as major methods to achieve it. It emphasises the need for maximum community and individual self-reliance and participation and involves collaboration with other sectors.

This comprehensive definition of primary health care is now broadly accepted in Australia especially when it comes to improving the health of disadvantaged populations [24, 25].

A well-resourced and robust comprehensive primary health care system is therefore a critically important platform from which to address the health of all Australians. This means a substantial reorientation of the primary health system as it is organised at the moment, which is substantially based on a profit-driven, fee-for-service model providing single episodes of care for individual clients. Fortunately, the Aboriginal community controlled health services (ACCHSs) provide a model for what this might look like.

The evidence for this is well-established: thirty years ago a landmark national review of the relationship between primary health care and health promotion in Australia, led by the National Centre for Epidemiology and Population Health, concluded that re-orienting Australia's health system towards primary health care would make a major contribution to health promotion. Health promotion is in fact one of the core elements of primary health care and is most effective when integrated into primary health care [26].

Boosting Action in Focus Areas

Please review page 19 of the Consultation Paper, which refers to the six focus areas that have been identified to boost prevention action in the first years of the Strategy and to impact health outcomes across all stages of life, before completing this question.

7. Where should efforts be prioritised for the focus areas?

Improving consumption of a healthy diet

Food Security is commonly defined using the United Nations Food and Agriculture Organization's (FAO) definition:

> *Food and nutrition security exists when all people at all times have physical, social and economic access to food, which is safe and consumed in sufficient quantity and quality to meet their dietary needs and food preferences, and*

is supported by an environment of adequate sanitation, health services and care, allowing for a healthy and active life [27].

Aboriginal people are an exceptionally high needs group in relation to food security. The *Australian Aboriginal and Torres Strait Islander Health Survey 2012-13* [28] showed that 22% were living in a household that had run out of food and could not afford to buy more, where 7% lived in a household that had gone without food when they ran out. In the NT Aboriginal population, 34% of the population had run out of food in the last year compared to 4% of the non-Aboriginal population. The national rate for Aboriginal people was 25%. In 2013, 97% of Aboriginal people in the NT reported inadequate vegetable intake and 49% reported inadequate fruit intake.

1. Any approach to addressing food security in Aboriginal communities must be 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 Aboriginal Peoples.

2. Support for Aboriginal groups that wish to live on their traditional lands to do so, given the clear physical, social and emotional wellbeing benefits that result including through greater access to bush foods and a more active lifestyle.

3. A stronger government commitment to reducing poverty and inequality. This commitment should include a significant and permanent increase in the Newstart and similar citizenship entitlements for all participants, and an additional loading on such payments for those in remote or very remote areas to address significantly higher costs of living.

4. A direct to consumer, point of sale subsidy to address financial barriers and increase affordability of essential food, including fruit and vegetables, cleaning and hygiene products 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.

5. An economy of scale store model, encouraging the collective buying power of small independent or community owned stores to access lower prices that can be passed to the community.

6. Significant increases in culturally appropriate and well maintained housing for Aboriginal communities, to ensure that Aboriginal families have access to appropriate food storage, preparation and cooking facilities.

7. Aboriginal Community Controlled Health Services to be recognised as the preferred providers of public health and nutrition programs and other initiatives to address food security in Aboriginal communities.

Reducing alcohol and other drug-related harm

Reducing alcohol related harms is a key goal of the preventive health strategy. This is an area where the integration of health promotion as part of primary health care has already been strongly demonstrated. Over many years Congress has been a powerful advocate for a wide range of alcohol reforms in the Northern Territory and nationally.

In October 2019 the Northern Territory Government introduced a package of reforms to deal with the jurisdiction's long-standing issue with high levels of alcohol-related harm, including family violence. The reforms included [29]:

- a floor price to prevent the sale of cheap alcohol;
- a Banned Drinkers Register (BDR) to reduce the access to take-away alcohol by problem drinkers;
- Point of Sale Interventions at all bottle shops in three regional centres;
- a new Liquor Act that includes risk-based licencing and greater monitoring of on-licence drinking; and
- a commitment to high quality, ongoing independent evaluation.

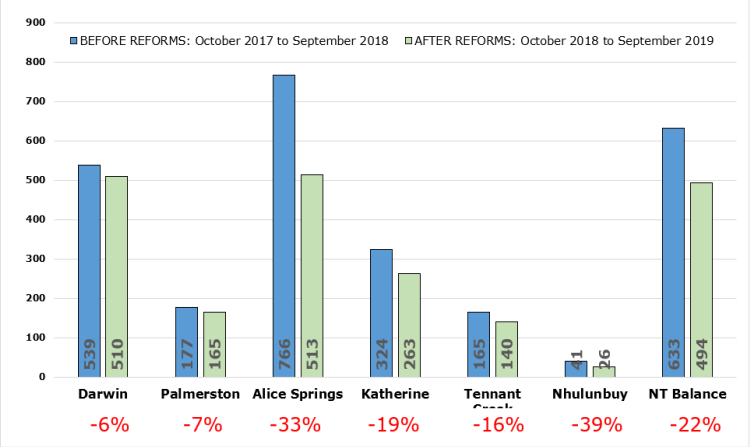
These reforms are informed by the best available evidence from around the world on what works to reduce alcohol related harm. Over the first full year of operation they have demonstrated very significant reductions in wholesale sales of alcohol, down 7% across the Northern Territory as a whole. Reductions in sales have been greatest in those cheap types of alcohol associated with the greatest harms, with cask wine supply falling 48% and fortified wine sales down 31% following the introduction of the reforms (see NTG Open Data Portal https://data.nt.gov.au/dataset).

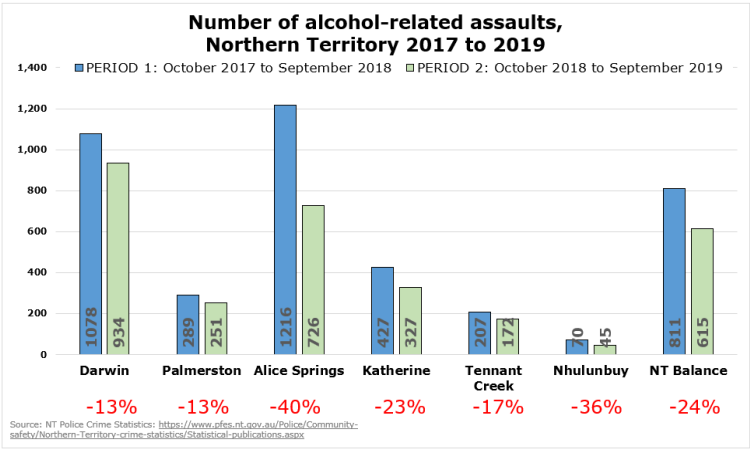
As a consequence, there have been dramatic falls in alcohol-related harm across the Northern Territory including:

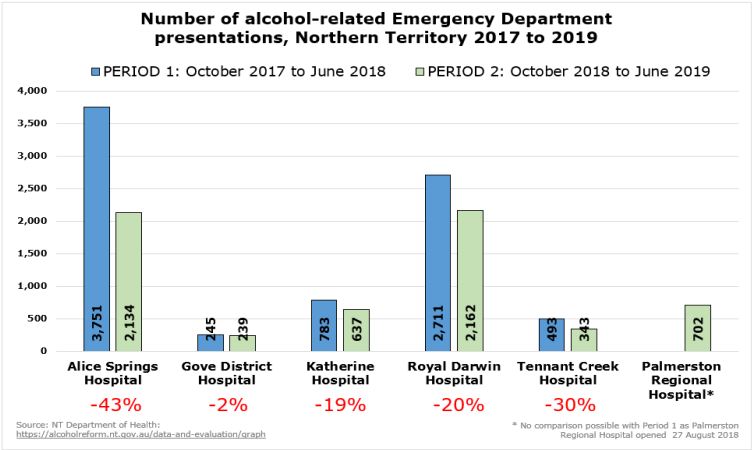
- a reduction of 1,000 alcohol-related assaults across the Northern Territory (down 24% from 4,105 to 3,105);
- a reduction of 525 domestic violence assaults where alcohol was involved (down 20% from 2,644 to 2,119);
- all areas of the Northern Territory benefited, with Alice Springs and Nhulunbuy seeing the biggest falls in alcohol-related assaults (down 40% in Alice, and 33% in Nhulunbuy) although Darwin (down 12%) and Palmerston (down 13%) also saw significant reductions in alcohol-related violence;

- there were similarly large falls in the number of alcohol-related Emergency Department presentations (2,151 fewer presentations or 21% across the Northern Territory)

These results provide objective evidence for population-level reductions in alcohol-related harm, and should be a priority for the preventive health strategy.







There are a number of approaches which are sometimes suggested which have little or no evidence to support them in reducing alcohol harm.

Mandatory treatment linked to criminal sanctions has very little evidence of success in reducing alcohol consumption for high-risk drinkers. It appears to work least well for young people, can add to the disadvantage experienced by marginalised groups, and may displace voluntary clients from limited treatment spaces [30].

In general, education and persuasion strategies, including school-based education and media campaigns, have at best a minimal, short-term effect in raising awareness and reducing alcohol consumption, and as a substantial review of the international literature notes, 'cannot be relied upon as an effective approach' [31].

Approaches which discriminate on the basis of race are likely to be counter-productive. The experience of racism is associated with increased alcohol consumption. Indigenous Australians commonly experience high levels of racism, from relatively minor incidents such as being called racist names, through verbal abuse, to serious assault [32]. There is a strong association between racism and poor mental health and alcohol misuse [33]. As well as addressing racism directly, this also points strongly to the need for interventions to tackle alcohol in Aboriginal communities to be non-racially discriminatory.

Continuing Strong Foundations

Please refer to page 20 of the Consultation Paper which highlights the importance of continuing and building on current prevention activity, before completing this question.

8. How do we enhance current prevention action?

Aboriginal community controlled health services (ACCHSs): a successful model of non-profit-based, prevention-focused primary health care

ACCHSs were first established by Aboriginal communities in the 1970s. ACCHSs promote a comprehensive model of primary health care (see above), including culturally safe practice and a multi-disciplinary team approach. These factors make them the best-practice service platforms for addressing prevention and complex health and wellbeing issues.

A number of evidence and literature reviews have attempted to assess the effectiveness of ACCHS in comparison to mainstream primary health care [34, 35]. In doing so, they have been hampered by the fact that ACCHSs' service population has significantly more complex health needs, and frequently live in rural, remote or outer-suburban areas where private practice business models struggle and service access is a particular challenge. In addition, ACCHS provide a comprehensive model of care that goes beyond the treatment of individual clients for discrete medical conditions to include:

- a focus on cultural security;
- assistance with access to health care (e.g. patient transport to the ACCHS and
- support and advocacy to access care elsewhere in the health system);
- population health programs including health promotion and prevention;
- public health advocacy and intersectoral collaboration;
- participation in local, regional and system-wide health planning processes; and
- structures for community engagement and control;
- significant employment of Aboriginal and Torres Strait Islander people.

Nevertheless, the evidence is clear that ACCHS are the most effective model for addressing Aboriginal and Torres Strait Islander health, with:

> *... some studies showing that ACCHS are improving outcomes for Aboriginal people, and some showing that they achieve outcomes comparable to those of mainstream services, but with a more complex caseload [35].*

In particular, ACCHSs contribute significantly to reductions in communicable disease, improved detection and management of chronic disease, and better child and maternal health outcomes including reductions in preterm births and increases in birth weight [36].

The key role of ACCHSs is supported by the fact that Aboriginal and Torres Strait Islander people show a clear preference for the use of ACCHSs, leading to greater access to care and better adherence to treatment regimes. This is critical to prevention strategies and led one major study to conclude:

> *up to fifty percent more health gain or benefit can be achieved if health programs are delivered to the Aboriginal population via ACCHSs, compared to if the same programs are delivered via mainstream primary care services [37].*

Such advantages were recognised by a recent Senate Inquiry which recommended that:

> *… future selection criteria and funding guidelines should give weighting to the contribution and effectiveness of Aboriginal and Torres Strait Islander organisations to provide to their community beyond the service they are directly contracted to provide [38].*

ACCHSs not only deliver more effective services to the communities they serve. They also provide a platform for reorienting the health system towards illness-prevention and health promotion, through a combination of direct advocacy, community education, and the development, implementation and evaluation of evidence-based approaches to what are often seen as intractable health

challenges. Congress itself has developed a strong reputation in this area, with a large range of publications in the fields of:

- multi-disciplinary health promotion in primary health care [39];
- advocacy for population-level public health approaches to preventing alcohol-related harm [40, 41];
- non-residential treatment for clients with alcohol problems, based on three streams of care (medical; psychological and socio-cultural support) [42];
- integrated models of child and family services [43];
- early childhood education for disadvantaged children [44, 45]; and
- improved funding for, and collaborative planning and implementation of primary health care services in remote and regional Australia [46-48]

Therefore a key action to build a health system that is effective in preventing ill health – in both the Aboriginal and Torres Strait Islander and other populations – should be to build upon the successful models developed by the Aboriginal community controlled health sector with a not-for-profit, comprehensive primary health care sector.

Additional feedback/comments

9. Any additional feedback/comments?

It is expected that any consultation process for the development of a substantial policy or strategy – such as a preventive health strategy for Australia – will be evidence-based, not just in the background it provides but also in the actions it contains. In the case of the prevention of ill health, this would require addressing some of the major social determinants of health such as poverty and inequality; early childhood development; and housing and homelessness. It is disappointing that these are not addressed substantively in the Discussion paper's goals and focus areas. We have sketched an evidence-based approach to some of those in our responses above.

Linked to this is the web-based system for providing responses. This is better suited for gathering opinion rather than evidence, and undermines the capacity of stakeholders to present their own argument supported by appropriate referencing. To help offset this, we have provided substantive feedback in the format required, including numbered citations to the following references.

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