



AMSANT RESPONSE TO NATIONAL PREVENTATIVE HEALTH TASKFORCE PAPER

AUSTRALIA: THE HEALTHIEST COUNTRY BY 2020

December 2008

Executive Summary

AMSANT fully supports the goal of the National Prevention Taskforce to reform the approach in Australia to the prevention of illness and the promotion of health and well-being. Prevention and the capacity to promote good health has been a glaring weakness of our health care system for decades and we urge the Taskforce to review the 1986 Ottawa Charter for Health Promotion and its accompanying literature to assist with the task of building a better system.

AMSANT concurs with the Community-driven and Governance principles presented in the Taskforce's paper as guidelines to building an effective framework for preventative health. However we do not support the establishment of a stand-alone national coordinating body for preventative health reform. **We would prefer a National Primary Health Care Agency established to set standards, drive and monitor primary health care, including its preventative focus, and reporting annually to federal parliament and to CoAG.**

AMSANT recommends a stronger focus on building the primary health care workforce, particularly in remote settings and in Indigenous health. **Remote primary health care workforce deficiencies bear heavily on capacity for preventative efforts and effective health promotion.**

Key Prevention Issues

AMSANT believes there are a number of issues with regard to preventative efforts that need to be raised and addressed:-

1. The Australian health system needs enhanced workforce capacity and skills to address prevention – more resources, better training and effective on-going professional development.
2. There is an urgent need to build the evidence base for preventative activity, and this will require committed, coordinated and well-funded trials in a variety of settings.
3. The bullet needs to be bitten – the Commonwealth needs to assume full funding and planning responsibility for the primary health care sector with the states and territories engaged as key stakeholders in new arrangements.
4. Medicare needs further root and branch reform to underpin the development of a universal health care system with genuine capacity to deliver comprehensive primary health care to communities.
5. The National Preventative Health Taskforce must play a leading role in tackling the social and physical causes of ill health in Aboriginal Australia.

Relevant Initiatives from the Aboriginal Community Controlled Health Sector

The Aboriginal Community Controlled Health sector has an enormous amount to offer the Taskforce in its preventive endeavors, particularly in relation to primary health care practice and community engagement. Some key elements are as follows:-

- The ACCH sector provides the closest approximation currently operating in the Australian health context of community-engaged comprehensive health care provision.
- AMSANT believes the Aboriginal community controlled health sector has undertaken considerable systems development of relevance to mainstream health in efforts to establish health promotion and preventative capacity (see Appendix 1: Pathways to Community Control).
- AMSANT commends to the Taskforce the Expanded Health Services Delivery Initiative approach in the NT to the achievement of comprehensive PHC services for Aboriginal people via an agreed core set of primary health care services, including a key focus on preventative care (see Appendix 2: Indigenous Access to Core PHC Services in the NT).
- AMSANT is concerned that a number of special health program areas are poorly addressed at the Aboriginal community level and currently offer only a limited service delivery to clients and families much in need. Particular areas of concern include mental health, alcohol and other drugs, environmental health, ear health, and aged and disability care. To this end AMSANT has developed a model for ‘integrating alcohol and other drug, community mental health and primary health care in Aboriginal health services in the NT’ which integrates treatment and rehabilitation concurrently with prevention and health promotion within a single comprehensive primary health care service provider (see Appendix 3).

Priority Areas for the National Preventative Health Strategy

AMSANT supports the initial focus of the National Preventative Taskforce on three priority areas: obesity, tobacco and alcohol. We make the following points.

Tobacco

- AMSANT broadly supports the recommendations made in the Taskforce’s tobacco control document as these apply to the mainstream Australian population.
- We have concerns about potentially harmful effects of raising the price of cigarettes to \$20 per packet and its impacts on poorer households and dependent family members.

- AMSANT advises that nicotine replacement therapy (NRT) be subsidized for all health care card holders, not just for targeted groups.
- AMSANT supports the concept of setting a target for Aboriginal smoking rates.
- The \$14.6 million of Commonwealth funding ear-marked for Indigenous tobacco control needs urgent allocation to community-based projects in a variety of locations.
- 7 mg patches and gum and lozenges for heavily dependent smokers should be added to the PBS
- Aboriginal Health Workers (AHWs) need to be supported to lead health promotion activities including tobacco control programs.
- A special focus of support should be applied to Aboriginal staff of ACCHSs to quit smoking themselves.
- All primary health care ACCHS staff need skills in tobacco control work
- AMSANT supports the creation of 'specialist tobacco control workers' to train and support generalist ACCHS staff and to support and advise community tobacco control programs
- Robust evaluation of community tobacco control programs is required inclusive of strong process evaluation to identify weaknesses in project design or community consultation processes.

Alcohol

- AMSANT has long been engaged in alcohol issues in the NT as this jurisdiction has the second highest per capita alcohol consumption in the world with rates for both non-Aboriginal and Aboriginal people being much higher than the Australian average.
- AMSANT has two member-endorsed policy positions on alcohol which explain our positions. These are:-
 - 1) Options for Alcohol Control in the Northern Territory - January 2008 (see Appendix 4)
 - 2) A Model for Integrating Alcohol and Other Drug, Community Mental Health and Primary Health Care in Aboriginal Medical Services in the Northern Territory (see Appendix 3)
- AMSANT agrees that regulating alcohol supply and cost are the most effective ways to reduce alcohol-related harm.
- AMSANT is not in favor of the types of alcohol bans enforced under the Australian Government Emergency Response (NTER)
- The previous 'Living with Alcohol' program in the NT was relatively successful
- AMSANT recommends that liquor outlet density in the NT be significantly reduced until per capita alcohol consumption has reduced to the national average alcohol consumption.
- The NT Liquor Act needs to be reformed so that the primary consideration in granting a license is the level of potential community harm as opposed to benefit.
- It is essential that a current liquor license can be revoked on the basis of evidence of significant community harm.
- Liquor licenses should only be granted for a finite time and then reviewed.
- Regulation of take-away alcohol is also a crucial element of supply reduction as most heavy drinkers rely on take-away alcohol.
- The NT Liquor Licensing Commission needs to be reformed so that it represents the interests of the community rather than the liquor and hospitality industries. The Aboriginal and community representation on the Commission needs to be increased.

- AMSANT supports the right of remote Aboriginal communities to make their own decisions about alcohol control
- Regional alcohol management plans need to be based on input from Aboriginal communities, based on evidence from elsewhere and properly trialed and evaluated.
- AMSANT supports the general banning in the NT of the cheapest types of alcohol (two- and four-litre casks of wine and fortified spirits)
- Responses to alcohol-related harm: There needs to be a greater capacity to respond to alcohol-related harm, particularly in regional centers. Advertising and Labeling: AMSANT supports a total ban on alcohol advertising in the NT and nationally. The voluntary code-of-conduct for alcohol advertising is clearly not working as outlined in the AMSANT position paper. AMSANT supports mandatory warning labels on all alcohol products.
- AMSANT supports consideration of raising the legal drinking age to 21 years for all Australians, although it is acknowledged such a measure would require considerable community consultation.
- AMSANT agrees that legislation banning the serving of alcohol to intoxicated patrons is only likely to be effective if accompanied by adequate enforcement and substantial fines. Repeat retail offenders should have their liquor license revoked.
- AMSANT supports a minimum floor price for alcohol and a volumetric approach to alcohol taxation, although it is appreciated more evidence may be required before such a measure could be implemented nationally.
- AMSANT supports greater surveillance of alcohol sales and alcohol-related harm around Australia to build an evidence base for the most effective measures to reduce alcohol harm through the regulation of alcohol availability, supply and other measures.
- AMSANT has outlined an approach to the treatment of alcohol and other drug and mental health problems within the community controlled sector in the NT (see Appendix 3).
- AMSANT agrees that clinical leadership and expertise is required in the alcohol and other drugs field - this leadership needs to be developed both within the specialist program and the PHC sectors
- Within the PHC sector, AOD expertise needs to be integrated with mental health expertise given the high rates of dual diagnosis, particularly for Aboriginal people.

Obesity

- AMSANT agrees that obesity is a significant public health issue for the mainstream as well as for Aboriginal Australia, but physical fitness is at least as important.
- AMSANT strongly endorses a total ban on the advertising of junk food (high energy density /low nutrient).
- There needs to be a strong health promotion capacity added to the PHC workforce to support a focus on nutrition and physical activity in high risk groups.
- GPs need improved capacity to refer to allied health professionals through Medicare-supported team care arrangements for people with complex conditions or chronic diseases.
- Alternative strategies are required to provide allied health services to low income/rural/remote areas and to engage allied health professionals in broader health promotion strategies that are not covered by Medicare rebates.
- Specific measures are required to support active living for low income families and communities.

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- AMSANT supports subsidies for food in remote communities given the high cost of fruit and vegetables and the low incomes of the majority of residents in these settings.
- AMSANT supports the setting of national standards for stores in remote communities including minimum national standards for availability and freshness of a range of essential foods.
- AMSANT supports efforts to improve housing and nutrition hardware, such as access to stoves and fridges and capacity for their maintenance, as being vital in improving nutrition given the severe overcrowding and poor housing maintenance in remote communities.
- The ACCH sector has a central role to play in addressing physical activity and nutrition challenges, but requires additional funding to build health promotion capacity in ACCHSs including enhanced training of the multi-disciplinary Aboriginal health workforce.

In supporting these three priority areas for preventative action AMSANT is concerned that other areas with particular relevance for Aboriginal health are quickly included for analysis and action, including: mental health; environmental health; ear health; aged and disability care; and child and maternal health. It will also be vital for the Taskforce to place great emphasis on the broader determinants of health and illness.

Introduction

The Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) is the peak body for Aboriginal community controlled health services (ACCHSs) in the NT with 25 member services located in urban, regional and remote locations throughout the NT. AMSANT is also a jurisdictional affiliate of the national body, the National Aboriginal Community Controlled Health Organization or NACCHO.

AMSANT fully supports the goal of the National Prevention Taskforce to reform the approach in Australia to the prevention of illness and the promotion of health and well-being. A genuine preventive focus has been a glaring weakness in our national health care system for many years now. In saying this it is prescient to recall the 1986 Ottawa Charter for Health Promotion and its six priority areas for action. These priorities areas remain as pertinent as ever, the first requiring us to 'build healthy public policy' and address intersectoral challenges. Despite some successes in public policy in areas such as tobacco and road trauma, it could be argued we have had 20 wasted years in terms of prevention since the 1986 statement. We ask the Taskforce to link back to the Ottawa Charter and its associated literature to help guide our future directions.

AMSANT concurs with the Community-driven and Governance principles presented in the Taskforce's paper as guidelines to building an effective framework for preventative health. In particular AMSANT supports the notion that the maintenance of good health is a shared responsibility, shared between individuals, families, communities and governments, but also between sectors of government, business and other community organizations – all have responsibilities and a contribution to make.

We have one area of dispute – AMSANT does not support the establishment of a stand-alone national coordinating body for preventative health reform. The proposed function is supported, however preventative health approaches and health promotion are essential elements of comprehensive primary health care. In addition, the work of the National Preventative Health Taskforce must tie in closely with that of the National Primary Health Care Strategy. **We would therefore prefer to see a National Primary Health Care Agency established to set standards, drive and monitor primary health care, including its preventative focus. There will be wasted opportunities and a danger of prevention being marginalized if PHC and prevention into separate entities.** A National Primary Health Care Agency would have a mission linked to the Ottawa Charter and would be responsible for formulating national PHC and preventative policy and for funding strategically targeted evaluation and research. The new agency should report annually to federal parliament and regularly to CoAG. It should have an independent board with strong community/consumer representation including from Aboriginal, rural/remote and disadvantaged communities, as well as academic and policy expertise.

There also needs to be stronger emphasis in the Paper applied to the primary health care workforce. This workforce has not been well elaborated in Australia to cover the range of individual and community needs. In remote settings and in Indigenous health in particular there are significant gaps in workforce in terms of the services and skills offered and in the numbers of workers available per capita to provide services. **Remote primary health care workforce deficiencies bear heavily on capacity for preventative efforts and effective health promotion.**

Key Prevention Issues

AMSANT believes there are a number of issues with regard to preventative efforts that need to be raised and addressed:-

1. In Australia, in general terms, we have not been good at preventative work and promoting wellness. Not only has our health workforce lacked resources to take on effective work in this area, it has also lacked the necessary training and skills which has resulted in a lack of confidence to engage in community preventative action and cross-sectoral health promotion initiatives. This is in contrast to recent improvements in the treatment and management of illness, in particular chronic diseases. **Our health system needs enhanced workforce capacity and skills to address prevention – more resources, better training and effective on-going professional development.**
2. Amongst the ranks of senior health managers and planners in Australia, and within the academic research domain, there is considerable skepticism surrounding the efficacy of preventative work and the whole field of health promotion. With little else on offer however, other than increased resources poured into disease management and hospital care, this has left us poorly equipped to ‘stop people falling in the river’. We badly need to answer the question ‘how does health promotion work’, especially in complex areas like obesity. A secondary question is ‘how can we ensure health promotion is effective in the groups that need it most, such as in Aboriginal communities’. **There is an urgent need to build the evidence base for preventative activity, and this will require committed, coordinated and well-funded trials in a variety of settings.**
3. For significant progress to occur in our primary health care capacity and the ability of our health system to effectively engage communities, it will be essential to resolve the ‘blame game’, the morass of dysfunctional systems and programs arising from the collision of Commonwealth and states/territories agendas at the health interface. The states and territories have historically struggled with their primary health care responsibilities in terms of workforce and prevention, particularly in relation to service delivery in rural and remote regions. **The bullet needs to be bitten – the Commonwealth needs to assume full funding and planning responsibility for the primary health care sector with the states and territories engaged as key stakeholders in new arrangements.**
4. A key driver of workforce and access to services in the Australian healthcare system is Medicare. Unfortunately, despite recent minor adjustments, Medicare has supported the development of universal ‘medical care’ rather ‘health care’, with the consequence that we have a well-elaborated General Practice system operating in the community health space, but a hopelessly under-resourced and poorly developed multi-disciplinary system of community care. General Practice alone cannot deliver what is required for a genuinely preventative focus with capacity for quality health promotion. **Medicare needs fundamental root and branch reform to underpin the**

development of a universal health care system with genuine capacity for the delivery of comprehensive primary health care to Australian communities.

5. AMSANT notes that ‘closing the life expectancy gap’ between Indigenous and other Australians is one of four key targets put forward in the Taskforce paper for achievement by 2020. Having set this broad target, however, there a few firm preventative strategies proposed in the paper to grab hold of. Certainly the general preventative strategies proposed for all Australians will generally also be of benefit in Indigenous communities. Yet the failure to-date of tobacco prevention programs in the Aboriginal context, despite a high degree of success in the mainstream over the past 20 years, should alert us to the requirement for special and concerted measures. And given the challenges for Indigenous Australians in relation to the broader determinants of health – education, housing, employment, transport and general well-being – it is imperative for the Taskforce to re-double its focus on preventative measures and promoting health for Indigenous Australia. **The National Preventative Health Taskforce must play a leading role in tackling the social and physical causes of ill health in Aboriginal Australia.**

Relevant Initiatives from the Aboriginal Community Controlled Health Sector

Recent times have been tumultuous in the Aboriginal health sector, particularly so in the Northern Territory where the Australian Government Emergency Intervention into Aboriginal Child Health has been an all-encompassing reality. However the sector has an enormous amount to offer the Taskforce in its preventive endeavors, particularly in relation to primary health care practice and community engagement. Some key elements are as follows:-

- With the stagnation of the community health movement in Australia, the Aboriginal community controlled health (ACCH) sector has virtually been playing a lone hand in the further development of comprehensive primary care. Despite considerable and chronic shortfalls in funding, the ACCH sector has sought to develop comprehensive health teams of salaried GPs, nurses, Aboriginal health workers, allied health professionals, and other staffing categories with the aim of delivering an extensive but necessary range of primary health care services on the basis of multi-disciplinary team care. Such an approach to community health care is an essential ingredient for effective preventative work and health promotion. **Although the ACCH sector has struggled over the years with funding and recruitment challenges, it provides the closest approximation currently operating in the Australian context of community-engaged comprehensive health care.**
- As a concept ‘community control’ of health is at the core of the Aboriginal community controlled health project. In the ACCH sector it happens to be ‘Aboriginal’ community control, but the principles need not differ greatly with any context of ‘control’ of health by a given community. In ACCHSs the core of governance is an incorporated community-elected board of management comprising Aboriginal residents of the local community. To be sure the bulk of funds for such health services are externally derived from two levels of government, but these funds are then

managed and acquitted under incorporation and the strategic directions of the organization are set by the Aboriginal board. In these circumstance the opportunity for dialogue and priority-setting with the local community are considerable – board members are in fact embedded members of the local community. Further, effective community engagement must be a prerequisite for successful health promotion initiatives. **AMSANT believes there are lessons here for mainstream health service models with considerable systems development and praxis within Aboriginal community control of great relevance for health promotion and preventative work more generally in Australia.** To further background Aboriginal community control of health AMSANT is pleased to furnish the Taskforce with a copy of the document ‘Pathways to Community Control’ developed by the NT Aboriginal Health Forum (see Appendix 1).

- For many years now AMSANT and its member ACCHSs have been working to develop the concept of agreed ‘comprehensive primary health care services’ which the health system must be in a position to provide Aboriginal people, whether they reside in towns or cities, or whether they live in the most remote parts of the NT. The provision of such services is considered essential for the achievement of improvements in Aboriginal health. This work has been based on the WHO Alma Ata declaration of 1978 which proposed four essential domains of comprehensive PHC: clinical care; social and preventative programs; policy and advocacy; and community engagement and development. The application of these domains of comprehensive PHC have been furthered in the NT as a result of the Coordinated Care Trials program from the late 1990s and the Primary Health Care Access Program (PHCAP) in the early 2000s. Now, as a consequence of the Australian Government Intervention in the NT and its Expanded Health Services Delivery Initiative (EHSDI), new funding has been put on the table to further expand comprehensive PHC services to Aboriginal communities over the next two years.

To facilitate the effective utilization of these new funds AMSANT and its partner agencies (the NT Dept of Health & Families and the Commonwealth Dept of Health & Ageing) have proposed a set of core PHC services that must be provided at all agreed sites across the NT. A per capita funding formula for the equitable provision of this range of services has also been agreed with weightings to address remoteness and also levels of Aboriginal morbidity. **AMSANT commends to the Taskforce the EHSDI approach in NT to the achievement of comprehensive PHC services for Aboriginal people and the development of an agreed core set of primary health care services, including a key focus on preventative care.** This integrated and comprehensive approach, based both on a sound body of world literature and practical evidence from the Australian context, is presented in a document ‘Indigenous Access to Core PHC Services in the NT’ (see Appendix 2).

- AMSANT is concerned that a number of special health program areas are poorly addressed at the Aboriginal community level and currently offer only a limited and fragmented level of service delivery to clients and families much in need. Particular areas of on concern include mental health, alcohol and other drugs, environmental health, ear health, and aged and disability care. In these areas, generally speaking, there has only been a limited development over the years of capacity and expertise at the primary health care level, therefore rendering the work of visiting

program specialists to be less than optimal. This mismatch of community capacity and visiting programs further renders ambitions for preventative work and health promotion in these areas to be limited compared to the level of need. AMSANT believes that major enhancement of primary health care at the level of community health teams needs to occur in all of these program areas if genuine inroads are to be made into current pictures of morbidity. **To this end AMSANT and its members have developed a model for ‘integrating alcohol and other drug, community mental health and primary health care in Aboriginal health services in the NT’.** The model integrates treatment and rehabilitation that addresses physical and mental health issues concurrently along with prevention and promotion within a single comprehensive primary health care service provider. The required PHC workforce includes Aboriginal Family Support Workers, skilled counselors, mental health nurses or AHWs, and psychologists. This team will work alongside current remote clinical health teams and will also link effectively to visiting specialist services and will ensure effective utilization of specialist mental health and alcohol facilities in urban settings. A document outlining the model is provided (see Appendix 3). Similar comprehensive multi-disciplinary programs are required in other under-resourced areas within Aboriginal PHC.

Priority Areas for the National Preventative Health Strategy

AMSANT supports the initial focus of the National Preventative Taskforce on three priority areas: obesity, tobacco and alcohol. We have the following comments to make about these areas.

Tobacco

AMSANT broadly supports the recommendations made in the Taskforce’s tobacco control document as these apply to the mainstream Australian population. However, we would have some concerns about potentially harmful effects of raising the price of cigarettes to 20 dollars per packet. Poorer households spend a much larger proportion of their disposable income on tobacco and so stand to benefit if smoking use decreases. However, these same households will be adversely affected if cigarette consumption remains the same despite price rises. The effects of significant price rises will be most marked in remote Aboriginal remote communities where smoking prevalence rates are often above 50% for adults. In such communities the cost of essential goods is also markedly higher than in urban communities. Therefore if smoking continues at similar rates despite price hikes, there may be serious compromise to health through lack of access to other necessities of life. In this circumstance subsidies for fresh fruit and vegetables in remote communities should indirectly assist those who continue to smoke to buy essential items for themselves and their families.

Assistance to low socio- economic groups to quit: AMSANT advises that nicotine replacement therapy (NRT) be subsidized for health care card holders as opposed to the more limited approach recommended of targeting highly disadvantaged groups such as homeless people and people with major psychiatric illness. Subsidizing health care card holders for NRT will guarantee that the most disadvantaged groups are reached. Tobacco control programs should be funded in community health centers to target those

groups who have high smoking rates or who are unlikely to be reached by mainstream approaches. These programs would require robust evaluation. Psychiatric clinics and alcohol and other drug specialist agencies should also be funded to offer smoking cessation support and advice to people with major psychiatric illness or alcohol/illicit drug problems.

Indigenous tobacco control: AMSANT supports the concept of setting a target for Aboriginal smoking rates. The target quoted in the Close the Gap campaign is parity with non-Indigenous rates by 2020. This is ambitious, but achievable with concerted effort. However it may prove more difficult if the national rate drops to 9% by 2020.

The strategy suggests there should be a trial of three community based tobacco control projects - urban, regional and remote. However, this effort needs to be scaled up quickly if community based projects are to have a significant effect on population smoking rates. There are examples of recent successful community based tobacco control projects but funding is often short-term, and the lessons learnt from projects are not always well disseminated. Two examples of successful but short-term tobacco control programs in the NT are described below:-

- **Malabam Health Service** at Maningrida in Arnhem Land ran a successful tobacco control program using short-term research funding. The program was overseen by group of non-smoking elders with a wider reference group including Aboriginal people from various language groups, community organizations and youth representatives. It was implemented by a public health officer and a group of local non-smoking tobacco workers. The program used a variety of strategies including: health promotion and community events; individualized assistance to quit; promotion of smoke-free spaces; reduced exposure to ETS for children and; compliance with tobacco legislation. The project had beneficial outcomes including a significant drop in tobacco sales and improved compliance with legislation. Unfortunately the project ceased prematurely after six months due to a lack of accommodation for the public health officer and lack of on-going commitment from the funding body. Tobacco sales have risen again since the cessation of the program (Burgess, Paul 2008).
- **Imanpa community**, a small remote community in Central Australia, has run a tobacco project auspiced by the Alcohol and Other Drugs Service, NT Department of Health and Families. It raised community awareness, and provided individual advice and support as well as encouraging smoke-free spaces. Anecdotal reports indicate the project has been successful through a reduction in tobacco consumption, although not statistically significant (due to the small size of the community). Again, however, this project has not secured on-going funding (Martini, 2008).

Clearly to have long term effects of these community-based tobacco control programs require sustainable funding and support. Aboriginal tobacco control programs should also be delivered in a variety of settings, including prisons and youth detention facilities, community centers, and women's centers. Prisons would be a particularly useful setting given the extremely high disadvantage of this group.

The Commonwealth government has ear-marked 14.6 million dollars for Indigenous tobacco control, none of which has yet been allocated. This funding needs urgent allocation to community-based projects

in a variety of locations. These programs should be funded for at least two years to enable effective community consultation and planning prior to implementation and for the programs to mature and develop. Such programs are more likely to be successful if they use multiple strategies (as in the Malabam project) and if they undertake thorough community consultation and engagement prior to implementation. Programs demonstrated to be effective must receive continued support. There must also be plans to disseminate information about successful programs and models and it will be important there is capacity for rapid expansion to ensure that the majority of Aboriginal smokers have access to a local tobacco control programs. This will require funding additional to the \$14.6 million already announced.

Pharmacotherapies: The addition of nicotine replacement therapy to the PBS for Indigenous people is welcome. However the listing should be expanded to include the 7 mg patches and also the gum and lozenges for heavily dependent smokers who require additional measures and for those unable to use patches.

Support of Aboriginal health workers: Aboriginal Health Workers (AHWs) need to be supported to lead health promotion activities including tobacco control programs. They also have a strong potential role to play in individual counseling for tobacco cessation. The new community stream of AHW training should provide a sound basis for these health promotion skills, but there is also likely to be a requirement for qualified AHWs to develop further tobacco control skills on the job in health teams. Ultimately some AHWs may choose to specialize in tobacco control or they may focus on acquiring broader health promotion roles which include tobacco control.

Support for AHWs and other Aboriginal staff to quit: A special focus of support should be applied to Aboriginal staff of ACCHSs to quit smoking themselves as they would then be better placed to mediate tobacco control programs with other community members. ACCHSSs could be funded to provide tobacco cessation support including NRT to their Aboriginal workforce. Tobacco control programs may also be more effective for AHWs if there are also workplace changes to reduce stress for this group, such as clearer role delineation and improved pay and conditions. However AHWs who have been unable to quit smoking should still be provided with training in tobacco control.

Specialist Tobacco Control workers: All primary health care staff in ACCHSs need to be skilled in tobacco control work including AHWs, GPs, nurses, allied health and other program staff. However there is also a role for specialist tobacco control or health promotion workers within ACCHSs. Their main roles would be to train and support generalist health staff and also to provide support and advice for community-specific tobacco control programs prioritized by ACCHSs. Specialist tobacco workers would also have a role in collecting data about smoking cessation activities within the service (including brief interventions) and in continuous quality improvement initiatives designed to increase the effectiveness of tobacco control interventions.

AMSANT considers the placement of specialist tobacco workers with the NACCHO state and territory affiliates may be useful, but particularly so if there are sufficient health promotion staffing resources on the ground with ACCHSs to implement the necessary multifaceted tobacco control programs in communities. However, without capacity at the community service level, a single specialist tobacco

worker in each affiliate is unlikely to be effective. An alternative to placing specialist workers with NACCHO affiliates is to locate them with regional hub-based support services – in the NT such hub-based services are being established on a regional basis to support remote Aboriginal PHC.

Research and evaluation in Aboriginal tobacco control: Robust evaluation of community tobacco control programs is required inclusive of strong process evaluation to identify weaknesses in project design or community consultation processes. This will enable lessons to be learnt and program improvements to be made, particularly if Aboriginal staff and community members are included in the evaluation processes for community-based projects. Research priorities should include:

- How to reach the most disadvantaged Aboriginal smokers (prisoners, homeless, those with mental illness)
- The effect on smoking of improving social determinants of health
- How mainstream agencies such as Quit can work more effectively with Aboriginal people
- The effect of tobacco price rises on available income, particularly in remote communities
- The benefits of smoke-free spaces in Aboriginal communities
- Young people and smoking: what are determinants of being a smoker or non-smoker and how can these be influenced.

Alcohol

AMSANT has long been engaged in alcohol issues in the NT as this jurisdiction has the second highest per capita alcohol consumption in the world with rates for both non-Aboriginal and Aboriginal people being much higher than the Australian average. Consumption is higher in Aboriginal people in the NT than in the non-Aboriginal population and the consequences (including death and illness but also domestic violence and family disruption including affects on children) are particularly severe in Aboriginal communities. Within the NT context, Central Australian Aboriginal communities are more severely affected than those of the Top End. The level of alcohol-related harm in the NT constitutes a crisis situation that requires decisive government and community action.

AMSANT has two member-endorsed policy positions on alcohol which explain our positions. These are:-

1. Options for Alcohol Control in the Northern Territory - January 2008 (see Appendix 4)
2. A Model for Integrating Alcohol and Other Drug, Community Mental Health and Primary Health Care in Aboriginal Medical Services in the Northern Territory (see Appendix 3)

Alcohol supply as the key issue: AMSANT agrees that regulating alcohol supply and cost are the most effective ways to reduce alcohol- related harm. This is supported by evidence from NT community initiatives. Recent reforms to alcohol supply in the Alice Springs area have led to a reduction in violent crimes, including murder, and alcohol- related hospital admissions, although this is awaiting formal evaluation. Other evidence of the benefits of reducing supply includes the alcohol restrictions in Tennant Creek which included the banning of take- away alcohol sales on Thursdays - the day welfare payments are made. The results were a reduction in harms including significantly reduced rates of serious injury and admissions to women's shelters (Gray et al 2000). However, the efforts of Aboriginal communities to reduce or ban alcohol from communities have often been met with resistance and there has been a lack of effective policing of restrictions in some areas.

The NT Emergency Response and alcohol bans: More recently, the Australian Government Emergency Response (NTER) into child health in the NT introduced alcohol restrictions, including bans on alcohol in Aboriginal town camps. Regrettably these measures were undertaken without community consultation and without due consideration for evidence-based measures that had already been implemented in communities. The measures were also racially discriminatory in that alcohol was banned in remote Aboriginal communities and town camps only whilst access to alcohol for non-Aboriginal residents was unaffected. It has also become apparent there is a lack of capacity to enforce the new restrictions. There is at least anecdotal evidence that the NTER reforms have shifted drinking to more risky locations where help is less available rather than actually reducing alcohol consumption.

Living with Alcohol: A more successful government program to reduce alcohol-related harm was the NT Government's 'Living with Alcohol Program'. This Program, no longer in place, used an increase in alcohol taxes to pay for community-based alcohol programs and achieved a marked reduction in per capita alcohol consumption and death rates (Chikritzhs, T et al, 2005).

Numbers of liquor outlets: AMSANT recommends that liquor outlet density in the NT be significantly reduced until per capita alcohol consumption has reduced to the national average alcohol consumption. The NT Liquor Act needs to be reformed so that the primary consideration in granting a license is the level of potential community harm as opposed to benefit. In addition it is important that a current liquor license can be revoked on the basis of evidence of significant community harm. Liquor licenses should only be granted for a finite time and then reviewed. Regulation of take-away alcohol is also a crucial element of supply reduction as most heavy drinkers rely on take-away alcohol. As outlined in AMSANT's alcohol control position paper, the hours that take-away alcohol is available should be reduced to 12 pm to 8 pm on normal days with no take-away sales on Thursdays or Sundays. Individual communities should retain the capacity to ban take-away alcohol sales entirely from their communities.

NT Liquor licensing Commission: The NT Liquor Licensing Commission needs to be reformed so that it represents the interests of the community rather than the liquor and hospitality industries. AMSANT recommends that Aboriginal and community representation on the Commission needs to be increased. The Commission should be required to refer for advice to the NT Department of Health and Families with regard to every liquor license application. The Commission should be mandated to take this advice into account in their decisions and should justify decisions in the public arena if it goes against the advice of the Department of Health & Families.

Community capacity to manage alcohol availability: AMSANT supports the right of remote Aboriginal communities to make their own decisions about alcohol control with the proviso that they be furnished with thorough information on what has been tried in the past to reduce alcohol harm and what has worked. AMSANT does not support a blanket ban on alcohol availability in remote communities as there is evidence that it leads to a drift towards regional towns. There are also benefits associated with responsible consumption of alcohol, although admittedly the harms to Aboriginal people would appear to far outweigh these benefits at the current time. However, there is evidence in the NT that permit systems for alcohol can work well when this is associated with extensive community consultation and

engagement. Such an approach needs to be combined with evidence-based controls on alcohol availability. Regional alcohol management plans need to be based on input from Aboriginal communities, based on evidence from elsewhere and properly trialed and evaluated.

Alcohol price: AMSANT supports the general banning in the NT of the cheapest types of alcohol (two- and four-litre casks of wine and fortified spirits) as has already been largely achieved in Alice Springs. We acknowledge that the evidence base on the relationship between alcohol consumption and price is not entirely clear but believe that there is a strong argument for a minimum bench price mark for alcohol products by volume of alcohol.

Responses to alcohol-related harm: There needs to be a greater capacity to respond to alcohol-related harm, particularly in regional centers. Sobering-up centers and night patrols need secure ongoing funding with Aboriginal staff who are well supported, remunerated and trained for this difficult but important work. All such workers should be trained to deliver brief interventions, refer appropriately to relevant services, and to deal productively with aggressive or distressed clients. Again it is appreciated there is not a strong evidence base for the efficacy of these measures, but lack of current evidence does not equate with lack of effect. Research is needed on the best ways to engage with Aboriginal heavy drinkers to encourage them to seek help and to limit the harm to others.

Advertising and Labeling: AMSANT supports a total ban on alcohol advertising in the NT and nationally. The voluntary code-of-conduct for alcohol advertising is clearly not working as outlined in the AMSANT position paper. AMSANT supports mandatory warning labels on all alcohol products.

Legal Age for drinking: AMSANT supports consideration of raising the legal drinking age to 21 years for all Australians, although it is acknowledged such a measure would require considerable community consultation.

Serving intoxicated patrons: AMSANT agrees that legislation banning the serving of alcohol to intoxicated patrons is only likely to be effective if accompanied by adequate enforcement and substantial fines. Repeat retail offenders should have their liquor license revoked.

Taxation: AMSANT supports a minimum floor price for alcohol and a volumetric approach to alcohol taxation, although it is appreciated more evidence may be required before such a measure could be implemented nationally.

Surveillance: AMSANT supports greater surveillance of alcohol sales and alcohol-related harm around Australia to build an evidence base for the most effective measures to reduce alcohol harm through the regulation of alcohol availability, supply and other measures.

Treatment of alcohol problems: AMSANT has outlined an approach to the treatment of alcohol and other drug and mental health problems within the community controlled sector in the NT (see Appendix 3). Major problems with the current service system for Aboriginal people in the NT, but which are not unique to the NT, include:-

- Significant unmet need for services in remote areas as evidenced by high re-admission rates for mental health patients, late presentations of both substance use and mental health issues, high suicide rates, high hospital admission rates and death rates from alcohol-related causes.
- Lack of culturally appropriate alcohol services
- Low rates of preventative activities and early intervention
- Lack of capacity in ACCHSs (particularly in remote ACCHSs) to provide alcohol and other drug services to patients
- The separation of alcohol and mental health specialist services despite common causal pathways and high rates of dual diagnosis
- Poor integration of alcohol services with clinical primary health care for a client group with both high physical and psychological morbidity

The approach outlined in the 'AMSANT Model Integrating Alcohol and Other Drug, Community Mental Health and Primary Health Care in Aboriginal Medical Services in the NT' provides a community development approach to prevention and early intervention in mental health and AOD problems with this work being led and implemented by Aboriginal Family Support Workers. Clinical services will be provided by workers skilled in both mental health and AOD diagnosis and management. They will use evidence-based, culturally appropriate treatments including cognitive behavioral therapy and narrative therapy using agreed clinical pathways. The team will be supported by regional psychologists and visiting psychiatrists. Shared care protocols and agreements will be developed with AOD and mental health specialist agencies. The model could be funded at least partially through new COAG initiatives, but will also require additional funding from state and territory governments.

AMSANT believes this model has relevance for Aboriginal health nationally, but also for mainstream primary health care. The concept of integrated alcohol and drug and mental health services within PHC would require adaptation if implemented within mainstream community health settings, but the underlying concepts of the model would still apply.

Clinical leadership and specialist expertise: AMSANT agrees that clinical leadership and expertise is required in the alcohol and other drugs field. However, this leadership needs to be developed within primary health care as well as within the specialist sector if clinicians are to make an optimal contribution to reducing alcohol-related harm, given that bulk of engagement with people at risk of alcohol-related harm will be seen within the primary care sector. This will require leadership from the professionals working in PHC such as GPs, counselors, psychologists, nurses, AHWs and others as well as those working in specialist roles. Leadership could be supported through specific training programs, exchanges between specialist agencies and involvement of PHC practitioners in research on AOD services within PHC. Historically there has been limited communication and links between PHC and AOD agencies. Both areas need to be encouraged to form closer links and to work together through informal arrangements and shared care protocols.

Workforce development: Within the PHC sector, AOD expertise needs to be integrated with mental health expertise given the high rates of dual diagnosis, particularly for Aboriginal people. Greater training and support opportunities need to be developed for Aboriginal people wishing to work in the field, including increased training for AHWs wishing to specialize in mental health or substance use, and through the development of clearer pathways to other careers for Aboriginal people such as counselor, mental health nurse or psychologist. There is also a clear need for enhanced training and on-going professional development for GPs and remote area nurses in the substance use and mental health areas.

Obesity

AMSANT agrees that obesity is a significant public health issue for the mainstream as well as for Aboriginal Australia. Yet there is evidence that much of the health-related harm associated with obesity can be reduced by physical activity (Hu et al, 2005). Physical activity also has other potential benefits, including reducing depression and increasing community cohesion through community-based activities. What is needed is a broad strategy on nutrition, including food security, and physical activity rather than a single strategy aimed at reducing rates of obesity. Indicators of success should include indicators relating to food security, adequacy of diet and physical activity. Examples of useful targets could include:-

- Reduction in the proportion of low income people who experience food insecurity
- Increase in the proportion of people eating the recommended serves of fruit and vegetables per day
- Increase in the proportion of people undertaking a minimum of 30 minutes of exercise at least five times per week

Food: AMSANT strongly endorses a total ban on the advertising of junk food (high energy density /low nutrient). A tax on unhealthy food is likely to be regressive but subsidies for healthy food should be considered, particularly if the cost of fruit and vegetables continues to rise beyond the consumer price index. Greater regulation of junk food to reduce harms could also be increased; for example through bans on the use of trans fats, reduction of allowable salt levels, and other measures. Strategies to increase access of poorer communities to supermarkets would also assist, especially for those not owning a car who may largely rely on local small stores charging higher costs for lower quality produce. Specific strategies in low income areas could include support for the establishment of community gardens, free or subsidized transport to supermarkets / fresh food markets / food cooperatives, and nutrition support programs aimed at vulnerable groups such as women with young children, people with disabilities, or the frail elderly.

Health workforce: There needs to be a strong health promotion capacity added to the primary health care workforce to support a focus on nutrition and physical activity in high risk groups. Ideally this enhanced workforce would be placed in community health centers, or with alternative agencies where such health centers no longer exist. Health promotion programs focusing on nutrition and physical activity are often poorly evaluated. As previously highlighted, robust evaluation needs to be built into programs so that successful models can be replicated. Community health centers also have a role in advocacy to improve food supplies in disadvantaged areas within their remit.

General practitioners and availability of allied health: GPs can have some influence on their patients' diets and level of physical activity, but this is limited if not supported by other strategies and particularly by a strong allied health and health promotion workforce. GPs are able to refer to allied health professionals through Medicare-supported team care arrangements for people with complex conditions or

chronic diseases. However, low income people and many in rural and remote areas are less likely to access allied health professionals through this pathway because of gap fees and the lack of availability of these health professionals in rural and remote areas. Alternative strategies are required to provide allied health services to low income/rural/remote areas and to engage allied health professionals in broader health promotion strategies that are not covered by Medicare rebates. This should include grant funding of comprehensive primary health care providers such as community health centers and further reform of Medicare towards comprehensive health care.

Active living: The recommendations in the Taskforce's paper mainly focus on increasing physical activity in the workplace, tax breaks to offset the cost of physical activity, and reduced use of motor cars. These measures are all supported. However, there is also need for specific strategies aimed at low income people who may not be in paid work, own a car or pay significant tax. Such strategies could include subsidies for active transport such as bicycles, and community based recreation officers who would provide free or low cost recreation options and support for people in low incomes. Recreation officers would need to take a community development approach and work with disadvantaged groups to identify relevant recreation pursuits. This strategy could have additional benefits such as reducing social isolation, assisting at-risk young people and reducing depression. Community-based recreation officers are already employed by some local councils but there needs to be a planned strategy to up-scale these efforts so that all disadvantaged communities have low cost recreation facilities readily available.

The activity levels of young people from disadvantaged backgrounds could be increased by a scheme to assist parents with the costs of after-hours sports activities for their children and other community recreation activities. Better planning and regulation of the physical environment is also required, particularly in new housing projects, to encourage physical activity and active transport.

The Aboriginal-specific context: AMSANT agrees with food subsidies for remote communities given the high cost of fruit and vegetables and the low incomes of the majority of residents in these settings. A recent survey at the Galiwinku community in Arnhem Land found that the main driver of food choices was poverty. People were typically well-informed about the nutritional value of foods but could not afford healthy food choices. Increasing the availability of fresh food did increase consumption but reducing prices would also be likely to have a substantial additive effect to increased availability (Brimblecombe, J. 2007). An annual survey of food prices (conducted through a food basket survey) found the difference between Darwin and remote store food prices was 29% with the increase in food prices between 2006 and 2007 being the largest annual rise since the survey began in 1998 (Turner, 2007). Food subsidies should be highest for fruit and vegetables (given their relatively high cost and nutritious value) but should also be extended to other food staples.

AMSANT also supports national standards to be set and applied for stores in remote communities including minimum national standards for availability and freshness of a range of essential foods. These measures will only be useful if reinforced by regular inspections. More and better quality training and support for Aboriginal people working in community stores needs to be provided including education on nutrition so that these people can become positive influences on their communities. Training programs for Aboriginal managers in stores should also be enhanced. Community governance of stores should be supported where possible to encourage greater community engagement in store activities. Community-

governed stores must be able to employ nutritionists and invest in staff training – where there is achieved community-governed stores are likely to have greater success at employing local Aboriginal people who can drive community education and involvement in nutritional activities (Barnes, 2007).

AMSANT supports efforts to improve housing and nutrition hardware, such as access to stoves and fridges and capacity for their maintenance, as being vital in improving nutrition given the severe overcrowding and poor housing maintenance in remote communities. Nutrition is unlikely to significantly improve in communities with poor housing even with increased capacity in primary health care to support improved nutrition. There must be realistic but genuine targets set to improve housing and nutrition hardware and plans must be established to meet these targets, with accountability to government if these targets are not met.

ACCH sector and nutrition /physical activity: The community controlled health sector has a central role to play in addressing physical activity and nutrition challenges. This will require funding of health promotion capacity in ACCHSs including enhanced training of the multi-disciplinary Aboriginal health workforce. ACCHSs also have a leading role to play in advocacy and monitoring of food supply in remote communities. Youth activities aiming to increase physical activity and social engagement are crucial to both prevent chronic disease in early- to mid-adulthood. All these activities are possible through community controlled health services if they are funded and supported adequately. Evaluation of efficacy of community-based programs is also essential to increase evidence about what works. This will require committed funding from government and effective partnerships between ACCHS sector service providers and research agencies.

In supporting these three priority areas for preventative action – tobacco, alcohol and obesity - AMSANT is concerned, however, that other areas with particular relevance for Aboriginal health are quickly included for analysis and action, including: mental health; environmental health; ear health; sexual health; aged and disability care; and child and maternal health. All of these areas currently lack sufficient development and resources for satisfactory community engagement and the level of health promotion activity capable of preventing avoidable illness and disability. It will also be vital for the Taskforce to place great emphasis on the broader determinants of health and illness in all of these areas. As noted, a singular focus on addressing individual risk factors will have limited impact in Aboriginal communities. A National Preventative Health Strategy must get to the root cause of current problems with strategies for multi-sectoral and cross-agency collaboration and action.

Conclusion

AMSANT applauds the initiative taken by the Federal Labor Government to build an integrated and strategic National Preventative Health Strategy. We believe such a Strategy will be all the better if it returns to the work of the 1986 Ottawa Charter for Health Promotion and applies its priority areas for action. It will also be stronger if it is effectively integrated into the National Primary Health Care Strategy currently under development – these are not separate areas. Core to any real progress in preventative capacity is a significantly enhanced PHC workforce, both in terms of the numbers and range

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of health staff, but also in relation to the preparation of this workforce for preventative and health promotion work. Further fundamental reform to Medicare to drive the development of a universal multi-disciplinary health care system will be pivotal for success.

AMSANT believes the Taskforce must apply special focus to the needs and issues of remote and Aboriginal Australia in the development of an effective preventative strategy. In this regard it will be important to negate the impact of the blame game and its debilitating impact on the development of Aboriginal and remote health services – the Commonwealth must assume full responsibility for Aboriginal PHC. When this is achieved serious work can be undertaken on trialing and measuring what works in health promotion in this context. There can also be genuine application of the model and practice of Aboriginal community control in health care. We assert that ‘community control’ invites the kind of community engagement essential to underpin meaningful health promotion campaigns in areas such as tobacco use, alcohol abuse and with the burgeoning problems associated with obesity.

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