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AIDA SUBMISSION TO THE NATIONAL PREVENTATIVE HEALTH TASKFORCE

Introduction

The Australian Indigenous Doctors' Association (AIDA) welcomes the announcement by the Minister for Health and Ageing of the establishment of the National Preventative Health Taskforce (the Taskforce) and the development of a National Preventative Health Strategy.

AIDA is a not-for-profit, non-government organisation dedicated to the pursuit of leadership, partnership and scholarship in Aboriginal and Torres Strait Islander health, education and workforce. Currently there are approximately 125 Indigenous medical graduates and a similar number of Indigenous medical students in Australia.

AIDA is represented on over 30 government and non-government health, education and workforce groups, including the National Indigenous Health Equality Council, the Indigenous Health Equality (Close the Gap) Campaign Steering Committee and the Aboriginal and Torres Strait Islander Health Workforce Working Group.


We work closely with Medical Deans Australia and New Zealand, the Committee of Presidents of Medical Colleges and the Australian Medical Council to ensure that the medical education and training system is inclusive of Indigenous health content, is culturally appropriate and recruits, supports and graduates Aboriginal and Torres Strait Islander people into medicine.

As Indigenous medical practitioners, we offer a combination of both clinical and cultural competence and expertise, and therefore have a unique and central role in advocating for, and improving the health and wellbeing of Aboriginal and Torres Strait Islander peoples. We are keen to ensure that the needs of Indigenous communities and their respective health needs are articulated, protected, advocated for and respected.

Definitions of Indigenous Health and Wellbeing in Australia

For Aboriginal and Torres Strait Islander people, health is not just the absence of illness or disease. AIDA endorses the Australian Indigenous concept of health, which is outlined in the following definitions:

- (a) The 'NAHS' (National Aboriginal Health Strategy) definition:



“Not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life.”ⁱ

(b) The “Ways Forward” definition:

“The Aboriginal concept of health is holistic, encompassing mental health and physical, cultural, and spiritual health. Land is central to well-being. This holistic concept does not merely refer to the “whole body” but in fact is steeped in the harmonised inter-relations which constitute cultural well-being. These inter-relating factors can be categorised largely as spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal ill health will persist.”ⁱⁱ

It is recognised that health and health care are cultural constructs arising from the beliefs, values and assumptions about the nature of disease, the human body and human society. AIDA embraces the philosophy that *Life is Health is Life*ⁱⁱⁱ - a concept which includes the social, emotional, spiritual and cultural wellbeing of the entire community.

Indigenous Health in Australia

The poor status of Aboriginal and Torres Strait Islander health and the 17-year life expectancy gap is well documented. The burden of disease experienced by Indigenous Australians is estimated to be two and a half times greater than the burden of disease in the wider Australian population. Aboriginal and Torres Strait Islander people experience higher death rates than non-Indigenous Australians across all age groups, from all major causes of death.^{iv} This - in a nation which in general, has one of the healthiest populations^v of any developed country and which has access to a world-class health system - is unacceptable.


The 2008 AIHW Report *Australia's Health 2008*^{vi} reports that the top five causes of Indigenous deaths were (i) diseases of the circulatory system, (2) external causes of morbidity and mortality (mainly accidents, intentional self-harm and assault); (iii) neoplasms (including cancer), (iv) endocrine, nutritional and metabolic diseases (including diabetes) and (v) diseases of the respiratory system. Many of these conditions can be improved or prevented (and thus contribute to closing the gap) through better access to primary health care, better preventative measures and more effective transitions between levels of care for Aboriginal and Torres Strait Islander people.

Smoking

The implications for smoking for the health of Aboriginal and Torres Strait Islander people are significant in both the short and long term. *Australia's Health 2008* reports that 50% of the Indigenous population over 18 years are smokers.^{vii} Smoking rates for Indigenous women during pregnancy are greatly concerning - 52% for Indigenous women compared with 16% for non Indigenous women^{viii}. The downward trend for smoking in the Australian population^{ix} has not translated to the Indigenous population.

Alcohol

In relation to alcohol consumption, it is important to note that Indigenous adults were twice as likely as non-Indigenous Australians to have abstained from alcohol



consumption in the last 12 months. For those who do consume alcohol, after adjusting for differences in age structure, Indigenous Australians were twice as likely as non-Indigenous Australians to drink at short-term risky/high-risk levels at least once a week in the last 12 months, and equally as likely to drink at long-term risky/high risk levels in the week prior to survey (15% and 14% respectively).^x

Overweight/Obesity/Nutrition

The 2004-2005 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) found that obesity was an increasing problem in the Indigenous population. Self-reported height and weight measurements were collected for people aged 15 years and over in some remote areas. Height and weight information was not obtained for 17% of Indigenous people and 8% of non-Indigenous people.

This survey found that almost two-fifths of Indigenous people aged 15 years or older were in the normal or healthy weight range, but 23% were overweight and 24% obese. The overall proportion of Indigenous people who were overweight or obese (57%) was slightly higher than the proportion of non-Indigenous people (52%), but the proportion of obese Indigenous people (29%) was considerably higher than that of obese non-Indigenous people (17%). The difference in levels of obesity between Indigenous and non-Indigenous people was greater for females than for males.

Overweight and obesity were more common among Torres Strait Islanders aged 15 years or older (61%) than among Indigenous people in that age range (56%) (The difference was not statistically significant. The level of overweight and obesity was particularly high among Torres Strait Islanders living in the Torres Strait area, with 86% having a BMI of 25.0 or greater.^{xi}

Indigenous Wellness approach


The wellness approach in mainstream health looks toward prevention through lifestyle modification of individual key risk factors. An Indigenous wellness model extends this view to look at a more comprehensive approach:

“The aboriginal wellness model moves away from this healer/patient dyad and toward a more comprehensive understanding of the individual in contexts beyond the formalized biomedical environment.

Aboriginal wellness involves the physical, emotional, mental and spiritual aspects of a person, and always in connection to his or her family network and community.”^{xii}

Any wellness approach to health must be strengths based, and must build on capacity at both the individual and community level. Given the multi-dimensional nature of Aboriginal and Torres Strait Islander health, aspects of cultural maintenance, reclamation and reconnection are vital for cultural continuity and therefore wellbeing. A wellness approach also requires balance and harmony between the physical, mental, emotional, spiritual, cultural, economic and social aspects of life.

In considering the development of a National Prevention Health Strategy, the Preventative Health Taskforce should consider the adoption of a comprehensive wellness approach toward prevention and lifestyle modification of key risk factors.



Some key risk factors for Indigenous people developing chronic disease are smoking, alcohol misuse, poor nutrition, physical inactivity and sedentary behaviours. Reducing the prevalence of these risk factors will assist in preventing many chronic diseases including Type 2 diabetes, coronary heart disease, stroke, chronic obstructive pulmonary disease and certain cancers^{xiii}.

It is essential also to acknowledge issues of grief, loss and trauma that generate significant levels of stress for Indigenous individuals, families and communities. This, coupled with a perceived or actual lack of control over one's life are also significant risk factors for disease or ill health for Aboriginal and Torres Strait Islander people.^{xiv}

For Aboriginal and Torres Strait Islander people, access to culturally appropriate programs which target smoking reduction, alcohol intake, healthy eating and physical activity will significantly increase the quality of life and health of our communities.

Health Impacts of Racism

In recent years, a number of international reports have recognised that racism and its effects have a significant impact on health status. More specifically, the experience of racism by Indigenous people everyday can directly contribute to poor physical and mental health^{xv}.

Research in Australia by Paradies, Harris & Anderson (2008) has suggested that racism precedes ill health rather than vice versa. The most consistent finding in this body of research is the association between racism and mental health conditions such as psychological distress, depression and anxiety. Racism also appears to be consistently associated with health risk behaviours such as smoking, alcohol and substance misuse.

Pathways from racism to ill-health may include:

- Reduced and unequal access to the societal resources required for health (eg. Employment, education, housing, medical care, social support),
- Direct impacts of racism on health via racially motivated physical assault,
- Stress and negative emotional reactions that contribute to mental ill health, as well as adversely affecting the immune, endocrine and cardiovascular systems physiology; and
- Negative responses to racism, such as smoking, alcohol and other drug use.


It is widely known that the cost of chronic disease on the Australian health system is significant and will increase greatly in coming years. What is not easily measured is the estimated cost of racism to society and on the health system.

“Racism accounts for a significant burden of Indigenous ill health. Although international research has identified a range of factors that may be implicated in the relationship between racism and Indigenous health, there has been very little research on this topic in Australia. There is a need to understand the role played by acute and chronic stress in the relationship between racism and ill health. There is also a need to better understand the effects of racist events early in life and the health implications of cumulative racist experiences over the life course (as exemplified by the experiences of the stolen generation)”.

(Paradies, Harris & Anderson, 2008)

Health Promotion

We note that the Taskforce's Discussion Paper takes a broad view of prevention and views prevention as inclusive of health promotion.^{xvi} AIDA sees health promotion



programs as important as illness prevention programs. Health promotion assumes a position of wellness in the first instance – for example, before obesity, tobacco use and alcohol use become risk factors which contribute to illness, the right conditions for health and wellbeing need to be in place.

Health promotion is directly related to the social determinants of health, that is, the ‘upstream’ factors that influence health and contribute to the wellness of individuals, families, communities and indeed, the nation. It is well known that social determinants have a role in predetermining health – ie, the social, economic, cultural and physical settings must be right. This in turn requires genuine commitment, partnership and collaboration between sectors such as education, housing, justice and employment. Importantly, inter-sectoral commitment also requires governmental leadership to ensure that effective co-ordination occurs.

Health and illness do not exist in a vacuum. They are very closely connected to the provision of adequate housing, clean water and sanitation, proper schooling, having a job; access to transport and ability to communicate. To improve the health status of Indigenous Australians, and to close the 17-year life expectancy gap, Australian governments and their departments must work together to improve outcomes on issues such as education, employment, housing and environmental health.


Social and historical factors such as racism, history, oppression and the ongoing impacts of dispossession also have an influence on the health of Indigenous Australians, and are also viewed as social determinants of health. The Prevention Health Taskforce must acknowledge the social and structural constraints that impact on individual choice in life and individual behaviours. For real and lasting change, the Australian Government and State and Territory Governments must show leadership on these issues.

The Prime Minister’s Apology to Indigenous Australians on 13 February 2008 has been a promising first step in the right direction.

AIDA also believes that Indigenous health and Indigenous illness prevention would benefit from more support for a strengths-based, healing approach, one that incorporates kinship care, which builds on the cultural networks and kinship structures and can provide mentoring and role modelling for good health behaviours. For example, *Karpa Ngarrattendi* - an Adelaide-based Aboriginal Health Unit provides a cultural brokerage function between health professionals and Indigenous Australian patients and their families. It recognises patient’s familial and kinship relationships, attempts to accommodate language and gender needs, and acknowledges that working with the familial unit often has better outcomes for individual patients than working with the patient alone. The Unit takes a holistic approach by working on a cultural, spiritual, psychological, social and physical level.^{xvii}

Social and Emotional Wellbeing

It is important to view Indigenous health holistically and therefore important to see social and emotional wellbeing is an integral part of Indigenous Australians’ health and as having an important role in the prevention of illness. It needs to be understood within the holistic concept of health and not seen as an issue separate from physical health. Issues of social and emotional wellbeing cover a broad range of problems which can result from unresolved grief and loss, trauma and abuse, inter-generational trauma, domestic violence, issues associated with the legislated removal of children, incarceration, family breakdown, cultural dislocation, mental



illness, racism, discrimination and social disadvantage.^{xviii} These issues sit within an historical and social context, and have implications for poor physical health.

Depression and Psycho-social Stress as a risk factor

In relation to diseases of the circulatory system, it is important to note the evidence regarding the link between heart disease and depression and 'psycho-social stress', induced by social isolation, poverty, feelings of hopelessness and lack of empowerment and control over life opportunities^{xix}

It is important to note the fundamental connection between land and health for Indigenous people. Unresolved issues of land (as well as control of resources and cultural security) have been recognised as contributing to illness and health inequity for Indigenous peoples in international research. The landmark study by Chandler and Lalonde^{xx} in Canada showed that those First Nations communities that had more markers of cultural continuity including some form of self government and settled land claims had lower rates of youth suicide than those communities with fewer markers of cultural continuity.

Obesity/Overweight and Nutrition

Obesity and overweight are risk factors for cardiovascular disease which are a leading cause of death for morbidity and mortality Indigenous people.


Indigenous people and people from low socio-economic backgrounds can be more likely to be overweight or obese. The overall proportion of Indigenous people who are overweight or obese (57%) was slightly higher than the proportion of non-Indigenous people (52%), but the proportion of obese Indigenous people (29%) was considerably higher than that of obese non-Indigenous people (17%). Therefore, proportionately, there are significantly more Indigenous people who are obese than non-Indigenous people. In addition, the difference in levels of obesity between Indigenous and non-Indigenous people was greater for females than males^{xxi}.

The causes of overweight and obesity are multi-faceted and include such things such as limited access to healthy food, limited knowledge on healthy food preparation. Cost is a significant factor, with the price of basic healthy foods 50% or higher in rural and remote areas than in the major cities. Foods of better nutritional choice, including fresh fruits and vegetables, are often expensive due to transportation and overhead costs, or only minimally available^{xxii}. Furthermore, food products sold in rural and remote stores are generally often higher in fat and sugar content.

Cost of Healthy Food Basket

The 2006 Queensland Health Food Access Basket (HFAB) survey results highlight the extra expenditure needed to purchase basic healthy food by families living in outer regional, remote and very remote areas compared to those living in *major cities* and *inner regional centres*.

The cost the HFAB continues to be considerably higher in *very remote* stores throughout QLD, especially in those towns more than 2000 kilometres from Brisbane. In 2006 the mean cost of the HFAB was \$107.81 (24.2%) higher in *very remote* stores in QLD but \$145.57 (32.6%) higher in *very remote* stores more than 2000 kilometres from Brisbane compared with the same basket in major cities.



In the *very remote* category the cost of the HFAB was 24.2% (\$107.81) higher and the cost of fruit, vegetables and legumes in the basket was 20.6% (\$41.29) higher compared with the *major cities* category.

Higher prices and limited availability of healthy foods are barriers to healthy eating that can compromise nutritional and health status and add to the burden of obesity and chronic disease. Environmental influences, such as food access, remain major contributors to the higher death rates experienced by persons from more socioeconomically disadvantaged areas and remote regions. Extreme socioeconomic disadvantaged areas are found across QLD.^{xxiii}

Initiatives to address overweight and obesity in Indigenous Australian communities need to address the key factors of access to and knowledge of healthy foods. A number of strategies have been implemented in remote locations and are proving to be successful in increasing the consumption of healthy foods. These include food subsidies, the identification of healthy products (green dots) by a nutritionist and 'healthy store' policies.

Culturally appropriate family and community based education programs which encourage physical activity and healthy nutrition are required in order to address overweight and obesity among Indigenous peoples and prevent young people progressing to overweight and obesity leading to further ill-health in the Indigenous population.


Tobacco

Tobacco use is of particular concern for the health of Indigenous Australians, amongst whom smoking prevalence is more than double that of the non-Indigenous population.^{xxiv} The ABS (2007) found that in 2004-2005, half of the adult Indigenous population were currently daily smokers. The rates of regular smoking were high in younger age groups (57% for men 35-44yrs, 54% for women 25-34yrs & 35-44yrs).

AIDA acknowledges the implications of smoking on the health of Indigenous Australians. AIDA believes that smoking cessation programs for all Indigenous smokers, including mothers, should take into consideration the high levels of stress that many Indigenous Australians people live with, and the expectations around quitting smoking. Wood *et al* indicated that smoking - even in pregnancy (a time when mothers are particularly receptive to changing their smoking habits) - may not be a priority for Indigenous women as smoking can be used to ameliorate or reduce stress and to provide opportunities for relaxation in the face of considerable social and economic pressures that they face in their lives. Overwhelmingly, smoking was believed to reduce stress and to provide opportunities for relaxation. The study showed that pregnancy did not necessarily influence attitudes to cessation, though women's understanding of the consequences of smoking during pregnancy was low.^{xxv}

Furthermore, Indigenous adults who had experienced more than one life stressor in the last 12 months had higher rates of current daily smoking (54%) than did those who reported that they had experienced one or no stressful circumstances (46%). Indigenous people who reported that they had experienced financial stress in the past year were more likely to be daily smokers than were those whose household had not experienced financial stress (58% compared with 41%).^{xxvi}

AIDA believes that smoking cessation programs should take into consideration the high levels of stress that many Indigenous Australians live with, and expectations



around quitting smoking. A study amongst Aboriginal people in north-east Arnhem Land indicated, amongst other things, that for Yolngu people, mastery over one's actions is negatively related to perceived recent stress, chronic stress and youth stress.^{xxvii}

AIDA supports the Indigenous Tobacco Control Initiative, announced earlier this year by the Minister for Health and Ageing. Smoking rates could potentially be much improved through effective prevention initiatives that encourage and support smokers to quit successfully. Smoking cessation and reduction would greatly impact on the gap in life expectancy as well as have positive, immediate and generational effects. The Australian health system has demonstrated enormous success in greatly reducing smoking rates in the non-Indigenous population.

Alcohol Related Harm

The National Drug Strategy Survey (1994) found that the proportion of current drinkers among Indigenous people was less than among non-Indigenous people. Of those that did drink, generally, Indigenous people drank less often. However, on those occasions on which they did drink, 70 per cent of males claimed to drink more than 6 standard drinks and 67 per cent of females claimed to drink more than 4 standard drinks.^{xxviii}

AIDA recommends that any alcohol use prevention strategy must be a comprehensive, long term and sustainable approach, which embraces supply reduction, demand reduction and harm reduction.

Strategies initiated by Indigenous people have included supply reduction strategies such as the regulation of alcohol; demand reduction programs incorporating health promotion, recreational and cultural initiatives; harm minimization strategies such as night patrols and sobering up shelters; and a wide range of treatment programs.^{xxix}

Health Workforce


A clinically qualified and culturally competent health workforce is essential for ensuring that Australia's health system has the capacity to effectively meet the needs of Aboriginal and Torres Strait Islander people, close the life expectancy gap and improve health outcomes. Indigenous health workers are often well placed to facilitate consultation with community, and to design and implement strategies regarding health promotion and illness prevention.

It is critical that the entire health workforce is equipped with both a fundamental understanding of Indigenous health in Australia, as well as a high level of cultural competence. These attributes facilitate better knowledge and understanding about local Indigenous people and their communities and thus the most appropriate strategies to engage regarding preventative health.

Pathways into the Health Workforce for Aboriginal and Torres Strait Islander people: A Blueprint for Action

It is important also that Indigenous Australians are trained and recruited into all of the health disciplines including health promotion and illness prevention.

AIDA recently delivered a piece of work, on behalf of the (former) National Aboriginal and Torres Strait Islander Health Council to develop a paper *Pathways into the Health Workforce for Aboriginal and Torres Strait Islander people: A Blueprint for*



Action regarding the development of an Aboriginal and Torres Strait Islander health workforce. AIDA commends this paper to the Taskforce.

Supporting Programs that Work

It is important to attribute recognition and support for programs that have been proven to contribute to Indigenous health promotion, illness prevention and early intervention. Such programs should receive sustainable and long term funding and support.

Examples of some successful health projects include:

The Mums and Babies Program, Townsville Aboriginal and Islander Health Service (TAIHS), Queensland^{xxx xxxi}

- In February 2000, TAIHS commenced a maternal and child health program which offered comprehensive integrated primary health care for young families. The program offers a range of services including antenatal and postnatal care, immunisation and child health monitoring, transportation assistance, childcare/ playgroup on site, STD testing, referral, advocacy and social support. In addition to these services, the program also offers brief interventions for risk factors such as smoking cessation, nutrition, breastfeeding and sudden infant death syndrome.
- The range of services are provided by a dedicated team comprising two health workers, one childcare worker, a driver and two female Doctors.
- Evaluations of the program found an increase in the numbers of women presenting for antenatal care; reduction in the number of pre-natal deaths; reduction in the number of low birth weight (less than 2500g) babies; and a reduction in the number of premature births.
- The care planning, screening and educational activity around risk factors also improved due to the increased opportunistic contact with women.

Family Wellbeing – Apunipima Cape York Health Council, Qld

This has been a long term program which addresses a broad range of health issues including social and emotional wellbeing, alcohol prevention and rehabilitation; substance, violence and anger issues and men's health. The key to the success of this program has been its process *“of initial engagement and personal capacity development which enhances individual social and emotional wellbeing. This provides a critical foundation for achieving a healthier life.”*


AIDA recommends the evaluation report^{xxxii} of this program to the Preventative Health Taskforce.

Adelaide Aboriginal Family Home Visiting Program

The aim of this service is to improve outcomes for children at the population level, based on evidence from home visiting programs already established overseas. It mostly services families with mothers under age 20 and often where the primary care giver is socially isolated, and where poor attribution towards the baby by the primary care giver has been identified. The focus of service is on Child/Parent attachment and relationships.^{xxxiii}

Nutrition Projects:

- (a) Jalaris Aboriginal Corporation WA – This project is based on a commercial kitchen which provides cheap; meals for the community. It was reported have



successfully changed children's attitudes to health foods; it incorporated cooking classes and a short course in nutrition.^{xxxiv}

- (b) Yarra Valley Community Health Service, Victoria– (i) “Down to Earth” – was a program with two local primary schools – established a kitchen garden; breakfast program. (ii) Wise Women and Spend Widely program – family nutrition program and (iii) Healsville Community Garden^{xxxv}
- (c) Red Cross / Outback Stores Partnership – Fruit for Breakfast - Aboriginal children in the Northern Territory will get a piece of fruit at breakfast every day this year thanks to an arrangement between the Red Cross and a remote food store chain. Since 2006, more than 30 communities have been part of the Red Cross's breakfast program, which gives nutritional food to students at the start of the day.^{xxxvi}

Maternal and Infant Care - *Anangu Bibi Family Birthing Program* – Whyalla and Port Augusta, SA

Key aspects of this program include:

- (a) expert cultural guidance from an Aboriginal Women's Advocacy group that included Elders from language groups in and around the Spencer Gulf area
- (b) Aboriginal Maternal and Infant Care (AMIC) workers in a leadership role
- (c) inter-cultural partnerships and skill exchange with midwives with GP back up
- (d) education and training for AMIC workers in antenatal, birthing and postnatal care, as appropriate
- (e) commitment to continuity of care and primary healthcare principles
- (f) 5 part-time AMIC workers, 5 part-time midwives allocated a case-load following a structured selection process
- (g) site services of (a) Port Augusta provided antenatal; intra-partum and postnatal until 6-8 weeks; and (b) Whyalla provided antenatal and postnatal care until 6-8 weeks
- (h) a management group for program support.^{xxxvii}

Benelong's Haven

Established in 1974 by Dr Val Bryant-Carroll OAM, Benelong's Haven Family Drug and Alcohol Rehabilitation Centre, offers a residential alcohol and drug treatment service for Aboriginal and Torres Strait Islander people. The Centre provides a mental health service for clients as well as an alcohol and drug treatment program. The program involves AA-style personal sharing of life stories, counselling, psychotherapy and daily psycho-educational groups. Current clients are mostly accepted through the justice system, mainly in the form of pre-trial admissions.

An upcoming study of clients participating in the program at Benelong's Haven finds that clients who completed 75 days of treatment significant decreases depression, anxiety and stress.^{xxxviii}



SmokeCheck

Queensland Health's SmokeCheck program specifically targets Aboriginal Australians in a culturally specific manner through Aboriginal and Torres Strait Islander Health Workers and other health professionals. The tobacco intervention leverages the networks of Indigenous Australian Health workers to assess the smoking status of clients at every opportunity. Based on the outcome of each assessment the health workers then assist each client to understand the benefits of not smoking, explore any ambivalence or concerns about smoking, and/or plan for a quit attempt.^{xxxix}

The Aboriginal and Torres Strait Islander Health Care workers receive specialist training and support material providing tailored messages which deal with the different stages of change (not ready, unsure, ready, staying a non-smoker). Statewide implementation of the program commenced in Queensland in 2003 has since trained an estimated 350 health workers.^{xi} SmokeCheck has since been implemented in New South Wales with an aim to deliver training to 75% of Aboriginal and Torres Strait Islander Health workers within the state.^{xi}

Indigenous Health Equality Campaign (Close the Gap)

AIDA is a lead partner in the Indigenous Health Equality Campaign to close the gap in life expectancy between Indigenous and non-Indigenous Australians.

A number of significant developments have occurred in the past year in relation to Indigenous health, and we draw these developments to the attention of the Prevention Health Taskforce.


Close the Gap National Indigenous Health Equality Targets - Outcomes from the National Indigenous Health Equality Summit^{xlii} sets out a number of targets and benchmarks to achieve the COAG goals of closing the life expectancy gap and halving the mortality gap for children under five. The targets address primary prevention, secondary prevention and tertiary prevention in relation to chronic disease.

AIDA also commends to the Taskforce the objectives outlined in the *National Indigenous Health Equality Summit Statement of Intent*, which was signed by the Prime Minister, the Minister for Health and Ageing, and the Minister for Indigenous Affairs, in March 2008.^{xliii}

AIDA welcomes the COAG allocation of resources to Indigenous health, announced on 29 November 2008.^{xliv}

Recommendations

- That the National Prevention Health Strategy support a broad range of Aboriginal and Torres Strait Islander culturally appropriate community-based prevention programs and services which focus on smoking reduction, alcohol intake, healthy eating and physical activity.
- That the Taskforce take account of the holistic view of Aboriginal and Torres Strait Islander health, and accept Indigenous social and emotional wellbeing as central to health promotion and illness prevention within Indigenous people and communities.
- That specific Indigenous health promotion / illness prevention strategies be embedded within the proposed National Prevention Strategy, and guided by



the objectives of the *National Indigenous Health Equality Summit Statement of Intent*

- That the targets and benchmarks outlined in the publication *National Indigenous Health Equality Targets - Outcomes from the National Indigenous Health Equality Summit* be strongly considered in the development of the National Prevention Strategy.
- That the Taskforce support broader, sustained implementation of the *National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000-2010*.
- That existing, proven health promotion and illness prevention projects and programs be funded and promoted as good practice models.
- That the Taskforce consult further with Aboriginal and Torres Strait Islander leaders, organisations and communities on the development of the National Prevention Strategy.

ⁱ National Aboriginal Health Strategy Working Party, 1989.

ⁱⁱ Swan, P. & Raphael, B. *Ways forward: National consultancy report on Aboriginal and Torres Strait Islander mental health*. (1995) Australian Government Publishing Service, Canberra, p. 14.
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ⁱⁱⁱ National Aboriginal Health Strategy Working Party, 1989

^{iv} Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008) *Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, 4704.0, Canberra, p. 151

^v Australian Institute of Health and Welfare (2008) *Australia's Health 2008*, Canberra, p. 6

^{vi} Ibid

^{vii} Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008) *Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, 4704.0, Canberra, p.138.

^{viii} Australian Institute of Health and Welfare (2007) *Aboriginal and Torres Strait Islander Health Performance Framework, 2006 report: detailed analyses*, Canberra.

^{ix} Australian Institute of Health and Welfare (2008) *Australia's Health 2008*, Canberra, p. 133

^x Australian Institute of Health and Welfare (2007) *Aboriginal and Torres Strait Islander Health Performance Framework, 2006 report: detailed analyses*, Canberra.

^{xi} Australian Bureau of Statistics (2006) *National Aboriginal and Torres Strait Islander Health Survey: Australia, 2004-05*, 4715.0, Canberra, p.730.

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^{xiii} Queensland Health (2008) *The Health of Queenslanders 2008: Prevention of Chronic Disease*. Second Report of the Chief Health Officer Queensland, Brisbane.

^{xiv} *World Health Organisation (2003) Social Determinants of Health: The Solid Facts*, Second Edition Ed. Richard Wilkinson and Michael Marmot.

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