NACCHO
National Aboriginal Community Controlled Health Organisation
Aboriginal health in Aboriginal hands
www.naccho.org.au

Inquiry into Diabetes

Submission to the Standing Committee on Health, Aged Care & Sport

September 2023

About NACCHO

NACCHO is the national peak body for Aboriginal and Torres Strait Islander health in Australia. We represent 145 Aboriginal Community Controlled Health Organisations (ACCHOs) and assist several other community-controlled organisations to improve health outcomes for Aboriginal and Torres Strait Islander people.

Our sector has more than fifty years' collective service. In 1971, Aboriginal people established the first Aboriginal medical service in Redfern, NSW. Mainstream health services were not working and there was an urgent need to provide decent, accessible health services for the medically uninsured Aboriginal population (pre-dating Medicare (1975)). Similar Aboriginal medical services quickly sprung up around the country. In 1974, a national representative body was formed to represent these Aboriginal medical services. That body has grown into what NACCHO is today.

NACCHO liaises with its membership (ACCHOs) and eight state/territory affiliates, governments, and other organisations, to develop policy, provide advice and advocate for better health and wellbeing outcomes for Aboriginal and Torres Strait Islander people. Together we address health issues including service delivery, information and education, research, public health, financing, and programs.

ACCHOs range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services which rely on Aboriginal health practitioners and/or nurses to provide the bulk of primary health care services. Our 145 members provide services from about 550 clinics. Our sector provides over 3.1 million episodes of care per year for over 410,000 people across Australia; about one million of these episodes of care are delivered in very remote regions.

ACCHOs contribute to improving Aboriginal and Torres Strait Islander health and wellbeing by providing comprehensive primary health care, and by integrating and coordinating care and services. They provide home and site visits; medical, public health and health promotion services; allied health; nursing services; assistance with making appointments and transport; help accessing childcare or dealing with the justice system; drug and alcohol services; and help with income support.

ACCHOs build ongoing relationships to provide continuity of care. This helps chronic conditions to be better managed and provides more opportunities for preventative health care. Through local engagement and a proven service delivery model, our clients 'stick'. Cultural safety in our services is a key factor of our success.

ACCHOs are also closing the employment gap. Collectively, we employ about 7,000 staff – 54 per cent of whom are Aboriginal or Torres Strait Islanders. This makes us the third largest employer of Aboriginal or Torres Strait people in the country.

Enquiries about this submission should be directed to:

NACCHO
Level 5, 2 Constitution Avenue
Canberra City ACT 2601
Telephone: 02 6246 9300
Email: policy@naccho.org.au
Website: naccho.org.au

Acknowledgements

NACCHO welcomes the opportunity to provide this submission to the Parliamentary Inquiry into Diabetes. We would be delighted to give evidence at Inquiry Hearings to elaborate further to support Aboriginal and Torres Strait Islander health.

We acknowledge the valuable input we have received from our Members and Affiliates, and other organisations participating in our consultation process:

- Aboriginal Health Council of South Australia (AHCSA)
- Aboriginal Health Council of Western Australia (AHCWA)
- Aboriginal Medical Services Alliance Northern Territory (AMSANT)
- Queensland Aboriginal and Islander Health Council (QAIHC)
- Tasmanian Aboriginal Centre (TAC)
- Victorian Aboriginal Community Controlled Health Organisation (VACCHO)
- Winnunga Nimmityjah Aboriginal Health and Community Services (Winnunga)
- Danila Dilba Health Service
- Derbarl Yerrigan Health Service
- Dubbo Regional Aboriginal Health Service
- Geraldton Regional Aboriginal Medical Service
- Ngaanyatjarra Health Service
- Pilbara Aboriginal Health Alliance
- Mackay Hospital and Health Service.

We support the submissions to this consultation made by NACCHO Members and Affiliates.

Summary of recommendations

NACCHO recommends:

1. any interventions to address diabetes align with the National Agreement and its four Priority Reform Areas.
2. Government adopts a 'heath in all policies' approach, recognising that health outcomes are influenced by a wide range of social, commercial, political, environmental and cultural determinants.
3. the Australian Government allocates diabetes funding based on burden of disease not population.
4. working in partnership with the sector and young Aboriginal and Torres Strait Islander people to develop better health programs to support young people with diabetes.
5. the Australian Government supports ACCHOs to conduct nationally standardised screening and follow-up of Aboriginal and Torres Strait Islander children for diabetes.
6. the development of resources to support implementation of new screening recommendations.
7. changes to MBS to improve availability of point of care diagnostics aligned with best practice.
8. the Australian Government supports ACCHOs to deliver high-quality models of antenatal care which include midwife continuity, and antenatal and postnatal screening for diabetes, and breastfeeding support.
9. funding for GLP1 RA for Aboriginal and Torres Strait Islander people with obesity, given its association with type 2 diabetes and establish regulatory framework that prioritises equitable supply toward communities with the greatest burden of type 2 diabetes.
10. changes to the PBS to allow concurrent prescribing of GLP1 RAs and SGLT2 inhibitors for Aboriginal and Torres Strait Islander peoples with type 2 diabetes.
11. Government funds novel models of CGM use and evaluation for Aboriginal and Torres Strait Islander people.
12. ACCHOs are funded to deliver holistic health promotion, prevention and engagement programs that normalise good health.
13. ACCHOs are funded to establish health promotion and prevention teams to support community health.
14. funding to embed non-dispensing pharmacists in ACCHOs to support chronic disease management.
15. funding ACCHRTOs to work in partnership with universities to develop nationally accredited skillsets and pathways to support Aboriginal Health Practitioners to become Credentialled Diabetes Educators.
16. ACCHRTOs are funded to co-design nationally certified diabetes prevention and better health resources to support ACCHO workforce upskilling and training.
17. the Australian Government redirects funding to support Aboriginal and Torres Strait Islander people with diabetes to the ACCHO sector.

National Agreement on Closing the Gap

At the meeting of National Cabinet in early February 2023, First Ministers agreed to renew their commitment to Closing the Gap by re-signing the National Agreement, first signed in July 2020. The reforms and targets outlined in the National Agreement seek to overcome the inequality experienced by Aboriginal and Torres Strait Islander people and achieve life outcomes equal to all Australians.

This Government's first Closing the Gap Implementation Plan commits to achieving Closing the Gap targets *through implementation of the Priority Reforms*. This represents a shift away from focussing on the Targets, towards the structural changes that the Priority Reforms require, and which are more likely to achieve meaningful outcomes for our people in the long term.

The four Priority Reforms offer a roadmap to meaningfully impact structural drivers of chronic disease for Aboriginal and Torres Strait Islander people:

Priority Reform Area 1 – Formal partnerships and shared decision-making

This Priority Reform commits to building and strengthening structures that empower Aboriginal and Torres Strait Islander people to share decision-making authority with governments to accelerate policy and place-based progress against Closing the Gap.

Priority Reform Area 2 – Building the community-controlled sector

This Priority Reform commits to building Aboriginal and Torres Strait Islander community-controlled sectors to deliver services to support Closing the Gap. In recognition that Aboriginal and Torres Strait Islander community-controlled services are better for Aboriginal and Torres Strait Islander people, achieve better results, employ more Aboriginal and Torres Strait Islander people, and are often preferred over mainstream services.

Priority Reform Area 3 – Transformation of mainstream institutions

This Priority Reform commits to systemic and structural transformation of mainstream government organisations to improve to identify and eliminate racism, embed and practice cultural safety, deliver services in partnership with Aboriginal and Torres Strait Islander people, support truth telling about agencies' history with Aboriginal and Torres Strait Islander people, and engage fully and transparently with Aboriginal and Torres Strait Islander people when programs are being changed.

Priority Reform 4 – Sharing data and information to support decision making

This Priority Reform commits to shared access to location-specific data and information (data sovereignty) to inform local-decision making and support Aboriginal and Torres Strait Islander communities and organisations to support the achievement of the first three Priority Reforms.

> 'Too many government agencies are implementing versions of shared decision-making that involve consulting with Aboriginal and Torres Strait Islander people on a pre-determined solution, rather than collaborating on the problem and co-designing a solution.'[1]

[1] Productivity Commission 2023, Review of the National Agreement on Closing the Gap, Draft Report, Canberra, July.

Review of Closing the Gap

In its recent review of the National Agreement on Closing the Gap, the Productivity Commission described government progress implementing the Agreement's Priority Reforms as mostly weak. It found no evidence of systemic change and that Government policy did not reflect the value of the community-controlled sector. The Commission noted that few tangible steps had been taken to increase the proportion of services delivered by ACCOs and that there was a need to improve funding to ACCOs to provide more flexible and longer-term contracts that cover full costs of services and reduce reporting burdens.[1]

The review recommended designating leaders to promote and embed changes to public sector systems and culture, embedding a responsibility in conditions of employment for public sector employees to improve cultural capability and relationships with Aboriginal and Torres Strait Islander people, and improving accountability and transparency.

> NACCHO recommends any interventions to address diabetes align with the National Agreement and its four Priority Reform Areas.

Health in all policies

A broad range of structural and social factors (social determinants) influence health outcomes for Aboriginal and Torres Strait Islander people. Entrenched cycles of poverty, exacerbated by poor education and employment outcomes and increased interaction with the justice system contribute significantly to poorer health outcomes for Aboriginal and Torres Strait Islander people.

The Australian Institute of Health and Welfare (AIHW) notes that the links between socioeconomic disadvantages such as poverty, social dysfunction and exclusion, stress, racism and poor health are well established.[2] This is true across urban, regional and remote areas. The consequent disparity in health outcomes between Aboriginal and Torres Strait Islander people and other Australians remains significant – 34 per cent of the health gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians is attributable to social determinant factors.[3]

Consideration is therefore needed of the impact of *all* policy decisions on health outcomes for Aboriginal and Torres Strait Islander people. This allows scope to identify and address those issues around social disadvantage which contribute to higher rates of chronic health conditions such as diabetes, as well as preventable disease.

A Health in All Policies approach would require consideration of the impact on health outcomes for Aboriginal and Torres Strait Islander people in all policy decisions. Such an approach aligns with the National Agreement on Closing the Gap. It also aligns with the ACCHO holistic model of care which considers factors that contribute to health and wellbeing as well as those that compound the likelihood and/or incidence of health conditions.

> '… an approach that incorporates Health in All Policies is the only way to achieve the health-related goals governments are pursuing. Otherwise, health systems will remain locked in a never-ending struggle as they respond

[2] IHW, 2.09 Index of disadvantage https://www.indigenoushpf.gov.au/measures/2-09-index-disadvantage
[3] Australian Institute of Health and Welfare. Determinants of health for Indigenous Australians 2022 [Available from: https://www.aihw.gov.au/reports/australias-health/social-determinants-and-indigenous-health.

to the ill health that often arises from weaknesses in other sectors'.[4]

NACCHO recommends Government adopts a 'heath in all policies' approach, recognising that health outcomes are influenced by a wide range of social, commercial, political, environmental and cultural determinants.

Burden of disease

We know that despite some gains, life expectancy for Aboriginal and Torres Strait Islander people is still significantly lower than for the non-Indigenous population. Similarly, the burden of disease (the impact of living with illness and injury and of dying prematurely) for Aboriginal and Torres Strait Islander people remains 2.3 times higher than for other Australians.[5] In the 2018-19 period, 49% of Aboriginal and Torres Strait Islander people aged 15 and over, lived with a disability or restrictive long-term health condition.[6]

AIHW data highlights the disproportionate rate and impact of type 2 diabetes for Aboriginal and Torres Strait Islander people with prevalence three times greater, hospitalisation rates four times higher, and death due to complications five times more likely than for non-Indigenous Australians.[7]

Against this background, research commissioned by NACCHO and conducted by Equity Economics found that the gap in health expenditure to achieve equitable spending based on need is an additional $5,042 per Aboriginal and Torres Strait Islander person per year. This accounts for the fact that Aboriginal and Torres Strait Islander people experience disease burden at 2.3 times the rate of non-Indigenous Australians.

For Aboriginal and Torres Strait Islander people to receive the same level of services as the general population, additional recurrent expenditure of $4.4 billion is required including $2.6 billion in additional Commonwealth Government expenditure.[8] Ensuring Aboriginal and Torres Strait Islander people can access culturally safe comprehensive primary healthcare is key to reducing the burden of disease.

NACCHO recommends the Australian Government allocates diabetes funding based on burden of disease rather than population.

[4] Greer S.L., Falkenback M, Siciliani L, Mckee M, Wismar M, Figueras J. From Health in All Policies to Health for All Policies. Viewpoint, Vol 7, 8, E718-E720, August 2022, doi: https://doi.org/10.1016/S2468-2667(22)00155-4
[5] AIHW, Australian Burden of Disease Study, https://www.aihw.gov.au/reports/burden-of-disease/illness-death-indigenous-2018/summary
[6] AIHW, Disability https://www.indigenoushpf.gov.au/measures/1-14-disability
[7] Australian Institute of Health Welfare. *Diabetes: Australian Facts* https://go.nature.com/3FRitsu (2020).
[8] Measuring the Gap in Health Expenditure, https://www.naccho.org.au/app/uploads/2022/05/NACCHO-and-Equity-Economics-Report-Measuring-the-Gap-in-Health-Expenditure_FINAL.pdf

Introduction

Aboriginal and Torres Strait Islander peoples are grossly over-represented in the diabetes burden of disease compared to other Australians. The prevalence of diabetes in Aboriginal and Torres Strait Islander adults is three times the national rate for non-Indigenous people, and youth onset type 2 diabetes is rising rapidly. There is an urgent need for earlier diagnosis and a focus on prevention.

Contributing factors are wide-ranging. Social disadvantage arising from impacts of colonisation and associated intergenerational trauma, discrimination, racism and endemic poverty contribute to a higher burden of disease. Accessing culturally relevant and trauma-informed care can be difficult and may require people to move away from family and Country.

In addition, the ACCHO sector is facing a primary healthcare workforce crisis. Across Australia there is a critical shortage of doctors, nurses, Aboriginal Health Workers (AHWs) and Aboriginal Health Practitioners (AHPs).

The ACCHO model of care, outlined in NACCHO's Core Services and Outcomes Framework[9], is recognised as the most effective health service delivery model to prevent, diagnose and manage diabetes for Aboriginal and Torres Strait Islander people and for Closing the Gap, however fragmented funding is limiting its capacity and effectiveness.

Funding the ACCHO sector to determine, design, and deliver culturally appropriate services will build capacity to improve health outcomes for Aboriginal and Torres Strait Islander people.

Diabetes in Aboriginal and Torres Strait Islander communities

In its 2022 report on diabetes among indigenous peoples[10], the International Diabetes Federation (IDF) notes that diabetes is now one of the most common health conditions that disproportionately impact indigenous populations worldwide.

The highest prevalence of type 2 diabetes in indigenous peoples aged 30 years and under, was reported in Central Australia in 2016-17 among youth aged 15-24 years (31.1 per 1000), and in those aged 18 years and under, the highest prevalence was reported in Torres Strait Islander children (21 per 1000) in 2001-2017.

The IDF review highlighted the need for culturally responsive and community tailored approaches to type 2 diabetes screening, prevention, and management to address the rich, socio-cultural diversity within and between indigenous nations.

The burden of diabetes and associated complications in Aboriginal and Torres Strait Islander populations looks set to worsen. Diabetes accounts for more than 70% of new cases of kidney failure, and Aboriginal and Torres Strait Islander people with diabetes are five times more likely to report kidney disease than people without diabetes.[11] Regardless of locality, Aboriginal and Torres Strait Islander people are five times more likely than non-Indigenous Australians to develop kidney

[9] NACCHO Core Services and Outcomes Framework: The Model of Aboriginal and Torres Strait Islander Community-Controlled Comprehensive Primary Health Care. National Aboriginal Community Controlled Health Organisation, Canberra, ACT: June 2021

[10] International Diabetes Federation (2022). IDF Diabetes report on diabetes among Indigenous Peoples - 2022. Brussels, Belgium.

[11] Kidney disease, Aboriginal and Torres Strait Islander Health Performance Framework, https://www.indigenoushpf.gov.au/measures/1-10-kidney-disease

disease, and four times more likely to die from kidney disease. Incidence of kidney failure is up to 20 times higher than non-Indigenous Australians in remote areas.[12]

Diabetes doubles the risk of dementia and increases risk of stroke and heart disease.[13] Younger age onset of diabetes is associated with higher risk of subsequent dementia.[14] Young Aboriginal and Torres Strait Islander people with diabetes have higher rates of comorbidities, 59% with hypertension, 24% with dyslipidaemia (the major predictor of cardiovascular disease[15] resulting in high mortality and morbidity), and 61% with obesity, all contributing additional impact on future burden of disease.[16] Other associated complications of diabetes include macular degeneration and diabetic retinopathy - which can cause vision loss and blindness, and lower limb amputation due to nerve damage and circulation problems.

In the next decade, the population of Aboriginal and Torres Strait Islander people aged 50 and over is projected to double to almost 250,000 people.[17] An estimated 33,000 are Stolen Generations survivors who we know experience a significantly higher burden of trauma and chronic disease and are more likely to develop dementia as they age.[18]

Rapid increases in youth onset type 2 diabetes

The rising incidence of youth onset type 2 diabetes in Aboriginal and Torres Strait Islander children and adolescents requires urgent action. Aboriginal and Torres Strait Islander children and adolescents have the highest rates of type 2 diabetes recorded in the world. Data from Western Australia shows the incidence of youth onset type 2 diabetes is 18 times higher than non-Indigenous children, with incidence increasing 6.2% year on year between 2000 – 2019.[19]

Youth onset type 2 diabetes is a far more aggressive disease than adult disease. Complications occur earlier, and mortality rates are higher, compared with type 1 diabetes.[20] Associated progression to kidney failure is faster. Canadian data demonstrated 45% of patients with youth onset type 2 diabetes progressed to renal failure 20 years after diagnosis, compared to zero people with type 1 diabetes. This suggests that without major changes to early diagnosis and support, many young people being diagnosed now will be on dialysis by the age of 30.

NACCHO members report a worrying trend in which young Aboriginal and Torres Strait Islander people consider a diabetes diagnosis to be inevitable. ACCHOs report a sense of doom in young people and a limited sense of agency that could support them to make healthier choices. Interventions to support young Aboriginal and Torres Strait Islander people with diabetes, and those

[12] Aboriginal & Torres Strait Islander Peoples | Kidney Health Australia Accessed 24 August 2023
[13] What's the relationship between diabetes and dementia? - Harvard Health, accessed 8/8/23
[14] Barbiellini, C, Fayosse, A, Dumurgier, J, et al, JAMA. 2021;325(16):1640-1649. doi:10.1001/jama.2021.4001
[15] Mooradian, A.D. (no date) Dyslipidemia in type 2 diabetes mellitus, Nature News. Available at: https://www.nature.com/articles/ncpendmet1066#:~:text=Dyslipidemia%20contributes%20to%20the%20increased,of%20small%20dense%20LDL%20cholesterol Accessed 24 August 2023
[16] Titmuss, A. et al. (2019) 'Emerging diabetes and metabolic conditions among Aboriginal and Torres Strait Islander Young People', Medical Journal of Australia, 210(3), p. 111. doi:10.5694/mja2.13002.
[17] Centre for Aboriginal Economic Policy Research (2011). *CAEPR Indigenous Population Project. 2011 Census Papers.* Paper 14: Population Projections. Canberra: ANU.
[18] Australian Institute of Health and Welfare (2022). *Population health impacts of dementia among Indigenous Australians*. Retrieved from: https://www.aihw.gov.au/reports/dementia/dementia-in-aus/contents/dementia-in-vulnerable-groups/population-health-impacts-of-dementia-among-indigenous-australians#prevalence
[19] Haynes, A., Curran, J.A. and Davis, E.A. (2021) 'Two decades of increasing incidence of childhood-onset type 2 diabetes in Western Australia (2000–2019)', Medical Journal of Australia, 214(6), p. 285. doi:10.5694/mja2.50970. https://onlinelibrary-wiley-com.virtual.anu.edu.au/doi/full/10.5694/mja2.50970
[20] Dabelea, D. et al. (2017) 'Association of type 1 diabetes vs type 2 diabetes diagnosed during childhood and adolescence with complications during teenage years and young adulthood', JAMA, 317(8), p. 825. doi:10.1001/jama.2017.0686.

at risk are critical in order to limit complications, and delay or avoid onset of diabetes across the lifespan.

NACCHO recommends working in partnership with the sector and young Aboriginal and Torres Strait Islander people to develop better health programs to support young people with diabetes.

A driving factor in the increasing rates of youth onset type 2 diabetes are intergenerational and epigenetic factors. International studies on First Nations women who were diagnosed with type 2 diabetes before 18 years found that 25% of their children had developed type 2 diabetes by seven years of age and almost 50% had developed diabetes before they turned twenty. The risk appears most related to intrauterine hyperglycaemia, which contributes to intergenerational metabolic changes[21] and increased risk of diabetes and cardiovascular disease in offspring[22]. In another international study of First Nations women, children born after the mother had developed diabetes had a 3.7-fold higher risk than their siblings born before the mother developed type 2 diabetes.[23] Diabetes in pregnancy (including pre-gestational type 2 diabetes and gestational diabetes) is more prevalent in Aboriginal and Torres Strait Islander women, possibly ten times higher than non-Indigenous Australian women.[22]

Available data suggests that elevated cardiometabolic risk in Aboriginal and Torres Strait Islander people begins in early childhood. The higher risk of type 2 diabetes in Aboriginal and Torres Strait Islander children is reflected in new Australian guidelines on screening. Aboriginal and Torres Strait Islander children are recommended annual screening from the age of 10 if they have one risk factor such as obesity, a family history of diabetes or were exposed to diabetes in utero.[24] However, this major change in screening recommendations has not come with appropriate resources to support implementation and existing MBS item restrictions on point of care diagnostics prevent subsidised testing aligned with best practice.

NACCHO recommends the Australian Government supports ACCHOs to conduct nationally standardised screening and follow-up of Aboriginal and Torres Strait Islander children for diabetes.

NACCHO recommends the development of resources to support implementation of new screening recommendations.

NACCHO recommends changes to MBS to improve availability of point of care diagnostics aligned with best practice.

---

[21] Ren, J. et al. (2018) Intrauterine hyperglycemia exposure results in intergenerational inheritance via DNA methylation reprogramming on F1 pgcs - epigenetics & Chromatin, BioMed Central. Available at: https://epigeneticsandchromatin.biomedcentral.com/articles/10.1186/s13072-018-0192-2 (Accessed: 24 August 2023).
[22] Ahmed, M.A. et al. (2022) Trends and burden of diabetes in pregnancy among aboriginal and non-Aboriginal mothers in Western Australia, 1998–2015 - BMC Public Health, BioMed Central. Available at: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-022-12663-6 (Accessed: 24 August 2023).
[23] Titmuss, A. et al. (2019a) Emerging diabetes and metabolic conditions among Aboriginal and Torres Strait Islander Young People, The Medical Journal of Australia. Available at: https://www.mja.com.au/journal/2019/210/3/emerging-diabetes-and-metabolic-conditions-among-aboriginal-and-torres-strait#4 (Accessed: 23 August 2023). https://www.mja.com.au/journal/2019/210/3/emerging-diabetes-and-metabolic-conditions-among-aboriginal-and-torres-strait#4
[24] Peña, A.S. et al. (2020) Screening, assessment and management of type 2 diabetes mellitus in children and adolescents: Australasian Paediatric Endocrine Group Guidelines, The Medical Journal of Australia. Available at: https://www.mja.com.au/journal/2020/213/1/screening-assessment-and-management-type-2-diabetes-mellitus-children-and (Accessed: 23 August 2023). https://www.mja.com.au/journal/2020/213/1/screening-assessment-and-management-type-2-diabetes-mellitus-children-and

Gestational diabetes

In a longitudinal study[9] of more than 10,000 Aboriginal women in the Northern Territory, investigating the risk of developing chronic kidney disease (CKD) or kidney failure following pregnancy with gestational diabetes mellitus (GDM), it was found that both GDM and pre-existing diabetes during pregnancy were strongly associated with future risk of CKD and kidney failure. Most women with GDM who developed kidney disease had progressed to type 2 diabetes first.

The study noted the importance of screening for risk of kidney disease during pregnancy and the postpartum period and of ensuring culturally appropriate strategies to prevent kidney disease in Aboriginal women. It recommended public health strategies that address the social determinants of health and improve access to health care services for Aboriginal women in the Northern Territory.

Breastfeeding

Breastfeeding offers health protection against diabetes for both mothers and infants. Research suggests that prior to colonisation Aboriginal women routinely breastfed their infants for two to four years.[25] The impact of colonisation and associated loss of cultural breastfeeding practices alongside the introduction of breastmilk substitutes, may have facilitated loss of breastfeeding knowledge and be contributing to lower rates of breastfeeding in Aboriginal and Torres Strait Islander populations.

For infants, breastfeeding provides all the nutrition and energy needs for the first six months of life. It protects against and reduces the incidence of many diseases, including reducing the risk of overweight or obesity and type 2 diabetes. For mothers, breastfeeding is protective against many adverse health outcomes including type 2 diabetes in later life.[25] One study found that breastfeeding reduces the relative risk of type 2 diabetes for the nursing mother by 9% for each year of breastfeeding duration.[26] ACCHOs are best placed to develop and deliver breastfeeding education during pregnancy, and postnatal support to establish breastfeeding.[27]

> NACCHO recommends the Australian Government supports ACCHOs to deliver high-quality models of antenatal care which include midwife continuity, and antenatal and postnatal screening for diabetes, and breastfeeding support.

Obesity

The risk of type 2 diabetes increases with increase in body mass index. The increasing prevalence of obesity has led to an associated increase in the prevalence of type 2 diabetes.[28] In 2018-19, 38% of Aboriginal and Torres Strait Islander children and adolescents were overweight or obese, an increase from 31% in 2012-13.

---

[25] Tanisha L. Springall a b et al. (2022) Breastfeeding rates of Aboriginal and Torres strait Islander women in Australia: A systematic review and narrative analysis, Women and Birth. Available at: https://www.sciencedirect.com/science/article/abs/pii/S1871519222000373 (Accessed: 24 August 2023).

[26] Aune a b et al. (2013) Breastfeeding and the maternal risk of type 2 diabetes: A systematic review and dose–response meta-analysis of Cohort studies, Nutrition, Metabolism and Cardiovascular Diseases. Available at: https://www.sciencedirect.com/science/article/abs/pii/S0939475313002743 (Accessed: 24 August 2023).

[27] Mitchell, F. et al. (2023) Factors influencing infant feeding for Aboriginal and Torres Strait Islander women and their families: A systematic review of qualitative evidence - BMC public health, BioMed Central. Available at: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-022-14709-1 (Accessed: 24 August 2023).

[28] PE;, K.S.A.-J.H. (no date) Why does obesity cause diabetes?, Cell metabolism. Available at: https://pubmed.ncbi.nlm.nih.gov/34986330/ (Accessed: 23 August 2023).

Latest available data from AIHW tells us the proportion of Aboriginal and Torres Strait Islander adults aged 18–24 living with obesity is 32% compared with the 51% of Aboriginal and Torres Strait Islander adults aged 45 and over.[29]

CASE STUDY: Derbarl Yerrigan - Walking and yarning group

ACCHOs can encourage social connection and better health through low-cost holistic health activities such as exercise and socialising. One such example, a walking and yarning group for heart health from Derbarl Yerrigan Health Service in Perth, provided opportunities for community members to connect, exercise, and engage with health services. The group provided opportunities for staff to do targeted health promotion around multiple physical and mental health needs including chronic disease management, improved social and emotional wellbeing and health literacy.

Although targeted at heart health participants, this program equally applies to participants with diabetes and other chronic diseases. It is a good example of being able to integrate and deliver a program with multiple, holistic health benefits whilst delivering significant improvements for participants.[1] ACCHOs report that community support for these types of activities is strong.

Medical management

Given the links between obesity and diabetes and the high prevalence of both in the Aboriginal and Torres Strait Islander population, equity approaches to new treatments for obesity must be considered. While surgical procedures for obesity are effective, there are very few options within the public hospital system, with almost 90% performed in private hospitals.[30] In an environment where only the socioeconomically advantaged have access to this treatment, funding for effective weight loss medications must be considered.

New medicines have been shown to markedly improve outcomes for patients with type 2 diabetes.[31] However, Australia's approach to the supply and funding these medications does not align with best practice and has no equity focus.

An equity lens applied to new medications as they come onto the market would ensure Aboriginal and Torres Strait Islander people and other vulnerable groups are able to access more effective treatments they would not otherwise be able to afford.

Horizon scanning for new therapies for youth onset type 2 diabetes must be prioritised and rapid access enabled for the high number of Aboriginal and Torres Strait Islander youth who can benefit from these treatments.

[29] Overweight and obesity, Summary - Australian Institute of Health and Welfare (aihw.gov.au) Accessed 23/8/2023.
[30] Australian Institute of Health and Welfare 2017. Weight loss surgery in Australia 2014–15: Australian hospital statistics. Cat. no. HSE 186. Canberra: AIHW.
[31] Vosoughi K, Atieh J, Khanna L, Khoshbin K, Prokop LJ, Davitkov P, Murad MH, Camilleri M. Association of Glucagon-like Peptide 1 Analogs and Agonists Administered for Obesity with Weight Loss and Adverse Events: A Systematic Review and Network Meta-analysis. EClinicalMedicine. 2021 Nov 27;42:101213. doi: 10.1016/j.eclinm.2021.101213. PMID: 34877513; PMCID: PMC8633575.

Glucagon-like peptide 1 receptor agonists (GLP1 RAs) have consistently shown their effectiveness and safety in weight loss, and PBS subsidy for these medications for Aboriginal and Torres Strait Islander people would treat obesity and could prevent or delay the development of type 2 diabetes.

Despite the benefit of GLP1 RAs for people with type 2 diabetes, the Australian Government has taken little action to ensure supply to Australians with the most to gain from these treatments. In an environment of global shortages, market demand, not need, has been the largest driver of access to these medications.

> NACCHO recommends funding for GLP1 RA for Aboriginal and Torres Strait Islander people with obesity, given its association with type 2 diabetes and establish regulatory framework that prioritises equitable supply toward communities with the greatest burden of type 2 diabetes.

Both sodium glucose transport 2 (SGLT2) inhibitors and GLP1 RAs have been found to lower all-cause mortality, decrease major cardiovascular disease events, and slow progression of renal disease compared to standard therapy. However, despite the evidence of their safety and benefits from co-prescribing, current PBS rules do not support their subsidised use when prescribed together.

> NACCHO recommends changes to the PBS to allow concurrent prescribing of GLP1 RAs and SGLT2 inhibitors for Aboriginal and Torres Strait Islander people with type 2 diabetes.

Beyond the urgent need to improve accessibility of GLP1 RAs and SGLT2 inhibitors, NACCHO looks forward to working with government departments and agencies to identify existing and future treatments for diabetes and obesity, and to ensure the accessibility of these are supported by tangible government policy and regulation. This may include waiving fees for registration and reimbursement of medicines within a specific category, and structured support pathways for equitable distribution of medicines to all Aboriginal and Torres Strait Islander communities in Australia, especially in times of medicine shortages.

Continuous Glucose Monitors (CGMs) can support better glycaemic control and prevent severe hypoglycaemia for people on insulin. Community led models of care need to be developed and evaluated regarding their effectiveness in supporting high quality care for priority type 2 diabetes groups, including pregnant women with type 2 diabetes and youth adolescents with type 2 diabetes who are on insulin.

Our community consultations identified that CGMs can also work well as a short-term education support, where wearing them for a period of a few weeks can help patients identify the impact of food choices and physical activity on blood sugar levels.

> NACCHO recommends Government funds novel models of CGM use and evaluation for Aboriginal and Torres Strait Islander peoples.

Dietary management

Good nutrition and exercise are key to effective management of diabetes. Unfortunately, due to colonisation and its continuing impacts, access to and availability of traditional foods has changed, and as a result, dietary patterns of Aboriginal and Torres Strait people have shifted from traditional diets, which were nutrient-dense, to energy-dense diets.[32]

[32] Shannon, Cindy (2002) Acculturation: Aboriginal and Torres Strait Islander nutrition. Asia Pacific Journal of Clinical Nutrition.

It is estimated that among Aboriginal and Torres Strait Islander people, 41% of total energy intake is derived from discretionary food and drink items, which are high in saturated fat, salt, and sugar.[33] Higher consumption of carbohydrate-based foods, sugar-sweetened beverages, less fruit and vegetables, and processed meat result in sub-optimal dietary intake.[34]

Data from the ABS National Aboriginal and Torres Strait Islander Health Survey 2018-2019 shows that across all age ranges the proportions of Aboriginal and Torres Strait Islander people who met Australian Dietary Guidelines for fruit and vegetable intake ranged from 32.5% to 49% for fruit and from 2.5 to 5.3% for vegetables. [35] One study of six remote communities in northern Australia found that more than a third of Aboriginal and Torres Strait Islander children are not consuming enough fresh fruits and vegetables.[36]

Childhood development and learning can also be adversely impacted by iron deficiency and anaemia brought about by poor diet. The risk of non-communicable diseases, including type 2 diabetes and cardiovascular disease, which account for 80% of the mortality gap between Aboriginal and Torres Strait Islander people and other Australians, is also increased by poor diet quality. [37]

Strengths-based nutrition programs have shown success in markedly improving diabetes outcomes for Aboriginal and Torres Strait Islander peoples. A 10-week program reported by Power et al (2021)[38] promoted regular low intensity exercise, a diet of fresh, unprocessed foods, and engagement and support from the local Aboriginal community. The program which included emailing educational and health literacy videos using simple language and sending daily motivational videos via SMS, saw average weight loss of over 7kg, decrease in HbA1c by over 1.5%, reductions in medication and increased confidence in patients to improve their own health and well-being.

A 7-week intervention took a strength-based approach for Aboriginal people with type 2 diabetes in which participants followed a traditional lifestyle consisting of hunting and collecting their own foods at both coastal and inland locations. This included beef, kangaroo, turtle, fish, crocodile, birds, fruits, vegetables, and honey. The high-protein diet saw an average weight loss of 8kg, ten percent reduction in BMI, and reductions in fasting plasma glucose concentrations and improvements in glucose tolerance. Both fasting insulin levels and fasting plasma triglycerides reduced to normal or near normal levels.[39]

Several health services are seeing encouraging benefits for diabetes patients and others, from culturally appropriate, healthy lifestyle intervention programs. Different programs exist, and some health services have been able to adapt such programs to meet local cultural needs. It is important to realise that programs developed for specific communities are not necessarily suitable for others.

---

[33] Australian Bureau of Statistics (2015) Australian Aboriginal and Torres Strait Islander Health Survey: Nutrition Results - Food and Nutrients, 2012–13. Canberra: Australian Bureau of Statistics

[34] Lindberg, R.; McNaughton, S.A.; Abbott, G.; Pollard, C.M.; Yaroch, A.L.; Livingstone, K.M. (2022) The Diet Quality of Food-Insecure Australian Adults—A Nationally Representative Cross-Sectional Analysis. Nutrients 14

[35] https://ncci.canceraustralia.gov.au/prevention/diet/fruit-and-vegetable-consumption Accessed 24 August 2023.

[36] https://www1.racgp.org.au/newsgp/racgp/food-security-and-nutrition-in-aboriginal-and-torr Accessed 24 August 2023.

[37] Australian Institute of Family Studies. Healthy lifestyle programs for physical activity and nutrition. Melbourne: Australian Institute of Family Studies; 2011

[38] Power T, East L, Gao Y, Usher K, Jackson D. A mixed-methods evaluation of an urban Aboriginal diabetes lifestyle program. Aust N Z J Public Health. 2021;45(2):143-9.

[39] O'Dea K. Marked improvement in carbohydrate and lipid metabolism in diabetic Australian Aborigines after temporary reversion to traditional lifestyle. DIABETES. 1984;33(6):596-603.

CASE STUDY: Cultural adaptation of DESMOND

DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) is a proven, evidence-based education program for type 2 diabetes, developed in the UK in 2003.

In 2011, Diabetes WA adapted DESMOND for Australia but found minimal attendance by Aboriginal and Torres Strait Islander people. In 2013, with research funding from the NHMRC, Diabetes WA began a project with Aboriginal and Torres Strait Islander communities to co-create a culturally adapted DESMOND program.

The adaptation program, called Diabetes Education and Self-Management and Yarning or DESY, included reducing writing, including culturally suitable pictures where possible, including simple messages, reducing medical jargon, extending the duration of the program to incorporate more breaks, and adapting the workbook and action plans to make them more suitable for Aboriginal people.

Over seven years, DESMOND facilitators, program participants and program observers (Aboriginal Health Workers) contributed to the adaptation, which also included changes to the program activities to address diversity amongst participants and provide different options for delivery. Pilot programs and post program yarning groups provided feedback from participants.

The project also investigated and developed pathways for Aboriginal Health Practitioners and community members to deliver DESY, and to adapt the program to include culturally safe pathways and tailoring with minimal cost to meet local population needs. Encouraging family members and carers to attend workshops with participants was key to building trust and improving health outcomes.

Aboriginal Health Professional training was developed in collaboration with ACCHRTOs (Aboriginal Community Controlled Health Registered Training Organisations), as was a quality development pathway for Aboriginal Health Workers. The development pathway was trialed for a CALD Community Educator project and used to deliver training to Māori Pacifica Health Workers. Learnings guided the completion of the pathway for Aboriginal Health Workers and an updated Aboriginal DESMOND facilitator guide.

Feedback from community has shown that DESY program participants return to multiple sessions, and that the program encourages self-management, self-determination, and psychological adjustment to living with diabetes.

Culture-centred solutions

Nineteen per cent of the health gap between Aboriginal and Torres Strait Islander and other Australians, is attributable to ‘health risk factors’ that include consumption of fruit and vegetables and levels of physical activity. These are often considered to be ‘modifiable’ risk factors, suggesting these factors are within the control of the individual to change. However, individual behaviours are influenced by myriad factors outside the control of the individual. Health programs that focus on nutrition without addressing the social determinants of health will have limited impact.[40]

For decades, government policy approaches seeking to improve health and socio-economic outcomes for Aboriginal and Torres Strait Islander people have not had the desired impact.

[40] Whalan S, Farnbach S, Volk L, Gwynn J, Lock M, Trieu K, et al. What do we know about the diets of Aboriginal and Torres Strait Islander peoples in Australia? A systematic literature review. Australian and New Zealand Journal of Public Health. 2017;41(6):579-84.

Responses have largely been programmatic - focussing on individual behavioural change rather than the kind of structural transformation that would engender more meaningful outcomes[41].

Few if any such interventions have been based on equal partnerships with Aboriginal and Torres Strait Islander people. Without genuine engagement, without self-determined approaches, such programs are unlikely to achieve their aims. The rising incidence in diabetes is evidence that current programs are ineffective.

Changing from a deficit narrative to a strength-based approach improves health outcomes for Aboriginal and Torres Strait Islander people[42]. A strength-based approach considers what Aboriginal and Torres Strait Islander people can achieve using their cultural identity, knowledge, skills, networks, and extended family.[43]

CASE STUDY: Townsville Aboriginal and Islander Health Service (TAIHS) – *Got Sugar*

Moa Island woman, Aunty Emily Marshall, leads culturally specific programs such as the *Got Sugar Diabetic Group* at the Townsville Aboriginal and Islander Health Service (TAIHS). Marshall, who has a nursing degree and three decades of nursing practice, says patients trust the Aboriginal and Torres Strait Islander health service, which allows it to have more reach.

The group provides a space for people to share experiences, learn about healthy lifestyle habits and manage their healthcare. Patients can access educators, dieticians, exercise physiologists and endocrinologists.

TAIHS provides care to over 8,000 patients in communities in north Queensland. It also provides transport to medical appointments and help with fees, for those patients in need.[1]

For Aboriginal and Torres Strait Islander people, culture is central to the health and wellbeing of individuals, community and Country. Locally led health promotion programs are critical to ensuring healthy-eating messages are designed and delivered in a culturally appropriate way.

At the 2021 Food Summit held by the Aboriginal Medical Services Alliance Northern Territory (AMSANT), participants stressed the importance of employing Aboriginal people to deliver and support nutrition and health. Community-wide nutrition promotion should use local language, cook-ups, group education, hunting trips and engage Elders to deliver education on traditional foods to children in schools.

There is an opportunity to link culture-centred nutrition education initiatives such as this with Ranger programs which can provide education about traditional food and support improved nutrition outcomes. The Indigenous Ranger program which has been developed to support conservation, also provides meaningful employment, training, and career pathways for Aboriginal and Torres Strait Islander people, and has physical and mental health benefits for those who participate.

> ‘Rangers reported they felt more pride, self-worth, health, and wellbeing, with closer connections to family, culture, and country. Ranger groups also reported a wide range of

[41] Baum F, Fisher M. Why behavioural health promotion endures despite its failure to reduce health inequities. Sociol Health Illn. 2014 Feb;36(2):213-25. doi: 10.1111/1467-9566.12112. PMID: 24528303.
[42] Fogarty W, Lovell M, Langenberg J, Heron M-J. Deficit discourse and strengths-based approaches. Changing the Narrative of Aboriginal and Torres Strait Islander Health and Wellbeing Melbourne: The Lowitja Institute. 2018.
[43] Fogarty W, Lovell M, Langenberg J, Heron M-J. Deficit discourse and strengths-based approaches. Changing the Narrative of Aboriginal and Torres Strait Islander Health and Wellbeing Melbourne: The Lowitja Institute. 2018.

community benefits as a result of the programs, including safer communities, strengthened language and culture, an ability to find meaningful employment, increased respect for women, and more role models for younger people.'[44]

Developing cooking skills and health literacy in young Aboriginal people is vital. Education and youth services should work closely together to educate and develop young Aboriginal people's cooking skills and appreciation for healthy eating. Such programs offer the potential for employment and upskilling by teaching cooking and nutrition skills within communities.[45] These promotional programs should aim to be led by Aboriginal people using local languages.

One example of a locally led health promotion program is the Arnhem Land Progress Aboriginal Corporation (ALPA) Health and Nutrition Strategy. ALPA employs two nutritionists to drive positive nutrition practices across community activities and stores.[46]

ACCHOs have suggested ways to promote good nutrition and normalise healthy eating include support for health services might include:

- Providing fresh fruit or other healthy food in schools or at community activities, or
- Delivering general health promotion programs in schools and Community Development Program employment programs that promote healthy eating and dental hygiene for everyone, without any association with disease or associated stigma.

The National Aboriginal and Torres Strait Islander Early Childhood Strategy supports Aboriginal and Torres Strait Islander communities and their community-controlled services to lead the responses to children's needs.

The ability for ACCHOs to establish permanent health promotion teams that might support activities such as these and other preventive health approaches could have a significant impact on community health outcomes. However, ACCHOs are not specifically funded for health promotion, and do not have sufficient resourcing to address this problem sustainably.

NACCHO recommends ACCHOs are funded to deliver holistic health promotion, prevention and engagement programs that normalise good health.

The importance of an ACCHO-led approach

ACCHOs play a central role providing culturally safe, trauma-informed primary health care for Aboriginal and Torres Strait Islander communities. They are trusted and accessible and help overcome many of the barriers to access experienced by Aboriginal and Torres Strait Islander people.

There is a clear preference for Aboriginal and Torres Strait Islander people to access community-controlled services. Over 50% prefer to attend an ACCHO over a non-Indigenous practice, and this number is growing. Many will bypass mainstream services to access an ACCHO, where they are confident their cultural safety is guaranteed.[47]

[44] Indigenous Ranger Programs | National Indigenous Australians Agency (niaa.gov.au) accessed 14 August 2023.
[45] Aboriginal Health Council of Western Australia (2020) *Inquiry into Food Pricing and Food Security in Remote Indigenous Communities* Australian Parliament: Canberra
[46] ALPA One Vision (2022) Health and Nutrition Strategy Viewed online at: https://www.alpa.asn.au/giving-back-through-benevolence
[47] Kathryn S Panaretto, Mark Wenitong, Selwyn Button and Ian T Ring, Aboriginal community controlled health services: leading the way in primary care, Med J Aust 2014; 200 (11): 649-652. | doi: 10.5694/mja13.00005

ACCHO-led care aligns with areas for action identified in the Australian National Diabetes Strategy 2021-2030, including:

- Ensure that Aboriginal and Torres Strait Islander communities have access to community-wide, culturally relevant services and awareness programs (including school education programs)
- Develop and implement community-wide, culturally relevant awareness programs for young people about diabetes to encourage their engagement with services
- Strengthen and provide support to primary health care services to better identify and manage diabetes (including among adolescents and children, acknowledging its intergenerational nature)
- Support and upskill the diabetes educator and dietitian workforce working with and within Aboriginal and Torres Strait Islander primary care setting and support the capacity development of the workforce to improve access to essential high-quality, evidence-based diabetes care.

CASE STUDY: Dubbo Regional AHS - diabetes care

Dubbo Regional Aboriginal Health Service provides culturally safe, wrap-around services for diabetic patients. On arrival, patients are greeted by friendly, local Aboriginal staff and screened by Aboriginal health workers. Primary care is provided by GPs, including a local Aboriginal doctor. Aboriginal health workers and nursing staff help patients by coordinating their care such as accompanying them in their telehealth endocrinology appointments and case conferences. Visiting allied health practitioners include a diabetes educator, dietician, optometrist, and pharmacist, who also do home visits.

Some diabetic patients are benefiting from an Aboriginal-led, healthy diet and exercise program, which has seen some type 2 diabetes patients coming off high-dose insulin. Participating patients receive weekly support from local staff.

Outreach services are provided to local schools where an Aboriginal health worker and a doctor conduct general health screening that includes looking for diabetes risk factors and organising follow up such as pathology testing if needed.

Capacity to deliver this type of effective, comprehensive care is limited by the growing number of patients needing support, staff shortages and short-term, piecemeal funding. In the past, the service has been able to assist patients with transport to appointments, some continuous glucose monitors and medicines, but this is no longer sustainable. Ongoing flexible funding to include more early intervention and health promotion would better support the service to expand programs to prevent, diagnose, and manage diabetes in the local Aboriginal community.

Workforce

As noted above, the ACCHO sector is facing critical workforce shortages. Workforce data reported to the AIHW shows a decrease of FTE clinical staff per 1,000 population of around 20-30 per cent in ACCHOs and a 50 per cent increase in the number of unfilled positions since the start of the COVID-19 pandemic in 2020.[48]

In our consultations, ACCHOs have overwhelmingly expressed the need for support to grow their workforce to address unmet service needs, and for training to support and sustain that workforce. The current piecemeal funding of programs makes it difficult to attract and retain staff and maintain

[48] Australian Institute of Health and Welfare (2022) Aboriginal and Torres Strait Islander specific primary health care: results from the nKPI and OSR collections viewed 16.11.2022 https://www.aihw.gov.au/reports/indigenous-australians/indigenous-primary-health-care-results-osrnkpi/contents/osr-introduction

patient continuity of care. ACCHOs engage local community members as part of their workforce, and therefore are an effective and efficient investment to improve both community health and local employment outcomes.

Growing workforce capacity in the community-controlled sector will enable ACCHOs to:

- Train and resource a stable workforce to provide Diabetes Educators
- Design and deliver diabetes education to encourage better nutrition and physical health.
- Provide appropriate diabetes diagnostic and management services as part of routine primary health care services that are easy to access by those in their communities.
- Increase antenatal services to diagnose, monitor, and manage gestational diabetes and related risk of chronic kidney disease.
- Develop culturally appropriate, strength-based programs to increase opportunities to prevent, diagnose, and manage diabetes in Aboriginal and Torres Strait Islander people
- Ensure holistic understanding of diabetes among workforce to ensure continuity of care for patients and families with diabetes.

NACCHO recommends ACCHOs are funded to establish health promotion and prevention teams to support community health.

To establish general health promotion programs and diabetes management teams, ACCHOs need better access to Diabetes Educators, AHWs and AHPs, and allied health staff, including dieticians and exercise physiologists to support patients. Improved access to affordable specialist care including ophthalmologists and endocrinologists is critical.

The Integrating Pharmacists within Aboriginal Community Controlled Health Services to Improve Chronic Disease Management (IPAC Project) has been effective in improving the health of Aboriginal and Torres Strait Islander peoples, including those with diabetes. The project resulted in statistically significant improvements in HbA1c and reduced rates of decline in renal function for diabetic patients in ACCHOs with pharmacists embedded and was recommended for public funding by the Australian Government Medical Services Advisory Committee in March 2023.[49]

NACCHO recommends funding to embed non-dispensing pharmacists in ACCHOs to support chronic disease management.

More Credentialled Diabetes Educators (CDE) in particular, would greatly assist ACCHOs to deliver and meet growing needs for diabetes care within their communities. Some ACCHOs indicated that while they currently have access to a nurse CDE (or similar) on a FIFO basis, they could easily support a full-time CDE across their network of clinics and/or communities.

In 2021, the Australian Diabetes Educators Association (ADEA) developed a three-month, mentoring pilot program for AHPs to develop and use diabetes knowledge. It was intended that mentees would then be well prepared to enrol in a Graduate Certificate course to become a CDE. The program, which included education on diabetes care and management, online training and mentoring support from Aboriginal and Torres Strait Islander Diabetes Educators, was well received by participants. However, it was noted that additional support to gain entry to the Graduate Certificate would have been welcome.

[49] NACCHO Media Release – MSAC support funding pharmacists in First Nations Primary Health Services, 12 July, 2023 https://www.naccho.org.au/media-release-msac-support-funding-pharmacists-in-first-nations-primary-health-services/

A similar, but longer mentoring or traineeship program, co-designed in partnership with local universities that offer the Graduate Certificate of Diabetes Education, would more effectively bridge the gap for AHPs to enter the graduate program and be supported throughout their journey to become CDEs. ACCHOs and ACCHRTOs are well-placed to co-design and support culturally safe training and pathways into higher education to build workforce capacity for diabetes care.

> NACCHO recommends funding Aboriginal Community-Controlled Health RTOs (ACCHRTOs) to work in partnership with universities to develop nationally accredited skillsets and pathways to support Aboriginal Health Practitioners to become Credentialled Diabetes Educators.

There is opportunity to expand the skills of current ACCHO workforce, as well as leveraging national initiatives such as the First Nations Health Worker Traineeship Program, to provide pathways into the health sector for local communities to build a strong workforce that includes both cultural and clinical experts.

ACCHRTOs are an established resource for Government across most states and territories. There are 11 ACCHRTOs nationally which support the workforce needs of the ACCHO sector and ensure the integrity of our model of care. While small, the ACCHRTO sector provides culturally embedded training options for Aboriginal and Torres Strait Islander students and ACCHO staff. ACCHRTOs can support nationally accredited skills development and training needs in the preventive health and diabetes space for ACCHOs, who can then cross-skill and mentor other ACCHO staff to support diabetic patients where required.

> NACCHO recommends ACCHRTOs are funded to co-design nationally certified diabetes prevention and better health resources to support ACCHO workforce upskilling and training.

Funding models

Currently, funding to deliver diabetes programs is largely delivered through Primary Health Networks (PHNs), Local Health Networks (LHNs), and peak bodies, including Diabetes Australia.

ACCHOs report that some of these organisations provide funding on the proviso that ACCHOs deliver specific diabetes programs that may not be culturally appropriate. Feedback from member services suggests that PHNs and peak bodies often don't have the skills to engage with, commission or deliver services for Aboriginal and Torres Strait Islander communities. It has been the experience of our ACCHOs that there is a widespread reticence of PHNs to engage with external organisations generally – not just with ACCHOs. While there is a Guiding Principles document for PHN engagement with ACCHOs, it is out of date, does not reflect the Priority Reforms of the National Agreement and does not include accountability for engagement or any requirement for PHNs to demonstrate their performance against the Guiding Principles.

Similar problems occur when funding for services to Aboriginal and Torres Strait Islander people and communities is allocated to peak bodies. ACCHOs note the reporting burden often outweighs the value of the funding. Some NACCHO member services receive funding from as many as 70 different departments, agencies, and organisations, each with unique reporting requirements, often for relatively small funding amounts. ACCHOs are not resourced to manage this level of reporting.

Stronger accountability measures are needed which require ongoing, sustainable and embedded engagement and co-design with Aboriginal and Torres Strait Islander communities by PHNs and peak bodies. Accountability measures should also be developed to ensure equitable distribution of funding by such organisations.

However, fundamentally, current funding models do not align with the Priority Reforms of the National Agreement. Funding to deliver health services and programs for Aboriginal and Torres Strait Islander communities should be prioritised through the ACCHO sector to reduce fragmentation and ensure a focus on holistic, person-centred care. Funding currently provided to PHNs and peak bodies should be transitioned to the ACCHO sector in line with Priority Reform 2 and actions under the Primary Health Care 10 Year Plan.[50] Funding the sector directly ensures culturally appropriate prevention and clinical services for individual communities can be designed and developed to meet the specific needs of that community. We know that health care delivered through ACCHOs delivers better health outcomes for Aboriginal and Torres Strait Islander communities.

Supporting self-determination and building the capacity of the community-control sector is central to Australian governments' commitments in the National Agreement on Closing the Gap. Funding the ACCHO sector to determine, design, and deliver culturally appropriate services for Aboriginal and Torres Strait Islander people will build capacity to improve health outcomes and provide valuable workforce development opportunities.

NACCHO recommends the Australian Government redirects funding to support Aboriginal and Torres Strait Islander people with diabetes to the ACCHO sector.

Addressing social determinants

Food security

Our consultations with ACCHOs revealed the critical importance of addressing food security. No amount of health promotion will help people manage their diabetes, if nutritious, fresh healthy food is not accessible or affordable.

Food insecurity is linked to overall poorer health in adults and children. It contributes to being overweight, to obesity, higher gestational weight gain, as well as to weight loss. Food insecurity can affect stress levels and mental health, and lead to feelings of shame.

Food security is a complex issue that comprises multiple factors, including low household income, unemployment, inadequate transport to food stores – particularly those that offer food at a lower cost – and higher food costs in remote areas.[51, 52] Food security is also impacted by poor housing infrastructure, and insecure access to electricity and potable water. These factors are disproportionately experienced by Aboriginal and Torres Strait Islander people, particularly in rural and remote communities.

Low household income is compounded by the increasing cost of living. Recent data from the Northern Territory shows that the cost of healthy food is 52% higher in remote food stores compared to supermarkets in urban areas.[53] As such, households in remote communities may spend up to 50% of their income on food alone – the cost of food is considered affordable when no more than 30% of income is spent on buying food. In recent years, the cost of food has also increased

[50] Primary Health Care 10 Year Plan 2022-2032, Action area C: Close the Gap through a stronger community controlled sector, https://www.health.gov.au/resources/publications/australias-primary-health-care-10-year-plan-2022-2032?language=en

[51] AMSANT (2021) Food Security in the Northern Territory: consultation analysis and discussion paper AMSANT: Darwin
[52] Markham F, Kerins S (2020) Policy responses to food insecurity in remote Indigenous communities: social security, store pricing and Indigenous food sovereignty. Centre for Aboriginal Economic Policy Research, Canberra: Australian National University
[53] NT Dept Health (2022) Northern Territory Market Basket Survey 2021 Northern Territory Government: Darwin

faster than the consumer price index.[54] Remote households dependent on inadequate government support payments are at a particular disadvantage.

NACCHO welcomes the development of a remote food security strategy being led by the Aboriginal Medical Services Alliance Northern Territory (AMSANT) and the National Indigenous Australians Agency (NIAA).

Research conducted with Aboriginal stakeholders in Victoria and has made a range of recommendations for community and government action to improve food security for Victorian Aboriginal communities. These range from nutrition education programs to better regulation of packaged foods.[55]

Housing

There is comprehensive, evidence-based literature that demonstrates the powerful links between housing and outcomes for health.[1, 2] Inadequate housing impacts food insecurity.

Across Australia, only 6% of Aboriginal and Torres Strait Islander communities have access to the health hardware needed to be food secure.[56] This includes sufficient food storage and preparation space, refrigeration and access to a functioning sink or stove. With lack of health hardware, there is a greater reliance on convenient, unhealthy, takeaway foods.

Adequate, safe and environmentally fit for purpose housing must be treated as a key primordial prevention measure for Aboriginal and Torres Strait Islander communities.[57] Improved hygiene facilities, water infrastructure and living conditions can improve food security and support prevention of communicable diseases including scabies, trachoma and otitis media.

Addressing overcrowding and ensuring Aboriginal and Torres Strait Islander people have access to safe and affordable housing is key to reducing the burden of disease borne by Aboriginal and Torres Strait Islander communities.

Water

Access to safe, palatable water is essential for healthy eating. A water industry report released in late 2022 revealed that for more than 500 remote communities (around 25,000 Aboriginal and Torres Strait Islander people), tap water is often not safe to drink.[58]

NACCHO is pleased to note the recent Commonwealth investment of $150 million to close the gap on First Nations water security. Adequate water systems are a critical primordial prevention measure to address endemic health and oral health issues in Aboriginal and Torres Strait Islander communities.

A small co-designed infrastructure project is delivering fresh drinking water to communities without clean water to help reduce intake of sugary drinks in children. Designed to address poor oral health in children, the project installs refrigerated, filtered water fountains in schools and communities. In just four years, there has been a significant improvement in oral health behaviours, a reduction in

54 AMSANT (2021) Food Security in the Northern Territory: consultation analysis and discussion paper AMSANT: Darwin
[55] Browne J, Walker T, Hill, K, Brown A, Mitchell F, Thow, S, Ryan J, Beswick H et al. Food Policies for Aboriginal and Torres Strait Islander Health: Community Report. Deakin University and Victorian Aboriginal Community Controlled Health Organisation 2023.
[56] Housing for Health (2013) *Improving Nutrition: The ability to store, prepare and cook food* Viewed online at: http://www.housingforhealth.com/the-guide/health-housing/improving-nutrition-the-ability-to-store-prepare-and-cook-food/
[57] NACCHO, Core Services and Outcomes Framework https://csof.naccho.org.au/
[58] The Conversation, https://theconversation.com/countless-reports-show-water-is-undrinkable-in-many-indigenous-communities-why-has-nothing-changed-194447

tooth decay, and notably, a dramatic reduction in the proportion of children with severe gingivitis from 43% in 2014 to 3% in 2018.[59]

Health for all policies

Recent research, arising from observations of worldwide response to the COVID-19 pandemic, suggests extending Health *in* All Policies to a Health *for* All Policies approach. It contends that intersectoral collaboration to promote health should be bidirectional, i.e., that strengthening health policies and improving health outcomes can also have major and tangible co-benefits for other sectors.[60]

Not addressing structural change has ultimately led to a high burden of disease for Aboriginal and Torres Strait Islander people. Stronger policies to achieve better health outcomes can have far-reaching benefits.

[59] The Conversation, July 23, 2020, https://theconversation.com/collaborating-with-communities-delivers-better-oral-health-for-indigenous-kids-in-rural-australia-141038

[60] ALPA One Vision (2022) Health and Nutrition Strategy Viewed online at: https://www.alpa.asn.au/giving-back-through-benevolence