DAA Submission

Dietitians Association of Australia

Draft National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families

February 2015

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 5800 members, and branches in each state and territory. DAA is a leader in dietetics and advocates for better food and nutrition for healthier people and healthier nations. DAA appreciates the opportunity to provide feedback on the draft National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families.

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DAA interest in this consultation

DAA acknowledges that the health of Aboriginal and Torres Strait Islander Peoples is poor relative to that of non-indigenous Australians. DAA supports improvements to Indigenous participation, control and delivery of health services to close the gap in indigenous health. DAA is concerned that much of the burden of disease carried by Aboriginal and Torres Strait Islander people is related to poor nutrition and other social determinants of health.

Accredited Practising Dietitians improve the health and well being of Aboriginal and Torres Strait Islander children and families in urban, rural and remote locations by working with individuals and communities to improve nutrition and food security.

General comments

DAA supports the principles of the Framework.

DAA understands that the document is intended to complement the national Framework for Universal Child and family Health Services but questions whether it is really necessary. There seems to be a high degree of similarity between the draft National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families and the National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023. Duplication of effort requires Aboriginal and Torres Strait Islander communities and others to spread their attention across bureaucratic structures rather than focusing their limited resources on well structured programs, service delivery and evaluation. It also seems to be at odds with the government intention to cut red tape.

Whatever the final shape of this Framework, DAA would like to see consistent long term resourcing to support implementation and evaluation of health services for Aboriginal and Torres Strait Islander Children and Families. It is imperative that health services interface with other sectors to improve the health of Aboriginal and Torres Strait Islander Children and Families.

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Specific comments

Page/section	Comment
p7 Chapter 3	DAA agrees that the 'health and wellbeing of Aboriginal and Torres Strait Islander children and families is determined by a complex interplay of factors. Education and literacy, and health literacy specifically, are also highly relevant factors along with those listed.[1]
p8 Chapter 3.1 also p32 Chapter 4.8.4	Good nutrition is appropriately listed as a factor in shaping early childhood as the foundation for future health and wellbeing. However good nutrition is important even before conception, not just in infancy and early childhood.[2] DAA would like to see reference to the importance of breastfeeding listed in the dot point *Maternal health and behaviours* to reinforce the importance of this.[3,4]
p9 Chapter 3.3	DAA supports the proposed evidence based practice approach to planning, implementation and evaluation of health services. The text in 3.3 states that 'Systematic reviews of RCTs are considered to be the highest level of evidence and sit at the top of evidence hierarchies'. This might be true of drug trials but the evidence used must suit the purpose for which it is intended. There are difficulties in applying the evidence hierarchy described in 3.3. Some of this is noted, including a comment that 'It is unrealistic to suggest that all child and family health programs can be based on interventions with RCT level evidence'. DAA argues that it is not just unrealistic but inappropriate. Several writers have identified that there are difficulties in applying NHMRC guidelines for assessment and application of scientific evidence in the field of nutrition, and this was also the case in undertaking the very large review which informed the revision of the Australian Dietary Guidelines. In that case food intake data from cohort studies was considered more reliable.[5] In the case of Aboriginal and Torres Strait Islander Health both qualitative and quantitative evidence would be valuable.[6] It is important that evaluation from previous work is available and informs the planning of future endeavours without duplication of effort. For example, the evaluation of the National Aboriginal and Torres Strait Islander Nutrition Strategic Action Plan has not been made public but could be used to inform planning of this Framework.
p16 Principles	DAA considers the development of a strong Aboriginal and Torres Strait Islander health workforce is essential to closing the gap on Indigenous health, particularly in relation to nutrition. More needs to be done to build the capacity of Aboriginal and Torrens Strait Islander Health Workers and Nutrition Workers. More also needs to be done to have more Aboriginal and Torrens Strait Islander dietitians qualified and credentialed.[7] It is also important that the non-Indigenous workforce supports the health objectives of Aboriginal and Torres Strait Islander children and families. DAA agrees that cultural competence of the health workforce is important.
p17	Transport and disability should be added to the other factors considered in 'Social and other services' depicted in the table 'Services across the Continuum'

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p20 Chapter 4.5.3	DAA agrees with Chapter 4.5.3. Implementation of the framework must be resourced such that the workforce is deployed as close as possible to communities, under long term funding arrangements and with workers in sufficient numbers to achieve positive outcomes for Aboriginal and Torres Strait Islander people. New approaches to service delivery should be considered where this has the potential to improve health outcomes. For example DAA members report that telehealth has been shown to be an acceptable substitute for face to face service delivery of medical nutrition therapy. Some State health agencies use telehealth, and private practitioners also use this technology, but the rules under Medicare chronic disease items prohibit such substitution by allied health practitioners.[8]
p20 Chapter 4.5.5	DAA strongly supports cross agency coordination. Improving nutrition related health outcomes requires coordination of education, housing, transport, health, food industry, communication and other sectors.[7,9]
p21 Table 2	Planning and programs to support increasing the Aboriginal and Torres Strait Islander health workforce are important. This must not only address adults in the workforce, but also school children to build school attendance, literacy in general, and science and health literacy in particular, as a foundation for training in health professions.
p35 Chapter 4.11.2	Nutrition should be noted as a key risk factor which should be identified and addressed by service models, along with smoking, alcohol consumption and mental health.
p38 Chapter 4.12.2	The reference by NACCHO and the Royal Australian College of General Practice for preventive health assessments is limited with respect to nutrition guidance. Accredited Practising Dietitians (APDs) are qualified and credentialed to lead screening and preventive health assessments in relation to nutrition. It is appropriate to list overnutrition in the list of items for screening, but undernutrition and food security should also be listed. As noted elsewhere improving nutrition at the community level requires coordination of effort including education for nutrition literacy and measures to address food insecurity.
p40 Chapter 4.15.1	There appears to be an error in this section which states ‘Diabetes was less common among Aboriginal and Torres Strait Islander young people’. This is at odds with other evidence e.g. The burden of type 2 diabetes mellitus among Indigenous children and adolescents is much greater than in non-Indigenous young people and appears to be rising, although data on epidemiology and complications are limited. Young Indigenous people living in remote areas appear to be at excess risk of type 2 diabetes mellitus.[10] No reference is given for the statement about young people and risk factors but one assumes this might be from the Australian Aboriginal and Torres Strait Islander Health Survey.[11]

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