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Department of Health National Preventive Health Strategy

ACEM Online Survey Response

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

The Australasian College for Emergency Medicine (ACEM; the College) acknowledges the significant role of the National Preventive Health Strategy (NPHS; the Strategy) to provide a 10-year plan for shaping the health and wellbeing of the Australian population. We welcome the commitment for increased investment in prevention and recognition of the broader causes of health and wellbeing, however we are concerned that climate change, mental health and addressing the social determinants of health including Indigenous health inequities are notably missing from the Strategy.

As outlined in ACEM's Position Statement on Climate Change and Health, climate change represents the greatest risk to global population health. It is therefore extremely concerning that the primacy and urgency of prevention actions to mitigate the health impacts of climate change have been neglected in the NPHS. Ensuring a healthy environment is a key social determinant of health and as climate change is a complex issue, it is highly important to engage in prevention efforts earlier to mitigate its lasting impacts. Prevention efforts to address the health impacts of climate change must be a motion of the NPHS from its outset rather than simply acknowledged as an emerging issue.

ACEM supports the life-stages approach of the Strategy's vision, however interventions must start prior to early childhood and recognise the significant role of antenatal care. This is especially true in our Indigenous population, especially those living in rural and remote areas. Furthermore, a strategy that encompasses a life-stages approach will need to have climate change as a key target for a holistic vision. Climate change does not discriminate and impacts all populations. There is a myriad of direct and indirect health effects of which includes rising temperatures, poor air quality, and natural disasters. These will worsen several complex issues in physical, mental, and social aspects of human wellbeing. The effects will be seen in areas of livelihoods, housing security, increased risk of infectious and non-communicable disease, directly impact physical injury, disability and chronic disease, and further exacerbate mental health issues.

Climate change will especially negatively impact our vulnerable populations. Our ethnic communities may be driven out of homes and away from traditional and cultural lands. This will widen the health inequity gap as this will involve significant changes to usual practice for our Indigenous peoples. The Strategy seems to disregard the urgency which climate change imposes, despite this being critical to enabling Australians to live in a climate and environment that preserves and protects their health and wellbeing. In order to adequately recognise and address the primacy and urgency of prevention actions against the health impacts of climate change in achieving the Strategy's vision, we recommend an aim must be that "Australians continue to live in a climate and environment that preserves and protects their health and well-being".

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

It is ACEM's view that the goals of the Strategy are too vague and need to be more specific if they are to be achieved. While they are worthy goals, they do not address the underlying health gaps that persist in Australia and direct focus away from valuable investments in prevention that address the underlying determinants of health and wellbeing.

We suggest the following alternate wording for goals 1-4:

1. Prevention is complex and to address these challenges we need collaboration between government and non-governmental sectors, to avoid duplication and work synergistically together.
2. Our primary, community, and acute health care settings should be adequately resourced to implement effective preventative health strategies, including primary and secondary prevention.
3. We need to urgently address climate change and its health impacts so that people can live in an environment that is healthy, thriving, and sustainable.
4. All communities should be encouraged to engage in prevention, recognising there are large health inequities to be bridged, especially among Indigenous Australians, the homeless, and those with lower socioeconomic status (SES).

ACEM comments on goals five and six:

5. This aim is identified to be too broad and difficult to achieve. There are large inequity issues and communities struggle to have an adequate level of health literacy. This is particularly seen within culturally and linguistically diverse (CALD) groups, Indigenous populations, lower SES, and those in rural, regional, and remote communities. Enabling individuals to make "the best possible decision" about their health does not adequately address inequity as extent to which these "choices" are truly available to the community varies considerably. The underlying risk factor that is shared across many modifiable risk factors for poor health is repeatedly poverty. Supporting social mobility, provision of adequate housing, a liveable social security safety net and experimenting with concepts like universal basic income would better address the causes of the causes.
6. Rather than adapting to emerging issues and new science, the aim should focus on current major issues including climate change, chronic disease, health inequity, and the growing mental health epidemic. Prevention efforts for these issues are critical from the outset rather than simply acknowledged as an emerging issue.

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

ACEM believes that Australia must invest in and build effective health information systems. The COVID-19 pandemic has shown the limitation of existing state-based infection disease surveillance systems and the importance of having a national disease response authority. We acknowledge the substantial national investment required to establish this, but it will enable local data at the community, district, and state level to be captured and further inform comparisons and document efficacy of locally trialled preventative health measures. Alongside national monitoring and evaluation systems, better resourced health information systems will capture data which can inform tailored decision-making for local regions. It is important for this data to be readily available, replicable, and established with clear targets and goals that align with the NPHS. This will support ongoing monitoring, evaluation and accountability at several levels of government.

As the peak professional organisation for emergency medicine in Australasia, ACEM believes that emergency departments (EDs) present particularly valuable opportunities for further enhancement

and expansion of health prevention and promotion activities. This is due to the ED patient population being disproportionately affected by risk factors, such as smoking or alcohol harm and more likely to be from a vulnerable or marginalised group who have less opportunity to encounter others within the health system.[1] We recommend that the mobilisation of EDs for health prevention action must be supported by adequate and separate resource to be effective and beneficial. We also recommend that the Strategy recognise the crucial role of EDs and engage in the unique expertise of emergency physicians within planning and preparation for large scale emergencies across the health system as part of the expanded agenda for preventative health actions.

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

The National Aboriginal Community Controlled Health Organisation's (NACCHO) definition of health encompasses physical, social, emotional, and cultural wellbeing of the whole community throughout a life cycle. With the recent impacts of the pandemic on mental health, ACEM would like to see a boosted focus on the promotion of mental, social, emotional, and cultural wellbeing.

Loneliness has become a recognised risk factor for mental and physical health issues. We suggest fostering positive psychological and social wellbeing campaigns to reduce the negative impact and implications loneliness can cause for physical health and other manifestations of disease later in life.

Following on from the NACCHO definition, reducing the impacts of climate change on health is an area of important and urgent focus. The negative health impacts of climate change are already being experienced by Australians and therefore requires accelerated preventative action. The Strategy must aim to mitigate the expected increasing and compounding impacts on the health and wellbeing of all Australians at all stages of life and particularly for those most vulnerable and with the greatest needs.

Unfortunately, the Strategy does not adequately address prevention issues faced by Aboriginal and Torres Strait Islander Peoples. Racism is a key social determinant of health for Aboriginal and Torres Strait Islander people so cultural competency, cultural bias, discrimination and racism must be prioritised as core components of all focus areas.

ACEM is supportive of the Strategy identifying 'reducing alcohol and other drug-related harm' as a key focus area, particularly as our member's clinical experiences have shown this to be one of the largest, preventable public health issues facing EDs in our region. ACEM is a member of numerous health and allied agency collaborations that share concerns about these harms and we support evidence-based approaches to harm minimisation through the multi-pronged approach of harm reduction, demand reduction and supply reduction.

ACEM supports an approach to harm minimisation that centres on people-focused policies and interventions which recognise the socioeconomic and cultural context of alcohol and other drug (AOD) use rather than extending prohibitionist and punitive approaches. As outlined in ACEM's Statement on Alcohol Harm, we recommend that Australian governments' efforts in relation to reducing the harm caused by alcohol should be focused on the following actions:

1. Protect children and young people from alcohol advertising
2. Reform alcohol taxation and pricing
3. Raise awareness of the harms caused by alcohol
4. Introduce controls on online sale and delivery of alcohol products
5. Strengthen controls on alcohol availability in Australian communities.

ACEM is also supportive of measures which seek to create safer environments to reduce harms from drug use such as needle and syringe exchange programs, community prescribing of naloxone (opiate

[1] Rhodes et al. Preventive care in the Emergency Department, Part I: Clinical preventive services – are they relevant to Emergency Medicine? Academic Emergency Medicine 2000; 7; 1036-1041.

antidote), medically supervised safe injection rooms and drug checking services (i.e. pill testing). Evaluations of these programs consistently demonstrate a reduction of transmission of blood-borne disease, reduced dependence and addiction and reduced deaths from overdoses.[2,3] Importantly, research has shown that drug use does not increase with the presence of such programs.[4]

5. How do we enhance current prevention action?

There are numerous amounts of effective preventive health programmes, however, there are often barriers in scalability and sustainability. Successful pilot programmes require enhanced funding to continue or will risk community distrust in government-led preventative health initiatives. Unsuccessful programmes must be evaluated and lessons learnt, shared, and incorporated into future interventions. National preventive health plans must be made widely available, sufficiently resourced and funded, and engage with local communities to tailor to the local population's needs. We suggest programme outcomes have a consistent level of quality irrespective of where the programme is delivered. We identify poorer health outcomes in rural, regional, and remote communities as compared with metropolitan. We attribute this to the lack of preventive health services access and would like the Strategy to address these inequities.

While the primary image of ED is to provide treatment to acutely injured or ill patients, health promotion is an active duty occurring throughout the ED patient presentation. ED physicians will often provide referral to resources which patients can reach out to and receive continuation of care. This includes smoking cessation counselling, alcohol harm, and screening and referral for hypertension.[5] [6]

We recommend that further opportunities and strategies for prevention action in EDs is considered. While this would require further funding and resources, it will enable timely and onward referral pathways for dedicated health prevention services.

To avoid duplication and provide effective preventive action, we suggest better coordination of care between ED, primary care providers, and community health services. EDs can be better resourced to provide equitable and effective preventive health interventions within a wide range of health issues for all groups but especially marginalised communities. This includes, but not limited to, care within AOD, antenatal care, domestic violence, and chronic disease management. A cohesive mental health strategy is also absent in the present iteration of the NPHS and would need significant addressing to truly be effective.

We recommend that each of the focus areas has a research program directed to improving the effectiveness of the current prevention measures and/or strategy. For example, in relation to reducing AOD-related harm, the focus might be on evaluating which interventions, and which combination of interventions, are most cost effective. Furthermore, current data collection and coding systems do not accurately capture the true burden of AOD-related ED presentations, leading to systematic underreporting of this issue and difficulty to assess the true burden and monitor effectiveness of preventive strategies. ACEM therefore recommends implementing compulsory collection of minimum AOD presentation data through addition of AOD data elements to the National Non-Admitted Patient Emergency Department Care (NAPEDC) Dataset.

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2 Department of Health, Australian Government. Review of methadone treatment in Australia. Canberra: Department of Health; 1995. Available from: https://www1.health.gov.au/internet/publications/publishing.nsf/Content/drugtreat-pubs-methrev-toc

3 Fernandes R, Cary M, Duarte G, Jesus G, Alarcão J, Torre C, et al. Effectiveness of needle and syringe programmes in people who inject drugs – an overview of systematic reviews. BMC Public Health. 2017; 17(309):1-15.

4 Harm Reduction Australia. What is harm reduction?. Harm Reduction Australia; 2018. Available online: https://www.harmreductionaustralia.org.au/what-is-harm-reduction/

5 Irvin et al. Preventive care in the Emergency Department, Part II: Clinical preventive services - an emergency medicine evidence-based review. Academic Emergency Medicine 2000; 7: 1042-1052.

6 Bensberg et al. A framework for health promoting emergency departments. Health Promotion International 2002; 17(2): 179-188.

6. Additional Feedback/Comments

As described above, the neutrality of the Strategy means that it fails to present an inclusive vision for prevention in Australia. It is ACEM's view, as echoed by many within the health sector, that the NPHS does not present ways of truly addressing the major health challenges that can, should, and must be prevented over the next decade – climate change, mental health, poverty, inequity and Indigenous justice.

In developing a focus area on wellbeing and cultural wellbeing, co-design with ACCHO should be undertaken. Recommendations on broader issues that contribute to health have already been provided by Indigenous leaders and must include addressing underlying social justice issues such as racism, incarceration, land rights, and the Uluru Statement from the Heart.