What's health got to do with it?

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Introductory words…

What do health—and specifically the community controlled health sector—and the education system in the NT, have to do with each other? The answer would be more obvious to educators in Aboriginal communities in the NT compared to teachers in urban mainstream schools, given both the higher disease and disadvantage burden suffered by children in remote communities, and the closer relationships of clinics and schools that serve the same small populations.

In such circumstances schools and clinics work together in many practical ways. But the relationship between health and education and what can be learnt from each other needs is much broader. And it needs to be strengthened—which is one of the aims of this conference.

In this presentation I want to tell you about our sector and its key characteristics, including community control, that we think have lessons for other sectors, including education.

I also want to talk about early childhood and its effect on health and how service delivery in early childhood plus other areas related to family functioning can improve educational outcomes.

And I want to say a few words about how schools and ACCHSs can work together including on advocacy around common causes that will improve both the health and educational outcomes of our children.

Community controlled health services are governed by boards elected from the community they serve. This means that Aboriginal control and leadership comes from both the top as well as the bottom. This drives not only better and more culturally appropriate health services, but the ability of our services to advocate for and with their communities on key issues affecting health and wellbeing. This could range from reducing the impacts of alcohol, to advocating on better housing and environmental conditions. This advocacy has power because it comes from the community and AMSANT collectively has an authoritative voice as a peak body.

Last year AMSANT celebrated its 20th anniversary with a conference that also marked over 40 years of community controlled health services in the NT. The Central Australian Aboriginal Congress, or Congress, was started in Alice Springs in 1974. We

now have a network of community controlled health services stretching across the NT, operating in every town in the NT and many remote communities, with our sector providing around half of the total primary health care services for Aboriginal people in the NT.

Our services generally provide a wider range of services than government clinics, including social and emotional wellbeing, mental health, and alcohol and other drug services, youth services, as well as early childhood programs and family support programs. Our model is based on multidisciplinary teams centred on a strong Aboriginal workforce. Importantly, Aboriginal people are at all levels of our organisations, including at the CEO level and particularly on governing boards.

We believe that this model is leading the way in comprehensive health service delivery. We have demonstrated good health outcomes and have been leading key developments in the theory and practice of comprehensive primary health care, including in eHealth and digital technologies. We have a seat at the table in a high-level health planning body, the Northern Territory Aboriginal Health Forum, that brings the Commonwealth and NT governments and AMSANT together in planning and decision-making around Aboriginal primary health care.

On any comparison in Aboriginal affairs, this is a success story.

There are many factors underpinning this success and it is worth reflecting on what the key factors are.

Aboriginal community control and leadership are significant contributors.

So too is the cultural security and cultural competence of our services.

The commitment to evidence-based action by our sector and the health profession in general is critical to effective and demonstrable outcomes.

Providing effective services also relies on ensuring that funding is adequate and equitable.

A focus on growing and supporting a strong Aboriginal workforce is key to strong Aboriginal organisations.

And finally, a commitment to resourcing quality initiatives and use of data as tools to drive an improvement culture.

I think I can confidently say that the success of our sector would not have been possible if even a single one of these factors was absent.

And what I'd like to suggest to you is that these same factors should be front and centre in the Aboriginal education sector. Let me go through the list.

I've already covered the key advantages of community control, but it's worth mentioning that a further advantage of community control is that it of itself improves outcomes in communities, because control and empowerment are key social determinants of health.

Research in Canada found that Aboriginal communities with the lowest rates of suicide in young people were those communities with the greatest control over services in the community – not just health but also services such as police, child protection and education. Aboriginal organisations controlled by the community provide a vehicle for Aboriginal people to lead on behalf of their community and to ensure services meet the needs of their community, are culturally appropriate and reach out to the whole community.

This leads to our second key factor: a high degree of cultural security and cultural competence.

It's important to note that Aboriginal community controlled heath services emerged, some forty years ago now, because mainstream health services had failed Aboriginal people. And the institutional racism that drove their development remains a factor in Aboriginal people not accessing mainstream health services, or receiving a lower level of service delivery to that of non-Aboriginal people when they do access health care.

Studies show lower rates of surgical procedures for eye problems and heart problems that are not justifiable on clinical grounds. Research also shows that Aboriginal people feel confident in the care delivered by ACCHSs generally, but often have poor experiences in mainstream health services. We believe that Aboriginal leadership is critical to ensuring our services are welcoming, culturally safe and competent. It helps ensure that an Aboriginal world view is reflected in our services.

So should we consider that schools are any different? Of course not. If a school is not welcoming, if it doesn't connect with children's cultural world view, should we really be surprised that school attendance levels are low?

Let's look at the third factor: the commitment of our sector and the health profession in general to evidence-based action.

Health practice is something that is rigorously evidence-based. Professor Russell Bishop yesterday gave us a humorous but apt example – what if we decided to follow someone's bright idea about how we might do appendix operations more simply or cheaply? It's unthinkable.

Yet in education, as Professor Bishop also noted, the so-called "good ideas" that we often see coming out of education policy, are often politically developed, not evidence based.

Where is the evidence that removing secondary schools from remote communities and replacing them with regional boarding schools will improve outcomes? Does this not smack of an ideological, or perhaps just a convenient cost cutting measure? It suggests a pre-determined outcome in search of a solution or problem to fix.

Indeed, perhaps a better answer comes from our fourth key factor: ensuring that funding is adequate and equitable.

Have we ever seen properly resourced secondary education in remote communities? I think not. Some of you may remember an analysis carried out some years ago on funding for schools at Wadeye. It showed that, per capita, Aboriginal kids at Wadeye were getting only 25 per cent of the funding kids received in the northern suburbs of Darwin.

Or you may recall the so-called Homeland Learning Centres in remote communities that were not classified as schools and therefore were not funded for basic school infrastructure or full-time teachers.

This is institutional racism, plain and simple.

And it ensures that schools remain badly under-resourced and therefore incapable of achieving acceptable learning outcomes for children.

Our experience in health has shown that without adequate and equitable per capita funding, it is simply not possible to provide comprehensive PHC services, and health outcomes suffer as a result.

It is the same with schools.

Let's turn to the fifth factor: a focus on growing and supporting a strong Aboriginal workforce.

We believe this is a fundamental component of community control and of creating services that are culturally appropriate. The health sector is also one of the biggest employers and has significant potential to provide sustainable Aboriginal employment in remote communities.

Schools can and should provide similar contributions to sustainable Aboriginal employment and career pathways.

Finally, our commitment to resourcing quality initiatives and use of data as tools to drive improvement. Continuous quality improvement is embedded in our way of working.

We have heard earlier about the Australian Early Development Index, or AEDI. This is an important and useful tool for monitoring and analysis. However, it is not linked to a quality improvement process that can translate the findings into improved practices and outcomes on the ground.

At the moment we can only dream of an education system for Aboriginal children in the NT that is based on the factors I have outlined that have driven the success of the Aboriginal community controlled health sector.

We need to turn that around.

But there's more to the story of what health has go to do with it.

As it turns out, health is critical to education.

And education is critical to health.

The evidence is very clear that improving educational levels will improve long-term health and life expectancy. This is particularly so for girls. We know that attainment of Year 12 education for girls is the best predictor of improved outcomes in health, wellbeing and educational achievement for their children.

By far the most critical period for its impacts on health and education is early childhood.

The scientific evidence is now very clear that pregnancy and the first three years are critical in determining a child's future health and well being, educational and employment outcomes.

We know that the roots of the chronic disease epidemic Aboriginal people are dealing with now, start from pregnancy. Our scientific evidence is growing about the complex relationships between environment and genetics through the emerging field of study known as epigenetics.

Epigenetics has shown us that an adverse environment during pregnancy and early years can switch on genes that will increase the likelihood of early development of chronic disease and a range of other poor health and wellbeing outcomes.

We also know that pregnancy outcomes for Aboriginal women in the NT are still significantly worse than those for mainstream women, with 12% of babies being low birth weight and 15% born prematurely, which is about 3 times and two and a half times the rate of non-Aboriginal kids respectively.

Around one in five children under five are anaemic, although encouragingly, the rates are now starting to fall slowly. Childhood anaemia is important because it affects brain development – with some of this cognitive loss being irreversible even with treatment. There is likely to be some cognitive loss by the time anaemia is detected.

Children also suffer high rates of infectious diseases, are frequently hospitalised, 4% of children under 5 are underweight, and there is a growing obesity problem starting even in children now, with growing number of cases of Type 2 diabetes in teenagers.

Ear disease usually starts in the first year and too often develops into chronic ear disease with hearing loss which significantly impacts on classroom learning. The rate of ear disease in many parts of remote NT is amongst the highest in the world – well above the 4% rate that the World Health Organization determines is a public health emergency.

Child protection notifications in the NT are the highest in the nation by a long way and sadly are continuing to climb whilst stabilising in other jurisdictions. Governments are spending a lot on social services for children, but mostly at the "pointy end" – investigations of notifications, child removals and supporting out of home care – rather than being directed towards supporting families before they hit crisis point.

Other issues that you are familiar with are the toxic effects of alcohol on pregnancy resulting in a wide range of effects on the developing brain, including Foetal Alcohol Spectrum Disorder. Alcohol misuse as also a cause of family dysfunction, neglect and exposure of children to family violence.

However, perhaps less generally well known are the effects of stress on young children, with a major US study showing that children exposed to more adverse events, such as death or imprisonment of a parent, are more likely to experience poor health and social outcomes such as alcohol and other drug problems, suicide, heart disease and teenage pregnancy.

A West Australian child health study has found that 20% of Aboriginal young people aged 12 to 17 years in WA were exposed to seven or more adverse events in the previous 12 months, whereas only 0.02 percent of non-Aboriginal children had this level of exposure – **a rate of 1000 times more**. This provides a sobering perspective on the shockingly high rates of suicide amongst young Aboriginal people.

However, importantly, the study found that living in a very remote area (such as homelands) as opposed to larger remote, regional or urban communities, reduced the risk of some adverse health findings, including smoking, alcohol and drug use.

Other major factors impacting on early childhood development include the quality of care-giving which is impacted by a wide range of factors such as parental stress, support or lack of support for families (including family but also professional support), and educational levels of parents.

We know that all of these factors can damage the child's development and long term potential, flowing onto poor scholastic outcomes for many remote Aboriginal students.

At this point I want to pause to acknowledge the need to see and understand the strengths and resilience of Aboriginal peoples and communities—and to recognise the central role of connection to culture, cultural identity and cultural continuity in maintaining these strengths and keeping people well, including children.

In the unrelenting focus on negative statistics we often forget this important point.

Professor Ngiare Brown, one of our deadly young Aboriginal doctors, recently noted that, and I quote: “people talk about being Indigenous as if it is a risk factor. Being Indigenous is only a risk factor in a racist, discriminatory world”.

For us, being Indigenous is actually a protective factor—a great source of strength, resilience and wisdom.

We know that connection to culture is very significant in maintaining resilience and protection from the adverse impacts of traumatic experiences.

And we also know that burden of illness and social disadvantage that we face is also seen in other marginalised and colonised populations.

Redressing this situation, closing the gap, or whatever other slogan we might adopt, faces the same realities. First and foremost, solutions must involve Aboriginal people as leaders and as communities in driving the changes that need to be made. Top down solutions will not work.

We’ve heard it time and time again, at last night’s dinner most powerfully articulated by Bob Somerville. Bob used the analogy of the pilot. I use the analogy of the driver – put us back in the driver’s seat.

We want to see an Aboriginal community controlled peak body in education, that can drive this agenda for our people and that can stand beside AMSANT and other Aboriginal Peak Organisations in advocating for broader change.

This should be a leading recommendation from this conference.

It is the precursor to developing a culture within education that will produce policies based on evidence and that are Aboriginal led, rather than based on ideology or milking the Aboriginal dollar for the benefit of the northern suburbs of Darwin.

In truth, dealing with the social determinants of health is our biggest hurdle.

Just as governments refuse to commit adequate funding to remote education, so they avoid expenditure in other areas of the social determinants. Providing adequate housing alone constitutes a huge unmet need and cost that appears as unattainable as ever.

We have to be strong advocates and strategic thinkers.

Inadequate or not, government expenditure is still considerable.

Where we can more easily make a difference is advocating for better use of existing funding. We know that so many of the programs and services that we see in Aboriginal communities are inadequate.

For example, an audit in 2011 found over 1000 programs directed to children under 15 years of age that were being delivered in remote communities, many of which were insufficiently evidence-based, or delivered only to a small number of communities or with insufficient intensity to have an impact. Many are provided by mainstream NGOs on a fly-in-fly-out / drive-in-drive-out basis without strong knowledge of those communities, or any Aboriginal governance.

There is considerable potential to re-direct and better coordinate such funding into evidence based programs delivered by Aboriginal organisations—either existing ones or new organisations that can be developed to take on such roles. **Put us back in the driver's seat.**

Aboriginal community controlled health services have an important role in providing the early health care for children. This includes early childhood programs, such as the Australian Nurse Home Visitation program, and the Abecedarian program. Other programs within comprehensive Aboriginal PHC are important to support families – including social and emotional wellbeing services, alcohol and other drug support and family support services.

There are many areas where we can be working more closely together. Schools and Aboriginal PHC services are the main service delivery organisations actually located in communities. Given the health challenges faced by many of our children and also by their parents, there is a good case to be made for a close working relationship. More broadly, schools can have a major role in promoting healthy behaviours, including around nutrition, physical activity and respectful relationships.

In conclusion I want to return to those things that we believe are the foundations of a Healthy Kids Smart Kids agenda:

Aboriginal community control and leadership.

Culturally secure and competent services and schools.

Evidence-based action.

Adequate and equitable funding.

A strong Aboriginal workforce.

And a commitment to a quality improvement culture.

With these things in mind, it is through the collective efforts of us all here today that we can secure a better future for our children.

Thank you.