



CRE-DH

Centre of
Research Excellence in
Disability and Health

SUBMISSION TO THE DRAFT NATIONAL PREVENTIVE HEALTH STRATEGY 2021–2030

in partnership with



About the submission

This submission is made on behalf of researchers from the Centre of Research Excellence in Disability and Health (CRE-DH) funded by the National Health and Medical Research Council, 19 April 2021.

About the CRE-DH

The Centre of Research Excellence in Disability and Health (CRE-DH) aims to identify cost-effective policies to improve the health of people with disabilities in Australia. There are four interconnected research areas in the CRE-DH focused on:

1. mapping the health inequities between Australians with and without disabilities,
2. analysing the social, economic and environmental factors that contribute to the poorer health of people with disabilities,
3. modelling the cost-effectiveness of health policy interventions, and
4. policy analysis and reform.

The CRE-DH is funded by the National Health and Medical Research Council. We are an interdisciplinary research group comprised of academics from five universities, a team of international advisors and a Partner Advisory Group of stakeholders from the disability and health sectors. The CRE-DH Co-Directors are Professor Anne Kavanagh (University of Melbourne) and Professor Gwynnyth Llewellyn (University of Sydney). The CRE-DH includes Chief Investigators from the University of Melbourne, University of Sydney, Monash University, UNSW Canberra and RMIT with multidisciplinary skills in epidemiology, health economics, health and social policy, psychology, psychiatry, public administration and public health. In addition, we have Associate Investigators from a range of national and international universities and the World Health Organization. We work in collaboration with key stakeholders including DSS, ABS, AIHW and peak bodies in the disability advocacy and service sector through our Partner Advisory Group. Several members of the CRE-DH research team and the Partner Advisory Group also have lived experience of disability.

Contact details

Centre of Research Excellence in Disability and Health
The University of Melbourne VIC 3001
cre-dh@unimelb.edu.au
credh.org.au
@DisabilityHlth

Submission to the Draft National Health Preventive Strategy 2021-2030

VISION

4. Do you agree with the vision of the Strategy?

We generally agree with the vision in particular with respect to addressing the broader causes of poor health and wellbeing. We believe however that reducing health inequalities should also be part of the vision. Employment, Housing, Discrimination and Violence are important determinants of health and well-being especially for people with disability [1-6]. We also believe that the fact these approaches should be 'evidence-based' should be in the vision statement.

1. Aitken Z, Baker E, Badland H, Mason K, Bentley R, Beer A & Kavanagh A. Precariously placed: Housing affordability, quality and satisfaction of Australians with disabilities. *Disability & Society* 2018; 22 Dec: 121-142. <https://doi.org/10.1080/09687599.2018.1521333>
2. Kavanagh AM, Aitken Z, Baker E, LaMontagne AD, Milner A & Bentley R. Housing tenure and affordability and mental health following disability acquisition in adulthood. *Soc Sci & Med* 2016; Feb;151:225-32. <https://doi.org/10.1016/j.socscimed.2016.01.010>
3. Emerson E, Fortune N, Aitken Z, Hatton C, Stancliffe R & Llewellyn G. The wellbeing of working-age adults with and without disability in the UK: Associations with age, gender, ethnicity, partnership status, educational attainment and employment status. *Disabil Health J* 2020; Feb. <https://doi.org/10.1016/j.dhjo.2020.100889>
4. Emerson E, Milner A, Aitken Z, Vaughan C, Llewellyn G, & Kavanagh A. Exposure to discrimination and subsequent changes in self-rated health: prospective evidence from the UK's Life Opportunities Survey. *Public Health* 185 (2020) 176-181.
5. Kavanagh AM, Priest N, Emerson E, Milner A & King T. Gender, parental education and experiences of bullying victimization by Australian adolescents with and without a disability. *Child: Care Health Dev.* 2018 Mar; 44(2);332-341. <https://doi.org/10.1111/cch.12545>
6. Milner A, King TL, LaMontagne AD, Aitken Z, Petrie D & Kavanagh A. Underemployment and its impacts on mental health among those with disabilities: evidence from the HILDA cohort. *J Epidemiol Community Health* 2017; 71:1198-1202. [10.1136/jech-2017-209800](https://doi.org/10.1136/jech-2017-209800)

AIMS

5. Do you agree with the aims and their associated targets for the Strategy?

We strongly disagree with the first two targets because for some of those born with a disability, these targets may be unattainable (and focusing on these goals may increase inequities for those with a disability and inequities in general because of their focus on achieving 'full health'). Further, the strategy does not define "in full health". Defining this concept and what it means for people with disability would help achieving better health for everybody. We do agree with the last two goals and targets. We welcome the focus on health equity and note that a large proportion of people with disability will be in the two lowest SEIFA quintiles and regional areas. Though we would also welcome a focused target on the health outcomes of those with disability. There is evidence that those with an intellectual disability live on average 26 years less than other Australians (Trollor et al. 2017) and people with disabilities in general often experience worse social determinants of health. We welcome the investment in preventive health.

Overall, having a rationale for each of the targets in the strategy would help understand where the aims and targets come from.

1. Fortune N, Singh A, Badland H, Stancliffe RJ & Llewellyn G. Area-level associations between built environment characteristics and disability prevalence in Australia: An ecological analysis. *Int J Environ Research and Public Health* 2020 17(21), 7844. [doi: 10.3390/ijerph17217844](https://doi.org/10.3390/ijerph17217844)
2. Trollor, Julian, et al. Cause of death and potentially avoidable deaths in Australian adults with intellectual disability using retrospective linked data. *BMJ Open* 7.2 (2017): e013489.

PRINCIPLES

Six principles are included in the Strategy to underpin the Framework for Action by 2030. The principles are designed to guide implementation and strengthen current efforts.

6. Do you agree with the principles?

Agree. We agree with the principles though we think that evidence-based strategies should have a stronger focus. We believe that multi-sector collaboration should be the priority especially when it comes to the health of people with disability as disability-related policies intersect

with many areas, not only health and involve several layers of government policy. Our recent work on public transport access and healthcare use highlight the need for public transport availability to help access health care and diminish the gap in healthcare use for those with and without disability which aligns with the other principles of empowering and supporting Australians as well as the 6th principle on equity lens.

The intersection between empowering and supporting Australians is particularly relevant to people with disability who are at far higher risk of experiencing violence.

The lack of training of the health workforce to deliver appropriate and effective health services to people with disability has been outlined in several of our work and we believe disability-specific training should be part of the medical staff curriculum.

1. Badji, S., Badland, H., Rachele, J. N., & Petrie, D. (2021). Public transport availability and healthcare use for Australian adults aged 18–60 years, with and without disabilities. *Journal of Transport & Health*, 20, [101001]. <https://doi.org/10.1016/j.jth.2020.101001>
2. Krnjacki, L., Emerson, E., Llewellyn, G., Kavanagh, A.M. Prevalence and risk of violence against people with and without disabilities: findings from an Australian population-based study. *Aust N Z J Public Health* 2016, 40(1), 16-21. <https://doi.org/10.1111/1753-6405.12498>.
3. Hughes, K., Bellis, M.A., Jones, L., Wood, S., Bates, G., Eckley, L., McCoy, E., Mikton, C., Shakespeare, T., Officer, A. Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies. *Lancet* 2012, 379(9826), 1621-1629. [https://doi.org/10.1016/s0140-6736\(11\)61851-5](https://doi.org/10.1016/s0140-6736(11)61851-5).

ENABLERS

Mobilising a prevention system is a key driver in achieving systemic change and better health outcomes for all Australians. Seven system enablers are identified in the Strategy that are critical to creating a more effective and integrated prevention system for Australia over the next 10 years. Each enabler is accompanied by desired policy achievements by 2030. The enablers and the policy achievements are outlined in more detail on pages 31-42.

7. Do you agree with the enablers?

Strongly Agree. We agree with the enablers and believe they are what is needed to improve further the delivery of quality primary healthcare to all Australians. We emphasise the importance of monitoring and surveillance to better guide policy and our work on the Monitoring Framework to measure and track inequalities between people with and without disability in relation to exposure to social determinants of health and wellbeing has shown the

importance of having good data to help with research and further guide policy practise.

8. Do you agree with the policy achievements for the enablers?

Agree. We agree with the desired policy achievements. Having a health lens applied to all policy is of utmost importance given the importance of the social determinants of health.

The enhanced continuity of care is particularly important for people with comorbidity who are disproportionately represented by people with disability.

FOCUS AREAS

The Strategy identifies seven focus areas, where a stronger and better-coordinated effort will enable accelerated gains in health, particularly for communities experiencing an unfair burden of disease. These focus areas have been identified to boost prevention action in the first years of the Strategy and to impact health outcomes across all stages of life. Specific targets and desired policy achievements are also identified for each focus area.

9. Do you agree with the seven focus areas?

Disagree. We agree with the focus areas and welcome that the report highlights that the seven focus areas do not equally affect all Australians but that there is instead a lot of heterogeneity. We would like to highlight that people with disability (not only those with mental disorders) are also a group which is most at risk of adopting unhealthy behaviours such as sedentary living, poor diet, smoking, some of this behaviour stemming from lower income. One area we think deserves greater attention as a cause of poor health is meaningful employment and this is especially the case for people with disability.

Milner A, King TL, LaMontagne AD, Aitken Z, Petrie D & Kavanagh A. Underemployment and its impacts on mental health among those with disabilities: evidence from the HILDA cohort. *J Epidemiol Community Health* 2017; 71:1198-1202. [10.1136/jech-2017-209800](https://doi.org/10.1136/jech-2017-209800)

10. Do you agree with the targets for the focus areas?

We disagree with the targets for the focus areas. The towards zero suicide target is not specific enough and zero suicide is not achievable. A reduction in suicide rate could be achievable but would need some focus on discrimination and violence.

This target is listed for the 7th focus area on protecting

mental health. We would argue that employment can be particularly relevant to protect mental health including for those with disability.

Milner A, LaMontagne AD, Aitken Z, Bentley R, Kavanagh AM. Employment status and mental health among persons with and without a disability: evidence from an Australian cohort study. *Journal of Epidemiology and Community Health*. 2014 Nov;68(11):1064-1071. DOI: [10.1136/jech-2014-204147](https://doi.org/10.1136/jech-2014-204147)

11. Do you agree with the policy achievements for the focus areas?

Disagree. We agree with most of the desired policy achievements for the focus areas. However, we believe that there should be targets for people with disability. Although the strategy recognises the importance of ‘the causes of the causes’, the focus areas for action are mainly about lifestyle risk factors whereas the social determinants of health are crucial to improve the health and well being of people with disability. Given the gaps in the social determinants of health between those with and without disability, a high level commitment to action on social determinants and reduce inequalities in this draft would be welcomed.

CONTINUING STRONG FOUNDATIONS

There are many effective and well-designed prevention-based programs and strategies developed by government, non-government organisations and communities that are currently in progress. This element of the Framework for Action acknowledges the immense activity that is already under way to better prevent illness and disease in Australia. It is outlined further on page 66.

12. Do you agree with this section of the strategy?

We agree with this section of the strategy.

FEEDBACK

13. Please provide any additional comments you have on the draft Strategy.

We are grateful for the opportunity to share our thoughts through this submission and hope this will contribute to the improvement of the health and well being of all Australians and in particular those with disabilities.

More than 4 million Australians have disability, or around 18% of the population [1]. Compared with those without disability, people with disability experience poorer health and increased exposure to health risks. They experience greater disadvantage with respect to well-established social determinants of health – for example, they are more likely than those without disability to experience poverty [2-6], violence [7, 8], social exclusion [2], housing insecurity [5, 6], unemployment and economic inactivity [5, 6, 9]. In

addition, lack of equitable and timely access to appropriate health care, particularly preventive care and proactive management of health risks and chronic conditions, has been identified as contributing to poor health outcomes for people with disability [10].

Strong, affirmative action is required to redress the health inequities experienced by Australians with disability.

That is,

1. Action on the social determinants known to impact negatively on the health of people with disability – including unemployment, poverty, poor housing and social exclusion.
2. Action to ensure that preventive health programs (e.g., cancer screening) are appropriately targeted, tailored and adapted so that they are effective in improving health outcomes for people with disability and reducing health inequalities.

The *draft National Preventive Health Strategy* recognises that health inequalities are experienced by certain groups within society, including people with disability (p.5), and several ‘Target populations’ are listed as groups who ‘experience a disproportionate burden of disease’ mainly as a result of social inequality and social disadvantage (p.17). The draft Strategy also discusses the role of ‘the causes of the causes’.

However, to be effective as a guiding policy document, the Strategy needs to be considerably strengthened, with more powerful and action-oriented wording on reducing health inequalities and tackling ‘the causes of the causes’.

Action to reduce health inequalities

The need to reduce health inequalities, as experienced by all the listed ‘target populations’ requires far greater prominence in the Strategy, and should be included in the Vision statement. For example,

‘To improve the health of all Australians at all stages of life, and reduce health inequalities, through early intervention, better information, targeting risk factors, and addressing the broader causes of poor health and wellbeing’

In addition, reducing inequalities should have higher profile across all of the focus areas, in Targets and ‘Policy achievements by 2030’.

In relation to preventive health programs and services, availability, accessibility, acceptability and quality are key dimensions to address in relation to each target population (<https://www.who.int/workforcealliance/media/qa/04/en/>). For example, there is evidence that people with disability face barriers in accessing preventive health screening services [10, 11].

Action on 'the causes of the causes'

The absence of strong statements about action on 'the causes of the causes' is a concern. The 'Boosting action' section of the draft Strategy has a focus on behavioural risk factors, as well as access to screening and immunisation. This Strategy will guide action over the coming decade. Therefore, it is essential that it should strongly urge high-level commitment to cross-sectoral action on 'the causes of the causes'. This is fundamental for reducing health inequalities.

Monitoring inequalities and 'the causes of the causes'

We endorse the importance of 'Monitoring and Surveillance' as a key enabler, and identification of 'Ongoing national data sets to support the monitoring and evaluation of this Strategy and a National Prevention Monitoring and Reporting Framework' as an 'immediate priority (p.42).

However, the text on p.39 concerning 'Monitoring and Surveillance' should be strengthened to strongly advocate for:

- specific monitoring of inequalities experienced by target populations, including people with disability; and
- monitoring 'the causes of the causes'.

Currently examples given are 'accurate health information available in different languages and accessible to all Australians including people with disability' and 'access to a nutritious and affordable food supply'. Key root causes for health inequalities that require multi-sectoral action to address should also be listed here, e.g., employment, poverty and housing.

REFERENCES

1. Australian Institute of Health and Welfare. *People with disability in Australia 2020*. AIHW: Canberra, 2020.
2. Emerson, E., Honey, H., Llewellyn, G. *Left behind: 2013. Monitoring the social inclusion of young Australians with self-reported long term health conditions, impairments or disabilities 2001 – 2011. Technical Report 1, February 2013*. Centre for Disability Research and Policy, University of Sydney, 2013.
3. Banks, L.M., Kuper, H., Polack, S. Poverty and disability in low- and middle-income countries: a systematic review. *PLoS One* 2017, 12(12). <https://doi.org/10.1371/journal.pone.0189996>.
4. Brucker, D.L., Mitra, S., Chaitoo, N., Mauro, J. More likely to be poor whatever the measure: working-age persons with disabilities in the united states. *Soc Sci Q* 2015, 96(1), 273-296. <https://doi.org/10.1111/ssqu.12098>.
5. Kavanagh, A.M., Krnjacki, L., Aitken, Z., LaMontagne, A.D., Beer, A., Baker, E., Bentley, R. Intersections between disability, type of impairment, gender and socio-economic disadvantage in a nationally representative sample of 33,101 working-aged Australians. *Disabil Health J* 2015, 8(2), 191-199. <https://doi.org/10.1016/j.dhjo.2014.08.008>.
6. Kavanagh, A.M., Krnjacki, L., Beer, A., Lamontagne, A.D., Bentley, R. Time trends in socio-economic inequalities for women and men with disabilities in Australia: evidence of persisting inequalities. *International Journal for Equity in Health* 2013, 12. <https://doi.org/10.1186/1475-9276-12-73>.
7. Krnjacki, L., Emerson, E., Llewellyn, G., Kavanagh, A.M. Prevalence and risk of violence against people with and without disabilities: findings from an Australian population-based study. *Aust N Z J Public Health* 2016, 40(1), 16-21. <https://doi.org/10.1111/1753-6405.12498>.
8. Hughes, K., Bellis, M.A., Jones, L., Wood, S., Bates, G., Eckley, L., McCoy, E., Mikton, C., Shakespeare, T., Officer, A. Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies. *Lancet* 2012, 379(9826), 1621-1629. [https://doi.org/10.1016/S0140-6736\(11\)61851-5](https://doi.org/10.1016/S0140-6736(11)61851-5).
9. Milner, A., LaMontagne, A., Aitken, Z., Bentley, R., Kavanagh, A. Employment status and mental health among persons with and without a disability: evidence from an Australian cohort study. *J Epidemiol Community Health* 2014, 68(11), 1064-1071. <https://doi.org/10.1136/jech2014-204147>.
10. Salomon, C., Trollor, J. *A scoping review of causes and contributors to deaths of people with disability in Australia (2013–2019). Exhibit 4-059-CTD.7200.0001.0060 3DN, UNSW. Report for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability*. University of New South Wales, Sydney 2019.
11. Ramjan, L., Cotton, A., Algosio, M., Peters, K. Barriers to breast and cervical cancer screening for women with physical disability: a review. *Women's Health* 2015, 56(2), 141-156.

Centre of Research Excellence in Disability and Health

+61 3 8344 0717
cre-dh@unimelb.edu.au
www.credh.org.au
[@DisabilityHlth](https://twitter.com/DisabilityHlth)

