Speech by Dr Dawn Casey at the National Aboriginal and Torres Strait Islander Environmental Health Conference – (NATSIE) 9 November 2026

Good morning, everyone.

My name is Dr Dawn Casey, a Tagalaka Traditional Owner from North Queensland, and I am the CEO of NACCHO.

Thank you Reverend Garlett for providing the Welcome to Country.

I acknowledge the Whadjuk people of the Noongar nation, the Traditional Owners of the land on which we meet, and I pay my respects to their Elders past, present and emerging.

I acknowledge every Aboriginal and Torres Strait Islander person in this room. And I acknowledge, in particular, the environmental health officers and workers. You are the reason this conference exists.

NACCHO is the national peak body for 150 Aboriginal Community Controlled Health Organisations. Each ACCHO is owned and governed by the community it serves. The first opened in Redfern in 1971, before Medicare existed, because our people decided to look after their own. Today our services deliver around 3.6 million episodes of care a year, from around 550 clinics across every corner of the country.

Let me begin with a simple proposition. Environmental health is not an adjunct or add-on to health care. It is critical to the delivery of comprehensive primary health care. It is where our understanding of health, whole of life, whole of community, tied to Country and to home, meets the science of how disease spreads.

Our people have understood that connection between healthy Country, a healthy environment and their own health and wellbeing long before the Western field of environmental health was conceptualised.

Pat Turner's 2019 address

In September 2019, Pat Turner stood in front of many of you and gave the keynote at this conference. Pat was then NACCHO's CEO and the lead convenor of the Coalition of Peaks. I have read her address again, and it has held up well.

She came with news. Six months earlier, the Coalition of Peaks and the Council of Australian Governments had signed the National Agreement on Closing the Gap. For the first time, Aboriginal and Torres Strait Islander people held the majority at the table where decisions were made: twelve of the twenty-two members of the Joint Council, chosen by us.

That Joint Council had just agreed to build a new National Agreement around three reform priorities. Pat was telling this room that the ground was about to move.

It did. The Coalition of Peaks went to communities and asked what they wanted. More than four thousand responses came back. A fourth reform, on shared access to data, joined the other three. And in July 2020, every Australian government signed the National Agreement on Closing the Gap.

Four Priority Reforms:

- Formal partnerships and shared decision-making
- Building the community-controlled sector
- Transforming government organisations, and
- Shared access to data and information at a regional level

. And I want to say plainly that they were not handed to us. Aboriginal and Torres Strait Islander people argued for them, fought for them and won them.

I will not pretend the implementation has been even. Last year Pat told a parliamentary committee that the states and territories were not implementing the National Agreement in good faith. Where the four reforms are honoured, our sector succeeds and communities flourish. Where they are not, the old pattern returns.

And in environmental health, the old pattern ran for a very long time.

Pat made that case in 2019 with the evidence in her hand. She drew on similar evidence that has been presented at this conference in various iterations since your first meeting nearly two decades ago. She called it a disconnect between data and decisions.

Then she made her asks. Fund housing audits and repairs permanently. Set national standards for a safe house. And train, credential and employ Aboriginal and Torres Strait Islander people as environmental health workers, in Aboriginal and Torres Strait Islander organisations, on the ground.

She also pointed us to the model. In 1986, Yami Lester and the Nganampa Health Council, in the APY Lands, noticed that despite the provision of more and more health services – people were still getting sick. They set out to stop this. Their approach was Aboriginal-led: fix the health hardware, support the family, and share what we know about how diseases are spread. Their legacy is the nine Healthy Living Practices, and programs across the country grew from it and are still being used widely today.

Pat asked for a workforce. This morning I want to tell you what happened next.

Core Services and Outcomes Framework

In June 2021, NACCHO released the Core Services and Outcomes Framework. It was commissioned by the then Commonwealth Department of Health, developed with the Royal Australian College of General Practitioners and co-designed across our sector. For the first time, in one place, it sets out the Aboriginal and Torres Strait Islander community-controlled sector's vision for comprehensive primary health care.

The artwork on its cover is by Kamilaroi artist Ethan French. At the centre is a meeting place. That is the community. Culture surrounds every part of the picture. That is the model: community at the heart, culture around everything, and community control, cultural authority and Aboriginal and Torres Strait Islander leadership bringing it together.

Environmental health sits inside that picture.

The Core Services and Outcomes Framework describes Environmental Health as science-based and action-oriented, combining deep cultural knowledge of how things work in local communities, with knowledge of how disease is transmitted. It sets out how a community-controlled service deals with disease:

- assess the burden of preventable illness caused by environmental conditions,
- respond to environmental threats,
- give communities the data and technical expertise to make their own decisions,
- and sustain family-centred support in the home.

That is comprehensive culturally safe primary health care. Environmental health is not tacked on to what our services do. It is, or should be, part of business as usual.

The Framework was also honest about what Pat had named. Standards for housing, maintenance and community infrastructure had largely been taken out of Aboriginal and Torres Strait Islander control, and in many communities the permanent environmental health positions, especially those delivered by Aboriginal and Torres Strait Islander people, had gone.

Since 2021, only a small number of ACCHOs have expanded into direct environmental health services. Not because Boards did not want them. Not because Communities did not need them. But because there was no stable funding and no pipeline of skilled workers to hire.

Aboriginal and Torres Strait Islander Environmental Health Roadmap

Which brings me to the genesis of the Roadmap.

The Priority Reforms were followed by the Health Sector Strengthening Plan, which is Priority Reform Two in practice: a plan to build the community-controlled health sector. It set out seventeen actions. Action A4 was the one this room has been waiting for: invest in a permanent, highly skilled and nationally credentialled Aboriginal and Torres Strait Islander environmental health workforce.

The National Indigenous Australians Agency or NIAA funded NACCHO to turn that action into a plan. I thank the NIAA for backing it, and for supporting NACCHO to deliver a sector-led Roadmap. We spent over two years consulting broadly to refine the National Strategic Roadmap, *Growing an Aboriginal and Torres Strait Islander Environmental Health Workforce*, which was launched in late 2025. Our consultation was supported by the Aboriginal and Torres Strait Islander Environmental Health Workforce Expert Steering Committee, many of whom are in this room today. This group brought together Aboriginal and Torres Strait Islander Environmental Health Officers, Workers and senior leaders within the Community Controlled sectors representing both affiliates and our member services. This was NACCHO's first advisory body to be comprised entirely of Aboriginal and Torres Strait Islander members.

Let me tell you how the Roadmap was built, what it found, and what it will cost us not to act.
It was built the way Priority Reform One says things should be built; by the people who do the work. The Roadmap has three main findings I want to draw out.

First, Environmental Health is the missing link to closing the Gap experienced by Aboriginal and Torres Strait Islander people and their Communities. As you are all aware, the environmental determinants of health underpin many of the inequities experienced by Aboriginal and Torres Strait Islander people and investment in environmental health is a clear and evidence-based pathway to improve a variety of outcomes to ensure that our people, especially our children, are thriving.

Second, the Aboriginal and Torres Strait Islander Environmental Health Worker is a critical and stand-alone role within the primary healthcare team. The Roadmap describes Aboriginal and Torres Strait Islander environmental health as a technically advanced, culturally and scientifically based discipline. These workers take on what the community has identified as its priorities: education and health promotion, home assessments and, where legislation allows, minor repairs to health hardware. They help tenants raise repairs with housing providers, and they hold those providers to account.

The Environmental Health Officer role is distinct but complementary to that of an Environmental Health Worker. Environmental Health Officers hold the statutory powers: enforcing public health law, monitoring water quality, inspecting food, responding to outbreaks. To be effective, these two roles need to be supported to work in partnership. We know there are few qualified Environmental Health Officers in this country who identify as an Aboriginal or Torres Strait Islander person.

The Roadmap acknowledges this unique role and skills of the Environmental Health Officer. It does not seek for Aboriginal and Torres Strait Islander Environmental Health Wokers to take on these statutory powers or take a regulatory role. It acknowledges the expertise the Environmental Health Officers have to share with Aboriginal Environmental Health Workers and asks governments to partner with the community-controlled sector to help the supervision and mentorship of Aboriginal and Torres Strait Islander Environmental Health Workers.

Third, jobs first. A key principle in the Roadmap is that training without a job pathway leads to unused skills, and the numbers prove it. Training needs to be hands-on and primarily in community.

We know that there are currently not enough people being trained in Aboriginal and Torres Strait Islander Environmental Health.

But we know how to train. Where Aboriginal and Torres Strait Islander community-controlled training organisations support students, we know that completion rates rise from under 30 per cent in a mainstream context to 96.8 per cent.

We are learning from what works. The Roadmap builds on the success of the First Nations Health Worker Traineeship Program, which supports 500 trainees today; and the Roadmap recommends that this program is extended it to include a Certificate II in Indigenous Environmental Health, with secure employment from the first day in training.

Now to the modelling. I make two arguments, and I make them in this order on purpose.

First. A safe house, clean water, a working tap and toilet and a way to wash are basic conditions for good health. It does not need a cost-benefit analysis to justify it or explain why the absence of these basic conditions can lead to ill health.

The second is for anyone who must put a number in front of Treasury. The clearest way to quantify the benefit of investing in environmental health on a national scale is through hospital costings. Modelling by NACCHO and Equity Economics estimated that environmentally attributed hospitalisations for Aboriginal and Torres Strait Islander people cost between $310 million and $710 million each year. Investing in Aboriginal and Torres Strait Islander Environmental Health also makes economic sense, as it avoids long term costs and reduces pressure on already constrained health systems.

Hospital costs are only what is easiest to count. They do not count the child who misses school because of ear infections or skin sores. They do not count the mental health toll of overcrowding or not being able to lock the door at night. And they do not count the jobs the workforce itself creates - jobs for our people, in our communities, especially in Remote and Very Remote communities.

The cost of hospitalisations is the floor of the benefit, not the ceiling.

Environmental health in ACCHOs through the RHD program

In 2021 NACCHO was funded to deliver the first community-controlled approach to acute rheumatic fever and rheumatic heart disease. Today 29 services receive additional funding to deliver ARF and RHD services across 114 sites in four jurisdictions. This supports around 100 funded positions, 61 per cent of them held by Aboriginal and Torres Strait Islander people.

The ARF and RHD program has demonstrated that by funding and supporting ACCHOs to deliver tailored services to their community, they deliver better outcomes. Last year, almost half of ACCHO clients received more than 80% of their prescribed secondary prophylaxis, a rate that is 1.5 times higher than the average adherence rate for all Aboriginal and Torres Strait Islander people with ARF and/or RHD. What's more, the trend over the past three years suggests that the secondary prophylaxis adherence rates of individuals who receive care in ACCHOs in our data is increasing, whereas the national data provided by AIHW shows that national adherence rates have been steadily decreasing.

As many of you know both ARF and RHD begin with a common streptococcal infection of the throat or skin. Skin infections are linked to crowding and to a lack of functional washing facilities. Repeated infections can lead to acute rheumatic fever, and then to damage to the heart valve, which is called rheumatic heart disease

In 2023, the rate of ARF for all Australians was 3.2 per 100,000 people. This has not always been the case. In 1946 in Melbourne, the rate of ARF per 100,000 people was 146. But in 2023 for Aboriginal and Torres Strait Islander girls aged 5 – 14, the national rate of ARF is 145.6 per 100,000 girls. Here we can see that

across the Nation today, the rate of ARF for Aboriginal and Torres Strait Islander girls aged 5 to 14 in 2023 equals the rate experienced by all Australians 80 years ago.

The health of Aboriginal and Torres Strait Islander girls has been frozen in time.

This inequity in the rate of ARF becomes more pronounced in remote and very remote areas, again, largely because of differences in the environmental determinants of health, where in some regions the rates of ARF still exceed 500 per 100,000 Aboriginal and Torres Strait Islander Children.

Western environmental health services which have efficiently driven the reduction in rates of environmentally attributable diseases in metropolitan centres such as Sydney and Melbourne are NOT working in Aboriginal and Torres Strait Islander communities.

The RHD Endgame Strategy found that safe, uncrowded housing, community-led health promotion and accessible primary health care, delivered together, can prevent more than two-thirds of new cases of Acute Rheumatic Fever. Our services sit where those three meet.

The program funds ACCHOs directly, and each service decides its own priorities. Those priorities include employing Aboriginal environmental health workers alongside Aboriginal health practitioners and health promotion staff.

The Kimberley region shows us what this looks like in practice. A clinic offers a family a voluntary environmental health referral when someone presents with scabies or a recurrent skin infection or suspected ARF. An Aboriginal and/or Torres Strait Islander Environmental Health Worker visits the home, assesses the health hardware, and works with the family on a plan. They stay involved for up to six months and help the tenants press for repairs. The environmental health referral sits on the clinic's form beside every other type of referral. Aboriginal Environmental Health Workers and Aboriginal Health Workers work in partnership to reinforce key health promotion messaging to build the client and their family's understanding of how environmental health in the home impacts their health. That is environmental health as primary health care.

Recognition of Environmental Health through the Diphtheria Outbreak

Earlier this year we had a Communicable Disease Incident of National Significance. A Diphtheria Outbreak was declared as it swept around remote and regional parts of the Northern Territory, Western Australia, South Australia, and Queensland. Through this recent outbreak, Environmental Health has again been recognised as an underlying and significant factor when it comes to infectious disease prevention, and control in communities. ACCHOs again supported a fast response to their communities, at their own initiative and in partnership with state or territory health departments, even responding prior to funding or formal government approvals on communications.

Local services made early linkages between diphtheria, skin sores and environmental health and used this context to ensure information and education were provided as quickly as possible to communities.

The diphtheria outbreak is another load the primary health care workforce and one that laid bare the lack of investment in environmental health responses, including wrap-around services to support other public health actions.

Diphtheria has been a rare disease in Australia since the implementation of vaccination programs in the 1940s. However, it remains endemic in many developing countries.

Is this what was want for our Aboriginal and Torres Strait Islander communities?

Even with relatively high vaccination rates among Aboriginal and Torres Strait Islander people, transmission of diphtheria still occurred. This in part demonstrates the power of environmental health and how prevention is better than cure.

Let me be plain about the barriers.

Funding is short-term and piecemeal. The training system is thin.

In 2025, only one Aboriginal and Torres Strait Islander community-controlled registered training organisation was delivering any Certificate in Indigenous Environmental Health. There are not enough Aboriginal and Torres Strait Islander trainers, and no endorsed skill sets for Aboriginal health workers who want to add environmental health to their practice.

Our NACCHO affiliates are leading. They are the state and territory peak bodies, and they work with governments every day. In the Northern Territory, AMSANT and NT Health have co-designed a program to be trialled in an ACCHO and in a government clinic side by side. In the Kimberley, the Aboriginal Health Planning Forum built the referral pathway I just described – embedded in the primary health care referrals process.

The National Health Reform Agreement

The agreement I want to finish on is to ensure that the Priority Reforms and the National Agreement on Closing the Gap are embedded in every health budget in this country.

The National Health Reform Agreement 2026 – 2031 Addendum is how the Commonwealth and the states and territories jointly fund public hospitals. It commits every government to the four Priority Reforms. It recognises the Aboriginal and Torres Strait Islander Health Sector as a legitimate partner in the health system. It gives an Aboriginal and Torres Strait Islander representative a standing seat on the System Reform Deputies Group, with decision-making authority equal to everyone else's. It requires an Aboriginal and Torres Strait Islander-led component in the mid-term review. It brings the commencement of the first independent Monitoring and Accountability Group with authority to hold all parties to account.

And the Schedule B Addendum does not sit alone. It focuses on Better Outcomes for Aboriginal and Torres Strait Islander Peoples, integrating health equity into core funding and governance. It is woven through the whole Addendum.

And I say that as someone who intends to be held to account along with everyone else.

So, what does it mean for environmental health? It sets the precedent for how all governments should work with Aboriginal and Torres Strait Islander people. It provides a framework for government agencies at all levels tasked with operationalising the National Agreement on Closing the Gap.

State and territory governments play the lead role in public health, community health and health promotion programs. That is where state-delivered environmental health often lives: in public health units, in Aboriginal and Torres Strait Islander environmental health units. Where many of the Environmental Health Officers in the room are currently employed.

The Schedule B Addendum requires those same governments to recognise ACCHOs as legitimate partners. This provides an unprecedented opportunity for partnership and investment in environmental health services within ACCHOs.

Make sure the definition of public health activities recognises environmental health delivered by community-controlled services.

Count what matters. Report environmentally attributable hospitalisations by jurisdiction, share them with communities and each community-controlled peak. You cannot fix what you do not count.

To the public health medical officers: many of you work beside Environmental Health Officers every day. Your outbreak responses and your notification data are the other half of that referral pathway.

In closing

Seven years ago, Pat asked governments to sit down with Aboriginal and Torres Strait Islander leaders, in partnership, and work out the investment needed.

Pat gave us the National Agreement on Closing the Gap and the Priority Reforms.

The knowledge is ours. It is older than any agreement in this room. The Roadmap is written, the cost for investment has been quantified, as has the potential benefit to the health system What remains is funding implementation

Somewhere in this country this morning there is a house with a tap that does not work, and someone with a skin sore. There is a child who is sitting in a classroom, unable to fully hear what the teacher is saying because of recurrent ear infections. There a family did not sleep well because they could not lock the door. We know the fix. And we know who should be knocking on that door: a worker from that community, employed by the service that family trusts, supported by a broader team: Aboriginal and Torres Strait Islander Health Workers, Practitioners and doctors to provide medical care, and an environmental health officer who answers the phone.

Let us build that pathway.

Thank you.