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20 March 2019

Committee Secretary
Education, Employment and Small Business Committee
Parliament House
George Street
Brisbane QLD 4000

Re: Submission re the Health and Wellbeing Queensland Bill 2019

Dear Committee Members

The Board of the Australasian Society of Lifestyle Medicine (ASLM) would like to congratulate the Queensland Government on this important initiative.

ASLM is a not for profit interdisciplinary society of medical doctors, allied health practitioners, public health professionals, researchers and educators working towards improved prevention, management and treatment of chronic, complex and lifestyle-related conditions.

Established in 2008, the society has been experiencing rapid growth in both membership base and stakeholder relationships. For example, we are members of the Obesity Policy Coalition in Australia and the Health Coalition Aoteroa in New Zealand. We work collaboratively with numerous organisations such as the Australia and New Zealand Obesity Society (ANZOS), the Public Health Association of Australia (PHAA) and a number of university departments and research institutes. Our direct reach is to around 9000 health professionals and many more through the networks of partner organisations.

With the American College of Lifestyle Medicine, we are also leading the international Lifestyle Medicine movement, with societies now established in 15 countries and many more starting up under the banner of the 'Lifestyle Medicine Global Alliance'. In practice, this means that we work in collaboration with a large international network of colleagues tackling health issues in their countries and are at the forefront of innovation in this field.

'Lifestyle-related' of course means behavioural, societal, environmental and other factors. A core philosophy of the society is that human health is a product of society, environment and ecology – and therefore a 'whole system' approach is required to ultimately improve the health of individuals. It is our medical and public health expertise in this respect that we would be pleased to make available to HWQ.

In practical terms, Lifestyle Medicine involves a range of professionals working together to address physical inactivity, poor diet or nutrition, smoking, alcohol overconsumption, chronic stress, anxiety, poor or inadequate sleep, social isolation, loss of culture and identity, health literacy and equity, exposures to toxins and other influences of society and environment.

As well as public health approaches to these issues, we are also involved in research and innovation in clinical processes, such as educating practitioners to help them incorporate Lifestyle Medicine into their practice, and into their practice systems and processes.

As an example of our work, one of our founders, Prof Garry Egger was one of the first to develop the discourse about how overweight and obese people were indeed victims of an 'obesogenic environment' largely driven by upstream factors related to the economy. Prof Egger and colleagues have worked not only to find solutions but to also change the narrative - to remove the burden of guilt from those individuals finding themselves overweight. As Dr Egger says, "It's not their fault but the fault of an economic system that demands constant growth. We live in an obesogenic environment, surrounded and overwhelmed by messages to consume more and do less." Led by Prof Egger and other ALSM colleagues, ASLM has continued to develop innovative evidence-based weight loss programs for delivery through medical and other clinical practice settings and has been contracted by some Primary Health Networks to trial these programs in their region.

As another example, for the last five years ASLM has been pioneering 'Shared Medical Appointments', which are well suited to managing and treating large cohorts of patients with chronic disease and well supported by the evidence overseas, especially in the USA where 'group appointments' have been well researched. However, Australia's current MBS reimbursement model (which was well suited to the pre-chronic disease era in which it was designed) is now unfortunately stifling the clinical innovation needed to address the more than 70% of patients presenting to their GP with a chronic or lifestyle-related condition.

We also advocate for Lifestyle Medicine to the broader community with evidence-based health information, and present education and conferences such as our annual international scientific/medical conference for health professionals, to promote better understanding of the underlying causes of poor health and disease.

Lifestyle Medicine is a comprehensive framework, described in detail in the peer-reviewed textbook: '*Egger G et al. Lifestyle Medicine: Lifestyle, the Environment and Preventive Medicine in Health and Disease, 3rd edition, 2017, Elsevier UK*.' An exciting outcome of this framework is that we are also pioneering ways to improve cultural safety and accessibility of healthcare for indigenous communities and other disadvantaged groups in our community.

Importantly, Lifestyle Medicine is both a discipline and a movement for health system change, to which we attribute the rapid growth of the society as health professionals look for solutions to the challenges they are facing in their practices and that we are collectively facing as a society.

The above is by way of introduction to the society and to clearly indicate our desire to be consulted by HWQ on these complex and often socially ingrained issues.

Going forward, we would welcome the opportunity to consult on a range of systemic issues underpinning both the rise of the chronic disease epidemic and the unpreparedness of primary care and the health system in general to address what is in fact a crisis of our society, of which the committee and HWQ will be well aware, however on which we will be able to bring specific expertise. These issues include, but are not limited to:

- The current MBS reimbursement system for primary care practitioners:
    - Reinforces the outdated pre-chronic disease era 'one appointment-one issue' consultation concept
    - Financially incentivises shorter consultations which in turn promotes symptom management and limits the opportunity for meaningful treatment of chronic disease
    - Limits clinical innovation, for example in the case of an innovative clinical process such as 'Shared Medical Appointments' for which there is no dedicated item number and uncertainty as to MBS reimbursement, which in turn limits uptake by practitioners
    - Fails to adequately incentivise primary care for keeping their cohort of patients in good health – in this request we note the trial of the 'Health Care Home' concept and funding model and hope to see this model taken up and adequately funded to achieve its potential (current concerns are that it will be underfunded and therefore unable to be effective)
- Education and training for practitioners in Lifestyle Medicine related fields
    - For example, doctors currently receive little or no education in nutrition, nutritional assessment or nutritional prescription while at medical school or in GP registrar training. This is a well-documented problem in the literature – in that the gatekeepers of the health system best placed to intervene are unequipped to do so
- Resources for practitioners to use with their patients
    - Practitioners are also poorly resourced when it comes to the complex and lengthy process of assisting patients with behavioural and lifestyle change. For example, interventions, programs, courses, applications and similar that should be readily available to, and operating in conjunction with the practitioner, and supporting the efforts of the patient and accessible to the general public
- Suitable education in primary and secondary school
    - It is our view that all Australian children should receive comprehensive health education, not just in respect to diet and nutrition, physical activity, smoking and alcohol consumption, but covering stress management, sleep, connection (with family, friends and nature), to create a minimum level of health literacy, and to develop a deep understanding of the economic and vested interests driving consumer choice and ill health

- Innovative health policy to:
    - Educate and incentivise consumption of fruit and vegetables
    - Promote increased physical activity and incidental exercise, for example in the manner of the 'Life Be In It' campaigns of the 70s and 80s.
    - Create greater awareness/warnings regarding processed meats
    - Reduce the allowable levels of added sugars, extending this perhaps to a measure of the energy density of manufactured foods
    - Reduce or preferably eliminate the influence of industry on dietary guidelines and health rating systems
    - Reduce the social acceptability of unsafe levels of drinking and the culture of drinking generally
    - Improve cultural safety and accessibility for Aboriginal and Torres Strait Islander people, and for other culturally disadvantaged groups such as refugees
    - Advocate for evidence-based lifestyle measures to address both mental health conditions and chronic disease generally
    - Promote evidence-based lifestyle-based measures for preventing cognitive decline and dementia
    - Promote ageing well and caring for the aged with a Lifestyle Medicine focus

We realise that some of these issues are federal in jurisdiction, but it will also require advocacy from the states to bring about change at a national level.

We are also well aware that many of these initiatives will require significant political will in the face of economic and vested interests and the machinery of influence.

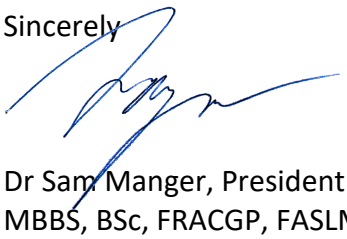
We hope that HWQ is able to act as a beacon in this regard, in turn influencing other states to follow suit as initiatives are shown to be effective or likely to be so, in improving health and wellbeing for Queenslanders.

ASLM would like to be included in discussions on the above, and to continue to contribute to the discourse on the science and research, education, professional practice, and issues further upstream such as economic systems, social inequity, climate change, urban planning and the built environment, human environmental degradation and ecological responsibility.

Our goal is of course the same as the goal of HQW – a healthy society with the health and wellbeing of its individuals at heart. We invite the Committee and HWQ to consult with ASLM in pursuit of its goals.

Once again, we congratulate the Queensland Government on this important initiative.

Sincerely



Dr Sam Manger, President
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