# *HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE*

**Members present:**

Ms L Linard MP (Chair)
Dr CAC Rowan MP
Ms RM Bates MP
Mr SL Dickson MP
Mr AD Harper MP
Mr JP Kelly MP

**Staff present:**

Ms D Jeffrey (Research Director)
Ms E Booth (Principal Research Officer)

# PUBLIC BRIEFING—INQUIRY INTO THE ESTABLISHMENT OF A QUEENSLAND HEALTH PROMOTION COMMISSION

## TRANSCRIPT OF PROCEEDINGS

**WEDNESDAY, 20 APRIL 2016**

**Brisbane**

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**Committee met at 9.01 am**

**PULSFORD, Ms Kaye, Executive Director, Preventive Health Branch, Prevention Division, Department of Health**

**WEST, Mr Mark, Senior Director, Preventive Health Branch, Prevention Division, Department of Health**

**YOUNG, Dr Jeannette, Chief Health Officer and Deputy Director-General, Prevention Division, Department of Health**

**CHAIR:** Good morning, ladies and gentlemen. I now declare this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's inquiry into the establishment of a Queensland Health Promotion Commission open. I would like to acknowledge the traditional owners of the land on which we meet and pay my respect to elders past, present and emerging. I am Leanne Linard, the chair of the committee and the member for Nudgee. The other members of the committee present here today are: Dr Christian Rowan, deputy chair and member for Moggill; Mr Joe Kelly, member for Greenslopes; Mr Steve Dickson, member for Buderim; Mr Aaron Harper, member for Thuringowa; and Ms Ros Bates, member for Mudgeeraba.

Thank you for your attendance here today. The committee appreciates your assistance with our inquiry. The inquiry was referred to the committee on 16 September 2015. The purpose of this briefing is to receive additional information from the department to assist us with that inquiry. There are a few procedural matters before we start. The committee is a statutory committee of the Queensland parliament and as such represents the parliament. It is an all-party committee which takes a non-partisan approach to inquiries. This briefing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath. You have previously been provided with a copy of the instructions for witnesses so we will take those as read. I remind all those in attendance today that these proceedings are similar to parliament to the extent that the public cannot participate. In this regard I remind members of the public that the public may be admitted or excluded by the chair. Could I please ask witnesses to speak into the microphones. Dr Young, I invite you to make an opening statement before we ask questions.

**Dr Young:** I have with me this morning Mr Mark West and Ms Kaye Pulsford, who are also from the Department of Health. Thank you very much for the invitation to provide the committee with a Department of Health perspective on how Queenslanders can best realise the opportunities of a new Health Promotion Commission. Before talking about a commission, I would like to highlight that our current health promotion activities are working and making a difference for the health of all Queenslanders.

Over the years that I have been the state's Chief Health Officer, we have been working steadily to improve the health of Queenslanders. I am exceptionally pleased to say that the data now shows that important progress has been made. We all know that adult and youth smoking rates in Queensland are at their lowest recorded levels. Since 2009, the adult smoking rate has been steadily decreasing by around 3.5 per cent every year. In 2015, only 12 per cent of adults smoked daily. Back in 2011, seven per cent of teenage students—that is, those aged 12 to 17 years—smoked each week. This has decreased to five per cent in 2014. Also, the age of first trying a cigarette has shifted from 14 to 16 years old over the last decade. This health data emphasises the point made in many of the submissions to this inquiry that our multistrategy approach to reducing smoking has been and is being effective.

Secondly, I am also very proud to say that recent data shows that we are actually making inroads towards addressing obesity. The adult and child obesity rate in Queensland is no longer increasing. From 2004 to 2010, adult obesity increased by 24 per cent. Since 2011—and you need many years before you can actually make this sort of statement—there has been no significant change. We are happy it is not just data collection; it is genuine—there has been no increase in adult

obesity. Similarly, in 2014-15, seven per cent of Queensland children were obese; whereas back in 2011-12 nine per cent were obese. I think we can safely say we have started to see improvements there. There are not as many data points, but we have started to see plateauing of obesity in children and now the first reduction.

These might sound like small wins—I do not think they are—however, across the world no jurisdiction has managed to significantly decrease adult obesity. Stopping the increase is an essential first step before you can reverse that trend, and I believe Queensland now has stopped that increase. The department's submission to this committee late last year outlined the policy and investment mix that is helping to change behaviours and support better health outcomes. Investments by other government departments also have an impact on the health and wellbeing of our communities. I would like to share with you some examples of this type of work that has occurred across government.

A new partnership between the Queensland Office of Industrial Relations and the Public Service Commission will develop a Health Safety and Wellbeing Framework. The framework will guide the development of activities that reduce work related fatalities and injuries, improve return to work rates and, importantly, reduce chronic disease risks and improve the health and wellbeing of government employees.

The Department of Transport and Main Roads encourages active transport—cycling, walking and other physically active ways of travelling—as part of an integrated transport system. A new cycling strategy and action plan will set out the direction, policies and priorities required over the next 10 years to get more people cycling more often.

The Department of Communities, Child Safety and Disability Services is developing a new seniors strategy that will improve the lives of older people but benefit people of all ages at the same time. Using the globally recognised age-friendly communities approach, the strategy will bring together policies, services and structures that are designed to support and enable older people to enjoy good health, live in safety and continue to participate fully in society, accessing services as needed.

The Department of National Parks, Sport and Racing aims to ensure that Queenslanders lead active and healthy lifestyles through participation in physical activity. The department provides a range of funding options helping to improve the sport and recreation facilities of local clubs, and a number of programs enable greater access and participation in physical activity by children and young people.

Smart Choices, the Healthy Food and Drink Supply Strategy for Queensland Schools, is about offering healthy food and drink choices to students in Queensland schools. The strategy was first released in 2005 and its implementation has been mandatory in Queensland state schools since 1 January 2007 and it is strongly encouraged in non-state schools. Recently, it has been elevated to a new level and that is being rolled out at the moment.

There is more that can be done. Queenslanders are aware that their lifestyle choices are not necessarily healthy. Many are trying to lose weight or actively prevent weight gain. Even so, 30 per cent of adults in Queensland are obese. Queenslanders want to lead an active and healthy life, and they see a role for government in preventing and reducing lifestyle related diseases. A Health Promotion Commission could operate as a catalyst for change and provide leadership across and beyond the health sector.

Turning to the terms of reference of this inquiry, I will provide the committee with: an overview of the current health of Queenslanders and what the trends tell us about the future; an outline of the many factors that affect good health—most of which lie outside the health system; an outline of how the benefits of improved health are also felt outside the health system; the importance of working collaboratively across government, industry and the community; and a brief description of approaches that can help. The information I am providing today is in addition to the department's submission of December last year and our recent responses to a number of issues raised in the submissions made to this inquiry.

Health is a core building block of personal fulfilment, thriving communities and a strong, competitive state. Queenslanders value their quality of life and wellbeing. Most but not all Queenslanders are healthy by national and international standards. We have some of the longest life expectancies in the world, similar to other Australians. We are living longer, but living longer with disease. Chronic diseases—such as type 2 diabetes, heart disease and cancer—are major contributors to the burden of disease. Other key drivers for a longer but not necessarily healthier life include an ageing population, shifts towards disabling conditions and away from fatal causes.

Preventable chronic diseases impact on the health and wellbeing of the community and the economy. Health expenditure costs in Queensland associated with chronic diseases were estimated to be $9.6 billion in 2011-12. For example, spending on diabetes alone has been predicted to rise by 400 per cent over coming decades. Chronic diseases cause significant productivity losses due to reduced workforce participation and increasing dependency on state benefits.

Some Queenslanders have worse health than others. Socioeconomic disadvantage, remoteness and being Indigenous all bring higher rates of disease and lower life expectancy. Accordingly, the Health Promotion Commission could provide a catalyst for further change and leadership for reducing preventable chronic diseases. It could also ensure that the diverse perspectives and experiences of Queensland are recognised and understood.

Moving to another issue, we know that while many individuals are making healthy choices—such as exercise or good eating—many are not. We also know that the healthy choice is not always easy. Individuals may not have the right information or they may face a number of social, environmental or other barriers. Individual efforts are often not enough, especially for those in our communities with fewer resources. It is increasingly understood that the lifestyle related behaviours that cause chronic health problems are caused by a complex mix of societal, environmental, socioeconomic and biological factors that are embedded into everyday life.

For example, in our communities and at work, the odds can be stacked against us. Our modern lifestyles are sedentary. Our transport system is built around the car so we sit as we travel and then we sit at computers all day. Junk food is heavily advertised and discounted, whilst fresh food may be hard to get, particularly in regional and remote areas. The healthy choice is easier for those who live in communities where safe parks and open spaces and locally grown fruit and vegetables are accessible and affordable, and where transport systems make cycling and active commuting easier. Importantly, when individuals and families have strong and secure foundations for good health—such as education, employment, and safe and affordable housing—they are more likely to have good health.

Health is created outside the health system. Stakeholders from across the community, industry and all spheres of government can contribute to creating a healthier Queensland. Champions for health and wellbeing are needed across all sectors. A number of approaches and tools can facilitate a more comprehensive collaborative approach to achieving health improvements. These include adopting a Health in All Policies, systems thinking and collective impact approaches, and using health impact assessment.

Accordingly, the health promotion commission could: support actions to address the social determinants of health and reduce health inequity; provide a focal point that identifies key leverage points outside the health system to facilitate long-term change; and facilitate coordination by identifying synergies, connections, redundancies and new opportunities. The benefits of improved health across the community are very broad. The gains are shared between individuals, employers, communities, all spheres of government, health, business and other groups. Co-benefits of an effective health promotion agenda may accrue to other policy areas including transport, housing, sustainable development, education and employment. For example, healthier people are more likely to be in paid employment and to take fewer sick days, with benefits flowing to their employers. Improving and sustaining the good health and wellbeing of all Queenslanders therefore has a number of important economic and social benefits. It leads to a stronger economy, increased productivity, reduced demand on health and social services, improved local environments, reduced health inequalities and a better quality of life.

The health promotion commission could provide a catalyst to position health as a whole-of-government priority, and it could encourage the use of common indicators to identify and measure health and non-health impacts and outcomes of health promotion. Working outside the health system requires a collaborative approach to achieve health gains. Working effectively in partnership is never easy and requires changing embedded ways of working, communicating and reporting. High-level commitment, specific skills, time and dedicated resources make collaborative approaches more achievable. Other factors found to facilitate collaboration including clear accountability and rewards for achievement of shared goals. When done well it has the potential to leverage additional knowledge, expertise and resources. These can add value to the existing health promotion efforts and enable a more integrated, dynamic and system-wide approach.

The health promotion commission could: ensure community ownership, engagement and participation; engage key stakeholders across community, industry and government and cultivate strong relationships and participation; and encourage a common language that helps to generate support and facilitate collaborative working leverage from rich networked relationships within government, across sectors and with regional, remote and urban Queensland communities.

Prerequisites of effective partnership include having a common agenda, shared measurement systems and mutually reinforcing activities. In addition, continuous communication and operational support help achieve greater impacts. Clear delineation of roles and scope of work for each stakeholder, including the Department of Health and the commission, will also enhance partnership working, as clarity maximises opportunities and reduces duplication. For example, in the first instance the commission may focus its efforts on influencing the environments in which health is created. The Department of Health may continue to concentrate on individual behaviour change, legislation and health monitoring and surveillance.

The health promotion commission could: deliver an agreed vision for a healthier Queensland with early wins and longer-term outcomes; encourage evaluation and data sharing; and support knowledge sharing of what works, why and how things have changed. Adequate resources, including financial and human resources, are critical for effective collaboration. The fixed commission budget suggests a more targeted scope and a strategic focus rather than a significant funding of health promotion activities. It is important that all government departments have the ability to contribute to a shared agenda for health promotion. This includes capacity within the Department of Health to promote health and wellbeing and to support collective action. Collaborative work presents opportunities to explore pooled or alternative funding models as well as changes to financing structures and incentive mechanisms.

The health promotion commission could use resources flexibly and explore options for collaborative, pooled or alternate funding models. A large part of the commission's ability to achieve its objectives will come from a combination of the status of a commissioner and the ability and credibility of the person serving in that role. The health promotion commissioner should be an individual who is well-respected in the field of public health and has the leadership abilities required for complex multi-stakeholder problem-solving. A clear mandate and the appropriate authority to act will enhance the ability to drive change. Governance structures can enhance collaboration and leadership and facilitate collaborative problem-solving. Diverse membership provides access to critical knowledge, skills, expertise and diverse perspectives, including those from regional and remote Queensland and Aboriginal and Torres Strait Islander people. The health promotion commission could establish a governance structure that ensures access to critical knowledge and skills for timely advice, flexibility and innovation and provide leadership to facilitate collaborative working.

In summary, I believe that much of the `doing' of the commission is about unlocking and supporting the doing potential of many different sectors, organisations and groups. An effective commission would operate as a catalyst for change whose success is measured by the impact of the actions of a diverse array of organisations and groups. This is a great opportunity for increased leadership in health promotion through: delivering stronger governance with a broad mix of expertise at the highest level; ensuring credibility and buy-in across government, community, industry and academia; using a strategic systems approach to collectively understand how best to make a difference and to measure collective impact; efficiently and effectively using human and financial resources; and having a realistic scope and focus on preventable chronic disease and the social determinants of health.

Thank you very much for the opportunity to go through that with you.

**CHAIR:** Thank you very much, Dr Young, for that very fulsome presentation. It did have a lot of additional information to that which you provided earlier which is very relevant to the inquiry, and I appreciate that. Have you seen an example of the sort of commission doing the sorts of things that you have outlined well domestically or internationally?

**Dr Young:** There have been a lot of commissions put in place over many years and they have, I feel, been very good for that point in time. I am not necessarily of the view that the commission that is proposed here should be the same as what has been put in elsewhere because we have moved on a lot. As I have just said, I really think this is about harnessing a lot of different skills across government and engaging better with all agencies that are involved. I think that we are seeing that. We are seeing other government agencies really take up the mantra about good health and what they can do because, as I have said, really the levers for good health do not sit in the health department. We pick up the outcomes of bad health, if I can put it that way. We do not really have a lot of ability to input very early on, which is when you need to input to have that big change.

We do in a few areas, of course—vaccinations is one clear one—but in so many other things it is really to stop any adverse impact on health you need that involvement early. Yes, there have been a lot of very effective commission-type organisations, and I believe you have looked into some of them in Western Australia and Victoria. Canada has a good one. I think each one was built for what was needed at that point in time, and it does not necessarily mean that is what we should copy.

**CHAIR:** I think my colleague just said we should definitely look at the Canadian one, but I do not think that is going to happen. We did look at Healthway in WA and we also looked at the Victorian Health Promotion Foundation in Victoria. It was, I think, really important for the committee to do so. It is one thing to read a brief about what it could look like and another to see how it does and does not work well. My view of looking at both was they were both very, very different and, as you say, there has been an evolution in what they look at and their purposes. It appeared that perhaps one is more focused on funding community groups to take preventative health messages out there; the other seemed to be very strongly weighted towards—although it does both—really building a research and evidence base, which I thought was obviously a fantastic resource and something which does do exactly what you are saying when you can look at things earlier and perhaps do more in the preventative space rather than then getting to Queensland Health where you are dealing with the outcomes.

One of the clear things that came up in discussion was the importance of the relationship that any such commission has with Queensland Health or the health department and how that practically works. Have you talked about shared goals, the clear delineation of roles and all those sorts of very important things? Is it the view that this would be a really positive thing and could really benefit and further the work of Queensland Health? I think sometimes there is a view that maybe we are already doing all of that and we can continue to do it. I am just wondering what the view is of the department more broadly about whether this would further Queensland's interests.

**Dr Young:** I think it would further Queensland's interests because health outcomes are so dependent on a whole range of areas and we do not have those levers necessarily. We would of course continue doing the work we are doing, which in many ways is about individual change and putting out some work with organisations doing the health promotion media campaigns. Of course it is not about stopping doing any of that or a different group taking that on. Also I would not like to see this group weighed down with doing what some of those other commission-like organisations do. It takes an enormous amount of work to put money out to non-government organisations and so forth, which is really operational work. I do not think that is what this commission should focus on. It should focus on that intellectual aspect of bringing people together and finding out the ideas and what strategies we should use, rather than the operational side of going out and doing things that are pretty standard for a department—whatever government department it is.

**CHAIR:** That was my next question about how you would weight those two, and you are clearly saying evidence, research base and that coordination role.

**Dr Young:** Yes.

**CHAIR:** One of the comments is again it should have independence from government so that they can pursue longer-term goals—and often when you are trying to build an evidence and research base it is a longer-term window—but still be closely enough aligned or partnered with having shared goals with Queensland Health about those key determinants and things you are looking at. Do you have any view of how the commission may be set up or established to have independence but still work closely with Queensland Health?

**Dr Young:** It not only has to work closely with Queensland Health, but all other government agencies. If it does not do that, it will not succeed. It cannot just sit there as an independent organisation making pronouncements. It has to engage with all of government but also all of the NGOs, community sectors and academia. It really has to have that major facilitation engagement role, listening to people across the whole breadth of the community and all organisations. It cannot work independently in isolation. That would not progress the agenda.

**CHAIR:** One of the comments made in Victoria is that there is not actually a commission of this sort of scope anywhere in the world, so they were quite excited by what the potential of such a commission would be, so I thank you for your comments.

**Dr ROWAN:** Thank you again, Dr Young, and to your other colleagues from the Department of Health for your submission. Following on from the chair, we visited Western Australia and Victoria and there are obviously different governance models in place. With regard to the governance structure of a proposed Queensland health promotion commission, do you have any further comments around an independent statutory board, who should potentially be on that board and where the department is represented in that structure?

**Dr Young:** I think it would be useful to have the department represented in any government structure purely so that there can be a shared understanding of what is happening, otherwise I think that is difficult for the commission. Although I firmly believe that health outcomes mainly are determined outside health, health has an enormous role in working that information through and

understanding what data is available and understanding what is happening, so early on I think it would be absolutely critical. I think it would be very difficult for any commission to succeed without that clear involvement from health.

**Dr ROWAN:** Coming back to an independent statutory board, do you have any comments around that?

**Dr Young:** I do not really. I think that they all have pluses and minuses, and it really depends on what you want to have come out of it. I think you can make pretty well any organisation work. In my view, it is the people and the engagement that you put in place that is the more critical part.

**Dr ROWAN:** The purpose of that is to avoid duplication and enhance coordination of the various entities that are existing in health promotion?

**Dr Young:** Yes.

**Dr ROWAN:** With respect to chronic disease management and I guess specifically obesity, which you alluded to before, what additional benefits could a Queensland health promotion commission possibly deliver in Queensland beyond all of the great gains that have already been achieved so far that you outlined in your testimony this morning?

**Dr Young:** It is about bringing all those other organisations closer together and facilitating that dialogue on a more even playing field. I think sometimes it is difficult seeing Health as the leader in this space because it is not; it is about all of these organisations. I think that is what the commission could achieve.

**Dr ROWAN:** In Western Australia when we saw the health promotion commission created, they basically had to source the funding for community organisations with programs that fit within the parameters of the health objectives that it was trying to achieve. Would Queensland Health see the Queensland health promotion commission funding sporting groups and other community organisations specifically in relation to sport and exercise and those sorts of things?

**Dr Young:** I do not think so. That is where I was trying to say that I think that is very, very time consuming for a small organisation to do. I think it can become overwhelming and so that is where all the energy of that organisation goes into, rather than into that much more important strategic discussion and facilitation of ideas. I really think the commission should come out with the strategy and the advice about what should happen and then leave it up to other bodies. They need to say, `Sporting organisations need to be funded to do X and Y and we think this should happen,' but I do not think they need to do that. That is just my view. Otherwise you would need a much bigger organisation than the one that has been suggested to date. I think you would have to look at it quite differently if they are going to get involved in actually funding different groups.

**Dr ROWAN:** If you look at some of the data across Queensland in relation to tobacco consumption, alcohol consumption and levels of obesity, should a health promotion commission be located physically in Brisbane or in a regional centre? Do you have any views on that?

**Dr Young:** It depends on who they are going to consult with. Where is it easier to go out and meet with people on a regular basis? You do not want to go and consult with sport and rec once a year; you want to get a dialogue going and get really involved. That is the only limitation I would see. I would decide who the main stakeholders are who are going to engage with this commission.

**Dr ROWAN:** Finally, in relation to measuring the effectiveness of any proposed commission—obviously there are ways of looking at the clinical effectiveness, for want of a better term, as far as the prevalence of obesity rates and rates of smoking tobacco and other things—just measuring the economic effectiveness, do you have any views or comments around who should do this and how it could be published in a transparent way to say that there is value for money in such an entity being formed and delivered?

**Dr Young:** Academia has a lot of experience in this and they have been doing it for many years, so I would think you would go to them and task them with that role.

**Dr ROWAN:** Should that be part of the creation of such an entity?

**Dr Young:** I think it is important of course. You have to evaluate the effectiveness of what is being put in place.

**Mr KELLY:** Thanks for that presentation, Dr Young. When I first heard of the health promotion commission I thought of the Mental Health Commission. Do you think there are any lessons to be learned from the Mental Health Commission? Do you think there is a sort of similarity in terms of the purpose of the organisations?

**Dr Young:** I think it has been very helpful looking at how the Mental Health Commission has evolved. In very many ways it is similar to this. Rather than them doing anything in terms of funding and so forth, they have been very strategic. They have gone out and engaged with the community. They have gone and listened to what the issues are. I think there are some similarities.

**Mr KELLY:** You talked about one of the purposes being looking at duplication of services. When we did our first inquiry on the role of technology in health promotion, it opened my mind to the fact that there is a lot of this stuff going on in the public sector, private sector and NGO sector. Is it an issue in terms of health promotion if we are duplicating services?

**Dr Young:** It is an issue. Of course it is and we never want to duplicate services. Then we have to be careful about are we duplicating here? I think we are sending out a message and we are dealing with it in a different way. That is why I do not think that the commission should get into the role of actually funding because that is duplicating. Then you have different structures set up and you are duplicating. To be a commission that goes out and facilitates and works with a whole lot of different groups and comes out with a strategic plan, you could say that is a duplication of what is happening now. I think it would clearly remove that from where it is happening and they would take that on. Then in terms of what their role is in terms of looking at where there is duplication, I think that would be part of what they do. For instance, I am always amazed at what some of the health insurance funds have been doing with some of their apps and their healthy initiatives. I am not sure that that is always taken on board. Therefore, does that mean that less can be done elsewhere? Possibly not because they are different groups that they are providing information to. There is a lot that I think a commission could do to look at duplication and make recommendations and facilitate ideas and views there. Secondly, in terms of whether the commission is a duplication, if we set it up well and sort out the boundaries of what the commission is to do and what government departments are going to do, I think you could minimise that.

**Mr KELLY:** It would be creating a sort of a broad plan which the health department would be a part of. There are issues at the moment in terms of the planning processes in Queensland Health. We call it a health system, but it is really a sickness system. If you take away the birthing side of things, we are really taking sick people and trying to make them better; they are already sick. But health promotion is really what you are saying: it is about trying to promote health and it is not necessarily done in hospitals. Are there conflicts in terms of health planning if you have to manage that acute care service as well as trying to manage the health promotion side of things?

**Dr Young:** There have been, but they have become less. A series of governments have put a lot more support, resources and energy into looking at prevention. It is done by different people. So you do have different people in the department and in the hospital and health services and in NGOs, the primary healthcare networks—a whole range of areas—that are focused on health promotion and prevention in a whole range of areas. We have the traditional health promotion in terms of tobacco, smoking, alcohol, good mental health—those sorts of areas. Then we also have our screening programs, which are prevention—so breast, cervical, bowel cancer screening, those areas—and we have all our communicable diseases prevention work which ranges from vaccination through to managing mosquitos, through all of that and then all our environmental health. There is a lot of work done to prevent disease. We just do not think about a lot of it as preventing disease—water quality, air quality. There is all that work. It is definitely done and it is done by different people. It is done within the health system, within local government, within a whole range of bodies, but the person who is dealing with that sick patient is not also dealing with promotion. They do not have to choose what they will spend their time doing.

**Mr KELLY:** When people are sick it has always struck me that that is an excellent opportunity to educate not just them but their families. My most recent clinical experience was in the stroke units. A lot of the education there is driven by the partnership with the National Stroke Foundation, and it is excellent. You have good resources, good support. Do you think the health commission could play a role in providing more of those sorts of partnerships and providing a better guidance or direction for Queensland Health in terms of a really comprehensive approach to patient education?

**Dr Young:** Of course it could. The issue is really how broad you want to make the role of the commission. That is secondary and tertiary prevention. It is whether you want to do the whole primary prevention, which I have mainly been talking about, or you do the early intervention, which is the screening, picking up diseases early, high blood pressure, or whether you do the prevention after an event has happened—whether it be a heart attack or a stroke—so that you prevent further episodes of that disease in that person. Indeed, you also then have the opportunity to work with families if they have increased risk of disease. There is an enormous span of work that can be done. My view is that

you always try to focus what you want any organisation to do so they succeed in that area rather than giving too broad a remit. There is also evolution: you can start with one remit and then broaden it as things go on. I think we have to be careful we do not give any new body an enormous amount of work that is not easily doable.

**Mr KELLY:** It was interesting that you talked about the social determinants of health. That is something I have been thinking about a lot over the last couple of years and I am reading that book by Dr Mahmoud at the moment. It is quite a fascinating book. A lot of the things that he talks about and a lot of other things that I have read are really quite challenging and ultimately are going to be sorted out in parliament rather than by a health promotion commission. What are the social determinants that you think the health promotion commission might be able to influence or have an impact on?

**Dr Young:** They are the things like education and employment and looking at those; looking at access to good, nutritious food in communities; looking at access to ability to safely exercise. They are those sorts of things, but probably the top one is education. That is really the biggest one that can make a big difference.

**Mr DICKSON:** Dr Young and your colleagues, thank you so much for coming along again. I was excited to hear the news about the reduction in smoking and also obesity. It is good to see all governments, regardless of what flavour they are, are succeeding, particularly with your help. To take this a bit further in relation to setting up a board of any kind, we have some fantastic DGs—people like yourself. I remember Dr John Glaister. He used to be my director-general. He was actually bringing people together in early 2014 doing exactly what we were talking about here today. That was the Main Roads, Transport, Education, Health, Sport and so on. There are already so many different facilities, vehicles and money. We have to do more with less in today's society as I see it. I do not think we are getting any more money. The income streams are not flowing in like they used to. We are succeeding now, so how do we do it better? Why can we not do that with the existing staff, the existing people? I am sure directors-general still get together every now and then. Why are they not working on this? Is this happening now? Can you let me know?

**Dr Young:** Yes, of course it is happening. People do get together across government agencies. This is just a different vehicle that I think can have some leadership to more easily bring all those groups together. It is broader than just government. Of course government all gets together, but this will make it easier for the government agencies, the NGOs and the community to all be involved in a dialogue.

**Mr DICKSON:** Dr Young, I hate disagreeing with you because I really like you a lot. Going back, we do not want to create any bureaucracies in Queensland or anywhere in this country; I think we have enough now. We have the people with the wherewithal and with the money. The Department of Health chews up about 28 per cent of the Queensland budget. If we do create this new entity what is that going to cost?

**Dr Young:** That has been decided, I believe, as part of the election commitment. It was $7.5 million over four years.

**Mr DICKSON:** It is an extra cost to the people of Queensland and we already have a government with well-paid directors-general who have the ability, which I know through Dr John Glaister, as I said earlier, back in 2014. So what has happened from 2014 to now in this area?

**Dr Young:** I actually believe it is a decision for government how they think we can advance the next phase of our health promotion activities in Queensland. As I tried to outline in my opening statement, I think we have come a long way. I think that we have really reached a point at which we need to accelerate. I do not want us to plateau. It is fantastic that we have improved when it comes to people being overweight and obese so we are very confident we are not getting fatter in Queensland. That is great. Now we have to improve so that we turn that around and we start actually decreasing the number of Queenslanders who are overweight and obese. It needs an extra push. This is one way that it could happen.

**Mr DICKSON:** I look at the terms of reference and it talks about ways of partnering across government and within industry and community including collaborative funding, evaluation and research. So I get back to the point again. We are looking to spend more money on something we already have. We already have the personnel and the logistic material such as our school ovals that we do not utilise on weekends and at night. Is it not a matter of being an innovative state and getting ahead of the game and utilising the existing funds we have and putting that extra money towards helping people in our hospitals?

**CHAIR:** Member for Buderim, I would raise two points. We are not debating the establishment of a commission because that is a commitment the government has made rather than the department. It is how the department feels they would best contribute to health policy in Queensland. The other thing is that in the submission the department made to the committee it also talked about a transfer of some positions. It is about using existing resources as well as new resources to try to get the best outcome, which partially answers your question.

**Mr DICKSON:** Madam Chair, I do understand that. That is why I am going through the Department of Health and teasing that out—how it is going to happen, where is it going to happen and what has happened over the last couple of years?

**CHAIR:** The government has asked the committee to look at what the role and scope et cetera might look like. The department is contributing information to that. They are not making the decision about what the role and scope et cetera would look like. The minister and the government will make that decision.

**Mr DICKSON:** With the greatest respect, I concur.

**CHAIR:** I am just trying to help Dr Young who I know is looking at you thinking, `I cannot answer some of your questions because they are not for Queensland Health.'

**Mr DICKSON:** I am happy. I thank you for all the hard work you are doing in your department. I emphasise could you please work within the existing budget if you can and push that issue. I know what a great job you do.

**Mr HARPER:** Any investment upstream is absolutely worth it downstream. We have it. You articulated it clearly today, particularly with the obesity and smoking rates. There is more to be done. How you do that, I do not know. I think the commission will absolutely point us in the right direction. I do not know whether the Healthway model, which generally funded those community bodies, is the right model. I draw your attention to VicHealth. Anyone with a background in health knows that VicHealth and the Department of Health had a differing view. I know members have touched on duplication and so on today.

I will give an example. One of the most informative and entertaining debates I saw was a bunch of cardiologist talking about thrombolysis versus stenting. They stood on their turf—this is the best way to do it. It is a matter of overcoming those barriers. If we have a health commission which has all the best intentions to have a healthier Queensland, how does Queensland Health overcome the barriers so we have good coordination of the whole issue?

It is an enormous job. I do not think 10 people from the department will be enough. It is an enormous job to have collaboration between all the NGOs right across this vast state. It is challenging, but this is a step in the right direction. I would hope that you would be able to articulate how you foresee overcoming those barriers that we saw particularly with VicHealth which had separate opinions.

**Dr Young:** It is always difficult, but debate is so important. This is not a science. It is about behavioural change. It is difficult. It is a matter of working with everyone and getting everyone's idea and distilling what we can use to move forward. I think we have shown with the work that we have done, particularly with smoking, that it can happen. If you take a process that takes a whole range of levers you never end up saying which is bit that works. If you take all of those and bring them together and harness them then you can achieve things. You always have people disagreeing about how to move forward, but they all want to move forward. It is a matter of taking all of those and working out how you can use them and how you can put them in place.

**CHAIR:** Dr Young, one of the incredible strengths of the Victorian Health Promotion Foundation was that they had a really strong evidence and knowledge base which was a resource for everyone. When I say everyone, it really was about a collaborative effort with significant bodies like the Stroke Foundation and the Heart Foundation down there, universities which are an absolute powerhouse of skill in terms of research and content, NGOs and the community generally.

My perception was the fact that they had this additional energy and work being placed on taking their heads above the clouds of delivery, as you were commenting on, of programs to look at what is happening and commissioning research in particular areas which really was supporting and assisting departments, not just Health as you said, to have stronger evidence based policies which really get into the heart of the problem. I think that was one of the great strengths and exciting things about the foundation down there.

They also mentioned that they have a real focus on a wellbeing agenda and they included things like women, diversity, domestic and family violence, which was perhaps broader than my initial thoughts when I had looked at the committee's remit. Do you have any comments to make about that?

**Dr Young:** They have been in place for a long time so it has been evolutionary. I really do strongly suggest that we have to give a defined role for this commission up-front and get them started and focused on an area so that we get good delivery then things can expand and increase. We cannot give them too much, remembering they are quite a small group—we are talking about 15 staff. I have just been given, very helpfully, information that the Victorian Health Promotion Foundation has 78 staff. If we want this group to succeed, which I am positive we all do, of course we do, then we have to be careful not to overwhelm them early on. That is where we can look at how the Mental Health Commission has worked. That has been a very defined area and much work has been taken to do that.

If we drown them they are not going to have those early wins that are so important to moving our agenda. I do not want a hiatus in terms of where we are today to where we can next go to. We have to move there as quickly as we can. I think we have to facilitate the commission early on to be able to get runs on the board early.

**CHAIR:** My colleague was talking about the dynamic between the department and the commission. One of the key things was getting the resourcing right and what our remit is—that is, what are we working on on the basis of the resources and what can we deliver. The third really important thing was the credibility of the commission itself and those who are leading it. Do you have any comments to make about what sort of skill set you think the head of such a commission should have? They certainly have very strong researchers which add significant weight and credibility. Do you have views about that?

**Dr Young:** I think it would be good if we were able to recruit someone with experience in the space so that they do not have to get up to speed. Many commissioners can have good, solid generic skills in engagement and facilitation but I think in this one if we want them to really get going quickly they need to have some experience and actual involvement in health promotion initiatives, whether it be from a research angle or a delivery angle. That does not concern me. They cannot be content free. I think they have to have some key knowledge in the area.

**Dr ROWAN:** I come back to what the chair was talking about as far as the scope and remit of a Queensland health promotion commission is concerned. When we were in Western Australia we found that one of the things their commission has been looking at is bullying, particularly amongst young people, and the health and wellbeing of young people experiencing all forms of bullying, whether it be physical or verbal or cyber bullying. No-one would want any form of bullying, whether it is amongst my Labor colleagues or amongst young people. Do you see that as a role for a Queensland health promotion commission or does that fall within the role of the Queensland Mental Health Commission?

**Dr Young:** You have answered that question. I definitely think it would sit far better with the Mental Health Commission.

**Dr ROWAN:** The former Australian preventative health agency has now been wound up. The Queensland Health Promotion Commission proposed model is really a jurisdictional, state based model similar to what existed at the national level. My question is around the Commonwealth's jurisdictional responsibilities particularly when it comes to primary care and general practice. How do you see this commission articulating issues with the Commonwealth from a governmental jurisdictional level and also with other entities that exist within the Commonwealth's jurisdictional space?

**Dr Young:** I would see it as part of the stakeholder engagement that this commission would have to engage with the Commonwealth and the various agencies within the Commonwealth—not just Health but a whole lot of other agencies—and work with them. They will have to work with all three levels of government—state, local government and Commonwealth.

**Dr ROWAN:** Would the Department of Health be the conduit to the Commonwealth from that perspective or would there be an independent relationship between the Queensland Health Promotion Commission and those entities?

**Dr Young:** I would not see the Department of Health as being a conduit for this commission for anything. I think they would be an organisation that develops all of those linkages themselves.

**CHAIR:** Thank you very much for your time today. The time for this public briefing has expired. If we need any further information, as we always do, we will write to you and seek that. I declare this briefing closed.

**Committee adjourned at 9.56 am**