Sub # 023

Health and Ambulance Services Committee Inquiry into the Establishment of a Queensland Health Promotion Commission

November 2015

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 5800 members, and branches in each state and territory. DAA is a leader in nutrition and advocates for food and nutrition for healthier people and healthier nations. DAA appreciates the opportunity to provide input into the consultation of the Health and Ambulance Services Committee Inquiry into the Establishment of a Queensland Health Promotion Commission.

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Sub # 023

The potential role, scope and strategic directions of a Queensland Health Promotion Commission

In determining the potential role, scope and strategic directions of a QHPC it is important first to define health promotion, and then to elucidate the potential roles and scope. In addition, it is also necessary to investigate workable governance structures and funding models.

Defining health promotion

The establishment of the Health Promotion Commission (HPC) in Queensland is to be applauded as an example of a government taking responsibility for ensuring the health and wellbeing of its constituents. Recently the World Health Organisation released the *Health in all Policies Framework for Country Action*[1]. The establishment of the Commission is in keeping with the tenets of this approach, acknowledging the core responsibility of government in prioritising health and equity.

After the Ottawa Charter the definition of health promotion at the Bangkok is "the process of enabling people to increase control over their health and its determinants, and thereby improve their health. It is a core function of public health and contributes to the work of tackling communicable and noncommunicable diseases and other threats to health".[2] Health promotion moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.

Health promotion operates within the context of primary health and across a continuum ranging from medical interventions, behaviour and lifestyle modification (targeting the general and at-risk populations) and interventions targeted at changing the socio-environmental causes of disease. Health promotion includes the prevention of disease and approaches that create health.[3]

A health promotion approach can include:

- Primary or early intervention with individuals, groups or communities to prevent disease;
- Community education around health issues;
- Community development to strengthen community capacity to engage in healthful approaches;
- Advocacy to improve the living circumstances of individuals; and
- Advocacy for healthy public policy. [4]

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[1] World Health Organization. (2014). Health In All Policies: Helsinki Statement and Framework for Country Action. WHO: Geneva. http://apps.who.int/iris/bitstream/10665/112636/1/9789241506908_eng.pdf?ua=1 Accessed November 14th 2015.

[2] World Health Organization. (2005) The Bangkok Charter for Health Promotion in a Globalized World. WHO: Geneva www.who.int/healthpromotion/conferences/6gchp/hpr_050829_ BCHP.pdf Accessed November 14th 2015

[3] Baum, F., Freeman, T., Jolley, G., Lawless, A., Bentley, M., Va "Rtto', K., Boffa, J., Labonte, R., Sanders, D. (2014). Health promotion in Australian multi-disciplinary primary healthcare services: case studies from South Australia and the Northern Territory. Health Promotion International 29(4):705-718

[4] ibid

Sub # 023

The role and strategic directions of a Health Promotion Commission in Queensland

The Queensland Commission will be ideally placed to act as a catalyst to improve the quality, equity, efficiency, effectiveness and responsiveness of the health system. In line with the *Health in All Policies* action plan, the Commission's roles will be to:

- Enable the commitment to health and health equity as a political priority by coordinating activities that take action on the social determinants of health
- Facilitate structures and partnerships that support the development and implementation of strategies that promote health
- Support relationships with all sectors, including the private sector to contribute positively to public health outcomes
- Strengthen the capacity the health department to engage other sectors of government and civil organisations through leadership, advocacy and mediation to achieve improved health
- Build institutional capacity and skills
- Include communities, social movements and civil society in the development, implementation and monitoring of health strategies.[5]

More specifically the Commission would be engaged in:

- **Advocating** across a broad range of issues that impact on effective engagement and delivery;
- **Building** knowledge networks and assembling and disseminating best available evidence;
- **Creating** environments for action that encourage innovation with respect to strategies, policy and dissemination;
- **Defining** priorities and strategic axes with a focus on outcomes;
- **Encouraging** multi- and inter-sectoral action;
- **Fostering** partnerships.

Strategic directions

As a peak body with the vision to facilitating food and nutrition for healthier people and healthier nation, our submission is focussed on those areas that support this vision. This is not without precedent. It is know that poor diet is the single most important behavioural risk factor impacting on health and priority health issues.[6] The burden of disease due to total dietary intake is now at least 14% of total disease burden, double that of cigarette smoking.[7]

Food and nutrition are like most areas of health a "wicked" issue. Wicked problems are: not able to be managed by traditional linear, analytical approaches; difficult to define; multi-causal; socially complex; not able to be managed through any one organisation; and characterised by

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[5] World Health Organization (2014) ibid

[6] NHMRC. (2013). *Dietary Guidelines for Australians.* Canberra: AGPS.

[7] Institute for Health Metrics and Evaluation. (2013). *The State of US Health: Innovations, Insights, and Recommendations from the Global Burden of Disease Study*. Retrieved from http://www.healthdata.org/sites/default/files/files/policy_report/2013/USHealth/IHME_GBD_USHealth_FullReport.pdf Accessed November 14th 2015

Sub # 023

chronic policy failure.[8] Food security, infant feeding, obesity and chronic disease would all be examples of wicked problems.

Where could the HPC make a difference?

- Only 15% of mothers are exclusively breastfeeding their infants at 6 months representing a lost opportunity for improving child development and reducing childhood obesity.[9]
- 22% of Aboriginal and/or Torres Strait Islander households were food insecure with seven per cent going without food; in non-remote areas this was about 20% increasing to nearly 31% in remote areas with two-thirds of these (21%) going without food.[10]
- In Brisbane 25% of households who are in some of our most disadvantaged suburbs are not able to access food on a regular basis.[11]
- Eating according to the Australian Guide to Health Eating costs about $15 more per person per week; the cost of a healthy basket of food increased by 37% over approximately 12 months; the healthy basket costs 16% and 27% in regional and remote communities in Queensland respectively.[12]
- In 2011-2012 28% of Queensland children were overweight or obese and about 1.1 million adults were obese by measurement and 1.2 million overweight.[13]
- Only 7% of Queenslanders are consuming the recommended serves of vegetables. Given that fruit and vegetable consumption is a known determinant in the prevention of diabetes, cancers, heart disease and obesity – improving consumption will have far-reaching benefits.[14]
- Workforce – between 2009 and 2013 there was a 90% reduction in the nutrition workforce able to engage in the prevention of diet-related disease.[15] The restructuring of Medicare Locals to Primary Health Networks has further reduced capacity in disease prevention and health promotion.

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[8] Australian Public Service Commission (2012). Tackling wicked problems: a public policy perspective. http://www.apsc.gov.au/publications-and-media/archive/publications-archive/tackling-wicked-problems Accessed November 14th 2015

[9] Australian Institute of Health and Welfare (2011) 2010 Australian National Infant Feeding Survey: Indicator Results. AIHW, Canberra.

[10] Australian Bureau of Statistics. (2015). Australian Aboriginal and Torres Strait Islander Health Survey: Nutrition Results - Food and Nutrients, 2012-13 4727.0.55.005,. Accessed 30 September, 2015, from www.abs.gov.au

[11] Ramsey, R., K. Giskes, T. Gavin and D. Gallegos (2012). "Food insecurity among adults residing in disadvantaged urban areas: potential health and dietary consequences." *Public Health Nutrition* **15**: 227-237.

[12] Queensland Health (2015). Healthy Access Food Basket. https://www.health.qld.gov.au/research-reports/reports/food/access/default.asp Accessed November 14th 2015

[13] Queensland Health. (2014). The health of Queenslanders 2014. Fifth report of the Chief Health Officer Queensland. . Queensland Government. Brisbane.

https://www.health.qld.gov.au/publications/research-reports/reports/cho-report/cho-full-report.pdf Accessed November 15th 2015.

[14] ibid

[15] Vidgen, H., Adams, M. Gallegos, D.(forthcoming). Who does nutrition prevention work in Queensland? : An investigation of structural and political workforce reforms. *Nutrition and Dietetics*

Sub # 023

Governance

There a number of key tenets to be considered when contemplating the governance of the Commission to ensure its sustainability and effectiveness.

Funding

The commitment of $7.5million over four years by the Queensland government to establish and support the functions of the Commission is to be commended. However, these funds will be inadequate to support innovative and sustainable practice. In Western Australia, the very successful *Healthway* uses the Tobacco Tax to fund ongoing activities. A levy on sugar-sweetened beverages could be successful in generating adequate funds. For example, based on a 20 cent levy/litre[16] and taking the lowest amount generated per annum of $10.10 per household, and if this is generated by only half of households in Queensland (of which there are approximately 2 million), the levy has the potential to generate substantial income every year.[17]

Transparency and independence

The Commission requires bipartisan support. It needs to be able to:

- act without fear or favour beyond the political cycle;
- provide frank advice;
- advocate based on the best available evidence;
- engage with a variety of partners in the private and public sector;
- deliver timely, innovative strategies.

Consequently, DAA recommends that the Commission be set up as an independent statutory authority established under an Act of Parliament. As an independent statutory authority the Commission will be able to: control its own funds; engage in commercial activities; and determine standards. The key to success will be for the Commission to work across sectors within and outside government. As a result the Commission should be established as a portfolio of the Department of Premier and Cabinet. The rules of engagement of the Commission should be carefully articulated to ensure accountability, transparency, and independence.

A Queensland Health Promotion Commissioner should be appointed, and report directly to the Premier of Queensland. The Commissioner should have a health qualification and experience and expertise in the preventative health space. An advisory board should be assembled to provide advice to the Commissioner. This Board should include the following (these are not mutually exclusive):

- Consumer representative
- Aboriginal and/or Torres Strait Islander representative with experience in working in the preventative health area
- Culturally and Linguistically Diverse representative with experience in working in the preventative health area

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[16] Sharma A., Hauck K., Hollingsworth B. *and* Siciliani L. *(*2014*)*, The effects of taxing sugar sweetened beverages across different income groups. Health Econ., 23*, pages* 1159–1184*, doi:* 10.1002/hec.3070

[17] Australian Bureau of Statistics. (2015). 4364.0.55.007 - Australian Health Survey: Nutrition First Results - Foods and Nutrients, 2011-12. http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4364.0.55.007main+features7102011-12 Accessed November 15th 2015

Sub # 023

- Practitioners or academics in the following areas:
  - Nutrition
  - Physical activity
  - Alcohol, tobacco and drugs
  - Sexual health
  - Communicable disease
  - Non-communicable disease
  - Health promotion theory
  - Epidemiology
  - Social marketing
- Members with expertise in
  - Legal
  - Accounting/finance
  - Risk management

The Commission should be given the authority to strategically direct the prevention activities of Hospital and Health Services and will have significant engagement with Primary Health Networks.

The effectiveness of collaborative, whole-of-government, and systems approaches for improving and sustaining health and wellbeing, including:

i. models used in other jurisdictions (including specific agencies or whole-of-government policy frameworks)

Health in All Policies (HiAP) is one strategy recommended to address the social determinants of health. It aims to include health and health equity principles and considerations in policy across all the sectors that influence health. Friel and colleagues utilise the example of the South Australian Government's Aboriginal mobility, safety, wellbeing work that highlighted a core issue related to limited mobility which impacted on social, physical activity and food access. It demonstrates the power to change a range of health outcomes with one strategy which needs to integrated across sectors.[18]

The INFORMAS group an international collaboration have been working to provide frameworks for action to assist in the alleviation of non-communicable diseases at a population level. They reiterate the importance of civil society and the scientific community playing an important role in the accountability of actions to improve food environments and in so doing reduce obesity and chronic disease. There domains of good practice and where actions would make a positive contribution include: food composition, food labelling, food promotion, food provision, food prices, food retail and food in trade agreements. A state level approach will not be able to impact on all of these areas but there is scope for the HPC to identify the areas of action and draw together the stakeholders required for action. [19]

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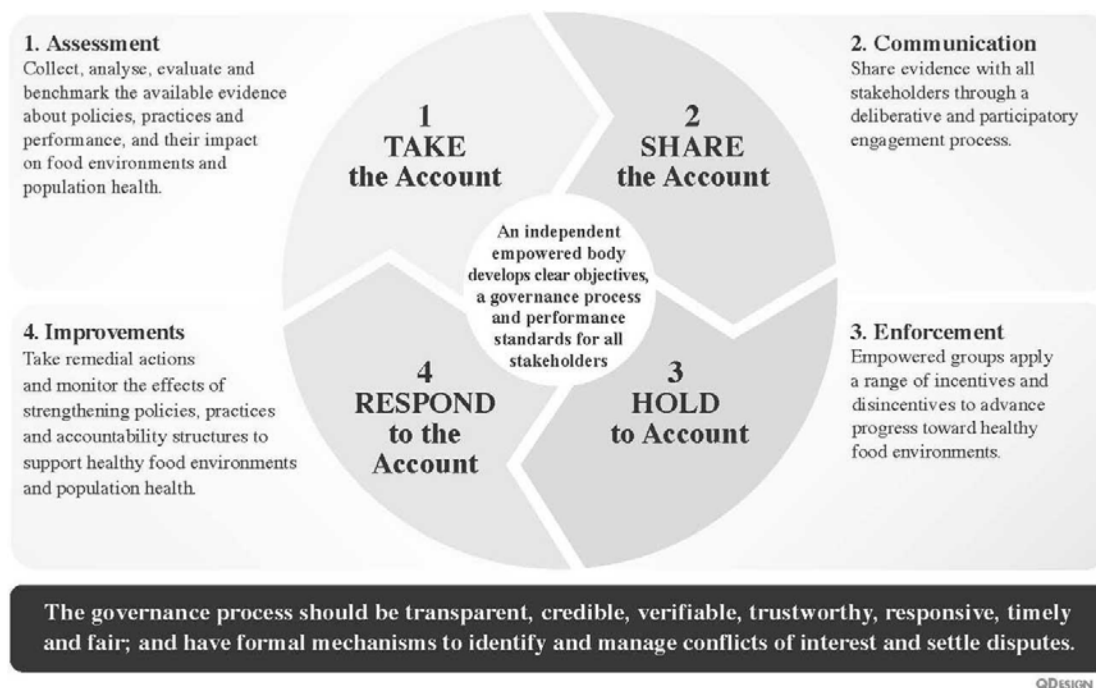
[18] Friel, S., Harris, P., Simpson, S., Bhushan, A. and Baer, B. (2015), Health in All Policies Approaches: Pearls from the Western Pacific Region. Asia & the Pacific Policy Studies, 2: 324–337. doi: 10.1002/app5.89

[19] Swinburn, B., Vandevijvere, S., Kraak, V., Sacks, G., Snowdon, W., Hawkes, C., Barquera, S., Friel, S., Kelly, B., Kumanyika, S., L'Abbé, M., Lee, A., Lobstein, T., Ma, J., Macmullan, J., Mohan, S., Monteiro, C., Neal, B., Rayner, M., Sanders, D., Walker, C. and INFORMAS (2013), Monitoring and benchmarking government policies and actions to improve the healthiness of food environments: a proposed

Sub # 023

Another framework that could be adopted by the HPC with respect to food environments but would be applicable across areas has been developed by Vivica et al (2014) and is illustrated below in Figure 1. Developed from a range of highly effective frameworks this four-step accountability framework provides a structure for action and engagement.[20]

Figure 1: Four-step accountability framework to action on unhealthy food environments[21]



DAA members are engaged in the development and implementation of a wide range of population based activities designed to change food environments, improve access to healthy food choices and change dietary patterns. Mobile health and the use of ICTs will continue to expand the options and scope for innovation. Examples of these include but are not limited to:

- Learning Eating Active Play and Sleep (LEAPS) an innovative program delivering and evaluating training to early childhood educators on the Health Eating and Physical Activity Guidelines for Early Childhood. The aim is to improve access to healthier food choices in early education and care settings.
- Parenting, Eating and Activity for Child Health (PEACH) a weight management program for children aged 5 to 9 designed to assist parents navigate obesogenic programs.

Government Healthy Food Environment Policy Index. Obesity Reviews, 14: 24–37. doi: 10.1111/obr.12073

[20] Vivica, I. K., Swinburn, B., Lawrence, M., Harrison, P. (2014). An accountability framework to promote healthy food environments. Public Health Nutrition 17.11: 2467-2483

[21] ibid

Sub # 023

- NOURISH a universal intervention designed to promote and protect appropriate feeding practice in infancy and early childhood. This project has significant scope to be developed into a mhealth intervention.[22]
- MumBubConnect – a text messaging service designed to sustain any breastfeeding for as long as possible.[23]
- The Ethnic Communities Council of Queensland Living Well Multicultural – a program specifically tailored for culturally and linguistically diverse groups and demonstrating outcomes with respect to eating and physical behaviours as well as weight, blood pressure and waist circumference.[24]
- TXT2BFiT is an app based program aimed at young adults and was the winner of the President's Award for Innovation in 2013.[25]

Approaches to addressing the social determinants of health

Links between social and economic disadvantage and poor dietary intake are well known. Food security which encompasses food access, availability, utilisation and stability over time and context highlights the need for a whole of population, whole of government approach. Food and nutrition approaches that will address the social determinants include:

- Monitoring and maintaining stability of food prices; unhealthy food choices are less expensive that healthy food choice.[26] INFORMAS have developed protocols for food price monitoring.[27] A 20% price reduction in fruit and vegetables resulted in increased purchasing per household of 35% for fruit and 15% for vegetables over the price-reduction period.[28] ACCESS/STABILITY.

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[22] Daniels L, Mallan KM, Battistutta D, Nicholson J, Meedeniya J, Bayer J, et al. (2014) Child eating behaviour outcomes of an early feeding intervention to reduce risk indicators for child obesity: the NOURISH RCT. *Obesity* 22(5):E104-E111

[23] Gallegos, D, Russell-Bennett, R, Previte, J, Parkinson, J (2014) Can a text message a week improve breastfeeding? *BMC Pregnancy and Childbirth* 14:374.

[24] Gallegos, D., McKechnie, R., Vo, B. Evaluation of the Ethnic Communities Council of Queensland Living Well Multicultural Program

[25] Partridge, S., McGeechan, K., Hebden, L., Balestracci, K., Wong, A., Denney-Wilson, E., Harris, M., Phongsavan, P., Bauman, A., Allman-Farinelli, M. (2015). Effectiveness of a mHealth Lifestyle Program With Telephone Support (TXT2BFiT) to Prevent Unhealthy Weight Gain in Young Adults: Randomized Controlled Trial. *JMIR mHealth and uHealth*, 3(2), 1-14.

[26] Queensland Health (2015). Healthy Access Food Basket. https://www.health.qld.gov.au/research-reports/reports/food/access/default.asp Accessed November 14th 2015

[27] Lee, A., Mhurchu, C. N., Sacks, G., Swinburn, B., Snowdon, W., Vandevijvere, S., Hawkes, C., L'Abbé, M., Rayner, M., Sanders, D., Barquera, S., Friel, S., Kelly, B., Kumanyika, S., Lobstein, T., Ma, J., Macmullan, J., Mohan, S., Monteiro, C., Neal, B., Walker, C. and INFORMAS (2013), Monitoring the price and affordability of foods and diets globally. Obesity Reviews, 14: 82–95. doi: 10.1111/obr.1207

[28] Ball, K., McNaughton, S.A., Le, H.N.D., Gold, L., Ni Mhurchu, C. Abbott, G. Pollard, C., Crawford, D. (2015). Influence of price discounts and skill-building strategies on purchase and consumption of healthy food and beverages: outcomes of the Supermarket Healthy Eating for Life randomized controlled trial. American Journal of Clinical Nutrition 101.5:10055-1064

Sub # 023

- Increasing access to high quality healthy food choices in disadvantaged areas and decreasing access to poorer food choices.[29][30] AVAILABILITY/STABILITY
- Increasing food literacy among individuals and populations.[31] UTILISATION

Population groups disproportionately affected by chronic disease

There should be a strong focus on the following groups:

- *Culturally and Linguistically Diverse families and communities*

  Evidence indicates that a number of factors contribute to declining health among refugee and migrant populations including: lack of recognition of overseas qualifications; unemployment; low socio-economic status in Australia as opposed to the status in their home country; lack of job satisfaction; and discrimination, contributing to prolonged stress and anxiety.[32] Some migrant populations experience rapid weight gain after migration to Australia, with many also arriving from countries experiencing the nutrition transition where chronic disease risk is higher.[33] The diabetes death rate was 25% higher than for the Australian-born population (Queensland Health 2014).[34] Recently, the Chief Officer's report identified higher hospitalisation rates for those born in in Oceania, North Africa and the Middle East, with Samoans, Tongans, Fijians and Australian South Sea Islanders having higher rates of hospitalisation for many conditions. Culturally tailored health resources and a Multicultural Health Worker Model, are widely recognized as a blueprint in providing integrated culturally responsive health care for CALD communities.[35][36]

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[29] Millichamp, Anna & Gallegos, Danielle (2012) Comparing the availability, price, variety and quality of fruits and vegetables across retail outlets and by area level socioeconomic position. *Public Health Nutrition*, *16*(1), pp. 171-178.

[30] Ball, K., Lamb, K., Costa, C., Cutumisu, N., Ellaway, A., Kamphuis, C. B., Mentz, G., Pearce, J., Santana, P., Santos, R., Schulz, A. J., Spence, J, Thorton, L., van Lenthe, F., Zenk, S. N. Neighbourhood socioeconomic disadvantage and fruit and vegetable consumption: a seven countries comparison. (2015) , International Journal of Behavioral Nutrition and Physical Activity 12:1-13

[31] Vidgen, H.A. and Gallegos, D. (2014). Defining food literacy and its components. Appetite 76: 50-59

[32] Queensland Government. (2004). Social Determinants of Health- Ethnicity Fact Sheet. Brisbane. http://www.health.qld.gov.au/ph/Documents/saphs/20397.pdf Accessed December 3rd 2013

[33] Australian Institute of Health and Welfare. (2012). *Australia's Food & Nutrition 2012*. Cat. no. PHE 163. Canberra: AIHW

[34] Queensland Health. The Health of Queenslanders 2014. Fifth report of the Chief Health Officer

Queensland. Queensland Government. Brisbane 2014.

[35] Goris, J., Komaric, N., Guandalini, A., Francis, D., and Hawes, E. (2012). Effectiveness of multicultural health workers in chronic disease prevention and self-management in culturally and linguistically diverse populations: a systematic literature review. *Australian Journal of Primary Health* 19(1):14-37.

[36] Henderson S., Kendall E., and See L. (2011). The effectiveness of culturally appropriate interventions to manage and prevent chronic disease in culturally and linguistically communities: a systematic literature review. *Health and Social Care in the Community*. 19(3), 225-249.

Sub # 023

- *Aboriginal and Torres Strait Islander families and communities*
  Research in remote communities has shown that, despite significant effort and with some achievements including decreased intake of sugar, increased availability and affordability of healthy foods (particularly fruit and vegetables) and improvement in some nutrient intakes, the overall effect has been a decrease in total diet quality characterised by increased supply and intake of discretionary foods high in saturated fat, added sugar and salt, particularly sugar sweetened beverages, and take-away foods. In urban areas nutritional problems were one of the primary areas identified in children from Aboriginal or Torres Strait Islander families.[37][38]
- *Families and communities living with disadvantage*
  Low incomes, low levels of health literacy and poor access to education are complicit in the poor dietary quality and increased rates of diet-related disease for families and communities living with disadvantage. More than 3 in 5 Australian adults (63%) were overweight or obese (70% of men and 56% of women). Overweight and obesity were more common in areas with the lowest SES than areas with the highest SES (66% compared with 59%).[39] There are also indications of higher rates of anaemia and lower bone density in this population as well.

In all these communities the approach should be strengths-based with a focus on extended family, community engagement, neighbourhood networks, community organisations and events with due acknowledgement of the existing social resources and assets within communities which should be supported to promote better health.

Conclusion
The Dietitians Association of Australia thanks the Health and Ambulance Services Committee for the opportunity to provide input into the Inquiry into the establishment of a Queensland Health Promotion Commission. We are excited by the opportunities that the establishment of the Commission will provide in developing strong partnerships for the development of strategies that will improve the nutritional health and wellbeing of Queenslanders. With nutritional health as the underpinning for increased productivity, socially and economically, this bodes well for the future. We strongly believe the establishment of the Commission could provide a template for other states leading the way to an integrated national approach. DAA and its members look forward to being a part of the solution.

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[37] Lee A, Rainow S, et al. (2015) Nutrition in remote Aboriginal communities: lessons from Mai Wiru and the Anangu Pitjantjatjara Yankunytjatjara Lands. ANZ J Public Health published online: 10 Aug 2015.
[38] Gardner, S. Woolfenden, S., Callaghan, L., Allende, T. Winters, J., Wong, J., Caplice, S. Zwi, K. (2015). Picture of the health status of Aboriginal children living in an urban setting of Sydney.

Australian Health Review - http://dx.doi.org/10.1071/AH14259

[39] Australian Institute of Health and Welfare (2015). Australia's Health 2014. AIHW: Canberra. http://www.aihw.gov.au/australias-health/2014/ Date accessed November 22nd 2015