phn BRISBANE NORTH

An Australian Government Initiative

27 November 2015

Research Director
Health and Ambulance Services Committee
Parliament House
George Street
BRISBANE QLD 4000

Dear Research Director

RE: Inquiry into the establishment of a Qld Health Promotion Commission

Brisbane North PHN supports the proposal to establish a Queensland Health Promotion Commission and submits the following in response to the parliamentary inquiry's Terms of Reference.

Role, scope and governance

The proper foundation must be laid for the Queensland Health Promotion Commission to ensure it has the independence and impartiality necessary to successfully lead a reform agenda that can bring about tangible improvements to population health outcomes in Queensland.

Selecting the appropriate governance arrangements will be critical to this success and, in line with experiences of other models implemented in Australia and overseas, a statutory authority with a whole-of-government focus, reporting to the Premier, is the preferred option. Such a model will better ensure the engagement of all sectors involved in health promotion and prevention, which will be critical to the success of the Queensland Health Promotion Commission.

In this respect, Mr Sebastian Rosenberg and Professor Alan Rosen have examined the various mental health commissions established in Australia, at both the State and Federal level, and New Zealand. They found there were 'significant differences not only in the construct of the respective commissions but also in the political circumstances in which each must work'. [1]

Of particular note, Rosenberg and Rosen highlighted the need for all commissions to strike a balance between maintaining independence from government, while also retaining the ability to exert the influence within government departments necessary to achieve change. [1] They suggested the decision to situate the National Mental Health Commission with the Prime Minister's portfolio and department helped to emphasise the Commission's whole-of-government mandate. [1]

Exemplar models for consideration

An exemplar model for health promotion, which has been adopted by the South Australian Government, is the World Health Organization's Health in All Policies (HiAP) Framework.[2] The HiAP Framework elevates the importance of accountability for the health impacts of policy at all levels of government and, in this respect, is ideally structured to address the social determinants of health. [3]

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The *Helsinki Statement on the HiAP Framework for Country Action* notes that the ideas, actions and evidence originally inspired by the *Alma Ata Declaration on Primary Health Care* (1978) and the *Ottawa Charter for Health Promotion* (1986) contributed toward its development.[3]

In Queensland, a whole-of-government model that could help to inform the Inquiry's deliberations is the former Beattie Government's *Queensland HIV, Hepatitis C and Sexually Transmissible Infections Strategy 2005-2011*.[4] The Strategy facilitated a holistic approach to service delivery and supported the use of local resources to address the health needs of people in target groups and to manage co-morbidity appropriately.[5]

Another example of an innovative approach to health promotion is Healthy Together Victoria.[6] This Victorian Government initiative funds a workforce of approximately 170 people across the state, largely in local government, community health services and non-government organisations.[7] Healthy Together Victoria advises that it follows a 'complex systems approach' to initiate action on the systems that influence the health and wellbeing of individuals, families and communities.[7]

In Western Australia, Healthway (the Western Australian Health Promotion Foundation) was established as an independent statutory body reporting to the Minister for Health.[8] Healthway seeks to promote and support healthy lifestyles to reduce the burden of preventable disease in Western Australia.[8] Its Board of Management represents a mix of government and non-government organisations and is responsible for setting strategic direction and goals, and makes all decisions relating to the allocation of funding for grants and sponsorships.[8]

It is also informative to examine experiences with health promotion in the United Kingdom. Following the release of the 2010 White Paper: *Healthy Lives, Healthy People: Our strategy for public health in England*, the British Government observed that 'one-size-fits-all' solutions were not effective because public health challenges tended to vary from one neighbourhood to the next.[9] To improve health throughout people's lives, reduce inequalities and focus on the needs of the local population, the British Government deemed it necessary to shift the commissioning of public health services from the National Health Service (NHS) to local communities.[9]

The UK reforms took effect three years ago. Among the challenges identified in the White Paper were the need for: a higher priority for dedicated resources; protecting the population from serious health threats; helping people live longer, healthier and more fulfilling lives; and improving the health of the poorest, fastest.[9] A key strategy adopted was the introduction of Health and Wellbeing Boards to build strong and effective partnerships focused on improving the commissioning and delivery of services across NHS and local government.[10] A document, prepared by Brisbane North PHN, with a more detailed explanation of the UK reforms is at Attachment A.

Strategic direction

Brisbane North PHN advocates in favour of a collective impact approach to health promotion in order to empower communities to address the social determinants of health. Priorities for the Commission should include a focus on chronic illness and its causes, including obesity, alcohol and tobacco consumption, and strategies to help reach particular communities of interest. For example, such communities could include people from Aboriginal or Torres Strait Islander backgrounds, people with disabilities, people who are homeless, and LGBTI communities, which tend to be mobile and are therefore less accessible through 'place-based' (or regional) approaches. However, the main success driver for any health promotion strategies will be the ability to operationalise national or state-wide policies at the local level. As indicated above, Local Government can undertake this role. But, given the different nature of Local Government in Queensland to jurisdictions in Victoria and the UK, Primary Health Networks are better placed to assume this operational role.

While Local Government in Queensland has proven effective at enhancing immunisation uptake and promoting the use of public parks and other active lifestyle amenities, Primary Health Networks are

uniquely positioned to lead health promotion initiatives for several reasons. Chief among these is their strong relationships to primary health care providers and 'at-risk' population groups, such as people with chronic/complex conditions. This point is particularly relevant given the crucial role that general practitioners and allied health professionals can play in the delivery of health interventions, if properly supported.[11] The high level of trust that patients place in doctors, nurses and pharmacists, further underscores the need to engage primary health care providers from the outset in the co-design of health promotion strategies and interventions.[12]

Many Primary Health Networks also have extensive experience in forming collaborative, cross-sector partnerships that can deliver breadth (through social marketing) and depth (through local interventions) to health promotion campaigns. A prime example of this is the North Brisbane Partners in Recovery (PiR) initiative.[13] Brisbane North PHN leads a 13-member consortium, which collectively oversees the PiR initiative. A Consortium Management Committee is tasked with management and coordination of North Brisbane PiR and includes representatives of Queensland Government mental health services. Representatives of the Committee are drawn from a diversity of local and state-wide organisations, with a significant or exclusive focus on mental health and with extensive experience in delivering quality services to people with mental illness and their families.

Each year, for the past three years, the North Brisbane PiR initiative makes grant funding available through its Innovation Fund to support collaborative activities that reform the human services system in order to improve the lives of people with severe, long-term mental illness. PiR agencies also employ a team of Support Facilitators who work with program participants and their families to coordinate the range of care services needed. Recently, a carer and consumer-led evaluation examined the first 18 months of the initiative and found that more than 90 per cent of surveyed respondents participating in the initiative reported a reduction in their 'unmet needs'.[14]

Conclusion

The recommended approach for a Queensland Health Promotion Commission is for an independent statutory authority, accountable to the Premier. There are many Australian and overseas examples of health promotion commissions that can inform this structure. Research into their relative merits is extensive and should provide ample guidance to the Inquiry. A Health in all Policies approach with an emphasis on addressing the social determinants of health will deliver better population health outcomes. However, the Commission must also consider how it will operationalise policies at the regional level and it is proposed that Primary Health Networks already have the experience in developing the multi-sector partnerships necessary for success.

Should you wish to discuss this submission further with me, please contact our Public Relations Officer Mr Simon Brooks on 07 3630 7330 or email simon.brooks@brisbanenorthphn.org.au.

Yours sincerely,

Jeff Cheverton

A/Chief Executive

List of References

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Attachment A

Best Practice Example and Health and Wellbeing Boards

United Kingdom Public Health Reforms

In 2010, the White Paper, *Healthy lives, healthy people*, highlighted the need to reform the public health system with the overall aim of tackling public health challenges. Studies have shown that 'one-size-fits-all' solutions do not work as public health challenges vary from one neighbourhood to the next. [1] The Government deemed it necessary to shift public health power from the National Health Service (NHS) to local communities by enabling them to improve health throughout people's lives, reduce inequalities and focus on the needs of the local population. This has now been in practice for over three years.

The challenges that the White Paper highlighted the need for:

- higher priority for dedicated resources
- protecting the population from serious health threats
- helping people live longer, healthier and more fulfilling lives
- improving the health of the poorest, fastest.

Source: HM Government, 2010.[1]

As part of the reforms, responsibility for commissioning of many public health services also moved to local authorities and many directors of public health have reported confidence of better health outcomes in the future and positive experiences of working in local authorities.[2]

Two clear successes from the reforms are:

- smooth process of reform due to a largely dedicated transferred ring-fence of budget and dedicated resources for public health to local authorities
- adaptability of local authorities in tackling public health and wellbeing for their local populations.

Source: Kings Fund, 2015a.[2]

Some of the programs which public health departments in local authorities are providing through commissioners or supporting include:

- *Sexual health services*: specialist services including: young people's sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools, colleges and pharmacies
- *National Child Measurement Program*: established in 2006 which measures the height and weight of children in reception (aged 4 four to five years) and year 6 (aged 10 to 11 years) to assess overweight and obesity levels in children)
- *NHS Health Checks*: for adults in England between the ages of 40 and 74 which assesses a person's risk of developing some diseases. The individual is given advice and support in order to help them to reduce their risk and if necessary medicines may be provided
- *Health and Wellbeing Board establishments*: hosted by local authorities which bring together representatives from the NHS, public health, adult social care and children's services and elected representatives from community services (e.g. Local Healthwatch and Age UK) to plan how best to meet the needs of their local population and tackle local inequalities in health.
- *Free school meals*: meals given to all children in reception and year 1 and 2 in state-funded schools and also older pupils who are eligible.

Health and Wellbeing Boards

Background

The ambition behind the introduction of health and wellbeing boards is to build strong and effective partnerships, which improve the commissioning and delivery of services across NHS and local government, leading in turn to improved health and wellbeing for local people. The *Health and Social Care Act 2012* creates a common flexible framework, by requiring the establishment of a health and wellbeing board for every upper tier local authority (Department of Health, n.d). All health and wellbeing boards became fully operational on 1 April 2013.[3]

Core statutory membership

The 2012 Act prescribes a core statutory membership of:

- at least one elected representative, nominated by either the Leader of the council, the Mayor, or in some cases by the local authority
- a representative from each Clinical Commissioning Group (CCG) whose area falls within or coincides with, the local authority area
- the local authority directors of adult social services, children's services, and public health
- representative from the local Healthwatch organisation.

Source: UK Department of Health, n.d.[4]

With this core membership, health and wellbeing boards present a powerful opportunity for genuine joint working between key players within every locality, a principle underpinned by the ability of local people to influence the shaping of services that really meet their needs. Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) are shared outputs prepared jointly by all members of the board, and there is a clear expectation that these be reflected in plans for commissioning in relation to the area.

Who are they and where do they sit?

Established and hosted by local authorities, health and wellbeing boards bring together the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch, to plan how best to meet the needs of their local population and tackle local inequalities in health.[1, 5] They are central to the UK Government's vision of a more integrated approach to health and social care.[3]

Key responsibilities

The Board's key responsibilities are:

- to ensure a coordinated approach to health, social care and public health across the County
- to lead the development of the Joint Strategic Needs Assessment
- to develop a shared Health and Wellbeing Strategy that will act as an overarching strategy for all the partners involved
- to receive and consider the commissioning plans of the GP led clinical commissioning consortia
- to be responsible for the development of HealthWatch.

Source: Warwickshire Health and Wellbeing Board, 2014.[6]

List of References: Attachment A

1. HM Government 2010. *Healthy Lives, Healthy People: Our strategy for public health in England,* Her Majesty's Stationery Office, accessed 23 Nov 2015, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf.

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