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Dear Ms Honeyman

Heart Foundation submission to Inquiry into the establishment of a Queensland Health Promotion Commission

The Heart Foundation welcomes the opportunity to make a submission to this Inquiry into the establishment of a Queensland Health Promotion Commission (QHPC).

A healthy economic future for Queensland will be shaped by the health and wellbeing of the population¹. That is why we need a coordinated, systems approach across whole-of-government and industry to prevent and manage chronic diseases and a focus on sustaining health and wellbeing for all.

Cardiovascular disease is the single leading cause of death for Australian men and women. The Heart Foundation's purpose is to reduce premature death and suffering from cardiovascular disease in Australia. As such, the Heart Foundation is Australia's leading heart health organisation representing:

- 700,000 Queenslanders who live with heart disease, stroke and blood vessel disease and the two in three families who will be affected by heart disease²
- 114,000 Queenslanders who are at high risk of having a heart attack or stroke and hospitalisation in the next five years³
- 90% of Queenslanders who have at least one risk factor for cardiovascular disease⁴
- all Queenslanders who want lead healthier lives.

The Heart Foundation submission will address all of the terms of reference for the inquiry: <https://www.parliament.qld.gov.au/work-of-committees/committees/HASC/inquiries/current-inquiries/Est%20QHlth%20Prom%20Comm>.

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

The election commitment to establish a QHPC is one the Heart Foundation has welcomed because of the need to prioritise, resource and fund coordinated approaches to improving and sustaining health and wellbeing in Queensland to a much greater degree than in the past.

Unless we do a better job of keeping people living active, healthy lives, our health care system will struggle to counter the burden of chronic diseases. The Queensland Government health budget currently accounts for 27% of the total state budget, with less than 2% of this spent on prevention. By 2020, it has been projected that the health budget will consume the entire state budget⁵.

We know that prevention works, but it must be sustained and appropriately funded. For example, tobacco control efforts over fifty years have shown we can succeed in saving thousands of lives and improving people's health and wellbeing through policy, legislation, education and programs.

The now defunct Australian National Preventive Health Agency set out a comprehensive strategy for Australia to become the healthiest country by 2020⁵. If we implement what we already know about prevention, we will succeed in improving the health and wellbeing of all Queenslanders at every stage of the health continuum.

Recommended principles to guide the QHPC

The Heart Foundation recommends the following principles be applied in developing the model for the QHPC:

1. Independence and bipartisan support
2. Expertise and leadership at the highest level
3. Adequate resourcing
4. Access and equity for all
5. Whole-of-government and industry approach
6. Have authority within government policy and legislative frameworks

1. Independence and bipartisan support

One of the greatest benefits of a QHPC or similar body would be if it is established as a truly independent body, separate from the political process, that could provide advice on the world's best practice approaches to improving and sustaining health and wellbeing without fear or favour.

Consecutive Queensland Governments from both major parties have said prevention is a priority. Despite this, the financial investment in prevention is well below what is needed. Improving and sustaining health and wellbeing must not be seen as an optional extra, rather as an essential component of our health system and other sectors, due to the multiple co-benefits for Queenslanders.

The QHPC would be best established as an independent company limited by guarantee with a separate board of directors, similar to the structure eventually adopted by Health Consumers Queensland. Greater visibility through a well-resourced independent body, strongly supported across government, industry and the community, will help give the issue status and reduce the vulnerability of this priority area from government processes. This governance structure will also allow for additional funding to be sourced via innovative methods.

The QHPC will need bipartisan support to be established and maintained. We cannot afford for the QHPC to be at the whim of whichever government is in power. The health and wellbeing of Queenslanders depends on this.

2. Expertise and leadership at the highest level

The QHPC should be able to draw on the expertise of independent advisors to provide strategic direction. Whatever structure is established to deliver this, the best independent advice possible needs to inform decisions about best practice approaches to improving and sustaining health and wellbeing and not political ideologies. It will need dynamic leadership, identifiable champions and the ability to negotiate the changing political landscape.

It is recommended the expert advisors be representative of a whole-of-government, community and industry approach, including people with expertise in health, transport,

planning, equity, government, non-government, university, community and industry so co-benefits are truly realised. The recommendations arising from the QPHC should be supported within Government at the highest level under the Premier and Cabinet.

3. Adequate resourcing

Overall public health expenditure needs a far greater funding commitment by governments as it is less than 2% of the total health budget⁶. State governments will benefit greatly from increased spending on prevention and improved health and wellbeing across sectors. Prevention delivers savings in state health care costs and reduced avoidable hospitalisations because 80% of premature deaths and 38% of hospitalisations are due to selected chronic diseases¹.

The Heart Foundation welcomes the Queensland Government's election commitments that have seen the re-instatement of some funding to effective preventive health strategies and workforce. However, this commitment is still inadequate to the size of the problem and we lag behind the top four countries that are leading the way - New Zealand spends 7%, Canada 6.5% and Finland and Slovakia 5%⁷. Australia is ranked 21st, spending only 1.7%.

Preventive health expenditure currently covers activities that aim to prevent illness and injury and protect or promote the health of the whole population or of specified population subgroups. It includes expenditure for communicable disease control, organised immunisation, selected health promotion, environmental health, food standards and hygiene, breast and cervical screening programs, prevention of hazardous and harmful drug use and public health records⁸.

The Heart Foundation is concerned that only \$7.5 million has been allocated to the establishment of the QHPC over four years, with five new positions proposed to be created and about ten positions to be transferred from the Prevention Division of the Department of Health for the QHPC. If these positions are removed from the Preventive Health Branch, this will have the net effect of cutting the preventive health workforce, which we strongly discourage. Instead, the Heart Foundation recommends the QHPC is allocated 15 additional roles to provide dedicated resources towards systems approaches to improving and sustaining health and wellbeing across sector to build the preventive health workforce which was significantly cut in 2012.

The proposed budget will impact on the scope of the QHPC. With the current budget allocation the work of the QHPC will need to be very focussed and strategic. In future, the budget and scope could be significantly larger than what is proposed in this initial phase of development. The relationship to the existing Preventive Health Branch in the Department of Health will need to be clear in terms of role, scope and strategic direction so as to avoid fragmentation, waste and duplication. The workforce of the Preventive Health branch also needs extra funding to re-build after the significant state-wide cuts that occurred a few years ago.

The relationship with the Queensland Mental Health Commission (QMHC) will also need to be clearly articulated, as the protective and risk factors for mental health and wellbeing addressed by the QMHC overlap significantly with the focus of preventive health priorities⁹.

The Heart Foundation recommends that the legislation that is drafted to establish the QHPC is written in a way that 'future proofs' the QHPC from being cut by future governments and also allows for growth and development in the budget, role, scope and strategic direction of the QHPC.

4. Access and equity for all

The QHPC must be a body established for the benefit of all Queenslanders, no matter where they live (urban, rural, regional or remote), or their socio-economic, racial or cultural background. Indigenous Queenslanders are experiencing significant disadvantage which is demonstrated in poorer health outcomes. Best practice approaches to improving and sustaining health and wellbeing could significantly improve this. For example, coronary heart disease is the single biggest contributor to the gap in life expectancy between Indigenous and non-Indigenous peoples and this is largely preventable⁶.

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

5. Whole-of-government and industry approach

The challenge of the QHPC will be to provide strategic direction to a collaborative, whole-of-government and systems approach to improving and sustaining wellbeing. A whole-of-government and industry approach is required because health outcomes (positive and negative) are the result of many factors outside of the health system.

One of the key challenges for improving and sustaining health and wellbeing is how to effect change in these social factors when many of the most important influencers, such as government institutions and industry, do not always appreciate the health consequences of their work, and continue to adopt a siloed approach to problem identification and solution^{10,11}. One of the potential key benefits of establishing a QPHC will be helping sectors beyond health to understand and identify the potential positive health and wellbeing co-benefits from what they do.

While whole-of-government taskforces have been set up to address prevention across consecutive governments (e.g. Towards Q2 targets, Queensland Plan targets), to date, two key issues have hampered long-term cross sector success: 1) a lack of policy coordination mechanisms, with siloed approaches to problem identification and solutions across government departments; and 2) failure to see policies and programs continue past the changing of governments.

The reality is that improving and sustaining health and wellbeing will need policy coordination mechanism to problem identification and solutions across government departments, as well as a sustained approach. Systems approaches are effective at improving and sustaining health and wellbeing, but must be considered alongside individual approaches, such as education and programs.

A highly challenging issue for a whole-of-government, industry and systems approaches is the legislative and policy environment in which the QHPC would need to work. For efficiency and to avoid duplication, the role of the QHPC (systems approaches) and the role of the Preventive Health Branch (more individual approaches) will need to be clearly specified and aligned.

6. Have authority within government policy and legislative frameworks

The QHPC will need to work successfully within existing government policy and legislative frameworks, but still be able to effect change. The recommendations arising from the QPHC should be supported within Government at the highest level under the Premier and Cabinet.

For example, to progress the building of healthy communities, we will need not only good health and wellbeing programs and campaigns to be implemented, but the coordination of good planning and infrastructure, in particular for active transport and urban planning infrastructure to enable increased walking, cycling and public transport use. The desired

health outcomes of these interventions is increased physical activity levels and greater social community connectedness.

Evidence shows people who use public transport are more physically active through walking or cycling to and from their public transport stop than people who drive. On average they get about 40 minutes more physical activity per day, which is five times more than driving¹². This is all about helping people to "make the healthy choices the easy choices".

The significant investment needed on infrastructure spending and planning reform will be overseen by other bodies outside of the QHPC, such as Building Queensland and other policy frameworks such as the Queensland Infrastructure Plan, however the potential to actually coordinate government processes to deliver a system that will support more people to actively travel, reduce congestion and improve health is enormous. The work of the QHPC will need to be integrated with overarching government policies. This demonstrates the necessity of a whole-of-government and systems approach.

Policies are also needed that encourage the use of active transport infrastructure, including more fare discounting, more increases in frequency of services and incentivising schemes for cycling and leaving the car at home.

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

A number of successful models to centralise public health efforts have been developed in Australia and the world. These include setting up distinct agencies to coordinate the work or whole-of-government policy frameworks.

The current Queensland model of a workforce embedded in the Department of Health has seen many achievements, especially in areas such as tobacco control. However, the profile of prevention and funding commitments by consecutive governments remains low. Therefore, change is needed and a greater emphasis on prevention is essential.

VicHealth Health Promotion Foundation has provided a strong and successful model for promoting good health and preventing chronic disease. Queensland would do well to emulate this. It would however need a significant increase in funding to provide its four key functions:

1. Create and fund world-class interventions
2. Conduct research to advance population health
3. Produce and support public campaigns
4. Provide transformational expertise and insights to government

An international model is ThaiHealth, the Health Promotion Foundation of Thailand which provides an autonomous government agency established in 2001. It has three prongs to its strategy:

1. Creation of knowledge (Research and evidence)
2. Social mobilisation (Public awareness)
3. Policy and System (Advocacy for policy and system change).

ThaiHealth is governed by a Board of Governance as well as an Evaluation Board. It uses a series of expert advisory committees. The Board of Governance is Chaired by the Prime Minister, and the Minister of Public Health as Vice-Chair, and an independent expert as Second Vice-Chair, giving this body the highest level of support and priority from government.

It has a relatively simple structure with eight action plans:

1. Tobacco control plan
2. Alcohol and substance abuse control plan
3. Road safety and disaster management plan
4. Health risk control plan
5. Health promotion plan for vulnerable populations
6. Healthy community strengthening plan
7. Health promotion in organisations plan
8. Healthy child, youth and family promotion plan

There is international support for establishing health promotion foundations and the International Network of Health Promotion Foundations¹³ could inform and assist the establishment of the QHPC. VicHealth, Healthway and ThaiHealth are among the founding members.

ii. Population based strategies other than personal interventions delivered by telephone or ICT.

The now defunct Australian National Preventive Health Agency set out a comprehensive strategy for Australia to become the healthiest country by 2020⁵. Population based strategies that will deliver health outcomes, will need to focus on the environment individuals live in and not only on personal interventions delivered by telephone or ICT. A previous HASC Inquiry looked at personal interventions delivered by telephone or ICT so we recommend referring to that report.

Within the [Active, healthy communities](#) web resource developed by the Department of Health, the Heart Foundation and the Local Government Association of Queensland, we outline that healthy populations come from healthy communities and healthy communities result when there are supportive environments for physical activity and healthy eating.

Health must be an integral consideration in planning in order to counter the mega trends of increasing levels of unhealthy food choices, physical inactivity and obesity in our population and the resultant increased disability, hospitalisations, costs to our community through direct health care costs and loss of productivity and premature death. The number of overweight or obese adults has increased by about 55,000 each year on average in Queensland since 1993, in part due to poor land use and transport planning of the past¹.

Strategies/programs such as Healthy, Active School Travel, Healthy Worker Initiative, Healthier. Happier. Program, incentives for active travel to work, amongst others need to be a part of an integrated approach to provide co-benefits across sectors. Please refer to the below sections on the economic and social benefits of strategies to improve health and wellbeing for further information and emerging approaches and strategies that show significant potential.

It is important a comprehensive approach is taken. Government, the health-care system, industry and non-government organisations should not focus overly on prioritising interventions because this could delay constructive action. A single “best” intervention is not the solution. For example, to reverse the obesity crisis, we need a comprehensive, broad, multipronged approach and we need to do as much as possible, as soon as possible¹⁴.

Policy and legislative reforms

Policy and legislative reforms are powerful behaviour modifiers as proven through tobacco control legislation which has reduced the promotion of, access to and consumption of cigarettes and saved thousands of lives a year in Australia. These policy and legislative reforms have included the banning of advertising, promotion, display of tobacco products,

banning smoking in many public places, increasing the price of cigarettes through taxation and bringing in plain packaging. All of this has been done alongside social marketing campaigns and programs to support smokers to quit.

Proposed legislative reforms that will support changes in behaviour include:

- kilojoule menu labelling, currently in the Queensland Parliament
- extension of smoke-free places, currently in the Queensland Parliament
- alcohol access reduction strategies, currently in the Queensland Parliament
- health and wellbeing outcomes embedded in planning legislation
- tax sugar sweetened beverages
- ban junk food advertising to children

Economic Instruments - Employment, Housing, Transport

Economic instruments are also extremely powerful and could go a long way towards addressing the determinants of health. A focus on policies that address unemployment, housing affordability and access to affordable public transport would improve people's health and wellbeing enormously. This is addressed in detail below on the social determinants of health.

2. That, in undertaking the inquiry, the committee should consider:

a) Approaches to addressing the social determinants of health;

In determining the best model and approach for preventive health in Queensland, it's important that the Committee considers the issue of how to approach the social determinants of health, because the health outcomes of the population are affected by so much more than the health system.

It is well documented that many of the key drivers of health and wellbeing reside in our everyday living conditions, also known as the social determinants of health. The World Health Organisation defines the social determinants of health as the circumstances in which people are born, grow up, live, work and age, as well as the systems put in place to treat illness. These circumstances and the way they are distributed are in turn shaped by wider economic and social policies, and political decisions¹⁵.

Reducing health inequalities is a matter of fairness and social justice. Health inequalities result from social inequalities which need targeted action. A more equal society is a healthier one¹⁶.

The Heart Foundation recognises it is often government's actions *outside* the health sector that can most significantly reduce health inequities. Addressing inequity in health outcomes requires engagement with other policy sectors, such as the housing, education, employment, and social policy. Siloed departments of government require social determinant advocates to design their policy proposals to work within these departments, rather than expecting silos to be swept aside¹⁷. In reality, social determinants action will deliver both on social justice and enabling a growing and more productive economy.

Progress on the social determinants of health has been limited in Australia. On a national level, there was great hope that the WHO Commission on Social Determinants of Health report¹⁸ would be ratified by the Australian Government following the tri-partisan support of a Parliamentary Senate Inquiry in March 2013. Despite the best efforts of those involved there has been little to no action since March 2013.

Various national bodies have been set up over time to report on and develop policies to address the issues around health inequities, however progress has been minimal. An

example of one such body was the Australian National Preventive Health Agency (ANPHA), which drew criticism in the Senate Inquiry for having a narrow, issues-based focus rather than a social determinants approach¹⁹. Similarly, the National Partnership Agreements, although initiated to 'really improve the lives of people and consequently their health and wellbeing', were criticised for 'perpetuating the policy siloes' of government.

The Queensland Government should learn from past experiences. Any agency which aims to take a coordinated whole-of-government, systems and policy approach to the social determinants of health may be best placed external to government, with authority to directly consult on and influence policy decisions across all government departments.

b) Population groups disproportionately affected by chronic disease;

Differences in living conditions give rise to *health inequities*, which are differences in health status between population groups that are socially produced, systematic in their unequal distribution across the population, avoidable and unfair.

We want all Australians to have the best heart health in the world, regardless of their income, heritage or address. In addition to our work in improving Aboriginal and Torres Strait Islander peoples' health, the Heart Foundation is also seeking to redress the disproportionate burden of cardiovascular disease experienced by socio-economically disadvantaged people, people living in regional, rural and remote areas and people from culturally and linguistically diverse groups. Approximately 1 in 5 coronary heart disease deaths could be prevented and 30% fewer hospitalisations if all Australians had the same rates of coronary heart disease as the most advantaged groups in our society¹⁷.

Some Australians are at much greater risk of cardiovascular disease due to their social and economic circumstances, their cultural background or where they live. Australians (aged 25-64 years) living in the poorest parts of Australia are 2-3 times more likely to die from coronary heart disease than those living in the wealthiest parts of Australia²⁰. People living in rural and remote Australia are 40% more likely to die from cardiovascular disease than people living in major cities. They are also 30% more likely to be hospitalised for cardiovascular disease²¹.

Indigenous Australians comprise 4.2% of the Queensland population (188,954 people). Burden of disease and injury was double that of non-Indigenous people with CVD accounting for 15%. Over one third of the total disease burden was due to the joint effect of 11 modifiable risk factors with high body mass the largest cause followed by tobacco use and physical inactivity¹.

The Heart Foundation also recognises the importance of health illiteracy as an independent risk factor in influencing health outcomes, particularly for vulnerable populations. We recognise that health literacy is often nested in conditions of disadvantage, compounding its effect on vulnerable populations. Improving health literacy means more than just health education. By improving people's access to health information and their capacity to use it effectively, they will be better equipped to overcome structural barriers to health²².

c) Economic and social benefits of strategies to improve health and wellbeing;

The case is clear that investment in prevention impacts across all sectors and provides a fourfold return on every dollar invested²³. Even small investments promise large gains to health, the economy and other sectors, with sustainable outcomes.

Evidence shows preventive approaches contribute between 50% and 75% to the reduction of cardiovascular disease mortality in high-income countries and 78% globally²³. A wide range of approaches are cost-effective, including interventions that address the

environmental and social determinants of health, build resilience and promote healthy behaviours, as well as vaccination and screening.

Catholic Health Australia and the National Centre for Social and Economic Modelling (2012) released a report entitled *The Cost of Inaction on the Social Determinants of Health*²⁴ which suggested if the World Health Organisation's recommendations¹⁵ were adopted within Australia:

- 500,000 Australians could avoid suffering a chronic illness;
- 170,000 extra Australians could enter the workforce, generating \$8 billion in extra earnings;
- Annual savings of \$4 billion in welfare support payments could be made;
- 60,000 fewer people would need to be admitted to hospital annually, resulting in savings of \$2.3 billion in hospital expenditure;
- 5.5 million fewer Medicare services would be needed each year, resulting in annual savings of \$273 million;
- 5.3 million fewer Pharmaceutical Benefit Scheme scripts would be filled each year, resulting in annual savings of \$184.5 million each year.

The WHO “best buy” interventions for non-communicable diseases²⁵ include several that are highly cost-effective, including tobacco and alcohol legislation, reducing salt and increasing physical activity. Interventions that focus on addressing social and environmental determinants (such as promoting walking and cycling, green spaces, safer transport), are shown to have early returns on investment with improved social benefits.

Workplace interventions that focus on improving employee health and wellbeing are also cost effective and beneficial to our overall economy and productivity. Effective healthy workplace programs can help to reduce the prevalence of obesity, increase productivity at work by 29%; reduce absence due to sickness by 21%, improve overall worker health by 24% and create a positive work environment and workplace culture²⁶. Additionally, healthy workplace programs show returns on investment within 1–2years²³.

Reducing the prevalence of risk factors is achievable and will deliver significant health improvements. Gains will come from treating and preventing high blood pressure, high cholesterol, high blood glucose, obesity, smoking and physical inactivity. One-third (31%) of burden in Queensland and 43% of premature deaths are associated with 13 modifiable risk factors¹.

d) Emerging approaches and strategies that show significant potential;

There are many examples of emerging approaches and strategies that have potential. It has been well documented that we need to make the healthy choices the easy choices. This should be echoed in governments, industry, communities and individuals, with all taking responsibility for better health outcomes.

However, we have decades of evidence to demonstrate that preventive health works. Let's learn from the past and implement what we know already as a first step.

An excellent source of approaches and strategies that show potential for increasing physical activity is the Heart Foundation's second edition of the Blueprint for an active Australia²⁷ which highlights ten key action areas to increase population levels of physical activity and provides a succinct summary of evidence and strategies to inform policy and programs.

e) Ways of partnering across government and with industry and community including collaborative funding, evaluation and research; and

To address the social and economic determinants of health, we know all sectors of our community need to be engaged. Government has the power to use levers to support changes in health behaviours, but it is the industry sector that is driving the market in terms of the environment in which we live, work and play.

For example, our obesogenic environment is a combined result of many private sector offerings on the market. Unhealthy fast food options tend to be readily available at multiple outlets. Finding healthy food choices is often difficult, with little information available to the consumer. To date, engaging with the industry has had limited impact on increasing healthier eating options for eating out. That's why we need government interventions using legislative levers such as the proposed new legislation to mandate kilojoule menu labelling.

A 'health in all policies' approach can assist this kind of industry driven innovation and has been done in South Australia and Tasmania. It is based on the understanding health is not merely the product of health care activities, but is influenced by a wide range of social, economic, political, cultural and environmental determinants of health. Actions to address complex issues such as preventable chronic disease and health care expenditure require joined-up policy responses²⁸. A recent example of joined-up policy from Tasmania is the embedding of health and wellbeing considerations in their Land Use Planning and Approvals Act.

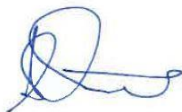
There are a multitude of ways partnering could occur. The essential element is it should occur in a 'business as usual' approach, as standard practice, with agreed evidence-based actions from all partners with targets that are measurable, demonstrable and evaluated.

f) Ways of reducing fragmentation in health promotion efforts and increasing shared responsibility across sectors.

A centralised, independent body for health promotion could reduce or increase fragmentation, depending on how it is funded and implemented. It needs to adhere to the principles recommended above including independence, expertise and leadership, adequate funding, access and equity and take a long-term view.

The Heart Foundation is available for consultation and/or to appear as a witness. I look forward to hearing the outcomes of the Committee's inquiry.

Yours sincerely



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