Inquiry into the establishment of a Queensland Health Promotion Commission

There are valid concerns regarding the sustainability of health system funding in Australia. Growth in health spending is expected to increase from '4.0 per cent of GDP in 2009-10 to 7.1 per cent of GDP in 2049-50' with growth stemming from 'increasing demand for health services and the funding of new technologies'.[1]

While Queenslanders experience some of the longest life expectancies in the world, we are also experiencing an ageing population, increases in chronic disease, a transition towards disabling conditions, and changes in risk factors especially obesity[2], pressuring our health system.

Well-implemented, evidence-based health promotion and evaluation has an important contribution to make to address the increasing demand for health services. Locally based health promotion specialists, focussed on their local populations' specific needs and contexts and working closely with local organisations and health practitioners while maintaining links with centrally-located specialists with state-wide focus, can considerably value-add to the public health response.

1. Health promotion – definitions, types, roles and evidence of cost-effectiveness

The World Health Organization defines health promotion as 'the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions'.[3] Health promotion has also been considered to be 'any combination of education and related organisational, economic, and political interventions designed to promote behavioural and environmental changes conducive to good health, including legislation, community development, and advocacy.[4] There can be considered to be two polar types of health promotion, individualist health promotion and structuralist-collectivist health promotion, with a continuum in between.[5]

Individualist health promotion can be defined as:

> a set of programs that provide health education about health risks to persuade people to change their lifestyles. A side group of professionals are involved in these programs, including doctors, nurses, allied health professionals, psychologist, educators, and media and marketing experts.[5]

Structuralist-collectivist health promotion:

> encompasses participatory health programs at the community level, legislation, and bureaucratic interventions, which range from small local programs to more significant [regulatory] measures[5]

The Ottawa Charter for Health Promotion brings both approaches together. Prerequisites for health are considered to be: peace, shelter, education, food, income, a stable eco-system, sustainable resources, and social justice and equity.[6] Through advocacy, enabling and mediating, the Charter seeks to:

- build healthy public policy, using 'diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change', recognising that policy-makers at all levels and in all sectors need 'to be aware of the health consequences of their decisions and to accept their responsibilities for health'
- create supportive environments, recognising that 'the inextricable links between people and their environment, the need to conserve natural resources and work and leisure environments need to be a source of health
- strengthen community actions, through 'concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health'
- develop personal skills, through provision of information and education for health, facilitated in school, home, work and community settings
- reorient health services, to move beyond the provision of clinical and curative services in the pursuit of health, with stronger attention on health research.[6]

Although national and international developments such as the Ottawa Charter, have focussed on 'making environments conducive to health', most health promotion in Western countries has been considered to narrowly focus on individualist health promotion.[5]

Like any discipline, one cannot state that all of the activities that have occurred under the banner of health promotion are effective or cost-effective. As with other areas of public health, challenges for evidence-based practice include that the level of uncertainty may be high, the time available to produce or act on advice may be quite limited, and 'compared to available evidence in clinical medicine … public health evidence is generally a result of the more complex interaction of the best available evidence from research and other epidemiological sources with judgements of the needs, recourses, local circumstances, and ethical and legal implications'.[7]

However, there is good evidence of the cost-effectiveness of a range of interventions involving health promotion. For example, the Assessing Cost-Effectiveness in Prevention study[8], led by the University of Queensland and Deakin University, found

> 'sufficient evidence… to justify immediate funding of the most cost-effective opportunities for health gain through prevention ..[including increases of taxes on tobacco, alcohol and some unhealthy foods and] increased funding for SunSmart programs, accompanied by rigorous evaluation to strengthen the evidence base for its effectiveness [and] to argue for expanded funding for a larger package of health promotion and illness prevention interventions … [including] a range of

> interventions promoting physical activity (pedometers, mass media, GP prescription and referrals).

Health promotion using social media is a relatively new area that deserves further exploration for a range of specific audiences and issues.

2. Local decision-making and accountability—crucial elements of our health system

In 2011, the Commonwealth of Australia entered into the National Health Reform Agreement with the states and territories of Australia. The National Health Reform Agreement aimed to 'implement new arrangements for a nationally unified and locally controlled health system … [to] improve local accountability and responsiveness to the needs of communities through the establishment of local hospital networks (LHNs) and Medicare Locals' amongst other objectives.[9] Local accountability and responsiveness are critical components of the National Health Reform agenda.

Subsequently, the Queensland Parliament passed the *Hospital and Health Boards Act 2011*, the object of which is to:

> establish a public sector health system that delivers high quality hospital and other health services to persons in Queensland having regard to the principles and objectives of the national health system

These objects are stated to be mainly achieved by:

> (a) strengthening local decision-making and accountability, local consumer and community engagement, and local clinician engagement; and
>
> (b) providing for Statewide health system management including health system planning, coordination and standard setting; and
>
> (c) balancing the benefits of the local and system-wide approaches.

Again, local accountability and responsiveness are critical components.

In 2012, following the cessation of specialist health promotion functions in Queensland Health's public health units, the remaining public health functions were devolved to Hospital and Health Services.

Changes to other Queensland legislation in recent years have also devolved decision-making regarding health issues such as water fluoridation[10] to local governments. Some of these issues are highly amenable to health promotion intervention at a local level.

3. Role of Medicare Locals and Primary Health Networks

In 2011-12, under the National Health Reform agenda, sixty-one Medicare Locals were established, with 11 of these in Queensland. Medicare Locals were established 'to improve coordination and integration of primary health care in local communities, address service gaps, and make it easier for patients to navigate their local health system'.[11]

Following Horvath's review[11], in 2015 Medicare Locals were closed and Primary Health Networks were established. Primary Health Networks aim to increase 'the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes' and to improve 'coordination of care to ensure patients receive the right care in the right place at the right time'.[12] Notably, these aims are regarding provision of healthcare services, not regarding primordial or primary prevention to which health promotion activities are particularly suited.

4. Locally-based, specialist health promotion functions in Queensland Health

Following the cessation of specialist health promotion functions in Queensland Health's public health units in 2012, the Queensland Department of Health maintained a small group of staff who we understand focus on state-wide programs to improve the prevalences of selected risk factors for chronic diseases.

A centrally-located group of health promotion specialists with state-wide responsibilities, whether the group is employed by the Department of Health or as a separate commission, can deliver important functions, for example in advocating for regulatory or legislative changes at the state level, developing resources that HHSs and other organisations can use or adapt for their local populations, and providing state-wide leadership. A potential benefit of a separate commission would seem to be that the group could be, or could appear to be, more independent of the government of the day.

While there is merit in evidence-based, well-implemented health promotion interventions and evaluation from such a state-wide group, a proportion of resources must be allocated to the HHSs who have intimate local knowledge of, and who are responsible and accountable for the health of, their local populations. There is also considerable geographical variation in the health statuses, prevalences of risk factors for preventable conditions and groups of the population primarily affected. For example, the proportion of adults who are obese ranges from 18% in the Gold Coast HHS to 35% in South West HHS.[13] This variation, as well as local cultural, environmental, demographic, services and other factors, dictate the application of different approaches in different areas.

Furthermore, HHSs are well-positioned, not only to directly use specialist health promotion practitioners, but to provide this service to local groups. HHSs have a wealth of local knowledge, often have close relationships with

non-government organisations such as Primary Health Networks and Aboriginal Community Controlled Health Services, are prominent in local media and have often earned the trust of a large proportion of local residents and organisations.

Currently in our Hospital and Health Service, both structural-collectivist and individualist approaches are used by doctors, nurses, environmental health officers, epidemiologists, allied health practitioners and others to minimise morbidity and mortality from non-communicable and communicable diseases. Activity occurs across the prevention spectrum, that is, in primordial, primary, secondary, tertiary and quaternary prevention.[14]

However, the activities of these practitioners would benefit from readily accessible, locally-based health promotion practitioners who could provide timely specialist advice, tailored to the local populations and their health needs regarding health promotion theory, such as behaviour change models, and its, application.[15] Accompanied by appropriate evaluation mechanisms, this will considerably increase the quality and quantity of the evidence for a range of interventions, contributing to more cost-effective allocation of resources, locally and in other regions of Queensland, and leading to better health for Queenslanders.

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