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

Members present:

Ms L Linard MP (Chair)
Mr MF McArdle MP (Deputy Chair)
Mr SE Cramp MP
Ms LE Donaldson MP
Mr AD Harper MP
Dr MA Robinson MP

Staff present:

Mr K Holden (Committee Secretary)
Mr J Gilchrist (Assistant Committee Secretary)

PUBLIC HEARING—EXAMINATION OF THE HEALTHY FUTURES COMMISSION QUEENSLAND BILL 2017

TRANSCRIPT OF PROCEEDINGS

TUESDAY, 27 JUNE 2017

Brisbane

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Committee met at 10.19 am

CHAIR: Good morning. I declare this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee open. My name is Leanne Linard. I am the chair of the committee and the member for Nudgee. Other committee members are Mr Mark McArdle, the deputy chair and member for Caloundra; Ms Leanne Donaldson, the member for Bundaberg; Mr Sid Cramp, the member for Gaven; Mr Aaron Harper, the member for Thuringowa; and Dr Mark Robinson, the member for Cleveland. Today's hearing is part of the committee's examination of the Healthy Futures Commission Queensland Bill 2017. The bill was introduced by the Hon. Cameron Dick, Minister for Health and Minister for Ambulance Services, on 23 May 2017. The committee is required to report on the bill by 24 July 2017.

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 nonpartisan approach to inquiries. This hearing 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, but I remind you that intentionally misleading the committee is a serious offence. Witnesses have been provided with a copy of the instructions for witnesses, so we will take those as read. Hansard will record the proceedings and you will be provided with a copy of the transcript. This hearing will also be broadcast live on the parliament's website. I remind all those in attendance today that these proceedings are similar to parliament to the extent that the public cannot participate. I remind members of the public that they may be admitted to or excluded from the hearing at the direction of the committee.

BRADLEY, Ms Amanda, General Manager, Australian Health Promotion Association Queensland Branch

DEL FABBRO, Ms Letitia, Committee Member, Public Health Association of Australia Queensland Branch

CHAIR: Thank you very much for coming before the committee and thank you for your submissions. I invite you to make a brief opening statement or any additional comments to your submission and then we will open for questions.

Ms Bradley: Today I am representing the Australian Health Promotion Association Queensland branch. Our president, Anita Cowlishaw, is overseas and sends her apologies. The branch would like to begin by congratulating the committee on their commitment to improving the health and wellbeing of Queenslanders. We would also like to reiterate that health promotion is 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 to address the social determinants of health. When done well, health promotion contributes to enabling whole populations to stay healthy and reduces the number of people accessing primary and secondary healthcare services. It saves money, but it does require a long-term vision and courage to invest in that vision and bipartisan agreement. The improved health of Queenslanders matters to everyone.

The Australian Health Promotion Association believes that our state can be recognised for its leadership, innovation, research and evidence based health promotion strategies. The Queensland branch requests the committee to consider the following: to include provision of leadership and cross-sectional health promotion planning and to key deliverables of the commission; to consider the performance measures in the context of evidence that may suggest that they are out of proportion to the proposed investment; and to examine the compulsory appointment of at least one commission board member with public health or health promotion experience.

With regard to leadership, preventing and reducing obesity requires more than a single intervention. Obesity prevention requires a multistrategy approach and community partnerships combined with action from the private sector, non-government organisations and academic

institutions. In order to reduce fragmentation in health promotion efforts, it is essential that the Healthy Futures Commission undertakes strong leadership and coordination across government sectors and the health promotion sector. The Queensland branch encourages the committee to consider setting key deliverables of the commission to establish a whole-of-government strategic action plan for health promotion in Queensland.

It is essential that the development of the strategic plan engagement occurs between all interested parties and stakeholders. Further statewide strategic leadership will ensure that the social determinants and inequalities related to obesity are addressed officially through intersectional and interagency approaches, with consideration to tailoring initiatives for vulnerable populations and geographical inequalities. Tailoring of initiatives can be supported by a grants program. However, oversight of a coordinated approach is required to ensure initiatives are not duplicated, gaps are addressed and financial efficacy of the commission is achieved.

With regard to performance measures, as highlighted in our submission to the health promotion commission inquiry, evidence suggests that health promotion strategies that target children have been identified as having a higher cost benefit due to the longer time frame over which the health benefits and health behaviours can transpire. It is important to note that this approach requires long-term investment and takes several decades to achieve good results. Therefore, it requires long-term commitment from government to address this issue. In addition, the association has concerns that the committee's target to reduce childhood obesity by 10 per cent and increase physical activity by 20 per cent amongst Queenslanders by 2026 is potentially unrealistic with the current provisions outlined in the bill, particularly regarding staffing and financial provisions. The New South Wales Premier's priority is to reduce childhood overweight rates and obesity by five per cent in 10 years. New South Wales has a substantial workforce and financial provision at both the state and the local health district level to support the achievement of this target. The association urges the committee to reconsider the targets and provisions within the bill to ensure that the commission is being established under predetermined success.

With regard to appointing at least one public health expert to the commission board, the Queensland branch strongly believes that the appointment of the Healthy Futures Commissioner should have a public health and/or health promotion background to ensure that they have fundamental understanding of the sector and can advocate accordingly. Leadership and strategic direction are essential for the role of the commissioner and the Queensland branch strongly feels that expertise, knowledge and skills in the field are required for the role to function effectively and ensure the long-term success of the Healthy Futures Commission.

On behalf of the Australian Health Promotion Association Queensland branch, I wish to thank you for the opportunity to attend the healthy futures bill inquiry. The Queensland branch wishes to congratulate the committee on progressing the healthy futures bill. The branch looks forward to working with the Healthy Futures Commission to improve the health of Queenslanders and ensure that Queensland has an active health promotion workforce to lead the work of the commission. Thank you.

Ms Del Fabbro: Good morning. The Public Health Association of Australia, the PHAA, is recognised as the principal non-government organisation for public health in Australia working to promote the health and wellbeing of all Australians. Our mission as a leading national peak body for public health representation and advocacy is to drive better health through outcomes including increased knowledge, better access and equity, evidence informed policy and effective population based practice in public health. The PHAA commends and congratulates the Queensland government on its commitment to recognise the importance of health promotion through the establishment of the Healthy Futures Commission Queensland. The PHAA is particularly supportive of the inclusion of social determinants of health and addressing health inequalities in the legislation. However, we are a bit disappointed that the scope of the proposed commission has narrowed since the last inquiry and we are keen to ensure that Healthy Futures Commission Queensland is able to effectively promote good health and the reduction of health inequities in all Queenslanders.

We have identified four points in our written submission, and I will just draw your attention to those. The first is that the PHAA recommends that the Healthy Futures Commission Queensland include in its main focus a population-wide focus rather than limiting the scope to just children and families. For all Queenslanders—not just children and families—population health and healthy behaviours are influenced by a complex interplay between social, cultural, political, environmental and economic determinants of health. Limiting health improvements and resources to a specific segment of the population may lead to further inequality and result in outcomes that might be counter to the spirit of the commission.

The second point is that issues such as the management of chronic disease have a large role in health promotion in healthy lifestyles. The PHAA believes that the functions of the Health Futures Commission should not be restricted to obesity but, in keeping with a holistic view of health, healthy lifestyles will include addressing issues such as mental health and alcohol and other drug use. The previously proposed Health Promotion Commission was more inclusive and its proposed aims and roles were more broad and we are not sure why that was narrowed in this most recent iteration.

The third point that the PHAA would like to highlight is that addressing the social determinants of health should be specified as a core function in the commission. It is identified in your documents and we strongly support your inclusion of reducing health inequality and advocating for social conditions and environments for health as the main function of the commission.

In order to promote health, including healthy lifestyles, reducing health inequality, health inequity and addressing the social determinants of health, the Healthy Futures Commission Queensland really has a leadership role to play in promoting health in all policies and leading that in Queensland, like in South Australia. A health-in-all-policies approach would see population health considerations incorporated into the policy development processes of all sectors, from education to transportation to town planning and beyond. Health is produced in all settings and a health-in-all-policies approach would enable the impacts of other sectors on health to be monitored.

I arrive at my final point and I just wish to highlight, on behalf of the PHAA, that we think there might be not adequate funding to support this bill as it specifies that funding is allocated in grants. We are just wondering how the other aims of the commission will be able to be achieved with that 55 per cent being allocated to grants and grant monitoring. In the establishment of the Healthy Futures Commission board we also think there should be consideration given to the inclusion of an Aboriginal and/or Torres Strait Islander representative on that board. Thank you for your time. The PHAA really appreciates the opportunity to contribute to this important public hearing and to contribute to the health of Queenslanders on an ongoing basis.

CHAIR: Thank you both for your opening statements and for your submissions to this inquiry. Having chaired the initial inquiry, I know that submissions were made to that inquiry also and they were very instructive and comprehensive. Thank you for the contribution you have made to this conversation overall.

Mr McARDLE: Thank you for being here today and making your submissions. I note that in your tabled document you question the percentage figures proposed within the terms of the bill as being achievable and you referred to New South Wales's five per cent in relation to obesity. Would you see that as better figure to aim for or are you putting it up as an example?

Ms Bradley: It is an example.

Mr McARDLE: Do you have an idea as to what it should be?

Ms Bradley: I am not an expert in nutrition and physical activity—that is not my area of expertise—but I think it is really important to look at targets that are achievable for the commission. I think using examples from other states is helpful in guiding what they have been able to achieve in certain time frames and potentially looking at evidence based data. There will be other organisations presenting on this that have more expertise in this area—Diabetes Australia, Heart Foundation—that might be able to speak to that. We were just concerned that, for the amount of investment, that seemed really aspirational. I really like aspirational goals, but I am also conscious that you do not want to set up a commission to fail; you want to set up a commission to achieve and go beyond expectations, I think.

Mr McARDLE: Could I paraphrase your concern that the figures presented are aspirational and maybe do not reflect reality?

Ms Bradley: Potentially.

Mr McARDLE: I got the impression initially that the commission was going to be a new standalone body, but that is not the case. The last evidence we heard was from the department. This is one more body looking at a specific set of circumstances. There are a range of initiatives by this government—other governments had initiatives as well—but you are saying the time has now come to go to a whole-of-government approach, giving one body the imprimatur across all limbs; is that right?

Ms Del Fabbro: I would direct you to the experience in South Australia, at the health-in-all-policies initiatives they have used. They have had, I think, a coordinated approach that has emphasised intersectorality in terms of measuring health outcomes. When a policy is developed in whatever sector, about access to technology for example, it asks, 'What are the health outcomes of that new policy?'

Mr McARDLE: That feeds into the model in South Australia; does it not?

Ms Del Fabbro: Yes, that is right.

Mr McARDLE: The bill here places this body under Queensland Health jurisdiction, shall we say, but independent thereof. It does not look into Transport, Local Government, Education or anything, which is critical, but also the Department of Premier and Cabinet. Coordination by Queensland Health without the input of those other very important departments contained in legislation can cause problems going forward, can it not?

Ms Del Fabbro: I think it probably could cause problems, but I can take that question on notice and get back to you, if you like.

Mr McARDLE: I do not think you really could, but if you want to do so then by all means. Would the Premier and Cabinet be important in relation to this matter?

Ms Del Fabbro: Certainly I think the Premier and Cabinet is essential in providing leadership for major policy changes.

Ms Bradley: I think when we develop policy in relation to humans and it sits in Transport, Education or another department—it does not sit in Health—there is a risk that you have unintended consequences. Western society has not been great at looking at the unintended consequences of what it means to build 10 apartment blocks in a small space or to have five alcohol outlets in a small community or to have seven takeaway outlets in a small community. Those responsibilities do not rest with the Minister for Health; they rest in other places.

Mr McARDLE: Local Government or—

Ms Bradley: Absolutely. From a public health perspective, health in all policies is the best approach. In saying that, if you have scope to address obesity and it is an identified gap then that is not a bad thing to do.

Mr McARDLE: The planning in regard to greenfield sites, say, on the Sunshine Coast, rests with either Noosa Shire Council or the Sunshine Coast council. They control the placement of fast-food outlets in relation to schools et cetera. This bill does not control that, and it should not control that, but that is an example of what you say really needs to be looked at fairly closely. Having a petrol station or a 7-Eleven right next to a school is inherently a dangerous situation, is it not?

Ms Del Fabbro: There is some research that indicates that the 500-metre buffer is the danger zone for placement of those kinds of outlets in proximity to schools.

Mr McARDLE: In answer to a question, the director-general made the comment that funding here would be for one-off projects. Can I get your comment on funding one-off projects as opposed to funding of a whole program which could run for a number of years? To me there is a disconnect between the two.

Ms Del Fabbro: You have a strategic direction and objective of a 10 per cent reduction in obesity, but one-off projects, unless they are also very strategic and coordinated, can be quite piecemeal and not strategic.

Mr McARDLE: Why not then just use the current model? Why have a new commission to put in place this new regime? Why not use the Preventative Health Unit or other units within Queensland Health to do exactly the same thing? What is the benefit you see of a commission over the current regime if they are looking at one-off projects?

Ms Del Fabbro: I think it is that potential emphasis on social determinants of health, health inequality and inequities in health distribution and that potential to see improvements in the way we produce health in our communities.

Mr McARDLE: Could that not be done internally already? Why do we need a separate commission to do that? Why not bring that into Queensland Health and have that done by Preventative Health? Where is the bonus in that?

Ms Del Fabbro: I do not think there are provisions for that in existing preventative health structures because of the emphasis on Queensland Health for sickness care and improving people's lives once they are already sick. There needs to be that other emphasis on prevention.

Ms Bradley: I think we have also seen a reduction in investment in non-communicable diseases, for example. Preventative Health has a strong focus on communicable diseases and we have been able to reduce the rate of many communicable diseases. It is in the non-communicable diseases that we are seeing a long-term impact—like, for example, the impact of overweight and obesity on the health system. I am absolutely committed to a whole-of-government approach that is

a public health best practice model, but I am also conscious that in the reality of the world we do not always get what we want and we try to do the best with the resources we have. I think a focus on non-communicable diseases is commendable and I am not sure that the Preventative Health Unit has that capacity at the moment.

Mr McARDLE: But you could make a new unit, could you not?

Ms Bradley: Potentially.

Mr McARDLE: Would you see the review of outcomes as critical as well? I do not think the commissions in South Australia or Victoria have done a report—I might be wrong—on the outcomes that have been published.

Ms Del Fabbro: I am not 100 per cent sure.

Mr McARDLE: We will check that out. Would you like to see an annual, biennial or triennial requirement for a review as to the outcomes of the commission as part of the process?

Ms Bradley: Good practice in public health is to measure what you do.

Mr McARDLE: That should be a regular, ongoing process?

Ms Bradley: Absolutely. Evaluation has to be built into the design of every program. I think that is absolutely critical. Even if you are doing a grants process, if that is the approach that ends up being the preferred approach, it would have to have built into it an evaluation element so that you knew whether or not what you were doing was effective, how effective it was and how cost effective it was.

Mr McARDLE: The terms of the bill do not allow you or the Heart Foundation or Diabetes Queensland to put up a number of people to the minister to select a person or persons to sit on the board. I think that is a problem. Diabetes Queensland and the Heart Foundation are principal suppliers of services to the state and to the people of Queensland. Do you agree that it would be advantageous to have a mechanism whereby certain bodies or a body can put forward nominations? That picks up your question about the health professionals.

Ms Bradley: I know at the moment you have some people with experience in law, finance and medicine I think is mentioned, but my interpretation of the way it is currently worded—I could have this wrong—is that you could have a board of entirely lawyers, for example. I do not think you would, but that is a risk.

Mr McARDLE: I take your point.

Ms Bradley: Having at least one person on that board who is an expert in public health I think is important.

Mr McARDLE: Having input into that would be an advantage as well?

Ms Bradley: Absolutely.

CHAIR: The bill will establish an independent statutory authority. The commission would obviously not be a similar model to a department, and it would be independent. Is it your view, on behalf of your organisations, that such a model allows for and promotes greater flexibility, ability to partner with and a more dynamic structure that would work alongside and complement those health promotion activities in the department rather than just duplicate?

Ms Del Fabbro: Yes. I think it has the potential to do that, yes.

CHAIR: The first submission from your organisation focused heavily on the HIAP model in South Australia. That was something that you both did and you have commented on it again today. That is certainly a model that we as the original committee picked up and commented on in the report. There are elements certainly I can see there of a hybrid between Victoria and South Australia in the proposal that has come from the health minister. The health-in-all-policies approach really is, when we are talking about addressing health inequity, through interventions, often I think innovative interventions, addressing behavioural change, so I think that is the important discussion to have. We are not talking about health promotion and just putting messages out there. I think the commission, and certainly what I have seen, is about innovative interventions to bring about behavioural change within disadvantaged communities as well as structural changes in the social and cultural environment. My perception of reading the initial briefing material that was provided by the Department of Health around this was that the independence of the commission would allow a focus on, as you were talking about, grants, to perhaps go some way to that sort of approach. Is it your view that that is the case? They gave an example of an Indigenous community, a walking track, things like that, that it may go some way to achieve that HIAP approach to health inequality.

Ms Del Fabbro: I think it has the potential to do that, but whether or not there is enough funding to do that comprehensively would be the other question

CHAIR: Your view is that it would do that, but more would be better?

Ms Bradley: More is always better.

CHAIR: I take your point: more is always better. There was a comment made in your initial submission that has been carried through in your updated submission. That is, it is essential that such a commission lead and advocate for the reinvigoration of health promotion and to ensure that health promotion is acknowledged and considered an elevated priority on policy agendas. How important do you feel it is that health promotion as a policy imperative receives bipartisan support in Queensland?

Ms Bradley: It is critical, but I am incredibly biased because I am a health promoter and that is what I do. I think health promotion is often misinterpreted to be health education. Health education is one element of health promotion. When you think about addressing the social determinants of health and using strategies to do that, whether it be policy development, advocacy or working alongside communities to enable them to make changes to the way they are structured to improve the health of their community, those things all come into play. I think a core tenet of good public health policy is that you work alongside communities to help them define what their issues are and how they can best use resources to address them.

CHAIR: The feedback that consistently came through in Victoria and South Australia was that, with these sorts of activities and commissions and aspirational goals to achieve behavioural change and focus on health promotion and public health, there needs to be bipartisan support and everyone buys into the positive effect that such a commission could bring about.

Ms Bradley: I said that in my opening statement. It requires courage. I think the fact that we have three- going to four-year terms of government does not allow for long-term health policy commitment in many ways. It does not allow us to have a long-term vision and say, 'In 2030 or 2050 this is what we expect in our population and that is the goal we have, and in 10-year increments these are the key outcomes we will have achieved and this is the investment we are going to make and commit to.' We all believe that health is important. I do not think a single person in Queensland would say that the health of the whole community is not important.

Mr CRAMP: In terms of an appropriate time frame to improve childhood obesity, you spoke about New South Wales and you said that is just a gauge. Are there any time frames that have been seen as successful overall that we should use as our own goal in this state?

Ms Del Fabbro: As Amanda said before, I am not an expert on those kind of time frames.

Mr CRAMP: Your organisation has not looked at those sorts of things and thought that has worked out really well for those groups or those states?

Ms Del Fabbro: There is a special interest group in the PHAA on nutrition, so I will take that question back to that group.

Mr CRAMP: If you can take that question on notice, it would be great to see if there is any historical data from your organisation's viewpoint that you rely on.

Ms Bradley: I am sure that other organisations presenting today will have specific information. We are both generalist organisations.

Mr CRAMP: It is an interesting topic.

Ms Bradley: Yes, we raised it. Our committee was concerned about it. You can do anything with the right amount of investment.

Mr CRAMP: You are just reiterating what the member for Caloundra said. Potentially this is achievable, but not with a minimal investment of personnel and funding?

Ms Bradley: If you had a really clear strategic plan and if it was the purpose of the commission to write a plan—for example, the women's strategy in Queensland. At the moment a clear strategy has elements across a number of goals, and communities are able to contribute and say how they are achieving those goals. I think that is a really interesting way of looking at achieving goals, because there will be organisations that are not currently funded or will not get grants that will be contributing to reducing childhood obesity. You will not be able to see what they are doing in this process if you are just looking at the grants that you are allocating and the outcome of that investment. It is much bigger than that, and that is why I think a health-in-all-policies approach is potentially easier to get a long-term approach and to see the impact you are having.

Mr CRAMP: Moving onto grants, in our previous briefing I raised concerns with the department about the grants process. They are really looking at one-off starter projects and I suggested exactly what you are saying, Ms Bradley. This is certainly not putting words in your mouth, but there are programs out there already that really contribute in a positive manner, yet they are technically going to be ineligible to receive funding from this program because they are not a start-up grant. Alternatively, if we do see a start-up program occur that is successful, potentially there is no ongoing funding once they move to a certain point. I have real concerns about a piecemeal approach and that a lack of continuity may not achieve much if we do not identify the good programs out there. Would that be a correct statement?

Ms Del Fabbro: I would agree that you need a strategic approach to this complex issue, and you have made a start on that by indicating that you will form partnerships. That is an indication to us that you may be looking at that intersectionality and all the different impacts on obesity, but that needs to be really strategic in its vision. Like Amanda said previously, have those goals set out strategically well into the future, because addressing obesity requires a chipping-away process with a long-term agenda.

Mr CRAMP: Would it be appropriate to see some of this grant money continue on with successful programs, or do you think it should stop? To the best of my knowledge, it is going to stop after a period of time. Do you think it is feasible to continue to use grant money to fund these programs while they are considered successful? Is that your organisation’s viewpoint, or should they stop?

Ms Del Fabbro: I think the PHAA would have interest in the longevity of this commission process to its broadest form.

Mr HARPER: You are obviously both invested in health promotion and, as you know, the government has a 10-year plan. As you have just touched on, it needs to be a long-term vision. There are only a couple of members here who went to Victoria and Western Australia during our investigations. There seems to be a lot of feedback that long-term vision is core and that when governments roll over there is bipartisan support. How long have you both been working in your respective organisations?

Ms Del Fabbro: I have been an executive committee member in Queensland since 2008 and working in public health for 25 years.

Ms Bradley: I am only newly part of the committee of the Health Promotion Association this year, but I have been working in public health and health promotion for 15 years. My first job was tobacco control.

Mr HARPER: We have certainly made some huge progress in that particular area, with smoking rates decreasing. Obviously the focus here is on decreasing obesity. I come from regional Queensland, so enabling any community to get more active is a good thing. If you have dealt with previous governments, has there been funding for health promotion previously? Has it been withdrawn? Are we on the right track? What has happened previously?

Ms Del Fabbro: In about 2012 there were big changes in Queensland in terms of health promotion workforce funding withdrawal on quite a large scale. For Queensland that had a significant impact on the ongoing work in that area, and I think organisations are still experiencing the flow-on effects of that and the reshuffle in terms of where funding comes from and how organisations are able to meet the needs of their communities.

Ms Bradley: I think the other impact is that when you reduce your workforce you also reduce your workforce experience. The Health Promotion Association of Australia has just become a registered international organisation for health promoters, so in July health promotion will become a registered profession. When you do not invest in a particular sector your workforce goes elsewhere for jobs. We have seen a massive reduction in the workforce in Queensland. I know that the organisation I work for in my day job often has public health students on placement and their dilemma is: where do they work? There is a real need for a public health approach and they have a strong belief. I think you go into this work with a real belief in helping people and seeing change, so many of them have gone to Victoria.

Mr HARPER: I do not know what funding was around a number of years ago, but obviously there have been impacts as a result of it being withdrawn. I hope we are on the right track with $20 million over the next few years. Obviously, as you said, more is always welcome to achieve those targets. I do not know whether you can take this on notice, but how much was withdrawn previously? I want to make sure we are on the right track in terms of what we are investing.

Ms Bradley: I think the difficult thing about health promotion is that it sits across so many sectors. You are talking about local government and not-for-profits; you are talking about the health services, so the PHNs, and the restructure from Medicare Locals to PHNs at a federal level. It is really complicated. It is not simple.

Mr HARPER: I just want to make sure we are on the right track.

Ms Bradley: When you see a reduction in commitment by government then you definitely see a reduction in outcomes, and that is why I think a bipartisan approach is so critical to the health of all Queenslanders.

CHAIR: Our time has expired. Thank you very much for coming here today. We appreciate your assistance.

BOYD, Dr Bill, President, Australian Medical Association Queensland, via teleconference

CHAIR: Dr Boyd, thank you for your submission. Would you like a make a brief additional comment in relation to your submission and then we will open for questions.

Dr Boyd: Our position overall is that we are supportive of the Healthy Futures Commission. We think it is a good initiative. We made three suggestions with regard to the bill. We feel that there is a need to ensure the commission has a broader public health focus than just obesity. Perhaps the minister's first reading speech and explanatory notes focus just a bit too much on obesity and we could have a broader focus. Secondly, we suggest staggered terms for the board members to ensure that when the board renewal happens at least some of the members of the previous board will still be in place. That has been alluded to in previous parts of this submission in general where there has been talk about surviving the three-year term of government. Our second suggestion is designed to help with that. Our third suggestion is that funding available to the commission's healthy future fund is a good start, but, given the state of public health in Queensland, it could quickly be overwhelmed, so we suggest ongoing review of the funding to ensure its purpose is fulfilled from the start.

CHAIR: Dr Boyd, thank you for your submission, which got to the point, as I know your opening statement has. I thought the point that you raise in regard to staggered terms is a very good one. Certainly you do not want to lose the experience on the board and you want to have continuity. Often doctors are the first person that someone may see in this regard. As the parent of young children, I know if you engage early the doctor can form a relationship with a young child. How do you think a commission, as proposed by the health minister in this bill, can best partner with medical professionals that you represent to deliver on the outcomes?

Dr Boyd: Are you asking how best the medal profession could work with the commission with children in mind?

CHAIR: Yes. How best can such a commission partner with the medical professionals that you represent to bring about the outcomes that are proposed in the bill?

Dr Boyd: I think by including AMA Queensland representatives in the discussion. Hopefully, as the thing progresses we have meaningful advice that we can give to the commission. It would be by the inclusion of representatives from general practice and certainly from AMA Queensland.

CHAIR: Dr Boyd, given the focus in the bill, the explanatory notes and also in the evidence provided to the committee in the departmental public briefing on local relationships and partnerships, do you have any views about how that sort of relationship can most practically work with the medical professionals that you represent and the PHNs, which are really on the ground and often know what is happening there? Are there any practical suggestions that you would like to make as to how best the commission can connect with those established relationships and resources?

Dr Boyd: I would say that communication is really going to be the foundation on which all of this will work. It is careful and meaningful communication with all of stakeholders, so that everyone knows the details of what the commission is doing and has the ability to input and that those inputs are available to everyone to listen to.

CHAIR: If communication is key, do you have any particular practical ideas or views as to how the commission can best do that, given that the medical professionals we are talking about, who are often on the ground and are imbedded in these local communities where the grants may well be distributed, are probably getting communicated with about a lot of things all the time?

Dr Boyd: I am sorry, the sound is not so great. I missed the point of that question. Could you ask it again, please?

CHAIR: Do you have any practical suggestions about how the commission should be communicating with busy medical professionals who are embedded in local communities where grants may be best targeted towards disadvantaged groups and so on?

Dr Boyd: When it comes to communication, the practicalities are that we are all busy. If the wordiness of whatever is coming out could be kept to a minimum and if we could have succinct summaries of submissions, that would be very helpful. If stakeholders have to read through large amounts of documentation, I would have to say that that detracts from the effectiveness.

CHAIR: In the second last paragraph of your submission the point is made that the Healthy Futures Commission has an incredible opportunity to transform the way Queensland develops and delivers public health policy in this state. Could you extrapolate on that point and tell us why the AMAQ feels that a commission of this nature would provide additional value to public health measures currently being performed by the department?

Dr Boyd: I think the important point AMAQ makes is that the whole exercise is whole-of-government. The word 'silos' has been used before. The intent of the commission is to get all the various stakeholders working together, singing from one song sheet if you will. If that can be achieved, the outcome is much more likely to be satisfactory.

Mr McARDLE: Dr Boyd, in your submission you say that we need a whole-of-government public health plan, which echoes an earlier submitter. Can you explain what that would incorporate or entail?

Dr Boyd: Not just in Queensland but around Australia, the experience has been that you get a number of departments all doing the same thing but working almost in parallel universes where they are not communicating laterally with each other. If we can get a genuine whole-of-government effect, the people in the various departments will be working towards the same goal and communicating laterally with each other so you do not get duplication. That is going to cut down cost and time. It has to be the way to go.

Mr McARDLE: One thing that has crossed my mind is that the bill places the commission within Queensland Health's province. It does not take into account Education, Transport, Local Government or the Premier and Cabinet, at least as the bill currently stands. I think you are making the comment that they and other departments need to be on board to really make this viable. Would that be a correct statement to make?

Dr Boyd: I think so. What we are talking about here is public health, and public health is contributed to by a wide range of activities and departments. We know that money can be spent in one area on a particular project or initiative and similar money might be spent elsewhere in another department that has no idea that they are duplicating what is going on. As I said, the whole point of this commission being whole-of-government is to allow the various departments that, in good faith, are trying to further public health to work together to make the thing efficient.

Mr McARDLE: The commission will deal predominantly with the issues of obesity and physical activity in a primary sense. Is that enough for you? Does that need to be widened to cover things such as mental health and other issues?

Dr Boyd: I saw in some of the previous material we were given that commissions tend to blow out and we have to be very careful. We have a $20 million budget, which is targeted at the moment. Ideally, we would look at these other areas. There are so many other pressing areas in public health. To start bringing other areas into this Healthy Futures Commission would be, as I say, ideal, but it would cost more money and risk the commission blowing out. Our suggestion is that we do need generally to focus on broader public health than just obesity, if that is of any help.

Mr McARDLE: Can you identify other areas that the commission needs to focus on at this point in time?

Dr Boyd: The pressing public health issue that overlaps with obesity and diabetes is particularly mental health. There is a huge burden of mental health issues in the community. People who have mental health issues tend to be less interested in their own physical health. That will come into the management of obesity and diabetes. There is drug use and socio-economic pressures on sections of the community that tend to be overrepresented in the obesity and diabetes area.

Mr McARDLE: There is a panoply of issues.

Dr Boyd: Public health covers an awful lot of stuff. I am not a public health expert particularly, but as we go through life we can all see the problems. I would say mental health is up there.

Mr McARDLE: At this stage, the commission is charged with looking at the prevention of obesity and other issues. It is not charged with dealing with those who have diabetes or who are obese, as I understand the briefing from the department. Where does the crossover happen? If it is physical activity that you are looking at, why would you not target those who are already diabetic or obese? Why would you have two separate entities looking at what is, in essence, the same thing?

Dr Boyd: I think one of the notions is to try to target young people with education in an effort to prevent them developing these degenerative diseases as they go through life. Things such as diabetes and obesity do not happen overnight; they happen over a number of years, generally. If this commission can contribute to preventing at least some of those people developing these degenerative illnesses, it will have achieved something. We know that people who have major problems with obesity find it very difficult to overcome that. I was speaking to a lady this morning who has had a gastric stapling and lost something like 50 kilos after surgery. The whole focus of this commission would be to try to help that lady before she ever got to that stage.

Mr McARDLE: To do that, why do we need two bodies that are completely distinct and separate? Why do we need a commission that has its own board, its own budget and its own requirements as opposed to a body that already looks at those who have diabetes? Why do we need two separate bodies?

Dr Boyd: This is in the system, with lots of different departments doing very similar work.

Mr McARDLE: That is exactly the point that I am making.

Dr Boyd: The whole-of-government approach to this issue is designed to bring all of these departments together to minimise the duplication of what they are doing, to learn about what each other is doing and to communicate so that they are aware, rather than, as I said, having these parallel universes going along doing the same sort of stuff but oblivious to what is happening elsewhere. It would be good if we could get an outcome whereby the departments are talking to each other and understand what is going on, so that we have one approach to the problem.

Mr McARDLE: Dr Boyd, would you agree that it is important, in a commission of this nature or indeed any body of this nature, that there be an annual, biennial or triennial review undertaken as to its success or otherwise and that that be published? Secondly, how do you gauge success in an arena like this when there are so many different organisations, government departments and quasi-government departments focused on the same outcome?

Dr Boyd: First of all, a review of the success or otherwise of any program would have to be a good thing if you have reliable statisticians collecting good data and demonstrating that what is trying to be achieved is being achieved or, indeed, not being achieved. That is up to the people who collect those sorts of numbers. Can you repeat the second part of your question, please?

Mr McARDLE: How do you gauge the success of a body such as a commission as a stand-alone body when you have a plethora of organisations, state government departments et cetera working on the same outcome? You have HHSs, PHNs, AMAQ, GPs and the whole kit and caboodle. How do you gauge the success of one commission when we know this is an across-the-community issue?

Dr Boyd: I do not know if I can answer that question in a meaningful sentence. I think there are people who keep endless amounts of statistics. We have highly computerised systems these days and I hope they would be able to inform us whether or not the measures the commission takes are showing something. It is going to come down to statistics. Individual practitioners, individual members of the commission and I are not going to be able to find that out ourselves. We rely on other departments to tell us. We do know from experience that education of the public done properly does produce results. I would have to say that the Queensland government smoking initiative has produced results. That is just one example. Other examples are seatbelts and stack hats for bicycles. There must be departments that are able to measure these things.

CHAIR: Thank you, Dr Boyd. The time for questions has expired. Thank you for joining us today and, again, I apologise for joining you late.

Dr Boyd: You are very welcome. I hope that I have been of some assistance.

CHAIR: Thank you very much. .

WHITEMAN, Professor David, Deputy Director, QIMR Berghofer Medical Research Institute

CHAIR: Thank you for the submission that you made to the committee. If you would like to make a brief opening statement, then we will have time for questions.

Prof. Whiteman: Thank you for receiving us today. I will make a brief opening statement. I am wearing two hats today: I am Deputy Director of QIMR Berghofer Medical Research Institute; I am also a public health physician and epidemiologist with a strong interest in the prevention of chronic disease.

For the committee members, QIMR Berghofer is one of the largest medical research institutes in the country. We have more than 700 staff, over 400 scientists and 100 PhD students, and our work is focused on four main areas: cancer, mental health, chronic diseases and infectious diseases. Today the committee is focusing particularly on some of the lifestyle attributes of diseases, with a particular focus on overweight, obesity, nutrition and physical activity. QIMR Berghofer has a great research interest in these exposures and we recognise their contribution to chronic disease.

In our submission we made several points regarding the activities of the commission. Firstly, we strongly support the establishment of the commission and strongly believe in the power of prevention for chronic disease. Our particular focus for this commission is to underscore the importance of research and evaluation in underpinning all of the activities of the commission. We strongly believe in applying the best evidence to interventions and to policy advice, and more particularly then collecting objective data and looking at the follow-up of any policy decisions or interventions so that you can measure whether or not that intervention has been successful.

I would say that QIMR Berghofer also stands to work as a partner of the commission. Our institute has expertise in statistics, biostatistics, epidemiology, public health and health economics as well as other aspects of medical science more generally. Just touching on some of the comments that I have heard since being in the room, while the focus is on obesity and physical activity we would also recognise that there are many other components of a healthy lifestyle for which childhood and early life would be a targeted period in which positive changes could be made for future health gains. I will leave my opening remarks there.

CHAIR: Professor Whiteman, thank you very much for making a submission. I was very interested to read it. I know that QIMR made a submission to the Thursday inquiry as well. Thank you also for the references that you included to a number of your recent research reports. I have asked the secretariat to access the report around childhood obesity, having read your media release, and I read some of your other work. That is something that I am very interested in, so thank you for the work that you do.

Anyone who has been on this process with me—which I think is just the member for Thuringowa—knows that I am very passionate about evidence based policy and what we can learn from the huge body of work that has been done. I know that groups like the Heart Foundation and the Cancer Council hold incredible amounts of data and information that can inform the initiatives and interventions that we go forward with. I am excited about what commissions of this nature and institutions like yours do to take us further forward, and I have made no secret about that. QIMR Berghofer has been very successful in establishing partnerships. Can you tell us what the commission could learn from your experience in that regard and how they can best partner with these sorts of bodies?

Prof. Whiteman: Certainly. A lot of our work, particularly in the public health field, has been in partnership with the cancer councils particularly. We have a strong interest historically in skin cancer prevention, as one particular example, and we have learned that working with the cancer councils in developing policy relevant research findings has been really important. We have met with stakeholders, discussed with them where the gaps are, and then designed studies to try and address those gaps. One particular example that is happening at the moment is around vitamin D. There is a lot of concern in the community about low vitamin D levels related to lack of sun exposure. The flipside is that if you ask people to spend more time in the sun, their risk of skin cancer increases. Trying to calibrate complex public health messages to a jaded community is difficult, so you need careful appraisal of the evidence to do that. This has a bearing also on physical activity, because when we ask people to exercise they are often doing that in an outdoor environment, so there are all sorts of attendant concerns from various parts of the community. Speaking with stakeholders early in designing a research project is extremely helpful for answering the right questions that people might pose.

CHAIR: You just mentioned a gap analysis of some sort there. Your submission to the committee mentions the same. Are you aware of any kind of analysis in that regard about gaps that we may have in Queensland now that would underpin the work of the commission? Obviously from the minister's comments it is focused on not just obesity but particularly obesity in children and families. Is there a gap that you have clearly identified?

Prof. Whiteman: Obesity prevention and obesity management are not my area of research expertise. Having sat on many grant review committees, it seems apparent that there is a gap in population based interventions, so knowing which messages to deliver to targeted sections of the population and what is the best medium for doing that. I have seen many research proposals coming forward to NHMRC and other granting bodies. My sense is that that is an unanswered question where there is a real research need. How we get the most effective intervention that delivers a result is not yet known. That is my perception just from having sat on these committees.

CHAIR: You mentioned that the focus of QIMR has been cancer, mental health, chronic disease and infectious diseases. You did have a study where you drew on Queensland Health data around childhood obesity. Does the institute have a lot of other holdings with regard to research in this area?

Prof. Whiteman: Yes. While those big-ticket four disease streams—cancer, mental health, infection and chronic disease—are the overarching research programs, we do a lot of work on the risk factors for those conditions. Obesity is a big risk factor for many cancers, and this is work that we have contributed to at the institute. We tend to think of obesity as being a contributor to cardiovascular disease, high blood pressure, diabetes and metabolic diseases. There is a large body of evidence showing that it is very important also as a risk factor for many cancers which are now becoming more common because of obesity and the prevalence of it in the community. The association with cancer is what has been driving our work primarily but not exclusively. We recognise that if you can target obesity in life you get benefits across-the-board, not just for any particular one disease that you might be interested in.

CHAIR: You have referenced at reference 1 in your submission a media release, but would you mind taking on notice if there are any other particular works that the institute holds in this regard and sending copies to the secretariat?

Prof. Whiteman: Certainly. Yes, we will do that.

CHAIR: I know that members of the committee and I would be interested in reading your work in that regard. Thank you; that would be wonderful. We have had a discussion this morning—and the deputy chair is out of the room, but some of his lines of questioning have been about whether the commission's focus is too narrow. Some have commented that it should be more brood; others have commented that it needs to be quite focused. Your media release about the release of your study findings about obesity in children states—

Childhood obesity is a major public health issue because it is likely to continue into adulthood.

You have commented on cancer, mental health and chronic disease particularly. Would it be fair to contend that, in focusing on these very early stages in children in trying to deal with or overcome some of those social determinants of health, some of those barriers that may later in life lead to lifelong illness on chronic disease are a good focus for a commission?

Prof. Whiteman: Yes, I do. I think it is realistic to have a particular focus on activity and obesity. Physical activity and nutrition is a big area when you break it down. It does cover a lot of aspects of the human condition. That is not to disregard the importance of mental health and substance abuse and the other problems that beset society but, being realistic, if the resources are limited, having a focus of activity in my experience leads to better targeted interventions and better outcomes because there is a body of expertise and a body of resource that can be directed to that. While I would like to see more preventive activities across-the-board, I can understand the desire to focus on the early stages.

CHAIR: Am I correct that you are the department coordinator for public health?

Prof. Whiteman: I was until recently, until I took this new role.

CHAIR: I am interested in some of the studies and work that the institute does with regard to health economics. You also mentioned epidemiology. I would imagine that they are both directly relevant and of assistance to the commission. I think what came through is not just the willingness but also the strong interest in the institute in partnering and supporting the commission with regard to access to some of your very skilled people.

Prof. Whiteman: Yes. The institute has been recruiting quite strongly in the areas of biostatistics and health economics. We recognise that is a really important set of skills to have in a health and medical research institute. We have quite a centre of expertise there already and the expertise is growing. We do partner routinely with other agencies and other bodies. Those people are used to collaborating and used to working on other data and using it to inform policy. That was the long answer; the short answer is, yes, we are very happy to help.

CHAIR: I am very interested in the discussion that we had in the first inquiry about establishing a health promotion commission. It came through in the Department of Health's evidence to the committee—and it came through in many of the stakeholders' submissions, too—that there is a difference between health promotion and communicating messages but then also effecting behavioural change. At the end of the day, important messages are great and many listen to them, but it does not always effectively change behaviour. In your learned opinion, what have you seen consistently coming through with regard to skin cancer and changing behaviour? What works?

Prof. Whiteman: The thing that we have learned is that it is often locally and contextually driven. This is where evaluation and research is so critical to getting the messages right. It is not always the case that you can import things off the shelf from other populations. What works in Sweden or the US or the UK may not necessarily work in Queensland with our different environment, big distances and decentralised population. The flipside of that is oftentimes you need to replicate a study's research in our local population to see what does work. This is really an area called implementation science. That is where it differs from health promotion which, as you say, is not exclusively but often about communicating to people how to address lifestyle and health issues but then going further. It might be providing a service or providing a resource or changing school policies and practices. Certainly, with the experience we had in skin cancer with No Hat No Play, Slip, Slop, Slap and SunSmart schools, it was a multifactorial approach. Each of those interventions contributed in different ways, and we see that for smoking as well. It is regulation, legislation and denormalising the behaviour. These are complex social interventions and they require evaluation every step of the way.

CHAIR: The department commented that they wanted the grants that the commission is envisaged to provide to be innovative and flexible and applicable locally, contextually and culturally to the environment that they are going to be introduced into. As you mentioned, Queensland is obviously very decentralised. It is a really dynamic state and what works in one place does not necessarily work in another. Rather than going in and telling them what to do, they want the community to suggest what may work in their context. Do you think that may be an effective way of trying to effect some behavioural change?

Prof. Whiteman: Yes. In principle, I accept that that can work as well. It is probably a two-way thing. I am not an expert on obesity prevention; I put that up-front. There are likely to be known interventions that do work that we are currently not doing or not doing as well as we could. Some of those could be imposed from afar—'imposed' is too strong a word; perhaps 'attempted'. Then it is important to evaluate how that is working in Mount Isa or in a remote community. If your evaluation shows that uptake has not been as high as you had hoped or not as high as you see in Sydney or Melbourne, then you can do on-the-ground research to find out why it is not working and what the barriers are to implementing the process. Often, these are iterative processes. Research and evaluation should be built into the implementation, so that you know whether or not you are having an effect and whether or not you are investing efficiently and wisely.

CHAIR: QUT certainly made that point in their initial evidence before the committee. It came through strongly that obviously you need to evaluate it. There are innovative evidence based solutions, but there is not necessarily the capacity to fund those on the ground to be implemented to see and then evaluate whether they can change the behaviour in a larger population study. You partner closely with the government, universities and other research institutes. Is there anything in particular that you feel the commission can learn in terms of to how best to partner formally, to make sure that all of those bodies are working together practically?

Prof. Whiteman: At a practical sense, one of the barriers to collaborating has been the growing regulatory burden that surrounds collaborative research. Increasingly, there are more legal agreements required and even challenges in simple things such as transferring funds from one centre to another. That has become very burdensome for researchers and for institutions generally. It seems to be an increasingly legalistic environment in which we are conducting research. If there are ways in which a whole-of-government approach might minimise or simplify some of those barriers to collaboration, that would be a good thing. We invest an awful lot of time in shuffling bits of paper to

try to get a study or a collaboration off the ground or a student moved from one site to another. It can be daunting and off-putting to resource-poor research institutions that are struggling to keep their research going. That may not be the answer you were looking for.

CHAIR: No, I was not looking for any particular answer. I imagine the will is certainly there.

Prof. Whiteman: The will is definitely there.

CHAIR: It seems everyone wants to work together. There being no further questions, I thank you very much for coming today and for your submission.

Prof. Whiteman: Thank you.

FOREMAN, Ms Rachelle, Health Director, Heart Foundation

CHAIR: Ms Foreman, welcome back to the committee. You are a regular contributor. Would you like to make an opening statement and then we will open for questions.

Ms Foreman: Firstly, I thank you very much for the invitation to provide the committee with the Heart Foundation's perspective about the establishment of the new Healthy Futures Commission. As you would be aware, the Heart Foundation has had a very strong interest in this. We have been with you on the journey, Madam Chair.

CHAIR: You have.

Ms Foreman: We have been a strong advocate for the establishment of a health promotion commission, which is now coming through in this bill to establish the Healthy Futures Commission Queensland. Part of the reason for that is that we think there is a desperate need to shine a greater light and have a stronger emphasis on prevention. Currently, it is very well hidden in the Department of Health. It is a tiny fingernail. Also, we see the opportunity to really engage cross-sectorally in this issue. Again, that is a little bit more difficult within a preventive health branch in a tiny part of a massive department. As per the previous focus, it is not just the role of government; we need the community, industry and the non-government sector to play a role as well.

We have previously outlined that cardiovascular disease is one of the major contributors to death and disability and is very largely preventable. Our purpose is to do all we can to prevent preventable and premature death and suffering. We definitely think a healthy economic future for Queensland will be shaped by the health and wellbeing of its population. That is a concern in terms of where we are currently tracking. In particular, if people are healthier and have higher wellbeing, they will be more productive and will contribute in the workforce and also in the community. There are also opportunities to reduce the drain on our economy through things such as the Health budget, which is currently the largest part of the state budget. The Heart Foundation recognises the need to prioritise, resource and fund coordinated approaches to improving and sustaining the health and wellbeing of Queenslanders, not just in primary prevention but also at every point along the health continuum. Just because you have now had your stomach stapled does not mean you need less access to fresh food than someone who is yet to go to that point.

We think the independent commission proposed to be established would be well placed to contribute to this much needed whole-of-government approach and the opportunities to implement effective interventions. However, it is only one piece of the very complex puzzle, as you have already heard today. The continuing focus on acute health care is not sustainable. In essence, our current Health budget is an illness budget, with less than two per cent of the budget going to public health and the lion's share of what does go to public health, as was already alluded to by the Health Promotion Association, going to immunisation and cancer screening. Lifestyle and behaviour changes are only the fingernail of the fingernail, if you like. We know that health promotion works, but only if it is multistrategy across multiple sectors and is appropriately funded and sustained.

I next want to talk about the independence and governance of the commission and the board membership as proposed in the bill. We see the independence of the commission as essential in a similar way as it is for the Queensland Mental Health Commission. We support that the board's function is to decide the objectives, strategies and policies to be followed. While we support an annual project funding plan be approved by the board, we do not support that it must be approved by the Minister for Health. This would appear to undermine the independence of the commission, which needs to be in control of its own work plan and budget, as the Queensland Mental Health Commission is currently. It is essential that the commission be truly independent from political processes and be transparent in its work.

What we want to see most of all is a strong commission with bipartisan support that can withstand any changes of government and the political environment over time. It needs to be protected through those government cycles. We like the long-term vision, not the current three-year budget that has been proposed. It needs to allow for future growth and development in the budget, role, resources, capacity, scope and strategic direction. An example of where this has not worked well is the initial establishment of Health Consumers Queensland. It was not set up truly as an independent authority, which meant it was hamstrung from delivering the very things it was created for. We have now seen that approach changed, so that it is a truly independent body. I think you would all agree that it is getting on with the job.

The commission needs to be able to review the evidence and make strong recommendations on investment in policy, legislation and strategy that will promote the health and wellbeing of Queensland. We think the proposed board of six would seem adequate, but we do not agree that all

members should be appointed by the Minister for Health. We think a mixed method would be preferable, as per VicHealth and Healthway, where some members could be nominated through independent processes, as per my previous comments about not being truly politically aligned. Without doubt, though, it needs to be a skills based board with strong cross-sectoral representation, given that many of the biggest influences on health lie outside of the health sector.

Finally in terms of resourcing, the case is clear that investment in prevention works. It impacts across all sectors and provides a fourfold return for every dollar invested. However, it does need a greater focus and resourcing across the government, industry and other sectors. We welcome the proposed increased investment in the commission, from the initial $7.5 million proposed over four years to $20 million over three years, but we see this as only a down payment. The Heart Foundation will be advocating for this budget to increase over time so that more can be achieved. As was already said, more can be done with more. By comparison, the budget for VicHealth in 2015-16 was $38.6 million for a one-year period and for Healthway it was $22.5 million for a one-year period.

We support the focused approach of the commission in its first iteration and establishment, but we do not think the forever goal of the commission should be wedded to just children and families and childhood obesity and adult physical activity. We think that is a good focus in the first stage, so that it does not just flit away into oblivion, but that should not be the focus of the commission forever and a day. As it develops and is better resourced, its scope could increase. As it stands, the focus is a huge task within the initial remit, but, again, with more and with a greater sense of achievement it could expand into the future. However, we also recognise why those two areas of focus, with an underpinning of social determinants of health, have been the initial priorities chosen, because they strongly align with two of the very areas that have goals and targets in Advancing Health 2026, so it is kind of hooking its caboose to something that is already on the tracks, so to speak.

We also recommend that more than the proposed minimum of 55 per cent of the current budget be spent on grants, sponsorship and evidence generation. For example, of the $22.5 million of the Healthway budget in 2015-16, $18.5 million was spent on grants and sponsorships, which is 82 per cent of their budget. However, the overall budget is modest. It will have a little time to gain momentum, so that might be something that happens over time.

We also want to see grants funding and programs—I guess this goes to some of the deputy chair's previous questions—that can be sustained long enough to be evaluated and achieve outcomes in Queensland communities. One-off grants for 12 months cannot do this as proposed, as genuine partnerships take time to establish. Another question asked is whether there should be an ability for the grants to be provided for proven interventions to scale up in communities. As we just heard, there are nuances in every community. Just because it has been tried somewhere else should not mean it is no longer eligible for funding. Similarly, if something is successful, why could that not be tried in another community with tweaks and nuances for that particular circumstance?

We need to minimise the perpetual cycle of pilot programs. That probably goes to one of your earlier questions about what we have seen not work, Madam Chair. Things are working and then they lose funding. We think that could be a role of the commission or the Preventive Health Branch in Queensland. For example, if something is working beyond the grant, where is the pot of money that would allow that to be sustained? There are very few things in this world that are sustained on air. In my experience, sustainability from the government means no more investment, no people, no money, no nothing. If you can show me something that does that, I would be very appreciative to know about it, because there are very few things that can achieve that. As in the public briefing from the department, we also think there is a very strong relationship between this commission and the Preventive Health Branch of the department and, as alluded to, the Aboriginal and Torres Strait Islander Health branch, given that that is one of the focus areas. That will help with the role, scope and strategic direction and avoid fragmentation, waste and duplication.

Finally, I want to make the comment that the commission does not exist in isolation. In our submission we made the point that it needs to be supported within government at the highest level. You can imagine the commission swimming one way and the government policy swimming in a totally different direction, making it incredibly hard for the commission to achieve its objectives. There is a need to ensure that government decisions made outside the commission do not undermine the desired outcomes of the commission. The government should not approve policy and legislation that does not support the necessary social conditions and environments to help children and families adopt a healthy lifestyle. Having a Healthy Futures Commission does not absolve government of this responsibility. Thank you. I am open to questions.

CHAIR: Thank you very much.

Mr McARDLE: Ms Foreman, I note in your submission you refer to a La Trobe report that came out only about a month or so ago at the latest. They talk about Australia being close to the average of the OECD but less than Canada, New Zealand and elsewhere. They also make the point quite clearly that not all the figures are incorporated into the national health accounts as to what is spent on preventive medicine. Is that the case?

Ms Foreman: I cannot comment on the AIHW's methodology, but they have tried to be consistent over time about what they include in the public health realm. Certainly since we have seen hospital and health services established in Queensland we have requested breakdowns of the preventative health funding from the department, and they tell us that they cannot give it to us because they have no idea what hospital and health services are spending in this space. I think it would be a very, very small number—maybe a round number like zero. It is difficult to get the sum of the parts doing it. If you at least look at consistency, as the Health budget has grown the proportion going to public health has shrunk.

Mr McARDLE: They make the comment that actual spending on prevention may be anywhere between three and 12 times as much as reported in the national accounts. That is a significant difference to the $89 per person.

Ms Foreman: That is partly also because they are only measuring what the government is spending, and of course there are other pots of money, with not-for-profit organisations and local governments et cetera that spend money. We do not have line of sight of that and we certainly do not have joined-up approaches around a lot of that.

Mr McARDLE: I think that goes to your point that there are other departments and agencies undertaking work in this field—Education, Transport and Local Government—that are not taken into account in calculating what the outcome is in relation to prevention.

Ms Foreman: Yes. Those reports only take into account what the Health budget is spending. As you would well know, we very much advocate for other government departments to be spending more in their space. As public health is the fingernail of the budget in the health department, so is active travel in the budget of the transport department, so are healthy considerations in the education department et cetera. The comment about health in all policies is a good one. I do not necessarily see it is the role of the commission to have that, but it would be fantastic if the Department of the Premier and Cabinet took a role in that. What we see is that other departments make decisions with no consideration of health impacts 10 or 20 years down the track, and they are running counterintuitive to what the commission is trying to achieve.

Mr McARDLE: My concern is that without DPC involvement it is hard to corral the departments with DPC involvement within the terms of the bill or commission or MOU between the health department and DPC. Departments can run off on their own. There is no coordination, at least at a low level, with DPC involvement in getting the whole thing down on paper together.

Ms Foreman: Yes, and we would not be against this sitting in DPC. I think that having the highest level of support sends a very strong message to all sectors and also to the health department.

Mr McARDLE: You mentioned Mount Isa. In Mount Isa and the Torres Strait, the median age of death is much lower than it is for the rest of Queensland. Would you see those two areas being targeted to begin with and then look at the rest of the state? How would you allocate the funding across Queensland?

Ms Foreman: I only have a few minutes.

Mr McARDLE: Take your time.

Ms Foreman: I think as the director-general and the Chief Health Officer alluded to, there is an important role for the commission to identify some of those key hotspots that they called for grants for in the first instance. I do not think we would want open slather on that and you would want to be looking at a whole range of datasets to determine that, not just age of death or life expectancy. Because two of the focus areas are childhood obesity and adult physical activity, they would be some of the things you would look at, but then you would overlay that with the SEIFA index and social determinants of health type data, and then you would start to look at where it is.

One of the other important things that we have alluded to in our submission is that partnerships do not just happen overnight. There is an assumption by people that people who live in rural communities all know each other and whatnot. There is a big turnover of staff in those communities, so one second you are working with someone and the next second it is someone else. That may also be one of the criteria: genuine partnerships that can get on with the job.

Mr McARDLE: One of the areas that concerns me is local government involvement, because they are the mainstay of planning on the ground, approving applications for building et cetera. An example near where I live is a school that is having a petrol station by 7-Eleven built right next door. They will have drinks and what have you. Schoolchildren can walk out the gate, take literally a five-second walk and grab a slushie and the fast food that some of these stores sell. Is that an issue that we should be dealing with today?

Ms Foreman: Absolutely. It is no secret that the Heart Foundation has played an active and vocal role with regard to this. Our behaviours are impacted by not only our own values and personal attributes but also the environment in which we live, work, play, pray et cetera, so planning is a critical element of that. Your personal choice is one factor, but the fact that it is right there is another factor. In healthy planning we have been very strong advocates for the fact that health and wellbeing should be a key consideration in the Planning Act and all the instruments that flow below it because of the fact that decisions are made that totally do not care about health outcomes and therefore we are flying across the wind.

Mr McARDLE: How does this commission deal with what I think is a very important issue in greenfield sites and brownfield sites? This petrol station is as of right. You cannot object to it. You cannot take it on board to the relevant jurisdiction to argue the point. There are a lot of those that exist over time because, as time goes by, what was approved years ago cannot then be challenged. How do we get local government involved in this in a meaningful way? I see them as one of the major areas of focus to get people up out and walking in parks, using bike tracks et cetera under the commission.

Ms Foreman: You could definitely have one of the board members with a strong role in local government as a start, because they are a big part of where the rubber hits the road in terms of bringing communities and infrastructure and planning decisions and programs together. A lot of them support Heart Foundation Walking as the coordinator, so that might be one element. I think some of the key partnerships will come from local government at the local level. The commission is not going to be able to solve the planning decision that was made some time ago, but, again, if you had the highest level of support for the commission and its intentions out of the Department of the Premier and Cabinet then hopefully you would start to see some of those health-in-all-policies things also being considered beyond the commission as well.

Mr McARDLE: The Heart Foundation undertakes local initiatives. You have walking groups right across the state which are locally based. They are funded in part by the state government allocation of funding to you by way of T-shirts and the like.

Ms Foreman: The state government, under an election commitment, funds the Heart Foundation predominantly for a state based coordinator and then it also funds some of the Queensland implementation costs. Some of that includes a recognition scheme for those who opt into it because some people need extrinsic motivation. Other people opt out because they feel that they do not need that sort of thing. It does create a sense of community. Most of our resource goes into establishing local partnerships and finding the people who can support the volunteers on the ground in a community development model to then support walkers. Our research shows that the people it attracts most are those who are either totally sedentary or insufficiently active, and it does help them to become sufficiently active.

Mr McARDLE: I have been a walker with yourself once or twice. You set a very cracking pace as well. My point is that already locally you are doing a lot to prevent obesity and diabetes in young people, older people and those people at risk. How is this program different in funding one-off grants to deal with the same people you are dealing with now? Where is the difference between what you do at the moment and the walks that you and I have been on in Caloundra with older and younger people? How is this program any different from what you do now in relation to preventative medicine?

Ms Foreman: Heart Foundation Walking is a fabulous program, but it is only one program. It is not a silver bullet.

Mr McARDLE: We have Diabetes Queensland here who would agree with you. They do the same thing as well. How is it different from you to get money from the commission to do what you do now?

Ms Foreman: The opportunities for the commission—and as I have alluded to, I do not think they lie in those one-off small grants—really need to be in fostering a comprehensive approach. We did see that, for example, in 10,000 Steps Rockhampton. Heart Foundation Walking was part of 10,000 Steps Rockhampton, but so was a primary healthcare engagement strategy, local government signage and things. There were joint approaches at the community level, and they did test what

messages would resonate with the community and they ran challenges. 10,000 Steps is funded by the government to continue those online challenges, but it is really that ability to bring it altogether at the community level where I see the big opportunities, as well as involving other sectors.

Mr McARDLE: Would you see there are now two funding streams to do the Heart Foundation walks?

Ms Foreman: There are a number of funding streams for Heart Foundation walks.

Mr McARDLE: Would that be a new funding stream to do the same thing?

Ms Foreman: Probably not. As the Chief Health Officer and the Director-General alluded to at the public briefing, what they do and what they fund is sort of at that statewide level and they also do some policy and legislation at that level. They do not—although they can—delve into that local activation type thing. We would like to see Heart Foundation walks—

Mr McARDLE: But you do.

Ms Foreman: But ours is a national model that then is statewide and then we use a local community development model. Again, it is only one aspect. If you take the example of food, that is a very complex beast that needs multiple strategies to impact it. The other thing around Heart Foundation Walking, as great as it is, is that it mainly attracts middle-aged women, so we need programs that will attract younger women and men. We are fairly good at attracting people from disadvantaged communities because it is a free program, so that is an important consideration. It is really that join-up at the local level where the big opportunities will come to kind of get things going on a bigger scale.

Mr McARDLE: We have heard the phrase 'whole of government' today in defining what the commission should be looking at, which is wider than, I suspect, obesity, children and activity. Would you agree that the commission should be a wider remit as opposed to what it is at the moment?

Ms Foreman: Yes. There does need to be an initial focus, because by the time you set up your board and staffing and processes for grant deliberations it will gobble up a bit of that funding, so you do want to have as much as possible going to the grassroots level. Eventually it needs to broaden. The other thing is that, as was alluded to by QIMR Berghofer, the physical activity, nutrition and childhood obesity area is very big so we need to start somewhere and then build, but we do think there is an opportunity—particularly if this was auspiced by the Department of the Premier and Cabinet—for it to be just the first big focus on prevention. We hope this is not the last and that it continues. We also hope that it makes the government realise that some of the decisions it is making elsewhere outside of health are really having a detrimental impact on health. That is the whole-of-government thing. The commission will have a limited role in being able to influence all of that—that is just the reality—but at the local delivery level for some of the grants and sponsorships there is definitely an opportunity to involve Education, Transport, Planning, Local Government and Health in what is delivered on the ground.

Ms DONALDSON: In your submission you talk about strongly recommending that the grants be significant in size and to organisations with a strong track record rather than small grants to isolated pockets of the community. Previously people have talked about making them local and that what may work in one community or an isolated community may not work with another community. Do you think that, in addition to larger grants, there is a need for smaller organisations that might have a great program that may not be established but that could make a difference?

Ms Foreman: Yes, there is definitely always going to be that opportunity. One of the things that is really important is that the organisations that receive funding are able to administer that grant and deliver what they said they were going to deliver and also do the reporting back to the commission. We know that that varies significantly. Are some of those agencies best to hold the grant or is it best that they be brought in on a broader project as one of the key partners? That is always the challenge. When you look at things that have a collective impact, there is always a backbone organisation. That is one that usually has a track record, has a firm stronghold in that community and can bring others in so that it can partner well.

Ms DONALDSON: There could be an auspicing body.

Ms Foreman: Yes, there could be some small-level grants, but they cannot all be like that. In reality, given the size of the problem and the collaborative and cross-sectoral nature, there need to be sizeable grants that can allow something significant to happen.

Mr CRAMP: I have some questions around the grants themselves. Your organisation is very well established. It has some successful programs. As an organisation, are you intending to look at this funding as potential funding for programs for your organisation?

Ms Foreman: We have a very strong track record in physical activity, so it is very possible that we would if it aligns with our strategic direction and intent. Yes, we possibly would be interested in those sorts of grants.

Mr CRAMP: With any opportunity for new funding, obviously, there are groups like yours that are long established and successful but there is also that new interest for other individuals or groups who perhaps do not even exist at all but, with new funding, suddenly exist. Is there any hesitation or reservations from established organisations such as the Heart Foundation that we will see new players come in? All of a sudden there is a funding source, so we will see programs establish. They may not have the expertise or experience that, say, the Heart Foundation and Diabetes Queensland have?

Ms Foreman: Yes, there is always that risk with money. It is like bees to the honeypot. I think the bigger risk is that you are going to get potential interest from players outside of Queensland even. We have seen that in previous examples. Some of the considerations of the commission in assessing grant success will be a good knowledge of the community and the issues and the ability to partner genuinely. Anyone can put anything on paper, but it will be important to make sure they have the track record and the ability to partner genuinely.

Mr CRAMP: You may have heard my previous question. It is something that I raised at our initial briefing. My concerns lie around the interest in new start-up programs. It is always good to see new ideas come to the table, but there cannot be a lack of ability for existing programs to also access that funding. Would you agree with that?

Ms Foreman: I mentioned that briefly in my opening statement. Absolutely, we would agree that just because something has been trialled somewhere else does not mean that it should not be eligible to be trialled here in a Queensland community. If something is successful in a Queensland community, it should not be ineligible to apply for it to be applied in another Queensland community. That would seem ridiculous.

I am sure some of you are aware of the open data innovation think tanks that are done by the government. It would be really interesting for those sorts of things to look at a hairy problem and get some out-of-the box thoughts. That could be the role of the commission. It does not give the grant to this community or that community but says, 'Here's an issue that we're finding in the evidence. Let's look at some thought leaders and what they think might be a good approach.'

Mr CRAMP: With regard to the board itself being selected by the minister, would your organisation be seeking to have a representative on any board in the future? Was that something that you would see as a positive?

Ms Foreman: Yes. As we alluded to in our submission, the Heart Foundation does not think that having all board roles appointed by the minister makes it truly independent. We note in VicHealth and Healthway that they have a mixed model for that.

Mr CRAMP: I take on board that that has been mentioned before. I just wanted to—

Ms Foreman: Yes. We think there should be a skill based board, and we have some skill based people who might be very appropriate for such a board.

CHAIR: The time for questions has expired. Thanks very much for coming.

TRUTE, Adjunct Associate Professor Michelle, Chief Executive Officer, Diabetes Queensland

CHAIR: Thank you, Professor Trute. I apologise that we are running late. Thank you for your submission. You are a regular submitter to our inquiries on the health committee. I invite you to make a brief opening statement and we will open for questions.

Prof. Trute: Thank you very much. Firstly, I want to thank you all for the opportunity to present today. It is good to see some familiar faces on the other side of the table and also behind me. We all have the same vision, the same mission: to make Queensland healthy. It is good to have like people in the room.

It is also very exciting for us at Diabetes Queensland to see that preventive health is a priority for the government moving forward, because it is an area where in the past we have had the responsibility of working with people living with diabetes. It is really nice to have some control over the pipeline in the preventive piece so that our jobs are a little easier at the really hard, tricky end.

As we are all acutely aware, chronic conditions are costing us millions and millions of dollars every year. A commission like this, if executed correctly, is going to make a massive difference to help reduce those sorts of burdens on the health system. We strongly support the aims and focus of the Healthy Futures Commission. The highlights that we appreciate are the fact that we are talking about our children, which is our future, and looking at children and the focus on children in their formative years. Everything that we do is grounded in evidence, so ensuring that everything that is delivered under the commission is evidence based, research based—not necessarily talking about laboratories and microscopes but looking at how we can execute programs that have been tested—to have some positive outcomes.

The other thing that is quite good for the commission is the area around developing partnerships. I see that as a bit broader than just cross-government—local, state and federal. I also see the benefits with regard to those partnerships sitting across departments, which is what we have spoken about today and many people have alluded to. It is also about harnessing the resources and the partnerships that sit within communities, recognising the community reach of those organisations that are out there as well and partnering quite well with those. That is a move forward. It is not about everything sitting within Queensland Health and them putting their arms around it and saying, 'Don't look at me because I'm dealing with it.' It is really about that broader reach and the advocacy for change that can bring about real change within our community.

With regard to health promotion, as I mentioned, diabetes is one of the areas that has a large amount of opportunity to be transformed by active investment in health promotion. In Queensland, we have about 230,000 people living with diabetes. Because of the preventive nature of it, 60 per cent of those with type 2 would not be living with it if they were looking at lifestyle, activity, obesity. They are obviously key triggers. There are also the complications that burden the health system as a consequence of people being diagnosed with type 2 diabetes and then ending up in hospital with regard to amputations and those sorts of things. It is a progressive condition. In Queensland I have more people who are living with type 2 diabetes and who are taking insulin than who are living with type 1 diabetes, which is the condition where you need insulin. It is a very acute, progressive condition. As our population is getting older, we really need to look at preventive measures.

With regard to recognising the effect that prevention can have, there was a recent study in the US that was released about six weeks ago. They have been running a type 2 diabetes prevention program over 15 months. The saving per person to the government was US$2,650 over that period, and 58 per cent of people who participated in that program delayed the onset of type 2 diabetes. The essence and success of that program spoke to the fact that the US is now putting it in under medicare as at 1 January. They are seeing that investment in programs like that work. The medicare items that would be linked to it would be ongoing. It is not capped. If you run a 12-week program, that is all included. If you visit a health professional four times a year under the auspice of that program, it is not capped; it is under medicare. These days, there is a really big momentum with regard to how prevention can work.

It is a similar program to what we are rolling out with My Health For Life in Queensland. From the partners who make up the alliance for My Health For Life—the Heart Foundation, the Stroke Foundation, ECCQ, QAIHC and the university—that is really good evidence with regard to how collaborations and partnerships within the community can work. I encourage the commission to look

at how that has been pulled together, because that is a good example of how that collaboration is working quite well.

With regard to children, a big focus of ours is to make sure we can prevent type 2 diabetes moving forward. The CHO speaks about the fact that if a child at the age of 18 is obese they have a threefold incidence of being diagnosed with type 2 diabetes later in life. That is a really hard statistic that we no longer can ignore when it comes to living with diabetes and also looking at preventive measures.

One of the most important roles of the commission that I would like to focus on is overseeing the change in behaviour at all decision-making levels. It is about recognising and being a really strong advocate to ensure that all levels of government are thinking about obesity, health and activity whenever they are doing anything legislatively. Whether that be at schools or in built environments, I would really like the commission to be able to extend its reach and its advocacy for hot topics like sugary drinks in schools and those sorts of things. If we can address those issues—and that is the broad piece that everyone is talking about at the moment—it will make a big difference. Some of the work that the commission can do does not have to be program based; it could be more in advocacy. If it can be truly independent it will be able to speak at that table, as opposed to being hamstrung if it sits within one area of government.

Earlier we were listening to someone with regard to areas that the commission could look at. I spoke about it in our submission. Needs mapping is one of the very first things I would encourage the commission to look at—to look at where the biggest need is, to look at trying to stop those social determinants with regard to low socio-economic areas not having access to fresh fruit and vegetables. This cycle is perpetuating worse health for those people living there. We know that if people are living with type 2 diabetes in an area such as that their disabilities are higher, they are leaving the workforce, they have a third of the income of somebody would does not live in those areas and who is not living with type 2 diabetes. It is something that is on our radar. Although the commission has quite a focused mandate, I think we can utilise that mandate and use the smarts of the commission, which is not necessarily going to have to be in project funding but in advocacy and being a stronger voice for people who cannot speak for themselves.

CHAIR: Thank you very much, Professor Trute. Thank you for your submission and the extensive additional information that you have provided in your opening statement. The committee appreciates your support and assistance with the inquiry.

Mr HARPER: Has the 230,000 been broken down into type 1 and type 2?

Prof. Trute: Yes, 15 per cent are living with type 1 diabetes and the balance are living with type 2. Every day 62 people are diagnosed with diabetes. At this point in time a mother is sitting in a room with a doctor who is explaining that her child has been diagnosed with type 1 diabetes. Type 1 diabetes cannot be prevented, but we are seeing more and more children who are diagnosed with type 2. Right now, as we speak, a mother is sitting there with a 16-year-old or a 14-year-old, the doctor is talking about blood glucose, and she is spinning out because we did not prevent that child from getting type 2 diabetes. We did not enable that parent or child to understand what they could be doing to prevent being in that doctor's surgery right now.

Mr HARPER: You would agree that childhood obesity is a key aim of this commission, and I would imagine you also agree with other submitters today that ongoing bipartisan support is required for achieving the long-term vision of reducing the rate of diabetes.

Prof. Trute: Obesity is not one agency's responsibility. It is not the case that one year one government is in and everyone is obese, and the next year when the other government is in no-one is obese. It does not work that way. If we can start implementing evidence based measures that we know work and that we can see are making a difference, then let us see how we can have that sustainable to move them forward.

My idea of sustainability is a bit different from just getting more dollars at the end. If we are rolling out a program that is facilitated and executed in Rockhampton, for example, and it is going to move to Bundaberg because they are not rolled out at the same time, the sustainability that is left behind in the upskilled health professionals and the sustainability that is left behind in the increased awareness of health is also sustainability within the program. If we can create a peer-to-peer network when we leave an area so that they are still looking after themselves, they will still have those behaviours. All we have to do is—a little bit like in America—four times a year just throw out a little bit more to help remind them about it and look at some techniques where you can use technology to

do that on a recall basis or something like that. That is sustainability. It does not always have to be the dollars that are paid out at the end from program to program to program. It is just one area.

Mr HARPER: I come from regional Queensland—sorry, member for Caloundra, it is not the Sunshine Coast; I am talking about 1,000 kilometres that way—where we do have high rates of chronic disease in remote Indigenous areas. You talked about mapping. Are there any other steps to target those hard-to-reach places where you think, 'We could use your data'? What else can you suggest?

Prof. Trute: It is about the needs analysis initially, but it is also about understanding what different agencies are doing in the area. A good example of that is with My Health For Life, when we do the Aboriginal and Torres Strait Islander communities partnering with the Royal Flying Doctor Service, because they are out in those communities. I know firsthand the dealings that they have with a little community just west of Rockhampton. My son is a police officer at Woorabinda, and what they have to deal with with regard to encouraging Aboriginal and Torres Strait Islander children to be healthy takes a different approach than the one used here. If they love AFL there; they are not so much Rugby players. We are not going to send a Rugby player up there; we will send an AFL player up there. You have to tweak it to whatever the community wants at the time, but you have to find a champion within the community. You cannot have a middle-aged white chick going there. You have to really make sure that it is targeted.

Mr HARPER: There has been some commentary around issues of duplication. What is your take on that?

Prof. Trute: I think that is what the needs analysis can also address. If this is new funding then with that comes a new mandate for this particular piece of funding. At the end of the day, if it is around half of the $20 million that is seen in programs—we are not talking about sheep stations—the challenge is: do we spread it thin or do we take a really strategic approach to those grants? For something like this, part of me says that whatever we do needs to be universal access across Queensland. That is why the IT and the start-up is not a bad approach, because there is a way of using technology to ensure that if you are at Rockhampton you have the same access to these initiatives as you would have on the Sunshine Coast. I think we need to think about areas like that—or 'what is the role of the local rowing club in all of this?' I am kind of really interested to unpack what that would look like because they do add value to the community, but whether is it through this grant funding or in partnership with the community or Sport and Rec I do not know. I think we have to look at this as an opportunity to showcase how we can have linked-up government and how we can have opportunities that go across different areas.

Mr CRAMP: Dr Young stated that there was some unintended mapping already done around the potential for areas that may need funding under this commission, but your written submission states that a research focused mapping of needs throughout the state needs to be done, so it is quite important. We have all of this money. We cannot just go throwing it out across the state. That initial funding will effectively be doing that, so which comes first and how long does mapping take? When groups have started up in other states, do you know how long it was before they had a hold on where this money was needed throughout the state?

Prof. Trute: I would encourage needs mapping prior to facilitating funding. A needs analysis has been done by the PHNs. The first step may be a desktop audit, for example, to see exactly what the PHNs have, then overlay an opportunity for organisations like ourselves, the Stroke Foundation, the Heart Foundation, ECCQ and QAIHC to put some of their data to it, and then use some of that data with an analysis by maybe QIMR or someone like that to understand it. The point is that we want to avoid duplication. We do not want to do the same programs that are being executed by other parties. I would rather ensure that the money that is invested lands where it is most needed.

Mr CRAMP: Right from the get-go.

Prof. Trute: Right from the get-go. I could sit here and execute an amazing debate about why Diabetes Queensland could do it, and Rachelle would do the exact same thing for the Heart Foundation, but you have to sit back and ask, 'What is best for Queensland?'

Mr CRAMP: It sounds like there is a real need to have skilled people from organisations such as yours with experience on committees or boards to oversee this project who can give us a head start in mapping that out.

Prof. Trute: As a fellow of AICD, and one of the things I advocated when I built boards is that the people who sit on boards have experience at the same level that the board is working at or more. You are not going to have a business with a $20 million turnover and have people sitting on the board

who only have experience at running a $3 million business—that is just how I see it—because the CEO wants to be able to go to that board and say, 'Do you know what? I am in a bit of a pickle here. Let's talk about it.'

The other thing is that we have to make this sexy for the public, so there also has to be someone with a bit of profile who can sit on the board. I do not know who that is, but it would be someone who the public knows straightaway and who understands health. You have to make it sexy so that people listen to it. You also have to attract quality executers of the funding. You need to position it so that you are going to get organisations and corporates. This is an opportunity for corporates to co-fund some of their programs. They put up 50 per cent and the fund puts up 50 per cent and therefore they execute this particular program. I know that we talk about corporates here, and I am a big advocate for ensuring that we utilise the corporates to help 'sing our song', because they can get into places that none of us in this room can because that is not the area in which we play.

Mr CRAMP: You mentioned high-profile individuals. Would I be correct in saying that high-profile people give organisations a certain credibility? I know that people in my community look to see established organisations, because things like the Heart Foundation's tick of approval and Diabetes Queensland hold weight with the general public.

Prof. Trute: I think government does not leverage off the brand and the credibility that sits within those larger community organisations as well as it could. My Health For Life is looking at those large organisations that can get to places that I cannot get to because I am Diabetes Queensland, but we all have the same mission. How do we execute it? It is about having an independent skills base on the board so you have someone strong in community who understands all levels and has experience in executing government grants. I could rattle five skills off straightaway, but that is what I am looking for.

CHAIR: Professor Trute, thank you for coming along today. Our time for questions has expired. You did mention an American study as part of your opening statement. Would you be able to provide that to the committee?

Prof. Trute: Absolutely.

CHAIR: That would be great. Thank you so much for your time.

FLEMING, Professor MaryLou, Director Corporate Education, Queensland University of Technology

CHAIR: Thank you for coming before the committee and thank you for your submission. Would you like to make an opening statement?

Prof. Fleming: I represent the Queensland University of Technology. Within that group we have exercise and nutrition science expertise, public health expertise, clinical scientists, nursing and psychology expertise. We also have an Institute of Health and Biomedical Innovation, which is our research arm. Within that we also a health science innovation group which does our health economics activity. We have a broad range of experience.

I am on the Metro North Health and Hospital Board, and we are working very closely with the primary health networks and other organisations in our communities to focus on people who do not need to be in hospital but who have chronic illness and who need to be in their homes and supported in their homes. We have very much a community focus as well as ensuring that we look after people who need to be in hospital. That is essentially what we are talking about with this continuum of care. We have young people at one end and people who are moving through life stages who are still well, and we need to help and support them to remain well. Then we also need the necessary services for people who, through no fault of the own—whether it is genetics or other factors—move into and require hospital services. We are talking about a continuum of care, but really for the focus of this exercise we are talking about people who are at this end of the spectrum: those who need to be supported to maintain a healthy lifestyle. Focusing on children and young people is a really important area, because in the majority of cases they are well and we are trying to build skills and expertise that will enable them to continue to remain well during their life, so I think it is very important.

The other important thing that I think we also need to keep in mind is that, when we look at all spending for goods and services in Australia, health spending over the last 10 years has gone from 7.9 per cent to 9.4 per cent, so we do have an economic imperative to sustain healthier people for longer. There is a saying in public health that you need to keep people at the top of the cliff before they fall down the waterfall and into the stream, where you have an ambulance waiting for them. You will always need the ambulance, but you do not need the majority of people to be getting in the ambulance. You need to be looking upstream at promotion and prevention.

We very strongly support the focus on population health. I have heard conversations this morning around health behaviours and health education and health promotion and public health which sometimes can be quite confusing. Public health is the broad overarching philosophy within which we have promotion and prevention. Health education contributes to health promotion, and public health is this continuum of care. I think it is very important for us to know what our focus is and why we are focusing as we are.

Alignment of key stakeholders is really important. I think it is essential that as many stakeholders as possible through this commission can be aligned and supportive of the activities of the commission. I also think it is very important given that we have complex health issues. Some people might say these are ‘wicked’ problems, and wicked problems need a range of sources of opportunity to solve. That is why we need transdisciplinary and multidisciplinary activity. If we talk about small start-ups, it might be possible to fund small start-ups, but what we need are people who are in a transdisciplinary context supporting multiple strategies. Even if we are looking at a small-scale project that may be able to upsize to a large-scale project, we need transdisciplinary and multidisciplinary health.

The other important thing is that there are clearly key challenges, and in her most recent report the Chief Health Officer highlighted those key challenges. I do not know, to be really honest, whether we need another needs assessment. I think we have data coming out of our ears around issues that are important for Queenslanders. We have data that has come from the primary health networks and the Queensland government from the Department of Health around key challenges and priority issues. The AIHW produces data and we have a whole range of other data sources. I think we have plenty of information around those issues.

The other important factor that I want to highlight is not only sustainability but also monitoring and surveillance of activities and comprehensive evaluation that includes the economic evaluation of programs. We need to know the cost benefit of the activities that we are engaged in. I do believe that we also need sufficient funding for this activity to occur, and I do not think we ought to be spending a large amount of that initial funding on a needs assessment. I think we already have the information there. I do think sustainability is very important. If we are putting program funds into activities, we need to ensure those are sustainable.

We have heard a lot of conversations this morning that sometimes programs do not work in other communities. That may well be the case, but there are still some fundamentals that would work essentially in most communities. You have to have the data. If the data has some different foci for one community compared with another, then you modify and change the strategies or the focus of those activities in those areas. That does not mean we cannot have a very comprehensive approach to each one of those communities. I have been working with the Wesley Research Institute on a three-community program. We have looked at Maranoa, Western Downs and Gladstone and we have compared and contrasted the issues there. In those communities they have identified four priority issues: overweight and obesity; mental health; substance use and abuse; and access to health services. Those things have been addressed in the Chief Health Officer's most recent report.

The final comment I would make is that this is a very complex area. It is complex in terms of where we address the issues. I am part of the 'worried well'. I know to put my shoes on. I know to go for a swim. I have access to shoes. I have access to a pool. I have access to the ocean. Some people do not have those areas of access, so we have to think about health inequalities. That is why I think it is very important that we look to identify the social determinants of health and focus on those issues as well. I think it is really important that we focus on Aboriginal and Torres Strait Islander health and wellbeing, but that needs to be generated and developed by Aboriginal and Torres Strait Islander people. Michelle made the point that we do not want middle-aged white men or women going into communities to tell them what they need. They need to be masters of their own destiny and use strategies that work in their communities that they know about. Thank you very much for giving me the opportunity. I congratulate the government on the bill to establish the Healthy Futures Commission.

CHAIR: You have touched on so many pertinent, valuable points that I have been ticking off my questions as you have gone, so thank you. You do have very good expertise, and not just within QUT. You mentioned you are on the board of Metro North, which covers my electorate and just a few others. It is a really small geographical space.

Prof. Fleming: Yes, it is a very small geographical space!

CHAIR: You work closely with the PHNs, which are always of interest to this committee, with what they do and what is happening on the ground. You made a comment that differs from many of the other people who have come before us today who think the first step is to do a gap analysis of what information we are missing so the commission can target its attention. You mentioned that you do not think that is necessary because we have so much information. If we have the information, how do you think the commission should best target its attention, given there is so much happening in the space already?

Prof. Fleming: That is exactly right. That is why I think that information gives us some opportunity to begin with, where the information tells us the major priority areas are. The Chief Health Officer's most recent report does that in spades. That is an excellent report. It is very comprehensive. It talks about the same issues that we have talked about. It talks about overweight and obesity, mental health, substance use and health service delivery in rural and remote communities in particular. I think the evidence is there. Maybe we need to sit down with the evidence. The primary health networks have also done networking activities and identified data. As I mentioned, the AIHW gives us data around Australia. I think we have that much data now that we do not need any more. What we need to look at is: given the data that we have, where are our priorities? How do we identify those priorities? How do we begin the challenge of dealing with those issues in rural and remote communities, with Indigenous communities, in communities where there are social determinants of health as a major contributor? I think we have all of that evidence. We have to sit down and look at that evidence and say, 'Here is our starting point, and it is based on evidence.'

CHAIR: When the Chief Health Officer came before the committee with the director-general to brief us on the bill, the report that you were referring to was referenced in the written briefing to the committee and also by the Chief Health Officer. On my reading of the explanatory notes it also informed the bill et cetera. I take your point about the availability of information and the different hats that people wear. My understanding is that the Chief Health Officer is also on the board of QIMR Berghofer, so I think all of that valuable, high-quality information is fed in to underpin and provide rigour to what the commission is trying to do and how it is trying to do it. What is your view about the commission's approach to try to provide grants—which they mentioned in their testimony to the committee was based on Victoria's model too—about trying to localise strategies to particular communities that come from and are driven by those communities to effect behaviour change? Do you feel that is a good approach?

Prof. Fleming: I do. That is where we are working, so community owned activities, community developed activities. I have been to a number of conferences now and I have been as far afield as presenting to agricultural shows and internationally. I did a presentation where I talked about rural and remote communities and the importance of community led, community developed activities with local government as a major contributor to those activities, because if they are not owned and developed and managed by communities, where is the buy-in? Where is the opportunity for those committees to say, 'Yes, this is really important for us. We want our community to continue, to survive, and we need to provide health and wellbeing as a major core of our community'?

CHAIR: There has been discussion that such a commission just duplicates what Queensland Health and the department do in the area of public health. Is it your view that the commission provides the ability to do something different in this space and perhaps more innovatively and more flexibly than the prevention unit already in the department?

Prof. Fleming: I think the prevention unit does a good job at the top level around identifying issues. Any commission would need to work very closely with the prevention unit and with the Chief Health Officer, but I do think a commission that sets itself apart from one government department and looks at that multidisciplinary, transdisciplinary activity, where government departments are engaged to help and support the notion of health and wellbeing, is a very good idea. I think as a compromise you could have the minister identifying some members of that commission and then also having a more open process to look at some members of the commission so that you have a combination of those areas. I do believe that we need a commission to focus our attention, otherwise there will be dissipated activity across a range of different departments and different government levels. You need something to pull it together.

Mr McARDLE: You made the comment that the commission stands aside from the government. How do you align that with the fact that the commission's plan is approved by the minister and they cannot act on the plan until that approval takes place?

Prof. Fleming: I would certainly like to see some support for the commission to be more independent. You would always be in conversation with the minister anyway because he is the chief health officer, so you would not want to be doing things that do not align with where he sees strategies, whatever government that is. We need to work closely with government.

Mr McARDLE: To follow your line of thought, you would like to see more independence between the commission and the government?

Prof. Fleming: Yes, and I do not think that would be too difficult, to be quite honest. I would like to see the opportunity for the commission to have some independence.

Mr McARDLE: The other point that has been raised by many people is that there is no buy-in by the DPC as the bill currently stands. There are many departments—Education, Transport, Communities, Local Government—that have a major component with regard to children and also what happens on the ground where both you and I live. Is that an important element, in particular with the DPC, to have a binding role to get all the departments together corralled in one room?

Prof. Fleming: As many other speakers have said this morning, I think that gives a very high level of support for an activity, which cannot be bad. I think that is quite a good proposal. I think a whole-of-government approach is very important.

Mr McARDLE: That is a phrase that has been used quite a lot. It has been used in the sense of obesity and activity being too narrow a focus for the commission and that it should be widened to include mental health. Do you think the commission's focus should be widened even now, because things flow from one to the other quite quickly?

Prof. Fleming: I think it is pretty hard to say that someone who is overweight or obese does not also have potentially some mental health issues or could also have some substance abuse issues.

Mr McARDLE: Or homelessness.

Prof. Fleming: Yes, certainly. None of this is siloed. Health is not a siloed activity. There is certainly a need to make sure that, across a range of sectors and for the benefit of the individual and the community, a whole-of-government approach enables that to happen. Governments are like universities: we sit in our silos. The Vice-Chancellor at QUT is trying to encourage us to work across our silos. I think that is a great opportunity too for the Queensland government.

CHAIR: The time allocated for this public hearing has expired. If members require any further information from witnesses they will be contacted. If any questions have been taken on notice, and a number have, the secretariat will be in contact to confirm the question taken and that the response will be due by Tuesday, 4 July. I thank all witnesses for their attendance today. The committee appreciates the assistance provided. I declare the hearing closed.

Committee adjourned at 12.45 pm