HEALTH AND AMBULANCE SERVICES COMMITTEE

Members present:

Ms L Linard MP (Chair)
Ms RM Bates MP
Mr SL Dickson MP
Mr AD Harper MP
Mr JP Kelly MP
Dr CAC Rowan MP

Staff present:
Mr B Hastie (Research Director)
Ms K Dalladay (Principal Research Officer)

PUBLIC HEARING—INQUIRY INTO PERSONAL HEALTH PROMOTION INTERVENTIONS USING TELEPHONE AND WEB-BASED TECHNOLOGIES

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 20 MAY 2015

Brisbane

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Committee met at 10.05 am

CHAIR: Welcome, ladies and gentlemen. Thank you for your attendance today. Before we start can I ask that all phones be switched off or to silent, please. I now declare this public hearing of the Health and Ambulance Services Committee open. I would like to acknowledge the traditional owners of the land upon which we are meeting today, and I acknowledge elders both past and present. My name is Leanne Linard; I am the member for Nudgee and the chair of this committee. The other members of the committee with me today are: Deputy Chair Ros Bates, member for Mudgeeraba; Mr Steve Dickson, member for Buderim; Mr Aaron Harper, who is out of the room just for a minute, member for Thuringowa; Mr Joe Kelly, member for Greenslopes; and Dr Christian Rowan, member for Moggill. We are supported today by our secretariat Mr Brook Hastie, Kath Dalladay and of course Hansard.

The purpose of this hearing is to assist the committee in its inquiry relating to personal health promotion interventions using telephone and web-based technologies. The inquiry was referred to the committee on 27 March 2015 and the committee is to report to the House by 12 June 2015. The committee has advised the public of the inquiry through it is parliamentary web page and by writing directly to stakeholders. The committee received a total of 23 submissions which are published on the committee's website.

I would like to advise you of a few procedural matters before we hear from our invited witnesses. 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. Committee proceedings are subject to the Legislative Assembly's standing rules and orders. People in the room not providing evidence are reminded that they are here to observe proceedings and may not interrupt. Anyone who does disrupt proceedings may be removed at the discretion of the chair. Hansard is making a transcript of proceedings which will become available as soon as practicable, and the proceedings are also being broadcast live on the parliament's website.

I would now like to welcome our first witnesses from QUT. I am sure we have a few QUT graduates on the panel, of which I am also one. We do not show any favouritism here! It is lovely to see you, QUT. Thank you for coming before us.

DRENNAN, Professor Judy, Queensland University of Technology

FOTH, Professor Marcus, Queensland University of Technology

MULCAHY, Mr Rory, Queensland University of Technology

RUSSELL-BENNETT, Professor Rebekah, Queensland University of Technology

CHAIR: I invite you to make an opening statement of about five minutes, and then I will open it up to the committee to ask questions. If you are not able to answer a question today you may take it on notice. The secretariat will be in touch with you about timings for providing your responses after the briefing. May I ask that you please state your name and the organisation that you represent before you speak for the purposes of Hansard.

Professor Russell-Bennett: I am Professor Rebekah Russell-Bennett from the QUT Business School. We are each going to speak for a minute, which is a challenge for academics. I really want to make two key points in what I am going to say. The first is that telephone and web-based technologies can be used for a variety of different purposes, and it is really, really important when setting policy or strategy that you determine up front what the aim is. If the aim is to create awareness or provide information, then a health promotion approach is usually the most effective way to use those technologies. If, however, you want to bring about behaviour change, you need to go beyond communication to look at a broader marketing mix, and that is where social marketing comes in. In the same way that fast food companies or soft drink manufacturers use the broad marketing mix from the service delivery from their brands and products to their pricing

strategies, their distribution, their retail outlets and their intermediaries finally using promotion, in social marketing we do the same thing. If the purpose of these interventions is to help combat some of the problems that are created with commercial marketing or to work with commercial marketing for a solution, then you really need to start with a broad-based marketing strategy and go beyond communication.

The second point is that you need to have sufficient funding to provide an evidence base. Many of these technologies are very new, there is not a lot known about them and I think there is a temptation to rush in and do something that is a fad and a bit of a buzz because you can and not have sufficient budget to evaluate them. Really if the Queensland government is going to be innovative, you also need to make sure that what you try comes with knowledge at the end about why it worked or why it did not. There is really no point in putting all your money into developing technology and then if it works, you do not know why; but worse, if it fails you do not know why. Having a strong evaluation strategy and the funding that is appropriate is a really, really critical success factor. I will just hand over to Judy.

Professor Drennan: I am Professor Judy Drennan from the QUT Business School. I am the only Australian representative on the board of directors of the International Social Marketing Association, and that means that I have a lot of experience with what is going on internationally. Also I am an academic, but I work very much with industry in developing things. My work is mostly with developing mobile app interventions for young people's social wellbeing. I went in the direction of using mobile phones because it is part of young people's daily lives and now it is part of our daily lives because it is always with us, it is always on; therefore, it is something that we can use and we can use it as a nudge, for example. The main thing about it is its connectiveness and transparency.

In terms of sharing experiences, it is very important in changing behaviour. Overall research has shown that mobile phone apps have been very important for developing changes in behaviour. We know that in weight loss, for example, it is highly helpful and there has been research to show that people have been able to achieve a decrease of 1.6 kilograms over a few months. It also increased physical activity by 35 minutes a day, increased vegetable intake and reduced drinking sugary products by about 155 mls a day. The thing that I want to point out here is that it has been found that weight loss, for example, is much more effective through the smartphone than by websites or by using paper. The reason is that with paper diaries you cannot share it. With mobile phones and with using apps that are shareable, we know that there is a modelling of behaviour because we know what other people are doing. There is also a normalising of behaviour so that if we do fall off the wagon, we know that we can get assistance with that and it is peer to peer. One example was with breastfeeding. Mum Bub Connect used two-way SMS, so it does not even have to be sophisticated. This was used along with a phone counselling service. The idea was to increase breastfeeding confidence and improve breastfeeding duration for the wellbeing of infants. The outcome is that mums in the program actually had higher levels of breastfeeding confidence, improved breastfeeding duration and they were also more able to cope.

I have done a lot of work using mobile phone interventions with the Young and Well CRC as well and I have done work in relation to alcohol, mental wellbeing and bullying. One of the things that I have found is that it is important to have participatory design so that when you are developing these things, it always has to be done with the people that you have in mind. For example, we did one with alcohol, but we had to make sure that it was something that young people wanted. We ended up with this thing called girls' night out, which has been very effective.

The last thing I wanted to say is that using a theoretical framework is very important. We have used the model of goal directed behaviour, which has been used across a range of different interventions. We know how it works and we have a clear evaluation of that. My main points are: being able to share the experience; having something that is with you all the time; using participatory design; and also the effectiveness of websites. I will pass across to Professor Foth.

Professor Foth: I am Marcus Foth, professor in interactive and visual design in the school of design at QUT, and I am the research leader for the school. I will pick up on one particular point that Judy made, which is around participatory design. I will do this by illustrating this with one particular case briefly. Judy mentioned the Young and Well CRC, which is a federally funded scheme, a large collaborative research centre led by the Inspire Foundation in Melbourne. We have been participants in that CRC and we have had one particular project, as Judy mentioned, that focused on alcohol consumption.

In that particular study, we looked at binge-drinking behaviours of young people, particularly the kinds of examples that you might see in Fortitude Valley on a Saturday night. At the starting point of that particular study, we started with an app but it was problematic. That particular app was

an alcohol counter. The app was used by young people, or was supposed to be used by young people, at the nightclub: if you order a drink, you take out your phone, you open the app and you go 'plus one beer', 'plus one spirit', 'plus one glass of wine'. That is not cool. It was completely missed at the beginning of that research that young people would not do that. It is not cool to take out an alcohol counter when you are surrounded by your mates and you want to have a good time. In the actual health research, it did not actually occur to anyone that this would be a problem.

From a participatory design point of view, we engaged with young people in qualitative research to understand what they are actually doing when they are out and about, having a good time. That led to a change in the direction where we arrived at what Judy mentioned, which is the 'Having a good night out' app. It takes a different approach. It actually works within the culture of young people as they are having a good night out. We introduced this notion of the stupid line. The stupid line is when you cross over and you are so intoxicated that you are an embarrassment to your mates. You do not want to cross the stupid line. The app uses the terms and the actual support mechanisms that young people already employ on their own terms and amplifies and supports those in order to reduce the alcohol intake, but also to make sure they are safe. It would suggest, for instance, that you watch out for your mates—are they still around; have you seen them; have they gone onto a different floor of the nightclub; suggest they might want to drink a bottle of water in between. It is a very different approach. The participatory design approach that was implemented right from the start of that research led to a much more successful outcome that has actually been taken up by young people.

Prof. Russell-Bennett: That is pretty well us. We have brought Rory Mulcahy along. Rory is the expert in the specific interventions, that is, the appendix and the table in our submission. We have brought Rory along in case you have any questions about a particular intervention that you would like to know about. Rory submitted his PhD yesterday, as well.

CHAIR: Congratulations.

Mr Mulcahy: Thank you.

CHAIR: Thank you, Professors Brennan, Russell-Bennett and Foth for your presentation. I will open up with a question in reference to point 3 in your submission around lack of accuracy, legitimacy and information. I was quite interested in getting to the heart of your statements around that one particular issue with current smart phone apps and technology. Tackling health issues such as physical activity, weight loss and nutrition is the lack of legitimacy of information and also accuracy or personalisation for the user. Obviously you have both been involved in and read many studies. With regard to legitimacy and also motivation to commit, to use and to keep using these sorts of technologies, is there a sense that good health itself is not necessarily enough of an incentive? I know it is multifaceted, but is there a lack of information, education, confidence or support that leads to an issue with people maybe not taking it up or it not being successful? Can we go to the heart of that legitimacy issue, as well?

Prof. Russell-Bennett: I do not think it is so much that people do not have enough information. Again, we do not take a population approach, so we do not assume that everybody is the same. Certainly within certain subgroups of the population, I think education could be an issue. For instance, if we are dealing with breast-feeding teenage mums, there is certainly a considerable lack of information. If you are dealing with middle-class well educated women, they tend to have the information, but whether that translates to behaviour is the issue.

A really important part of doing any program is to not do a population approach; to not assume everybody is motivated by the same things as they do not all have the same opportunity to do the behaviour and they do not all have the same ability. We know that most people in the mainstream know that they should drink less, they should exercise, they should eat a certain amount of fruit and veg every day. I will not ask everyone in the room, but I would doubt very much that we all even do that. It is not always about motivation and information. It is about the ability to fit it into your current lifestyle.

People prioritise the short term over the long term. Long-term health is out there; today's problem could be getting the kids to basketball on time or today's problem could be that you are single, you have a date and you have to look good. One of the things about marketing is we assume people are short-term oriented and they need immediate payoff, now. If you can embed that to also achieve a long-term goal, then what you have is a successful system. The social marketing approach tends to be to find something that yields the immediate benefit now, but also achieves the government long-term societal benefit down the track. There is a huge evidence base of making that work.

Prof. Drennan: One of the other things with developing these apps, to give an example, another one that I have done is this thing called 'Girls night out', which is specifically for young girls. They get their friends to come in and it is very simple. You are able to have a lot of fun with it. As their social group begins using it, it is a bit like we do with Facebook now: you keep going, 'What are we all doing?' It becomes kind of almost addictive in itself, but part of it is the fact that it has this alcohol aspect to it. The idea is that they will want to keep using it because it is fun and it keeps changing. The big problem with changing behaviour is the maintenance of behaviour. A lot of the work that I am interested in is how do we maintain that behaviour, because it is always all fine in the short term but how do you keep people maintaining it? You need to keep that interest up. You need to feel that they have to become involved. You need them to use their friends and their peers to keep that going as well.

Also, it is about not expecting extremes. In the work I do, we do not say, 'Do not drink'; we say, 'Drink moderately and understand what that is'. This idea of having someone not drink and the rest of them get completely drunk and the designated driver takes all responsibility, we do not think that is the way to get any maintenance of moderate drinking behaviour. We are doing a lot to ensure that using your mobile phone also incorporates getting your peers involved in it and making it something that is part of their daily lives. That is my view. Marcus?

Prof. Foth: I would briefly add that another aspect of the legitimacy is also the way that our study participants would perceive where the information or the advice comes from. Just having a government branded app is already a deterrent in the sense that there is baggage attached to being preached to, being told, being penalised or that there are rules or regulations. Again, young people would say that that is not cool. When it comes from a friend, the same message might be perceived very differently. If I say to my slightly intoxicated mate, 'Maybe you've had one too many; you should slow down and have a bottle of water', it will be taken on with much more trust and validity because there is an established relationship. The way that we approach this through participatory design and the social marketing behavioural approaches is to enforce and to support those existing mechanisms, rather than to come in as an outsider.

Prof. Russell-Bennett: And that is also where you can work with non-profits that also have credibility and legitimacy in a field. They can be really powerful allies. Because they are outside the political cycle generally, that can also be a plus in terms of a longer term strategy.

CHAIR: Thank you very much. I appreciate that. I will pass to the deputy chair, Ross Bates.

Ms BATES: It is lovely to meet you this morning and, as a former minister for IT, I am always very excited about innovative technologies. One of the things that I have read through a number of the submissions is the lack of regulation of apps. Anybody can put an app online. Even Professor Neil King, in his submission, mentions that things such as smoking cessation and alcohol reduction apps are often contrary to national guidelines. Where you do see the role of regulation for apps, given that anybody can put an app on the internet? How do you steer young people to apps that are appropriate, credible and legitimate?

Prof. Russell-Bennett: I do not think you can regulate. I think you can use policy, though. Because there is so much out there in the marketplace, people are looking for some guidance. If you go onto the app store and type in, say, 'health', heaps comes up. We are now of the point of view that it is not so much, 'What do I choose?'; it is, 'Can someone give me some pointer as to which ones are the better ones?'. I think government could have a really strong role in, basically, doing a checklist or promoting and endorsing particular apps. In fact, the government does not even need to develop these things themselves. Often, it is more cost-effective to find what is already out there and working, and then endorse that through various channels. It is about finding the key influences in the various communities or subgroups that you need to communicate with. It could be GPs, for instance, for quitting smoking. They could be your key influence. They are looking for advice as to, out of the 500 apps out there, which are the key ones. Again, they do not have to be ones that the government develops. In fact, I think you could say that there is always bigger and better technology out there. Commercial organisations have far more money. It is smarter to work with them and make sure that they are on track and then say, 'We'll endorse you'. In the same way that the Heart Foundation has done the ticks rather than coming up with their own range of food, which is just not viable, they worked with setting the guidelines. They have had a really strong branding campaign around that. I think Queensland Health could definitely do something in that space and be an endorser, not just a manufacturer of the technologies.

Prof. Drennan: I agree with that. I think that is really important. I was on the steering committee for the MARS, the Mobile Assessment Rating Scale. I think Neil will be talking about that a little later on today. I am part of that group, as well. I did some research last year with a student,

looking at the difference between a mobile app that is there for health reasons and one that actually changes behaviour and has the social marketing aspect to it. We developed additions to that scale to be looking at whether it actually changes behaviour and the things that we should be looking at. We want to incorporate that with the MARS scale. Things such as that are also very helpful to look at how good the apps are, whether they actually are achieving their goals and if they are doing the right thing. Those sorts of things make it easier for people to say, 'Okay, I've chosen this app. Does it do that? No, it doesn't do that, it doesn't do that and it doesn't do that'. That could also be useful for governments to use as well, so that they can see whether or not an app fits the criteria.

Ms BATES: I totally agree with you that IT is the enabler and we should obviously be looking at endorsing those apps that are reputable.

Prof. Russell-Bennett: It is taking a leadership role.

Ms BATES: Absolutely. I know that Microsoft has a competition every year to develop apps and those sorts of things. Our former government certainly was looking to get the industry to come up with all of the new applications, because they were out there and doing it rather than government, which often does not do it very well.

Prof. Foth: To quickly make one addition to that, it is very important to appreciate that, yes, IT is the enabler, but just at this table you have no computer scientists really who are working in that core field. My own background is in computer science, very early on. We also do not have core expertise in health. We work with people in IT, in the technical field or in health, but really those IT platforms as enablers have to be embedded in a much larger program or initiative that includes social change, thought and processes. The way to rank those is very different to how you would rank white goods. You cannot just have a system where you say, 'This is the No. 1', just because of what Rebekah explained earlier, that one size does not fit all. The one that works really well for me might not work very well for other people. That is a key insight that really has to be communicated, because otherwise there might be certain areas that are not really well covered. Another example, in addition to the apps that we mentioned, is 'Hello Sunday morning', which is actually a community-based initiative for people to just enjoy a Sunday morning again. They do not wake up at 2 pm, they are not hung-over from the binge drinking on Saturday night and they have a program where they slowly actually do things on a Sunday morning. That has received, I think, funding from federal sources. It is very successful.

Ms BATES: Thank you very much.

CHAIR: I call Joe Kelly.

Mr KELLY: Thank you for your submission. Your submission talks about using these technologies, not as a single campaign but as an integrated campaign. You also distinguish quite clearly between social marketing and health promotion. In addition to the IT based approaches, how do you envisage these things fitting into a broader campaign that is aimed at behavioural change?

Prof. Russell-Bennett: I think that is a really critical point. I am the immediate past president of the Australian Association of Social Marketing and one of my remits in that role was to try to help people think beyond the tactic of coming out with a com. strat—an add, an app or some fundraising event—but to actually think about it as part of a broader scheme. I guess that is where, if you take a social marketing approach, the framework of social marketing forces you to consider what is the service delivery. For instance, if it was a health program you were looking at to try to reduce weight, you would not just look at the app. You would look at how that integrates with, perhaps, other technologies that you have. Do not take surveys about what people do. Embed it within a pedometer app. You would look at it in terms of the community nursing services, GPs. You would look at it at a much broader level.

The framework of social marketing is the same as commercial marketing: what is our service? What are our tangible goods that might associate with it? What is the social price? So that could be the effort of getting out of bed in the morning and going to the gym—all of that falls under that price element. How do people access the behaviour? So you are thinking about all of these things. Are the walkways safe? Are they well lit? All of that—which is pretty broad and often outside of the communication department—is part of what we consider to be marketing. So it requires the communications department to have active access to information across the entire department and even outside the department, because police are also working with youth. If you are working with youth here and you are talking about reducing a risk behaviour, why are we not talking about it with communities and with police and all focus together? So it can even go beyond a department to work at a very high level to integrate.

Prof. Foth: I agree with what Rebekah is saying. In our experience with a lot of the submissions that we would have prepared in order to respond to tenders, it appears as if the cart is put in front of the horse, because the solution is already articulated in so many calls for tenders where you are being asked to develop an app. In fact, when Rebekah and I worked with the Australian Red Cross Blood Service, they said, 'All these other blood services overseas have an app. We want one as well.' That is a nice way of thinking but not really very useful in order to tackle the issues at stake.

If you look on page 16, there is the famous 'double diamond' approach that we subscribe to. So the initial proposal was, 'We want an app.' But we developed in the first place a return brief. We said, 'What is your real problem?' And we arrived at the real problem of: 'We want to increase the loyalty rates of blood donors and we want to look at all different ways and mechanisms to do so, and an app might be just one of them.' An app was one of them but it was a very different kind of app to what they had anticipated when the proposal was written in the first place. So that first phase is very often non-existent, and a design-thinking approach, especially embedded in a social marketing framework, is really useful to rethink the way that these briefs are worded and formulated in order to address the question that you raised which is how to have a broader initiative that is not just channel centric or technology led.

Mr KELLY: So the app is a tool rather than the entire solution.

Prof. Russell-Bennett: Yes, and sometimes it may not even be the appropriate solution. Just because you can do technology does not mean technology is the right way to address the problem. I see tenders coming out all the time labelled 'social marketing' and we are asked to provide a media channel strategy. It may be that mass media is not the appropriate approach for the behaviour. So it is about having a broader approach to the tendering process to allow the solutions to arise out of the process and out of the insight, rather than starting with the solution and then everyone tries to reverse engineer it.

Mr Mulcahy: I might add to that. I am a PhD candidate. As Rebekah said, I just submitted my PhD yesterday on mobile apps and mobile games and their effectiveness in changing behaviour. Research shows, as we are alluding to, that the approaches that work the best are ones with mobile apps but with additional elements. It seems that when a mobile app is by itself, yes, it is effective but it is not as effective as others that have a website or other additional elements within that. So it seems that, whilst apps are a very effective method, you need additional elements to help that as well.

CHAIR: I am mindful of the time, but I know we have many questions. I will pass now to Mr Dickson.

Mr DICKSON: Rebekah, Judy, Marcus—and congratulations, Rory—thank you so much for coming along. You have intrigued me this morning, particularly you, Marcus, when you talked about crossing that line and how we get to those people who have already made predetermined decisions such as 'We are going to go out tonight and get smashed.' It is not just alcohol; they are preloading now on crystal meth because it is a whole lot cheaper. Somehow we need to get them before they get out on the town. I am really interested in what your solution is. You are a very clever fellow, and I am sure you have a solution for us today. I am a big supporter of this. I think it is a very good idea. There are so many different areas.

I think Rebekah spoke earlier about all of the different departments that should be involved. I used to be the minister for sport, national parks and recreation, and we have a policy called Get in the Game and we have already tagged 45,000 young people a year. I think that is really where the solution is. I made this statement at the last meeting we had. At my age it is probably a little bit late, but we need to tag those young people and we need to make sure they live a very healthy lifestyle. So I think somehow and in some way we need to come up with an idea to get into their camp. I do not know how we are going to do it, but I am sure I am about to hear it from you.

Prof. Foth: I appreciate your confidence. I am not sure that I can solve Australia's crystal meth epidemic in two minutes. I do believe though that the approach would be along the lines of really trying to understand the reasons—I think the reasons are very diverse—of what leads people to substance abuse. In my own experience and research, an entire segment of substance abuse is self-medication. There might be underlying mental health issues that have not been diagnosed. A lot of the mental health issues have not been diagnosed because of the mentality, especially in the rural areas that some of you represent, that you are a bloke—you might be working in the mines or you might be a young person growing up in a country town—that you are tough and you do not talk

about depression. My own mates suffer from depression. They have a very hard time articulating this. It is far easier to self-medicate with alcohol and, as you said, with cheaper options these days such as crystal meth and other substance abuse such as cannabis.

So understanding, for instance, what is under the veneer of substance abuse is really important and then finding the right mechanisms to tackle those. They are regionally specific. They are specific to different demographics. They are specific to different personality types and preferences. So it might be that it is related to unemployment. It might be boredom. It might be that there are underlying mental health issues. They in turn could be triggered from a history in the family or they could be triggered from traumatic episodes in an earlier part of their life. It is a very diverse area which is why there is not really a golden bullet to solve this. But I think it is really important to understand that criminalising, chasing and so forth is just a remedy for the symptoms and is not tackling the causes.

Mr DICKSON: So what is your plan? What is the best way for us to get to young people—and I am talking probably under 12 years old? How do we do that? That is the age group I believe we need to target.

Prof. Foth: My simple answer—and I will hand it over to Rebekah straight away—is other young people.

Mr DICKSON: But how do we get to them?

Prof. Drennan: Through school.

Prof. Russell-Bennett: We have developed a moderate drinking program, working with the Catholic Education Commission, and it was for year 10 students, to get them before they are out drinking. What is interesting is that we are finding rising incidents of abstinence and moderate drinking in young people. The rate of binge drinking is actually declining in that group. It is actually increasing in my age group as we get divorced and go on online dating sites and do all of those sorts of things, but they are a fairly ignored group. We found that younger ones do not want to be preached to. They do not want education about alcohol. So we had experiential activities and online games. We got them wearing beer goggles and trying to walk a straight line, and we saw very different strategies and reactions between the girls and the boys. We had them lying in the gutter and their friends taking photos so they could see what they looked like. We showed them how difficult it is to even pour a standard drink—what is it and what does it look like? We had online games that simulated various behaviour and we saw distinct change in attitudes and behaviours because we made it fun essentially.

There was a fair amount of resistance from teachers because they thought it was a really serious topic and you should not teach it in a frivolous way. But by engaging young people in a way they want to be engaged with and not being preachy, we actually found that it had a lot of cut-through. So we did that through the school system, but I think there are many other mechanisms. Working with communities, working with social groups, working with sporting clubs, I think that is a really good way of working with people and I think it has to be working with them. They have to co-create the solution. It is not about being preachy and medicalising. Even when you say to people four standard drinks in a night is binge drinking, you will get laughed out of town. It is the medical definition but it is not accepted. People do not define binge drinking in those terms. They define it in terms of 'Am I falling over? Am I vomiting? Can I get home?'

Prof. Drennan: When you go across the stupid line.

Prof. Russell-Bennett: Yes. Even the way that we frame it from a policy perspective does not work.

Mr DICKSON: Education Queensland could be a very good vehicle.

Prof. Russell-Bennett: Yes, I think so but it is also about working with all the departments—all of them. I think it is a whole-of-government solution.

Mr DICKSON: We are short on time so I will look at that.

CHAIR: Sorry—I am mindful that you are heading to a launch—we have timed this very tight. I did not want to let you go without Dr Rowan having an opportunity. I know he has a page full of questions but if we can maybe keep it to one if you can and maybe short answers so we can get something to address his issues.

Dr ROWAN: Thanks very much for the presentation. My first question was around opportunistic screening versus health promotion versus specific health interventions which you talked about before in relation to behavioural change. In your view what is the most cost-effective from a public health perspective when there are limited financial resources? But if you had to look at those three, is it a combination or is there one that is more effective than others in your experience?

Prof. Russell-Bennett: It depends on the target group. Again, there is no one population approach. But I think it is about working with other organisations that already either have an in with the group you are trying to reach or are already part of the solution, so working with non-profits who may have access already to a particular group or working with commercial organisations that have the same goal as you—so working with a company that sells health food that is about getting people active. Those kinds of partnerships are really useful. They have more money. If you have a common goal, I think it is about working with those kinds of agencies. Where your goals diverge is where the government needs to step up and take responsibility, but government does not have a bottomless purse. I think it depends on the group that you are trying to reach. There is no one way unfortunately.

Dr ROWAN: I have one other quick question. Should the Queensland government be paying for apps or delivery devices like iPhones for at-risk individuals in vulnerable communities? Is that something that should be considered?

Prof. Russell-Bennett: I think they should be involved. If there is nothing on the market that is suitable and appropriate then government should take the lead. Again—and this is a plug for the university—you can work with universities in research collaborations and they are massively more cost-effective than outsourcing to a commercial agency and you get the benefit of scholarly informed research and an evidence based approach. The knowledge goes out to the public good to inform other agencies and usually if you do full research collaboration you will get it at a fraction of the price.

Prof. Drennan: Also, we work in multidisciplinary teams, as Marcus was saying. We work with people who develop apps at the QUT and we work with psychologists. So we work with teams where we already have a long work history, and most universities are in the same boat. I think if you work with universities who have been working in this area for a long time it is cost saving because we are not charging huge amounts of money or anything.

Dr ROWAN: So just to clarify, with the design and subsequent commercialisation of some of the health promotion apps, are the universities retaining the intellectual property of that or is that shared?

Prof. Foth: It is usually negotiated on a case-by-case basis. Yes, the university has a commercialisation entity. In QUT's case it is called bluebox, but that is not the default position for every single research project. It really depends on the different contributions that the stakeholders are making. In terms of the launch that we are going to now—which is with the federal minister for science, Ian Macfarlane, and the Lord Mayor—the IP is actually held by Brisbane City Council, by CitySmart. So that is an example of it is not always the case that the university retains the IP in all cases. But also right now, for instance, the university is offering $100,000 to any new research projects that are directly with industry or directly with government. So that is another way to look at the benefits, in order to corroborate what Judy and Rebekah were saying, that it is quite cost-effective. Not only that; it also can leverage further funding sources from other areas such as from the university.

CHAIR: Thank you very much for your submission and thank you very much for your fulsome answers today. Professor Russell-Bennett, Professor Drennan, Professor Foth and Mr Mulcahy, thank you for your time and best wishes for your launch. I now ask our next witness—Ms Sherron Madden of Medicare Local—to come to the table.

MADDEN, Ms Sherron, Preventive Health Manager, Greater Metro South Brisbane Medicare Local

CHAIR: I now welcome, Ms Madden. Thank you for coming along today from Greater Metro South Brisbane Medicare Local. Would you like to make an opening statement?

Ms Madden: Absolutely, thank you. I am actually the Preventive Health Manager for Greater Metro South Brisbane Medicare Local, so my portfolio of work that I am in charge of covers everything from prevention right through to chronic disease management. I have been fortunate to be involved with the Positive Impact program for the last five years. You will have received a fairly comprehensive submission about the program—what we have delivered, as well as our outcomes. I have just given Brook a summary sheet too, and I will cover off on a couple of those things in my opening statement. We are thankfully contributing to the growing body of evidence for telephone based interventions to change people's lifestyles. I guess my opportunity today is to show you the key points of difference with our model compared to just the actual intervention being telephone based.

We believe a lot of the success of the program that we deliver is the integration and the collaboration that we have with general practitioners. We are locally based. We actually receive only referrals from GPs. So we have 100 per cent referrals from GPs. As a result of that, we are actually encouraging general practitioners to do the screening of people at risk of chronic disease. Already we are starting that change towards a more preventative rather than reactive model of care out there in general practice. We see the GP as being at the coalface and the person whom an individual interacts with the most.

In terms of actually promoting the program, the established networks that we use are through the Medicare Local. If we have a future moving forward we will be using the PHN as well. These people have engagement teams that are already out there supporting general practitioners and providing them with resources as well as services that will actually benefit their consumers.

We have a high level of engagement from our GPs. We have over 540 GPs who are referring to the program. That is in just over two years—since the beginning of 2013. That represents about 77 per cent of our practices. It shows that engagement model using an established network rather than actually having to pay for social media or direct promotion.

It is a scalable model because it is phone based. Because we have an established network that we work through we can actually roll this out not only statewide but also nationally quite easily. We have that model already established within a Medicare Local area which currently covers about one million people.

In closing, in terms of the success of the intervention, as I said, we think the key point of difference is the integrated approach by actually using existing primary care services that are out there and already funded as an inroad to the population that we are targeting. We are also evaluating with a university partner to ensure that we are getting robust outcomes from the service and it is not just funding going into a service where we are actually not getting results.

In the last 2½ years we have actually lost almost two tonne of weight in our Medicare Local area and 16.4 metres of waist circumference as well, which is quite significant when you are looking at reducing the risk of chronic disease in those people who are obese, overweight and unfortunately eating poor nutrition as well. Thank you for the opportunity to come. I am really looking forward to some questions. Hopefully, I will be able to give you some really encouraging answers.

CHAIR: Thank you, Ms Madden, and congratulations on those results. It is certainly something to be proud of. I just wanted to come to the benefits of Positive Impact in your submission. High GP referral of participants and good retention rates are something you draw out in your submission and something you have certainly drawn out this morning. I was wondering if you could extrapolate on that a little? How have you been successful in encouraging that buy-in from GPs? Do you feel that this GP support is what has aided in those retention rates or what do you attribute those to?

Ms Madden: I will start first with engagement. In terms of how we have engaged GPs, it is about going out and providing them with the support in order to have the conversation. Feedback from GPs that we have received is that they are not comfortable talking about obesity or levels of activity or what people are eating. GPs are general practitioners of absolutely everything. To actually have robust conversations about somebody's lifestyle is very difficult for them to fit in.

One of the things that we have done as a program is actually create conversation starters and easy ways for GPs to open up that dialogue with consumers to say, 'You need to do something about this, but I have something that I can direct you towards.' I think providing a solution as well as the capability or the skill set to be able to open up those questions is the first key requirement.

Certainly GPs often say they do not have the conversation because they do not know what to do next. There are service gaps out there and there is limited support. It is up to the individual to pay for services so often they do not engage in them.

In terms of retention, I think the collaborative approach that we take and the fact that we work firstly at the request of a GP alongside the GP throughout the six- to 12-month program with continual interaction with the GP and the participant and then we actually discharge them back to their primary care giver, the GP, with a plan is why we actually get such successful outcomes. One of the things that we are actually working on as a project at the moment is looking at classifying the behaviours of certain cohorts that are referred to us—how long people stay for, why some go right through to the end and some do not, at what points do they drop off and also the retention rate for the different programs. That is still a work in progress.

Part of the evolution of our service over the last seven years has been looking at how we can improve it for a GP who is referring, but also definitely for the participant to keep them engaged and make those sustainable changes. Hopefully, that answered the question in the end?

CHAIR: That was good.

Ms BATES: Sherron, your submission refers to QUT evaluating your program. I guess I am really interested in your comments about cost-effectiveness and the cost shift. Is there any data that you can provide us with as an update?

Ms Madden: In September there will be. We have been working with QUT since the inception of Positive Impact. There was a predecessor program. However, since the beginning of 2013 we have been working with QUT. Of course, we need to get people through the program to start actually looking at post-discharge outcomes—the 18-month evaluation—for us to really see what that cost-effectiveness is going to be in terms of sustainable results.

We know the cost. We know the results that we get throughout the program in terms of weight loss, improved nutrition, improved eating behaviours, and there is a long list. What we are really interested in is whether that is maintained after discharge back to the GP. Certainly evaluation at the 18-month mark is actually showing that we have sustainable results with weight loss and activity as well as nutrition. There is, of course, a spike back up or back down to normal behaviour, but we are actually seeing positive behaviours being maintained for 18 months plus. The longer we perform the evaluation the longer term results we get. But in September there will absolutely be something available.

Ms BATES: We look forward to it.

Ms Madden: On both the financial as well as the health outcomes.

Mr HARPER: Well done on the work to date; it sounds really good. I was going to ask if there are any stand-out areas. We hear a lot about youth and embedding good practices in that cohort. In terms of strengths and weaknesses in your program, are we capturing the older population as well or is it targeted generally at the youth cohort?

Ms Madden: It is actually very broad in terms of category. Eighteen plus is our criteria. It is very open. We have an 84-year-old on the program. If you look at the older continuum you have fewer. Of course you do not want significant weight loss in the older population unless it is affecting their health. We do actually have a broad split of ages.

One of the stand-out populations in terms of age that we do not actually address successfully is the younger population that work full-time. One of the evolutions of the program that is going to be launched this month is the web based version. That is going to allow 24/7 access. So seven days a week whenever it is going to suit them they are going to have a web based version of what we are delivering over the phone. That will include all of the calls that we deliver in vignettes in video form. There will still be an interactive component where the back-end support will be provided by the dieticians to be able to answer questions and assist them to formulate health plans as well. That is probably a stand-out in terms of age. In general with health they are a very difficult population to actually attract.

The one stand-out from a positive perspective is that we are actually getting families who are making changes with the whole family. So the whole family is losing weight; the whole family is improving nutrition. As was mentioned before by the people from QUT, we have to get to the 13-year-old before they start to behave badly and start framing up their poor behaviours for life.

Through the parents we are able to talk about the whole family, what food they actually purchase, what meals they make, portion sizes, when to stop eating and how to pack healthy lunch boxes. That everyday nutritional side of things and everyday activity side of things in terms of incidental activity is a huge focus for the program. Just getting whole families to be active together has been a huge result for us as well. Behaviour change I think is the key; long-term behaviour change is the focus.

Dr ROWAN: Congratulations on the work undertaken thus far. What specific clinician engagement education strategies should be undertaken to increase the uptake and usage of these technologies in vulnerable populations once you get to looking at this across the state? If we take what you have learnt locally through these processes and then extrapolate it out into other areas are there specific clinician engagement strategies that could be used? An ancillary question to that is: should there be incentive payments to encourage GPs to facilitate these within specific target populations?

Ms Madden: Probably, Christian, if I could answer your last question first. I do not believe incentive payments are required. Certainly, peer research from GPs shows that incentive payments are not that effective. They do not respond to it. What they respond to very well is peer review and peer acceptance of certain things. We have not used any money to engage GPs. We have not used anything other than developing program collateral to support leave behinds and things like that to remind GPs about it. In terms of investment into promotion, that is about the extent of it.

In terms of clinician engagement, I think you have to take a team approach. You have to understand that GPs are very busy. You have to understand that individuals come in to a GP with a long to-do list of what needs to be addressed. Then to try to fit in that opportunistic education or discussion about lifestyle amongst a myriad of sore things, sickness and everything like that, you need to have that wider approach. We use practice nurses and the reception staff as well because often they are having the more casual, social conversations. We make sure everybody is informed about the service and the results of the service.

What we have done recently is actually engaged pharmacies, which is a bit of a hot topic, in the care team. We think it is a very valuable opportunity because there are a lot of people who self-medicate. They will go to pharmacies to actually find solutions—Optifast, meal replacement or whatever it may be. We had a classic example the other day where a pharmacist said, 'No, you do not want meal replacements. You actually want to go and have a chat to your GP about Positive Impact.' It is really exciting that they then followed up with their GP who knows about it and referred them to Positive Impact and we are now working with them around balanced nutrition, activity et cetera.

Dr ROWAN: One of the key learnings would be access and availability to a multidisciplinary workforce to ensure the best value for money and success from a clinical perspective.

Ms Madden: The workforce exists. We have primary care services that are already in place. It is utilising those services that people go to every day. The only thing we have probably found that is missing from this and it is certainly going to be a key trial for us moving forward if we are successful with funding is actually integrating psychology into this. We have found out that stage of change is critical at engagement or enrolment—right at the very start. We need the expertise of people looking at underlying behaviours to make sure that they are ready for this which will then influence that retention as well and appropriateness of somebody being involved with the intervention.

CHAIR: Thank you very much, Ms Madden, for your submission and also for your fulsome answers and expertise today.

Ms Madden: Thank you for the opportunity.

EAKIN, Professor Elizabeth, University of Queensland

CHAIR: Welcome, Professor Eakin. Would you like to make an opening statement?

Prof. Eakin: Only a very brief one. I have provided you with a very targeted submission around the Get Healthy service and attempted to make the case for why we might consider continued funding for the service here in Queensland. I have given you some very specific recommendations around the resourcing that would be necessary and the partnerships that would be necessary in order for us to achieve the type of benefit here in Queensland that we have clearly seen from the program in its delivery in New South Wales. I guess the last thing I really do want to emphasise is that while this is a targeted submission around this particular program, I am very clear that it is part of a broader suite of chronic disease prevention and management strategies. I am certainly not here to say this is the be-all and end-all, but one effective and evidence based program. I am happy to take questions

CHAIR: If I can just open with a question. You did indicate in the beginning of your submission that for over a decade your centre has researched these sorts of health based interventions and thank you for outlining what the strong evidence is supporting the ability of them to effect behaviour change, but what I was interested in is, with regard to your recommendations and recommendation 3, you were talking about the Get Healthy program, which obviously you are a very big supporter of, be integrated with other health promotion campaigns and initiatives and key health partners, such as hospital and health services, to maximise its reach. I just wanted to know in practice how you saw that working or how that could work to the benefit of the community.

Prof. Eakin: I have been very closely involved with the implementation of the program by the ministry of health in New South Wales and so that is the model that I would recommend as a starting point for at least consideration and adaptation here in Queensland. One of the key issues for promoting the program has been media advertisements and the like. In New South Wales the call to action for the Get Healthy service is embedded in their broader health promotion media based campaigns. Here in Queensland you would be familiar with our Healthier. Happier. campaign, but the call to action for this particular Get Healthy service has not been embedded. That is one, I guess, key opportunity and certainly, and I think Sharon has really nicely outlined for you, partnerships with general practice and with the new primary healthcare networks will be an important part for their promoting the program. Again that is something that has been done consistently in New South Wales. But I think there is also much broader scope for partnerships across workplace health promotion programs and across preventative screening programs. I have already had some preliminary conversations with BreastScreen Queensland about the potential to integrate referrals as part of that. I think the partnerships approach to working across government and across multiple services to promote the program is really the way it needs to head.

Ms BATES: Professor Eakin, you argue that GHS in Queensland should be funded beyond 30 June 2015. In June 2014 I recall that Lawrence Springborg announced I think it was $14.2 million funding for the shortfall following the federal budget announcement to cease the national partnership agreements on preventative health. Have you had any indication that this initiative of the then minister for Health will be continued under the new government? Have you had any indication at all?

Prof. Eakin: That is not something that I am personally aware of.

Ms BATES: Has there been an application to the current government to continue funding? It was mentioned in the submission that it should be funded beyond 30 June 2015.

Prof. Eakin: I am aware from colleagues at Queensland Health that funding for the program will terminate at the end of June so whether there has been further application—

Ms BATES: So you do not know if there has been an application for budget. Thank you very much.

Mr KELLY: Your report and the subsequent documentation we have on the program lists quite an impressive array of outcomes: significant weight loss across a majority of the participants, impressive increases around fruit and vegetable consumption and physical activity guidelines increasing. Those are all good things. Can any of those be linked to an actual decrease in specific diseases in target groups?

Prof. Eakin: There is certainly broader literature that speaks to the types of guidelines that are promoted in the program. So, approximately a three to five per cent weight loss being associated with decreased levels of some of our most common chronic diseases—cardiovascular

disease and diabetes. There is broader literature along those lines. I think what is important is that the magnitude of improvements that we are seeing in this program are consistent with those clinically significant levels of improvement in chronic disease prevention.

Mr KELLY: Is it possible to do some sort of economic analysis of the benefits of this program through a cost-benefit or cost-effectiveness analysis or any of the other models that are used?

Prof. Eakin: There certainly would be capability to do that. I know there is further cost-effectiveness analysis that New South Wales plans to undertake, but you are talking about something even a little bit broader than that that might model out the longer term benefits in terms of chronic disease prevention and, yes, that is definitely possible and I agree would be of value.

Mr KELLY: But it has not been done yet?

Prof. Eakin: It has not been done yet, no.

Dr ROWAN: Thank you for your presentation. Could this program or service be used to have patients ready for surgery on time? As an example, if you had someone who needed a hip replacement and they were a bit overweight and their alcohol usage was a bit excessive and they were on that list for 90 days to get them ready for surgery so they have that within the clinically recommended time frame.

Prof. Eakin: Yes. I think it certainly could. It is quite broad in its applicability to a variety of patient groups and I think one of the things that I have been most impressed with with the program is its ability to adapt to particular target groups. You have seen in the submission the adaptations that have been around type two diabetes prevention, around gestational diabetes and weight gain, targeting to Aboriginal and Torres Strait Islander groups. So, yes, I think that is possible. We have done some targeted work around providing this type of lifestyle support through the Get Healthy service to women following treatment for breast cancer. I think it is quite broad in its application.

Dr ROWAN: So it needs to be funded again?

Prof. Eakin: I would say absolutely, yes.

Dr ROWAN: Do you think it could assist with surgical waiting list management?

Prof. Eakin: I think that would be an excellent application, yes.

CHAIR: Thank you very much, Professor Eakin, for your submission, also for your answers here today. It is very much appreciated.

Prof. Eakin: Thank you for the opportunity.

COWLISHAW, Ms Anita, Australian Health Promotion Association

CHAIR: Would you like to make an opening statement?

Ms Cowlishaw: Yes, I would. Good morning and thank you for this opportunity to address the committee in regard to health promotion and the use of personal technology in relation to health promotion initiatives. I am actually here to represent the Australian Health Promotion Association Queensland Branch. Our president, Elisha McGuiness, sends her apologies and advises that she would be happy to follow up on any further inquiries that the committee has for her. Because I am representing a committee I do have a speech that they would like me to present to you. As demonstrated by the 21 submissions the committee has received during these proceedings, there are various stakeholders, including the Queensland government, not-for-profit organisations, universities and private entities, with vested interests in developing and implementing health promotion initiatives across Queensland.

One of the key objectives of the Australian Health Promotion Association is to advocate for and provide evidence based advice on health promotion approaches to relevant policy makers and project sponsors. Health promotion is described as the process of enabling people to increase control over their health and its determinants and thereby improve their health. Unfortunately, it is all too often that there is a widespread misconception of what health promotion actually is. Effective health promotion is multistrategic and addresses various social determinants of health. The World Health Organization Ottawa Charter sets out a framework for health promotion to enable the adoption and sustainment of healthy behaviours. It includes developing the personal skills of individuals and communities, creating supportive environments for health, strengthening community action on issues impacting people's health, developing healthy public policies and the reorientation of the healthcare system away from a solely acute care frame of model to a preventative focus. The impact of population health disease burden has limited efficacy when these strategies are adopted in isolation from one another.

The evolution of technology has contributed to an increase in accessibility to health messaging and support services across the state with the utilisation of wide-reaching web based platform and telephone services. Technology has contributed to the increased reach of this style of health promotion initiative through improvements in internet accessibility with the introduction of broadband services, the evolution of social media, such as Facebook, Twitter and YouTube now becoming very popular among consumers, and statewide telehealth services such as 13HEALTH and Quitline.

Professor Eakin spoke about the Get Healthy service. The Australian Health Promotion Association has also outlined some of the context of the Get Healthy service. The New South Wales Ministry of Health has led the way in relation to this style of health promotion initiative through the funding of the Get Healthy information coaching service using this telephone based technology. It addresses the prevalence of chronic disease for at-risk populations by providing information and education and motivational coaching aimed at encouraging participants to increase their physical activity levels and nutrition choices. It has a secondary prevention approach, meaning it focuses on people who are already at risk of or already chronically unwell. This is in contrast to a primary prevention focus which addresses keeping people healthy and out of hospitals. The New South Wales Office of Preventative Health within the Chief Health Officer branch manages the statewide implementation and management of the evaluation of the Get Healthy service through a cost-benefit analysis and with local health districts within their population health units assisting with local level support, community awareness and stakeholder engagement to support secondary referrals into the service.

Additionally, consumers can self-refer themselves into the service by using the Get Healthy website and the freecall 1300 number. The Get Healthy service was implemented across Australia and continues to be implemented across Queensland until 30 June 2015 through the partnership and funding agreements between the New South Wales ministry of health and Queensland Health. The implementation of Get Healthy in Queensland though is managed through the Department of Health through a consumer self-referral pathway.

The Get Healthy service has returned some impressive results; however, within a limited cohort. With the absence of longitudinal data we are unable to demonstrate that this approach enables people to maintain healthy lifestyle behaviours beyond their participation in the coaching service. Get Healthy appears to be a cost-effective alternative to the expensive clinician led counselling. However, the introduction of a statewide multistrategic health promotion initiative focusing on primary prevention will support lifelong habits and prevent overweight and obesity in

people across Queensland including those who are already chronically unwell. Primary prevention will enable these individuals to adopt healthy habits earlier thus resulting in less people becoming overweight and requiring secondary and tertiary prevention interventions at a later stage. It is widely acknowledged that it is much easier to keep the weight off than to lose it.

There are a number of other examples of effective web based and telephone based health promotion initiatives that have been evaluated well from both an outcome and cost perspective, some of which I am aware that you have heard about today. However, I am here to highlight there are limitations that do exist and you as a committee should exercise caution when considering at what degree you will invest in these services. Limitations of web based and telephone based initiatives include limited reach to very remote communities due to the lack of internet, limited uptake among vulnerable populations, requirement of consumer information management and monitoring of consumer communication, funding and infrastructure to support the upgrading of technological services and professional development and upskilling of supportive staff. Furthermore, limitations exist because of the lack of longitudinal evidence around the initiative's ability to sustain long-term behaviour change and improvements in health. The implementation of these initiatives which solely focus on developing individuals' personal skills without creating supportive environments to facilitate the change or to address the broader social determinants of health is very unlikely to have a long-term impact on most individual's health and as a result unlikely to have a significant impact on Queensland's overall burden of chronic disease.

An example of a multistrategic health promotion initiative that demonstrates long-term and sustainable behaviour change is the Healthy Lifestyle Program for her, commonly referred to as HeLP-her. HeLP-her was identified by the Victorian government as an evidence based health promotion initiative which addresses healthy lifestyle behaviours and supports the prevention of weight gain among Victorian adults. HeLP-her was designed by Monash University as an adaptable, low-cost, multistrategic health promotion initiative which incorporates web based and telephone based tools to support the long-term behaviour change. HeLP-her was delivered across a range of populations, including multiethnic, low socio-economic and rural and remote communities. Evidence shows that small behaviour change will modify risk factors for a range of chronic diseases including heart disease, diabetes, arthritis and cancer as well as the promotion of general wellbeing. HeLP-her focuses on small behaviour change through goal setting, problem solving, relapse prevention, self-monitoring, phone coaching and SMS messages. HeLP-her uses simple, non-prescriptive messages on healthy eating and physical activity consistent with the national guidelines as well as face-to-face service delivery and written and electronic services which are based on developing personal skills and building confidence to support long-term behaviour change. By doing so, it increases the consumer's empowerment and motivation to control their own health and surrounding environments as well as the confidence to make healthy lifestyle behaviour changes long term.

The adaptability of HeLP-her across the populations will allow service delivery and implementation across a broad range of stakeholders, including local governments, not-for-profit organisations, workplaces and schools. Effective implementation is achieved when the development of these supportive environments and high level of community engagement is obtained. Addressing social determinants of health in a broader context is the most important element of behaviour change, including supporting the community to address it in a social context and group delivery approach, allowing women to feel empowered, increasing the person's confidence to support each other and their families, and create a community that take ownership of their own health. As seen by the HeLP-her example, there is a place for web based and telephone based technology to support the delivery of implementation. However, to effectively address long-term behaviour change and reduce the rising rates of chronic disease prevalence across Queensland and obesity, you need to take into consideration all aspects of the Ottawa Charter and social determinants of health. Therefore, it is paramount that the Queensland government re-establishes the state and local level health promotion workforce.

CHAIR: Sorry, Ms Cowlishaw, but can I just ask how much longer that statement is?

Ms Cowlishaw: Not much longer; sorry. On behalf of the committee, it was put together. Therefore, it is paramount that the Queensland government does re-establish the statewide and local level health promotion workforce that will contribute to streamlining health promotion initiatives across Queensland, therefore fostering supportive policy and community environments and allowing stakeholders to collaborate effectively, mitigate the risk of initiative duplication, minimise consumers' confusion of numerous initiatives across the community sector, and maximise the source reliability among the community. Senior level government will support the leadership policy and strategic

planning towards the reorientation of health services to focus on primary prevention. Effective health promotion is not social marketing nor is it the delivery of health education or health communication. Instead, it is the collaboration of all of these and the five action areas of the Ottawa Charter.

CHAIR: Thank you very much.

Ms BATES: Thank you, Anita. I have a quick question. If the Get Healthy service was supported by continued funding, would you be able to further evaluate its successes with longitudinal data over a longer period of time?

Ms Cowlishaw: Yes, that would be correct.

Ms BATES: Thanks very much.

Mr HARPER: Thanks very much, Anita and your organisation, for being frank with the limitations of what is in front of us. There is a common theme in the submissions about whether interventions result in long-term behaviour change. What is your view?

Ms Cowlishaw: On behalf of the Australian Health Promotion Association the view would be actually to address all social determinants of health through a primary prevention approach, so not just using web based and telephone based services in isolation but the entire World Health Organization Ottawa Charter. So long-term impacts will be achieved through reinstating a statewide and local level workforce in health promotion.

Mr HARPER: Thank you.

Dr ROWAN: Thanks very much for the presentation. Do you have any comments on what regulatory and licensing framework needs to be in place in relation to the approval of health promotion messages as well as health promotion professionals?

Ms Cowlishaw: I would not on behalf of the association. I would have to get the president to follow up on that response, sorry.

Dr ROWAN: Okay. You can take it on notice. That would be great; thanks.

CHAIR: Thank you very much, Ms Cowlishaw, for coming today. If you could please take the thanks of the committee back to your organisation for its further submission. We will have the secretariat communicate with you after the hearing today about taking that question on notice and about how you can respond. Thank you very much again for your time.

Ms Cowlishaw: Thank you.

CHAIR: We will now take a short break and resume at 11.50. Thank you.

Proceedings suspended from 11.19 am to 11.48 am

HOURIGAN, Ms Aloysa, Nutrition Program Manager, NAQ Nutrition

CHAIR: The hearing will now resume and I thank Ms Aloysa Hourigan for coming before the committee today. Would you like to make an opening statement?

Ms Hourigan: Yes. Thank you. We are a community based nutrition education organisation and our focus is on prevention and wellness, particularly in the prevention of lifestyle related chronic disease. We would like to thank the committee for the opportunity to speak to our submission for this inquiry. We bring a lot of expertise in the development and delivery of health promotion strategies and we work collaboratively with a number of government and non-government agencies in a number of projects in the early years around health promotion, around preventing childhood obesity and the implementation of the Smart Choices food and drink strategy for Queensland schools. We do a lot of workplace wellbeing programs. We are currently working with the Department of Justice and Attorney-General, TransLink and a number of other corporate organisations such as mining companies.

In the area of phone and web based technologies, we have provided telephone advice for over 20 years. We have an online menu planning tool called Healthy Food Healthy Planet, which sits in our Healthy At Home website. We deliver online learning platforms that relate to healthy eating and food safety and we intend to do more online delivery in the future.

We understand that there is demonstrated effectiveness in telephone based lifestyle interventions, such as the Logan Healthy Living Program, but also recognise some limitations. It is a secondary prevention tool as opposed to primary prevention and it does not necessarily address the barriers presented by the food supply environment. While the effectiveness of the telephone intervention has been demonstrated up to at least six months post intervention, findings that were reported at a dieticians' conference in 2011 certainly had not demonstrated affecting the change in vegetable intake or in physical activity compared to usual care. So we would put to the committee that that demonstrates a need to still do more in the space of supporting improving vegetable intake from a primary prevention focus so that we can make the healthy choices, the easy choices for people. Certainly, in that Logan area, it is more disadvantaged. There are a lot of fast food outlets per capita—more than in areas of better social advantage. We certainly understand that the government currently has a commitment under the healthier Queensland action plan to look at reconsidering the Go for 2 and 5 social marketing campaign and things like kilojoule labelling at fast food outlets along with consumer education to help increase vegetable intake by Queenslanders, because increasing the vegetable serves of Queenslanders by just two serves in a year could decrease healthcare costs by at least 34 per cent. So we think that that is a significant gap. While the telephone interventions have a place, that is certainly a gap that could also be addressed and it would be nice to see investment in that area was well.

Certainly, in the area of telephone messaging as another means of intervention, while we are aware that there are some programs that have good outcomes, like the QUT Mums and Bubs program, I would acknowledge that, on attending an Australian and New Zealand Obesity Society conference last year there was a presentation from the Westmead area, which indicated that, in an adolescent weight management group where they use text messaging, that it was not perceived as desirable by young people. They found it a bit invasive of their privacy. I thought that was just worth noting—that it is not necessarily a one size fits all; that some things work with some target groups but perhaps not with others.

CHAIR: Is there anything else that you wanted to say particularly?

Ms Hourigan: Another thing that is of interest is another recent conference presentation addressing the relevance of behaviour change of current applications around healthy eating that people are using for personal use. A University of Queensland project reviewed about 24 apps and probably less than 50 per cent of them had enough strength to deliver behaviour change. So whilst their main messages were around behaviour change, at the moment those apps that are out there that people are using probably are not quite enough to get them over the line.

CHAIR: Thank you very much. Do you mind extrapolating on that? You say that they are not quite enough to get people over the line.

Ms Hourigan: When you look at behaviour change theory, it is looking at certain strengths in the approach to things that enables people to put goals to place and continue on and not relapse. It is some of those aspects that were not being met. I can get more detail of that for you and give it to you at a later time.

CHAIR: Thank you. Thank you also for the point that you made about no one size fits all. That is something that has been raised consistently by the people coming here this morning before the committee. Can I pass now to my deputy chair, Ros Bates. Do you have a question?

Ms BATES: Thank you, Ms Hourigan for your presentation. I just wondered if you could elaborate on the Aged Care Nutrition Advisory Service. Is it in conjunction with nursing homes, GPs, or both? Are you finding any evidence of malnourishment in the elderly, particularly those who live by themselves?

Ms Hourigan: Currently our aged care advisory service has mainly worked with aged-care facilities. Having said that, we also do quite a lot of work with respite centres from time to time. We are aware and certainly there is plenty of evidence about the malnutrition of people living at home. We have worked quite closely with Meals on Wheels over time. So we are very aware of what is happening in that space. Our organisation also runs a supplement distribution service for things like Ensure and Sustagen for when people cannot get enough nourishment through food. That is accessible to the general community. Sometimes we deliver it to homes for the elderly when they are not able to come and collect it. You certainly see the situation that people are living in and they are often doing quite badly in that space.

Just recently, we have also developed a finger food cookbook for people living with dementia, which we are just printing at the moment in response to the fact that there is so much malnourishment for people who are living with dementia. With the encouragement towards more people living at home with those issues for as long as possible, certainly something that needs to be addressed would be the nutritional intake.

Ms BATES: So malnourishment is more of an issue than obesity?

Ms Hourigan: For the elderly, yes.

Ms BATES: Thank you.

Mr KELLY: Thanks very much for your submission. The existing programs that you list here seem to focus on changing the behaviour of providers rather than the end consumer. Is this because you believe that that is a more effective way to achieve downstream consumer behaviour change?

Ms Hourigan: I think probably behaviour change has to be multilevel. It is about getting consistent messages everywhere. For example, in the early childhood sector, it is not easy to engage with parents directly but the early childhood educators engage with parents every day. So being able to give them messages that they then can pass on is a more realistic way of reaching the parents. In addition to those programs we have our Healthy Food Healthy Planet website—Healthy at Home—which is there for the general community. That is what we are really working at strengthening at the moment so that there is another level for people to go to. But professional development with educators and other health professionals, such as in schools with teachers, allows the messages to be more consistent, especially for children. Certainly, if you can help children at an early age to establish the habits that they need, then you are going to have a healthier future.

Mr KELLY: So you believe that if you change the behaviour of the provider, then you are going to have a positive impact.

Ms Hourigan: It is never all by itself.

Mr KELLY: No. A lot of your program seem to rely on the provider, be it a nursing home or an after-school-hours program, reaching out to you. Do your programs involve you intervening actively to try to change those behaviours?

Ms Hourigan: We engage people to be part of our service but we also develop a lot of resources. Certainly, we are reaching out to them all the time through various communications. We have to cover our costs. Therefore, we need to charge a small fee, but it is not a huge fee. But then we certainly support them and we ask them all the time what do they want, what is going to be supportive for them. I would say that, as an organisation, our aim is make sure that we are meeting the gaps and needs that are there. With all the projects that we have worked on we have always tried to do consultation with the community that we are trying to help before we go down any path.

Mr KELLY: Okay. Thank you.

Mr DICKSON: You intrigued me with that statement that you made relating to the percentage of young people who are giving you push back. What is the percentage of young people who are pushing back, who do not want their privacy interfered with?

Ms Hourigan: That was a particular study down in Westmead. It was an obesity management program that they had conducted and they happened to use phone technology, thinking that it would really appeal. I can get more detail on that program for you, but it was reported at that particular conference.

Mr DICKSON: I would like to get that.

Ms Hourigan: Sure.

Dr ROWAN: Within government schools specifically located in at-risk communities, should there be consideration of healthy lunches being provided directly similar to what occurs in the United States, Europe and parts of the United Kingdom?

Ms Hourigan: It is certainly something that has been spoken about at different times and probably that could be an advantage. In the early childhood sector I know that Indigenous communities are considering whether that is going to be something good that would happen in the early childhood sector. It may also be helpful for schools, but I guess there is always a cost attached to those things. So that might be a limiting factor. I think the other question that arises sometimes—it is like when you run breakfast programs—is that they can have good outcomes sometimes but you wonder if people are shifting the responsibility. So I guess it is a question that probably needs a bit more exploring, but it could improve the nutritional status of children, yes.

Dr ROWAN: Is there any evidence that you are aware of that it does have a cost-benefit analysis in the sense of those places internationally where they are being provided, that it is leading to better longitudinal outcomes as far as health and wellbeing are concerned?

Ms Hourigan: I think the US is probably not a great example in the sense that they do not have great outcomes at the moment because the food that was being supplied was not appropriate. If that gets looked at, there still has to be a lot of consideration of what actually is provided. In Europe—it might be Denmark or France where they supply meals—they do have better health statistics. Whether it is all due to that program is sometimes hard to demonstrate.

Dr ROWAN: My final question relates to nutritional education within the school curriculum. Is there an ideal time or a target age group when that works most effectively?

Ms Hourigan: I think the earlier you start talking to children about those things, the better. Certainly in adolescence it is harder to introduce a new idea if they have not heard it all the way along. It is still important to deliver it in secondary schools as well. The primary school age is when a lot of eating behaviours get developed. Certainly there is plenty of evidence that shows that if they are established early, they last better into adulthood.

CHAIR: Following on from Dr Rowan's question, have your studies looked at educating children about healthy eating? But at the end of the day they are going home obviously into a family environment where things may or may not available. Have you done any studies or had any results that show whether it is effective, given that you are not necessarily dealing with the parents directly?

Ms Hourigan: I think children can be good conveyers of messages. We recently did a project in the schools—it was through a philanthropic grant—with years 3 and 4. We asked for some feedback from parents as well. I have not seen all the completed feedback but there were some particular bits of feedback around parents saying, 'My child tells me we have to eat more vegetables.' I think the messages do get conveyed back home. Then there are things like when you have 'crunch and sip' time in schools and children bring fruit. Then there is a bit of pressure on parents from the child to provide that for the children. I think they can be a conveyer of change.

CHAIR: Thank you very much. If there are no further questions from my colleagues, I thank you for your submission and NAQ Nutrition for that submission and for your time here today. I invite our next witnesses, Professor Philip Baker and Professor Alison Marshall from QUT, to come forward.

BAKER, Professor Philip, Queensland University of Technology

MARSHALL, Associate Professor Alison, Queensland University of Technology

CHAIR: Professor Baker and Associate Professor Marshall, thank you for your time today. Would you like to make an opening statement?

Prof. Baker: Yes, we will. I will go first. I am Philip Baker and I am presenting on behalf of the Cochrane Review Overview research team of international collaborators from the US CDC in Atlanta, McMaster University, Canada and Cardiff and Portsmouth universities in the UK. We are part of Cochrane. Cochrane is the world's largest and most trusted non-profit collaboration seeking to identify which health treatments, interventions, drug therapies et cetera are effective and safe. So it is very important. We gather and summarise the best evidence from research to help decision-makers make informed choices about treatments and programs. We do this by producing systematic reviews.

Some types of evidence that are presented are more scientifically trustworthy than other types. This has been articulated by Australia's NHMRC in the hierarchy of evidence on page 2. This is what we say, from a scientific perspective, about treatments, our health programs of what constitutes something, the evidence that we use to determine effectiveness. At the top of the pyramid you can see are systematic reviews and randomised control trials and at the bottom are expert opinion and testimonials. How is this actually applied in practice? In preparing guidelines, most health professional bodies use systematic reviews as the starting point to inform the decision. Typically, governments around the world and their agencies commission a systematic review when they require objective evidence to choose programs, therapies et cetera. The World Health Organisation requires systematic reviews as the basis for all of their guidance they produce.

Why is this important for Queensland? Systematic reviews employ scientifically rigorous methods to objectively investigate the effects of interventions. What does it involve? It involves basically searching for all the research on a topic, appraising that research for that specific question, asking whether it is trustworthy and then synthesising and summarising it in a report which decision-makers can use quite readily. It is quite essential because individual studies on their own are not necessarily trustworthy and you cannot take an individual study and generalise it whereas an overview, a systematic review, looks across the research and looks for trends. This helps decision-makers make informed decisions. We have been going one step further in looking at not just individual interventions, but our work is asking the broader question: from the evidence of systematic reviews what points to strategies that increase physical activity and improve healthy diets?

I really need to point out the obvious, that just because a drug or an intervention works for one health condition, you cannot just take it and transfer it across all. Immunisations are great. However, you cannot take that immunisation for measles and tell someone it will work for HIV. That is the danger that can happen when we look at taking some of these things that have been identified elsewhere and moving them into physical activity and nutrition if they have not been designed and implemented in that setting.

In our submission we have identified high-quality, trustworthy, systematic reviews on the scope question of this inquiry and the evidence is contained within those studies which we have identified. Just to give you a summary of what we found in the table, for physical activity, telephone based behavioural change interventions as a group have showed significant improvements—again, it is about focusing on behaviour. Remote live contact during exercise—the internet, video or telephone—has been shown effective for older people in 24 studies. There is a Cochrane review by Richards which looks at 11 studies of over 5,000 individuals looking at remote and web interventions using tailored approaches towards the activities, using telephone as a feedback. I have found it to be beneficial. It is important to note that complementing these reviews are other trustworthy reviews which include dozens of studies and thousands of participants that show the importance of goal setting, also known as intentional interventions, as well as the importance of social support—things like walking in groups. Some systematic reviews point to the value of tailored print and computerised approaches, but the evidence base around some of these is problematic. For physical activity we have identified reviews which have not worked. For children specifically these are SMS messaging. Social media intervention such as discussion boards typically fail to provide benefit. In our brief we have also looked at nutritional behaviour and the approaches which have been shown to be effective for physical activity appear to be similar for nutritional strategies.

In closing, it is really important that health interventions must be able to reach and benefit everyone. We are trying to take a population approach and it is not just the advantaged people to benefit. The problem is that over the years many well intended interventions have fallen flat and they have actually broadened health inequalities and made it worse and brought greater disparity. The challenge is, when looking at the evidence, to see further consistency of the interventions' effect and look for the sustainment of it. We point out that new reviews are required. As research continues to emerge, they need to be added to the existing reviews or new reviews. So there needs to be continual looking. My colleague Alison, who has been undertaking some work in systematic reviews as well as randomised control trials, will give some examples of their work.

Prof. Marshall: I am Alison Marshall. I am an associate professor and I am an NHMRC-funded research fellow with QUT School of Public Health and Social Work. Thank you for the opportunity to present to you today and for conducting this inquiry because it is shining the spotlight on something that is really important to me. We need to get everyone moving more and eating less, not just those who are already showing signs of ill health. The greatest gains in population health will be achieved by stopping the well people becoming sick and consequently a burden on the health system.

My entire academic career has focused on developing and systematically evaluating physical activity interventions. I have collected empirical data from over 10 randomised control trials evaluating physical activity interventions delivered via the telephone, the web and, most recently, mobile telephones. I understand the evidence and I have used it to develop interventions that work.

I am here today to draw your attention to an evidence based, consumer focused, personalised, mass reach, individualised physical activity intervention that is capable of increasing physical activity by 20 per cent in a cost-effective way. It cost us $31 per person to deliver. We have created the next generation of telephone-delivered health promotion intervention. It provides a personally tailored physical activity behaviour change program in such a way that it looks and feels like a personalised interaction, but you do not actually need a person there to deliver it. The intervention is primarily delivered by automated mobile telephone text messaging.

These days almost everyone has a mobile telephone. In fact, some of us, including those subgroups at higher risk, rely on them exclusively. We need to exploit the reach of the mobile telephone and harness the benefits of text messaging for behaviour change. Text messaging allows for the in-the-moment, personally tailored behaviour change advice and support. Each message can be personalised in such a way that it creates a virtual relationship that is interactive and increases the perception of accountability.

We have spent seven years developing this program in consultation with Queensland Health practitioners and consumers. The result is an automated program that works and that is well received by all and can be already integrated into established systems. In our randomised control trials, we have seen a 20 per cent increase in the number of people meeting physical activity recommendations. A shift of that magnitude is consistent with the change observed in the other programs you have heard about today but is achieved using far less money and resources.

Others have suggested we should be spending at least $100 per person on prevention programs. Our program costs just $31 per person to implement and this cost will reduce with widespread dissemination. Our intervention's cost-effectiveness ratio was just over $8½ thousand, which is well below Australia's 'willingness to pay' threshold of $64,000 per quality adjusted life year. I have not heard of a more cost-effective health promotion program.

This program already ticks all of the boxes my colleagues this morning were advising you that are crucial for the development of an effective program. It communicates with people the way they want. It applies the best evidence we have. It is based on extensive user testing and has been shown time and again to produce the changes in physical activity that we need. Plus it delivers all of this in an automated program that can be supplied en masse with very little ongoing maintenance costs. What you have before you today is a program that is ready for mass dissemination, a program ready to achieve the improvements in behaviours that we know are necessary to improve the health of our communities.

I would like to also point out that we are not the only research group who have established the efficacy of text message interventions for health behaviour change. We have recently completed a meta-analysis of most up-to-date evidence. It includes data from 35 studies targeting a variety of health behaviours including nutrition and weight management. The overall effect size calculated demonstrates that text message interventions do work to change behaviour. So we need not wait any longer, we do not need any further developmental work; we need to disseminate now.

In essence, Queensland has a unique opportunity here to embrace the reach and flexibility of mobile telephone text messaging for health behaviour change. Our intervention is built on solid evidence. It uses clever and thoughtful programming to ensure that it looks and feels like a personal interaction, but it is a fully automated program. So you get the best of both worlds: a highly effective personalised program delivered with minimal budget.

I encourage the committee to build upon the evidence before them in my submission. We have an opportunity here to take the lead internationally by implementing the next generation of telephone intervention and establishing real gains in population health. You are not going to find better bang for your health dollar if you look elsewhere. Thank you for listening. I am more than happy to take questions.

CHAIR: Thank you very much, Professor Baker and Associate Professor Marshall, for your opening statements. Can I direct my question to you, Associate Professor Marshall. I read the submissions and papers with interest. I am in the target group: I have a four year old and an 18 month old and I am a mobile mum, so I certainly read that with great interest. Can you just give us a practical example of what the mums receive? What does a text message say?

Prof. Marshall: The text messages themselves are personalised to the woman's physical activity goal which is set upfront in the program, and various messages are targeted to the other theoretical constructs of the social cognitive theory which has been shown to assist in people changing their behaviour. In a typical week a woman would receive between three and five text messages. The very first message of the week would be assessing whether or not she met her goal for the previous week, and then the subsequent messages are about reminding her of the opportunities that are available in her local environment and the things that she told us in the initial setup of the program that would work for her. We also enlist the support of a social support person, who also receives text messages throughout the program, to prompt the person who is in the program to be more active.

CHAIR: So is it one-way or two-way?

Prof. Marshall: It is two-way for the participant and it is one-way for the support person, but there is provision for two-way for them as well.

CHAIR: With regard to a 12-week program, do participants continue to be more physically active after the program finishes and how have you looked at that? What studies have you done?

Prof. Marshall: For our evaluation we continued on for another six months to see what happened and whether or not there was a drop-off, and there was—I will not misled you there—but that is common amongst all interventions that have been implemented. What we did see was they did not drop back down to where they were before, so there was a little bit of sustained increase. We already have thoughts on what we could do then to help bolster that up.

CHAIR: What would they be? Is that ongoing contact after follow-up?

Prof. Marshall: Potentially that, but also looking at how we can work with that support person more completely as well and engaging them.

CHAIR: I just have one follow-up question. As someone who is obviously busy with young children and a job, what is your sense of why the text messages work from the point of view that people get many text messages and they could be lost. Also is it about trying to get them to prioritise and bring it to the forefront of their mind over other activities, or what is it that you feel makes them more active when they are busy?

Prof. Marshall: The program is initiated by a behavioural counselling session whereby a lot of the things that are barriers for the women or the person to being physically active are discussed. So we rank those and we look at those and we come up with solutions for those, and that is what is embedded within the text messages then to remind them of the things that they thought would work for them at the time. The consultation with the women following the program said, 'It was really great to get the message. Sometimes I could not read it at the time I received it, but I went back and looked at it again later and it reminded me that there is the park just down the road that I can go and push the pram around or the local swimming pool and stuff like that.'

CHAIR: It is keeping them accountable, essentially, to the initial goals that you set together.

Prof. Marshall: Yes. The initial counselling session is actually done with a person at this point in time and all of those text messages are signed off by that person's name, so there is a sense of accountability. It is almost a little contract going on for them.

CHAIR: I will pass it over to the deputy chair. Ros Bates, do you have a question?

Ms BATES: Thank you, I do. I just noticed in your submission here that you had an NHMRC funded randomised control for your program about the cost-effectiveness. Can you give us an indication on what the cost of the program is and what is the cost-effectiveness?

Prof. Marshall: The cost of the program per person when we delivered it was $62. The cost when we modelled it to actually disseminate it more widely was $31 per person, so that includes the upfront setup costs and things like that. The cost-effectiveness ratio was just over $8,500, which is well below the $64,000 cost that we use as our benchmark for getting a quality-adjusted life-year.

Ms BATES: It is great that you can actually prove your health economics. Often people who are presenting here have some great ideas but actually cannot give us the economics behind it.

Prof. Marshall: I represent a great team.

Mr HARPER: Thank you both very much for presenting today. You can probably both answer this one. You clearly have the tools but I would ask do you have the reach? Because, Professor Baker, in your particular studies you state that none of the reviews or interventions to increase physical activity specifically summarised interventions conducted in Indigenous settings. Can you tell us more about personal health interventions in those Indigenous settings? Are there challenges in those rural remote sectors like the tyranny of distance and those types of things?

Prof. Baker: The challenge with the method which we are using is that we are drawing upon research which has already been undertaken, and that draws back to the challenge of the existing research. Some of the limitations have been that they tend to be middle-aged women and the studies are less representative of men. We have to be very careful when we take programs that have very little information about some disadvantaged people's groups such as Australian Aboriginal people. Some of these studies that are included were done in Canada and the US, so I would point out that there is lack of information and some of those communities failed to have benefit, so being very careful about the translation. We have put in a diagram of 'it worked there, it worked here' and the evidence wheel from health evidence about the importance of adapting interventions to the appropriate setting to make sure they are culturally appropriate and they will get the benefit and not increase the disparity.

Dr ROWAN: Professor Baker, in your view from a research perspective what additional strategies should the state government be considering to assist with translational research for the obesity epidemic in Queensland?

Prof. Baker: I guess you have to step back to look at what are some of the components of obesity, so we come back to unhealthy eating and physical inactivity. The idea of doing the overview is we can identify some of the areas that work and some of the areas that do not work, and I think it is important to also name some of the areas that typically fail. The Brown review shows that mass media interventions for physical activity are ineffective, so investment in mass media is ineffective. In January we published a systematic review, the Cochrane review, of 33 studies looking at community-wide interventions to increase physical activity—these are the 'Rockhampton 10,000 step' type of studies—and those types of interventions generally failed to produce increases in physical activity levels in the population. That was a peer review. Certainly for children, schools are where the body of evidence sits for the areas that do work. We have been doing translational work with public health units in Canada and a lot of it is around schools. We have been working with places like the city of Toronto, which has 2,000 people working in public health, and going through the evidence specifically with them.

Dr ROWAN: Just to clarify that, the translational research is saying that in the primary school sector the interventions that are specifically put in that sort of space internationally is where it is most cost-effective?

Prof. Baker: That is where a lot of the research is pointing to the effectiveness around certainly physical activity and nutrition. There is an absence of evidence in many other settings and approaches.

Prof. Marshall: Can I just add regarding mass media and how it has been shown not to be effective in actually changing behaviour: that is true, but it is an essential component of a multistrategy campaign to get people active. You have to have something to market though in the mass media, and programs that are marketed well do attract and do work for people.

CHAIR: I just had one final follow-up question. I noted with interest in your submission, Professor Baker, that using SMS messaging in children made no difference to exercise. It was deemed to be ineffective. Of course then, Associate Professor Marshall, you are talking about mums—which is a different group, I understand—and saying it has been found to be highly

effective. I just wondered if the two of you wanted to talk a bit about perhaps why it is so effective in this group, but ineffective in children. Where does the point come where it is effective? We have obviously had different people presenting, and some have felt similarly and said that the SMS does not affect behavioural change, and others—

Prof. Marshall: Anecdotally I can offer something in terms of Facebook. Facebook used to be the thing that all young people wanted to be on. As soon as the older generation started getting on Facebook, they did not want to do it anymore. In terms of text messaging and them seeing it as a personal invasion, I am not sure about that. But certainly the older population groups use it as a main communication tool.

Prof. Baker: The other challenge with the text messaging in children is that there is a complete absence of quality research in the area. The Vodopivec-Jamsek systematic review identified only one included study: one randomised controlled trial of 32 children. The evidence is pointing to there being a dearth of evidence. That is one of the challenges when you are trying to advocate for something or trying to consider what to do if there is an absence of evidence. If there is a new drug that someone is trying to promote and they do not have clinical trials behind it, what is the view of the Pharmaceutical Benefits Advisory Committee on that? It would be knocked out. You have to provide robust evidence, something that qualifies as evidence, to put it forward. Of course we need to understand people's experience, so the implementation evidence is important as well when it comes time to actually apply it.

Ms BATES: I just have one quick question to Professor Marshall. I know kids used to use Myspace and then they have gone on to Facebook. My daughter uses Snapchat and Instagram. What are they using?

Prof. Marshall: To be honest, I do not know. My children are not old enough to know and I do not research in the area of children, so I am sorry, but I do not know.

CHAIR: Thank you very much, Professor Baker and Associate Professor Marshall. Thank you for your time today and thank you both for your submissions. It is appreciated.

FOREMAN, Ms Rachelle, Heart Foundation

CHAIR: Ms Foreman, thank you for your time in coming here today. Would you like to make an opening statement?

Ms Foreman: Yes. I would like to thank the committee for the opportunity to be here today. My name is Rachelle Foreman and I am the health director for the Heart Foundation here in Queensland. The Heart Foundation certainly has a very big interest in this space of prevention. As has been outlined already, we know that there is a significant problem with obesity in Queensland and in fact across the whole of Australia, so we are pleased to see the committee looking at this issue of interventions that are effective in increasing physical activity, improving nutrition and reducing weight.

As the data will show from the Chief Health Officer's report, we are not doing very well. Queensland does worse than any other state in some of these spaces: 40 per cent of adults and 59 per cent of children are not physically active enough for health benefits; only 60 per cent of Queensland adults consume two serves of fruit and only seven per cent consume five serves of vegetables. Thirty-seven per cent of the daily energy of adults in Queensland comes from discretionary food and drink, that is, those occasional things we are supposed to have, not over a third of our diet every day, and that has resulted in two in three adults and one in four children being overweight or obese. However, we support that we do not just focus on obesity because firstly there are few interventions that are shown to be effective once one is already obese, but also physical activity and improved nutrition have so many additional benefits irrespective of weight that we cannot lose sight of those for both the individual and communities. As a result of that, we know we need to help people establish those healthy habits at every stage of life.

The Heart Foundation also wanted to take the opportunity—since we know your remit as the committee is limited to health promotion interventions for individuals that use phone and web based technology—similar to the Health Promotion Association to reiterate a couple of points around prevention overall. There is a range of definitions, but the one we have looked at is that it is any measure that aims to either avoid or reduce severity of injury or disease, and I am sure you are aware we have an epidemic of chronic disease in Queensland that is clogging up our health system. The point we want to raise there is that does not just include what is termed the walking worried wealthy well, and we do want to keep those people as healthy as we can. It also includes early detection and detecting risk early and managing risk of chronic disease early. It also includes chronic disease management, because at any stage of the health continuum people can be healthier and we want to stop them sliding up to the next level which costs more money.

As the Health Promotion Association has identified, the Ottawa Charter is old now but it still holds true. While personal interventions are one element within the mix, we do need a range of strategies if we are going to see change in this space. That does include building healthy public policy and legislation, but we need supportive environments, both physical environments and also social environments. The Heart Foundation has just had Heart Week about moving more and sitting less and the question asked mainly was, 'Why? Why is a region so inactive?' There is a big cultural push behind that. It is the norm now to be overweight or obese and it is the norm now to be inactive. We are seeing that some of those populations that are active and that are a healthy weight are now minority groups unfortunately. We also need to strengthen that community action to change the community culture, develop the personal skills as you are addressing, and also reorient health services to prevention and keeping people well.

Because behaviour is influenced by individual values, your social network and your environments, there is no one sector that can address this and there is no magic bullet, I am sorry to say. I have sat at these sorts of committee meetings before and been asked, 'But if we could just do one thing.' Well, we cannot just do one thing or we are going to continue on the track that we are on. We know that health promotion and prevention strategies, if done well, have made a significant difference in the past. They started more in the environmental health space and then moved into measles and mumps and those sorts of conditions and now we know it can make a difference in behaviour change and chronic disease, and we have seen that with tobacco control. With a comprehensive long-term view, we have seen significant changes and we have just started to see some of those changes for Aboriginal and Torres Strait Islander people as well. What we do know in the prevention space is investment has continued for a long, long time to be low. Government funding just within the Health budget has fallen at less than two per cent in Australia and in Queensland, but we know that New Zealand spends seven per cent, Canada spends 6½ per cent and Slovakia spends five per cent. So we see government leadership and coordination across departments is critical to really make a difference. We also support the proposed establishment of

the Queensland Health Promotion Commission and the select parliamentary committee or whether it is the remit of this committee because we see that that will shine a light on prevention across agencies and really start to get some of that long-term traction.

We also wanted to raise the fact that the House of Lords in the UK has done a similar inquiry as yours and we wanted to just draw your attention to that. One of the things they found was that there has to be that mix of strategies. There must be a long-term view, and you must evaluate it. One of the failings of many government initiatives has been the evaluation. For those of us who have been around a while, we also want to draw your attention to the Smart State Council report that was done in 2008. We were integrally involved with that and really nothing has changed from then till now. It did recommend an increased focus on prevention and early detection and it also said that if we do not make those significant changes and start to address them the healthcare system will not be able to cope, and that has not changed today. All the hospital and health services will tell you that they are under increasing demand particularly from chronic disease that is largely preventable. They also highlighted the cost-effectiveness of these interventions in that for every dollar spent we see a $5.60 return within five years. So, again, unfortunately that is often beyond the term of any government, but it is not a short-term gain. We need to have the long-term view. I think it is important to also highlight that in the extensive consultation that was done in the Queensland Plan Queenslanders said, 'In terms of our view of where we want to be in the next 30 years, we want to be healthy, we want to be well.' We are a long way from that now and we really need to have significant change in where we are heading if we are actually going to see that come to fruition.

As I already outlined, we see prevention as quite broad and taking into account not just, as I said, the walking worried wealthy well but that continuum. Some of the evidence that we have provided in our submission covers across that spectrum, so we want to keep people as well as we can at all stages of their health and that includes primary prevention, early detection and chronic disease management. I am not going to go through all of them that we outlined chapter, line and verse because there is quite a range, but I just want to highlight a few things within them, and I know that Professor Liz Eakin has already talked predominantly about the New South Wales Get Healthy information and coaching service and the success that it has been over the longer term. Our submission talks about what that service is, but they have had significant uptake. So they have had good reach in the number of people who have done it. They have adapted it to provide programs for Aboriginal and Torres Strait Islander people. They have included a pre diabetes program et cetera and they have found change. When Queensland hosted their Obesity Summit in, I think it was, 2005, this was one of the strategies the Heart Foundation was proposing. Similar to Quitline, we should have a healthy lifestyle line and we have one here in Queensland, but unfortunately the uptake has been limited and predominantly that has been because no-one knows about it. There has been very limited promotion and certainly very limited targeted promotion.

CHAIR: Thank you very much, Ms Foreman. I am just mindful that the deputy chair, the member for Mudgeeraba, has to leave. She has a school coming in and it is very important that the member is there. Ros, would you like to ask a quick question before you go?

Ms BATES: Thanks, Madam Chairman. Thanks, Rachelle, for your presentation. One of the programs your submission supported was the primary prevention Get Healthy program. Given the Labor government has not committed to funding this program and funding runs out in June 2014, are you in favour of that program and would you like to see funding continue for this worthy program?

Ms Foreman: Yes, definitely based on the evidence from New South Wales where they have had it. It is the same model, but as shown in our submission once they did mass media to promote it to people they got a significant increase in uptake. Also when they established those referral pathways through primary care, again they got good uptake. In Queensland there have been 3,000 inquiries in total and only 550 enrolments in the whole of 2014 compared to 46,000 in New South Wales. We are starting to see a scale thing, but we certainly would support it based on Quitline as a similar model and based on New South Wales. We know it can work.

Ms BATES: Are you aware of any other programs that are in the same category of their funding running out?

Ms Foreman: That is the main one in this particular space that the inquiry is looking at, but we certainly would support it. As I said, we raised it as something that should be done in 2005 before it even existed. We have had a couple of staff who have done it themselves—mystery

shopped—and found it to be useful based on that individual goal setting and brainstorming some of the barriers and enablers for people. It is based on motivational interviewing really—not thou shalt but what do you think you would like to do and how confident are you and what would need to change to move that?

Ms BATES: It certainly seems to get a good rap from just about everybody who has submitted to our committee.

Ms Foreman: Yes.

Ms BATES: Thanks very much, Rachelle.

Mr HARPER: I have one quick question. When did that Get Healthy information program start? What year did it start?

Ms Foreman: In Queensland it was 2009.

Mr HARPER: And you had 3,000?

Ms Foreman: They have had inquiries. That is how many inquiries they have had and the data that we have seen from Queensland Health shows only 558 people undertook it in 2014, so we have not seen the whole lot. New South Wales started in 2009; Queensland, I think, was 2012. They adopted the model from New South Wales, but not the marketing model.

Mr HARPER: Thanks, Rachelle.

CHAIR: I think that point has been raised that Queensland did not invest as heavily as New South Wales in 2012, so we have not necessarily seen the same uptake.

Mr KELLY: Thank you, Ms Foreman. As my last post in nursing was rehab, it is very nice to hear people keen on getting people up and moving. I have spent many years of my life trying to convince people that that is the way forward. We have had submissions from many other organisations—some represented here today, others not—such as Diabetes Queensland and the National Stroke Foundation. It seems that those groups are advocating for very similar sorts of lifestyle changes and behaviour modification and that all of those lifestyle changes and behaviour modifications are going to have flow-on impacts into the disease areas that you are targeting—in your case, cardiac issues and for other groups diabetes and stroke. I recently had the opportunity to attend a talk by the federal Mental Health Commissioner and he similarly pointed out that there is some evidence around lifestyle changes of a similar nature having preventative impacts on the development of some forms of mental illness. If that is correct, would you see that there is any possibility of agreeing across-the-board on what the health education objectives should be? If that is possible, do you think we could get multiple organisations to work together in this area to deliver similar programs and perhaps gain some economy of scale?

Ms Foreman: I would make a couple of comments on that one. One is that I am an exercise physiologist by training initially and I have said it before but I will say it again: even when I was training the evidence was strong about the multiple benefits that, in essence, exercise was medicine. It is now stronger as the evidence has emerged. So, yes, we would love to see people move more. We do work closely with stroke, diabetes, kidney health and a range of other such organisations and mental health as well. Yes, the risk factors in essence overlap very closely for the development of those conditions. We are part of a national and a state alliance called the National Vascular Disease Prevention Alliance which includes preventing vascular conditions—heart, stroke, diabetes and kidney—and we also have members of the Aboriginal and Islander Health Council there as well. We do talk about those sorts of collaborative approaches, particularly in prevention and early detection as well. There are some similarities in rehab, but you cannot cookie cut across because there are some very specific differences in terms of medication but also for some exercise. So, yes, we are very supportive of that.

One example that we have been talking about to anyone who will listen is one of the current election commitments around Life! diabetes prevention. That has come from Victoria. It is actually about heart, stroke and diabetes prevention. We feel it would be a big missed opportunity not to take that broader approach to prevent heart, stroke, diabetes and renal disease because, as I have mentioned, the overlap between risk factors is significant. The Health Navigator program mentioned in our submission that Metro North Brisbane Medicare Local has been trialling actually has worked with the National Vascular Disease Prevention Alliance guidelines to develop that web based tool. When you put in all your info, up pops what looks a bit like an odometer or speedometer thing in terms of your risk for heart and stroke disease, your risk for diabetes and your risk for renal disease. So you can set the eligibility criteria into a program like Life! based on a tool like Health Navigator and then the lifestyle management is quite similar and then the medication management will be

somewhat different, because you cannot have diabetes to be in a pre diabetes program but you could have diabetes to be at high risk of heart disease or stroke. So we think it is workable and we think there would be a lot more bang for buck if you actually did take that comprehensive approach. In Victoria they started with diabetes prevention and then the minister said that they should add on top of that. Because they did not start thinking that way, it has perhaps not worked as well as we think it could here.

Mr KELLY: Thank you.

Dr ROWAN: You mentioned the Queensland Plan this morning. Is that a positive document for Queensland in the view of the Heart Foundation?

Ms Foreman: The Heart Foundation invested a lot of time and energy into the Queensland Plan, and there are a few reasons why. We are not just interested and health and wellness, which was one key pillar, but we were interested in agriculture, regional health and a range of things—so that cross-sector approach. I guess we were on the steering committee for the development of the blueprint underneath that because of the vested interest and I guess that very comprehensive view that we have taken into that. I do not know what the final number was for the consultation, but I believe it was somewhere of the ilk of 75,000 Queenslanders and agencies that put into that. I do not think you would come up with different foundation areas if you did it again. So I guess we would like to see action on keeping people healthy and well, whatever that looks like and under whatever banner you want to call it. Take the consultation that came out of that plan and use it to inform delivery.

Dr ROWAN: In relation your submission and presentation this morning you alluded to additional legislation. What additional legislation would you like to see from the Heart Foundation's perspective?

Ms Foreman: One of the ones that we have been advocating for and it is actually currently an election commitment is around kilojoule menu labelling, for example, in fast food outlets. I think it was wrongly assumed that that was already widespread in Queensland—and it is in some fast food outlets—but we did an audit that showed that only about a third displayed it, and displayed it as per the legislation in New South Wales. So that is currently a commitment, but we would like to see it become a reality.

There is a whole range of regulation as well that we would like to see in terms of where fast food outlets could be established within the proximity of a school, for example—no more than a kilometre. That came out, I think, in AMA Queensland's position as well. Similarly, we would like to see a limitation on sponsorships for certain sports. We understand the challenges around that but, as we said, there are cultural issues afoot. I do not know what the statistics are today, but I remember probably about 15 years ago reading an article that said that, in the whole of the USA, the mass marketing spend per capita against obesity was 50 cents a head and that McDonald's alone spent $1. That gives you an idea of the tide that we need to turn in terms of the barrage of messaging that people get for not only unhealthy food but also to be inactive.

CHAIR: Ms Foreman, thank you very much. Thank you for the submission of the Heart Foundation and thank you for your time here before the committee.

Ms Foreman: I appreciate it.

KING, Prof Neil, Acting Assistant Dean (Research), Faculty of Health Queensland, University of Technology

WILSON, Dr Jenny, Project manager, Queensland University of Technology

CHAIR: Professor King and Dr Wilson, thank you very much for coming before the committee this morning from QUT. Would you like to make an opening statement?

Mr KING: Sure. I have been listening since 10 o'clock this morning, so I am conscious to leave time for questions. So I will not take up too much time with an introduction. I am a professor of obesity, physical activity and nutrition with a particular focus on appetite regulation. For 25 years I have been researching effective strategies for weight management and weight loss. That is one hat that I wear. Why I am in this project is that I am also the Acting Assistant Dean of Research for the Faculty of Health. I also facilitate research projects such as this. Since we started over 18 months ago I have been rounding up the troops and you will see from our team of multidisciplinary experts that we have a range of faculties and experts on this project.

So why are we interested and what is the need? I do not really need to tell you, but of health apps in particular—of the 200 billion users, and that number is increasing—over half of them are related to health, fitness and diet. If we think about the food that we put in our mouth, the drink, or the alcohol, or how much we move, or how little, they are major contributors to obesity and weight gain. So we feel that it is really important, with the increasing use of these types of apps, that there is a real need for the consumer, the app developer and the stakeholders and the health professionals to have a level platform, some form of certification or evaluation service that allows us to test the efficacy and effectiveness of health apps.

I notice my colleague Marcus's comments this morning. He referred to the whitegoods—the Choice type of purchasing. It is interesting that we research things like private health insurance, our car insurance and our house insurance and there are reviews and regulatory bodies but, at the moment, if I want to purchase a health app or a diet app I probably have to go through nine or 10 before I really get the right one. That might cost only $20, but for some people that is quite a lot of money. So there is a real opportunity here for an evidence based service and I think that is what the consumer needs. This project is what we are calling environmental scanning. At the moment, we are contacting consumers, the various app developers and the stakeholders to see really what the needs are. We believe that there is a need, but this project will, hopefully in six months, confirm that.

In essence, what we are really after is something a bit like the Heart Foundation tick of approval—maybe not exactly the same, but something along those lines. It could be a rating system as well. It could even be the traffic light approach, where the consumer can identify. I also noted one of the comments this morning about one size does not fit all. We appreciate that the needs of the consumer varies and, therefore, by having this type of certification system the consumer can also identify what he or she needs in terms of their needs.

There is also, we believe and we know from the Digital Industry of Australia, a need from app developers. They need to know what the consumer wants as well. This is not about just health professionals but also the developer so that they can tailor their apps and their mobile platforms to suit the individual user.

Why QUT? You have already heard this morning about the MARS—the mobile access rating system—from one of our colleagues. That is in its infancy and still needs developing. We also have a School of Exercise and Nutrition Sciences in the Faculty of Health at QUT. So we are training dietitians, nutritionists and exercise physiologists. I think to that end we feel that we have an opportunity to partner with various organisations. We are conscious that this should not just be a QUT show. You will see from our list of partners in terms of Choice and some health insurance providers, as well as AIMIA, that we feel that we need to partner with an independent organisation. I will stop there and I am happy to take questions.

CHAIR: Thank you very much.

Mr HARPER: As discussed in a number of submissions, there is inadequate regulation of web based personal health promotions interventions. One of the notes that I have made is that health practitioners or other legal and professional people risk recommending inappropriate and ineffective apps. What regulatory systems do you envisage for exercise and diet apps in that space?

Prof. King: That is a really good question and it is certainly one that we have considered. We might not have the answer for that now but, in terms of professional organisations, we have partnered with the Dietitians Association of Australia—the DAA—and also ESSA, Exercise and Sports Science Australia. But from a regulatory point of view we are probably going to rely on another organisation to have that.

To also answer your question, a point of difference is that we are really conscious that, if I want to collect my food intake for a week and I get a diet app, that is completely different from the implications if I am diabetic and I do a sucrose, or a sugar count, should I say. So we are aware of the regulation but, to be honest with you, I have not really got the answer.

Mr HARPER: Okay. Right.

Dr ROWAN: Thank you for the presentation, Professor King. You alluded to a framework for determining the efficacy, clinical and cost-effectiveness of health apps. My question is: who is best placed to certify this? Would it be the Australian Commission on Safety and Quality in Health Care? Should there be a national healthcare standard in relation to health related apps?

Prof. King: I think that is where we are leaning towards. I think if we could have an advisory body or a national organisation that would be a regulatory body, then that is what we would prefer. As academics and researchers, I do not think that we are in a position to do that. So we need to rely on the professionals. Choice is on board, but they are not in that position either. They are a consumer organisation. So I think the simple answer to your question, yes, we would need that.

Dr Wilson: I think we also need to make sure that whatever is put in place does not tie things up so much that it stifles innovation. I think that is the balance that this area needs to get.

Dr ROWAN: Thank you.

Mr KELLY: We have talked about the liability issues for health professionals referring a patient or a person to using one of these. As a nurse, I would be very careful about referring them. In terms of the development, the management, the monitoring and the evaluation of these, do you think that it is important that we have health professionals involved in that process?

Prof. King: Definitely. I could not agree more. I think that if we do not consult them, then there is a risk of people either misadvising or just saying no completely. As I said, we have already engaged with the exercise and the dietetic associations, but this spans all health professionals. We have held small focus groups with some health professionals, particularly with the dietitians, but even GPs say that at the moment they are not in a position to recommend apps. So the answer is yes across all health professionals, but I appreciate the clinical implications and the risks involved if, for example, a nurse advises a diet app.

Mr KELLY: Okay.

Dr Wilson: If I can just add to that? The health professionals, the diet and the exercise professionals do a certain amount of sharing between each other about what works and what does not, but what they do not have is common standards. So you are basing it upon one person's opinion about what worked and what aspects worked, which is not necessarily useful to being able to rank them. It is the same as any kind of evaluation; it has a personal angle. So what they are seeing is something that will help them to be able to put those views in some form of standardised process.

CHAIR: Thank you very much Professor King and Dr Wilson for your time today in coming before the committee. That concludes our hearing today. Thank you again to all of our witnesses, to my colleagues, to our secretariat support and, of course, to Hansard. A transcript of the proceedings will be available on the committee's parliamentary website web page as soon as practicable. I declare this hearing closed. Thank you.

Committee adjourned at 12.55 pm