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 BRIEFING—INQUIRY RELATING TO PERSONAL HEALTH PROMOTION INTERVENTIONS USING TELEPHONE AND WEB BASED TECHNOLOGIES

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 6 MAY 2015

Brisbane

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Committee met at 11.34 am

CHAIR: Good morning, everyone. Welcome to the inquiry today and thank you for your attendance. Before we start can I ask that phones be switched off or to silent, please. I now declare open this public briefing of the Health and Ambulance Services Committee. I would like to acknowledge the traditional owners of the land on which we meet today and pay my respects to elders past and present.

My name is Leanne Linard. I am the chair of this committee and the member for Nudgee. I would like to introduce the other members of the committee here today: Ms Ros Bates, the deputy chair and member for Mudgeeraba; Mr Steve Dickson, member for Buderim; Mr Joe Kelly, member for Greenslopes; Dr Christian Rowan, member for Moggill; and Mr Aaron Harper, member for Thuringowa. I would also like to introduce Brook Hastie, who is our secretariat support, and Kath Dalladay.

The purpose of this briefing is to assist the committee in its inquiry relating to personal health promotion interventions using telephone and web based technologies. This inquiry was referred to the committee on 27 March and the committee is to report to the House by 12 June. The committee has advised the public of the inquiry through its parliamentary web page and by writing directly to stakeholders. The committee has received 21 submissions to date which will be published on the committee's website today. The committee intends to hold a further public hearing in relation to this inquiry during the next sitting week. Details of that hearing will be released over the course of the next week.

I would like to make mention of a number of procedural matters before we hear from departmental representatives. This 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 orders. Members of the public are reminded that they are here to observe proceedings and may not interrupt. Anyone who disrupts proceedings may be removed at the discretion of the chair or by order of the committee.

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 and introduce our witnesses. Thank you for coming and thank you for your time this morning.

CHALMERS, Ms Victoria, Director, Health Contact Centre, Community and Scientific Support, Health Support Queensland

KINGSWELL, Dr Bill, Acting Deputy Director-General, Health Services and Clinical Innovation Division, Department of Health

PULSFORD, Ms Kaye, Senior Director, Preventative Health Unit, Office of the Chief Health Officer, Health Services and Clinical Innovation Division, Department of Health

CHAIR: I invite you to make an opening statement of up to five minutes before I invite 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.

Dr Kingswell: Thank you very much for the opportunity to speak today on personal health promotion interventions using telephone and web based technologies. I had understood that we had more than five minutes. I did have a written presentation that I have provided to Hansard. To deliver this in five minutes I am going to give you a truncated overview.

CHAIR: Yes, that is fine, thank you. We can incorporate that into *Hansard*.

Dr Kingswell: A short overview?

CHAIR: Yes, thank you. That would be great.

Dr Kingswell: We had four headings that I will not be able to address in detail, but essentially we had an overview of health promotion behaviour change and the complexities, challenges and opportunities involved in working at that end of the healthcare continuum. We were to speak to the evidence for the effectiveness and cost-effectiveness of health promotion interventions. We wanted to provide a range of additional information about personal health promotion interventions that are being used in Queensland and elsewhere, and then there is some discussion about potential opportunities for partnerships and the innovative use of emerging information and communication technologies for personal health promotion. I expect that you are probably most interested in what is happening in Queensland Health, so I might go straight to that.

In relation to some of the existing telephone coaching programs and web based personal health promotion interventions in Queensland and interstate, we will provide some information on what is funded and provided by Queensland Health. I will start with the Get Healthy Information and Coaching Service. Get Healthy was developed by the New South Wales ministry of health in 2009 and is now implemented in ACT, Tasmania, South Australia and Queensland. The service has specific content for Aboriginal and Torres Strait Islander people and includes a type 2 diabetes prevention module. In Queensland, triage into this service is undertaken by 13HEALTH, which is based in the Health Contact Centre. In terms of scope, Get Healthy specifically targets adults aged 18 years and over, and people can self-refer or be referred by their general practitioner or other healthcare provider.

The type 2 diabetes prevention module specifically targets people over 40 years of age as well as Aboriginal and Torres Strait Islander people. The service caters for people at different points in their behaviour change continuum: those that are at a precontemplation stage—essentially those that are not aware that they have a problem—through to those that are ready to get engaged in the program. They can enter into a six-month coaching program with 10 individually tailored telephone calls, and that is a useful approach for those in the preparation and action stages of behaviour change. Coaching is provided in a tapered schedule, with high intensity in the first 12 weeks to promote initiation of behaviour change and less frequent calls in the latter stages. In the 2013-14 financial year Queensland Health invested $850,000 in that program and 870 Queenslanders inquired about the program. Ninety-nine per cent of those people went on to enrol in the six-month coaching program, and an additional 21 people sought information about the program.

The next program is the Queensland government's flagship Healthier. Happier. obesity campaign. This social marketing intervention targets people in the precontemplation and contemplation stages of behaviour change. It encourages people to make a self-assessment around their behaviours and take incremental steps to change those behaviours. It has an extensive web presence and includes information about nutrition, physical activity and practical tools. Two key aspects of the campaign are the health and fitness age calculator web based app and the health and fitness age challenge app. Almost half a million Queenslanders have undertaken the health and fitness age calculator and more than 136,000 have downloaded the health and fitness age challenge app. The health and fitness age calculator asks people to perform a quick and honest assessment of their weight, nutrition and physical activity habits. By entering details, they are provided with a health and fitness age which they can compare to their chronological age. Information is also provided on how they can improve their health and fitness age.

The free four-week health and fitness app challenge encourages people of all shapes and sizes to do simple everyday things to improve their health and fitness age. Participants are provided with a personal motivator who sends reminders, tips and facts about the areas they need to focus on to improve their health and fitness and they can track their progress. Tracking research found that a large portion of people who completed the calculator had started to make healthier changes.

The Department of Health has implemented a range of other web based interventions to address the needs of Queenslanders identified through market research. Examples include the VacciDate application, which tracks and reminds parents when to get their child vaccinated, and the Your Future's Not Pretty web based application that encourages and supports young women to quit smoking. The Sun Mum campaign has a social media presence that delivers regular sun safety reminders to over 37,000 Queenslanders. There is a Positive Impact program run by the Brisbane South Primary Health Network. This program offers a free telephone coaching service for members of the Greater Metro South Brisbane Medicare Local community who have a body mass index of more than 27 kilograms per metre squared and are ready to regain their health by making lifestyle changes. General practitioners can refer patients into the Positive Impact program after reviewing

blood tests and assessing their physical measurements including weight, height, waist circumference and blood pressure. Eligible patients then receive free individual lifestyle advice over the telephone from a qualified dietician, who guides them through a six- or 12-month program. It has also been adapted to be culturally specific to Pacific Islander and Aboriginal and Torres Strait Islander populations.

There is another program that targets people already diagnosed with a chronic disease: the Coaching patients On Achieving Cardiovascular Health, COACH program. This was developed in Victoria in 1995 and is now implemented in five Australian states including Queensland. It also has tailored content for use in Aboriginal and Torres Strait Islander people.

In terms of scope, COACH offers eligible Queenslanders diagnosed with coronary heart disease, type 2 diabetes, prediabetes or chronic obstructive pulmonary disease a structured telephone coaching service free of charge for up to six months. The program aims to assist participants to achieve risk factor targets for their health condition and to reduce the risk of future complications. Participants can self-refer or be referred by a healthcare professional. They are provided information about the program in discharge planning documents.

An audit has recently been published investigating over 2,700 Queenslanders with coronary heart disease or type 2 diabetes who completed the COACH program between February 2009 and June 2013. The audit indicated statistically significant improvements in risk factor status as well as positive lifestyle changes such as reduced smoking and alcohol consumption combined with increases in physical activity. A total of almost 5½ thousand referrals have been made to the COACH program over the five-year period from 2009 to 2014.

The Department of Health invested $1.09 million in the 2013-14 financial year in the program. A total of 995 Queenslanders with a diagnosed chronic condition enrolled in the program during this period. However, 999 clients graduated, having regard to a number having enrolled in the program prior to that financial year. For a client to graduate, they need to complete the six-month program and achieve the desired medical levels for their risk factors. The cost per client was $1,088.50.

The Healthy Lifestyles Brief Intervention Online Training Program was delivered by the Queensland Health Clinical Skills Development Service, and it enables clinicians to deliver the skills and confidence to conduct brief interventions with their patients as part of routine care. Evidence shows that clinicians can significantly improve the long-term health and wellbeing of their patients through the use of brief interventions.

Two specialised courses are available online for health professionals who work with non-maternity patients as well as for midwives, child health nurses and other clinicians who work with pregnant and breastfeeding patients. The online training program includes structured models incorporating knowledge and skill based content relating to healthy eating and physical activity, and alcohol, tobacco and other drugs. It uses case studies, tips, demonstrations, resources and useful links to help them apply these learnings to their practice.

Additionally, the Mental Health Professional Online Development program, or MHPOD, is an online professional development resource designed to support the implementation of the national practice standards for the mental health workforce. MHPOD is useful for people working in mental health or with patients who are experiencing mental illness. The professional online development program features 58 topics based on the national practice standards for the mental health workforce, each with evidence based content, multimedia, interactive activities, knowledge check questions and suggested reference material. It is funded by all states and territories on the AHMAC cost-share funding model.

Headspace, the National Youth Mental Health Foundation, offers support to young people in person through a network of 80 centres nationwide or via e-headspace, which is a confidential, free and secure space where young people aged 12 to 25 or their family can chat, email or speak on the phone with a qualified youth mental health professional. How am I going for time?

CHAIR: Dr Kingswell, obviously we have your submission but you can have a few more minutes if there is anything specifically you wanted to add to that.

Dr Kingswell: I am being directed to turn my attention to potential opportunities for partnerships. We all have a role in health promotion, and this inquiry will receive submissions from a wide range of organisations with an interest in providing telephone and web based personal health promotion interventions. Most people wanting to make lifestyle changes will move between programs and services on their journey towards better health. For some people we may only get one chance to deliver a program that meets their needs and supports them to make successful lifestyle changes.

The challenge for everyone working in this area is to work together to provide a more seamless experience for Queenslanders as well as better outcomes for individuals, families and communities. This can be assisted by having one central point of contact for people seeking to embark upon lifestyle improvement, an effective mechanism to triage people to an appropriate intervention and the ability to cross-refer people between different interventions as their circumstances change. This approach was trialled by the Health Contact Centre earlier this year with the Upselling Prevention Initiative. This initiative focused on opportunistically engaging with consumers about preventative health topics at the time they called either 13HEALTH or 13QUIT. Following resolution of their original reason for their call, clients were asked about their general health status and, where appropriate, offered an opportunity to receive more information about a health issue and potentially referral into a brief intervention.

The pilot targeted four risk factor groups: healthy weight, good nutrition and physical activity; tobacco smoking; high blood pressure and cholesterol; and cancer screening, specifically breast and cervical screening. During the trial 400 participants in each of those groups were offered brief interventions. The trial was undertaken using existing resources and is currently being evaluated by the Queensland University of Technology. Preliminary data from the Health Contact Centre indicates that just under 1,500 clients were recruited through this opportunistic intervention, with 30 per cent of these offered weight, physical activity and nutrition intervention. A total of 1,051 people accepted the intervention, information or follow-up offered.

CHAIR: Thank you very much, Dr Kingswell. Thank you for your submission. Are you happy to provide a copy of your introductory statement, because you have figures in there in addition to what we have which would be really beneficial for the committee?

Dr Kingswell: I have provided a copy to the Hansard reporter.

CHAIR: Thank you very much. That will be very beneficial. In the public submissions that we have received—and I am aware that you have not had an opportunity to look at those—I noted a number of comments were quite supportive of the COACH telephone service. Was there an empirical base for that program? How did that come about?

Ms Chalmers: Yes is the straight answer to your question. The COACH program had a randomised control trial, and over the years since it has had a further randomised control trial as well as evaluation studies. The paper that Dr Kingswell referred to earlier that was published in the *Medical Journal of Australia* in February this year was a five-year review of the program that is delivered by the Health Contact Centre. It certainly identified that people participated in the program. The majority of people graduated. `Graduated' means that they achieved the desired levels for their risk factors. That is using pathology results as a way in which to verify that as well as a level of self-reporting. It showed there was no difference in patient outcomes for Indigenous or non-Indigenous people.

We deliver the program statewide. At the Health Contact Centre we also use videoconferencing as a way in which to engage other members of the family who have particular roles such as meal preparation or their partner to exercise with. But predominantly it is just as effective when it is a sole interaction with an individual on a regular basis in telephone conversation at a time and a day that suits them. We work extended hours on this program and also on Saturdays.

CHAIR: You spoke about that program being evaluated and some of its benefits and results. Have the other initiatives that are addressed and outlined in the submission from the department been evaluated and reviewed? If so, can you please outline what those evaluation criteria and findings were as to how successful they are and what changes they are making?

Ms Pulsford: Unlike the COACH program, which is based on people with a diagnosed disease, we are talking about people who are moving into the preventive or early stage. Whilst there are evaluations done of the programs, there is not the same ability to do randomised or controlled trials. Honestly, a lot of it is data in terms of the number of people who commence a program, the number of people who complete the program and what the weight loss is. I can provide you—not off the top of my head—with the average weight loss of people who have undergone the full program Get Healthy. There is an average number of kilos lost by the participants et cetera. We do evaluations of our programs usually at the end of a three- or four-year funding period. Certainly that is the case with the Get Healthy program. It is a national program that is run in almost all states.

CHAIR: These programs, in my opinion, are very important, but it is so important that we know what is working and what is not working so that government funds are targeted to where we can get the best outcome in the community. That is more what I was looking at and any information

you had in regard to how programs have been assessed and the effectiveness of them. If that could be taken on notice and provided to the committee, that would be wonderful.

Dr Kingswell: In the notes that we have provided to Hansard, there are some examples of tracking research that we have done around these programs. With our health and fitness age challenge, for example, in the tracking research 48 per cent of participants reported they have started exercising more and are eating more fruit and vegetables, 39 per cent reported they have started to drink less alcohol and 35 per cent reported they have started to drink fewer sugary drinks. These programs are followed up with evaluation but perhaps not the rigour that has been applied to the COACH program.

Ms Chalmers: If I can add to that, there is a level of criteria that, if applied over a range of programs, will provide the analysis that you are looking for. But it is quite challenging because the programs are designed to range from the mass population right the way through to those who have a diagnosed chronic condition. One size does not fit all in terms of that range. Some of those elements that are set under the criteria can vary, but generally to get a level of assessment, as Kay was talking about, the recruitment and selection of participants is really important to the evaluation, as is the number, the length and the frequency of calls to participants, particularly the telephone based ones. COACH can be used in conjunction with other modes of self-management—how much the GP is involved in the ongoing care and interventions—and the overall numbers of participants in a program to provide the outcome that is sought, for example reducing obesity, improved wellbeing and/or change in health service utilisation. The outcome that is being achieved by this program will depend on the number of participants that you need to achieve that on a mass population scale.

CHAIR: We can always learn from successful programs and what people are doing in other states. You have mentioned that some of these programs are national. Is the department able to provide information—I appreciate that this is something you would need to take on notice—on what other states are doing in this regard and perhaps initiatives in this space which have been very successful? Is that something you could look at and provide to the committee?

Dr Kingswell: The short answer is yes.

Ms Pulsford: If we could liaise with Mr Hastie about the scope of all of that—

CHAIR: I would imagine the department within its holdings would have information about what is happening now. If the department could provide what it has now, that would be beneficial. Before handing over to the member for Mudgeeraba, I have one last question. With regard to the evidence—and you have spoken to this already a little—do we have a sense of whether some of these programs effect long-term behavioural change? I am interested in changing behaviours. You mentioned earlier that people were eating more fruit and drinking fewer sugary drinks. Do we have a sense of how long that improved behaviour lasts?

Ms Pulsford: There is certainly evidence, for example around Go for 2&5, when that campaign was run previously. We were able to track the increasing purchase. This is the thing with all of these programs, and I am just being totally honest here: it was the increased purchase of fruit and vegetable. That is not consumption, but it did show that in the six months after the program ended there was continued elevation of purchase of fruit and vegetables. As you know, obesity is affected by such a multiplicity of elements: planning, food supply, whether it is the easy option, access—all of those sorts of things. Whilst you might start on a trajectory around coaching and so forth, yes, we can track. I think they track them six months after they finish the program. There are no longitudinal studies that I am aware of that show what you are asking me, which is, does it make a permanent change?

CHAIR: Thank you. Member for Mudgeeraba?

Ms BATES: Thank you, Madam Chair. My question is a follow-on from the last one. I appreciate that you have not seen the submissions that we have today, but there is a submission from the Australian Health Promotion Association that states—

> Current evaluation and review of the effectiveness of telephone and web-based interventions does not demonstrate long-term behaviour change. Consideration should be given for further follow-up of participants ... through a longitudinal cohort study to ensure sustained behaviour change beyond the life of the intervention before a further significant financial investment is made.

You mentioned before that there have not been any randomised control trials. Can you comment on how a government can then ascertain the cost-benefit ratio for these programs?

Dr Kingswell: I am not sure that many of these programs would really lend themselves to a randomised control trial in that the participant cannot be blinded to their involvement in it.

Ms BATES: Sure, but longitudinal studies?

Dr Kingswell: The longitudinal studies certainly would be the gold standard for determining whether these worked, whether you did have long-term behavioural change and, obviously, changes in health indicators as a result of that.

Ms BATES: Can you think of any barriers to successful telephone or web based personal health promotion interventions? Are there any that you have come across in implementing these programs that you have not been able to jump over?

Dr Kingswell: There are practical barriers in Queensland, given the size of our state and the spread of our population. I know there is a particular program that was targeted at the Indigenous community, the Hitnet program, which Queensland Health invested in in the early days, in about 2003, to put kiosks in prisons, health clinics and some schools that had specific content on, really, everything from personal injury through to sexual health, mental health and so on. It specifically targeted young Indigenous people. Of course, getting them into those communities and—they are computers, if you like, fixed to the floor in clinics and prisons and so needed the bandwidth for them to operate effectively. There are those sorts of barriers—getting to people.

Ms BATES: It was actually mentioned, again, in the Australian Health Promotion Association submission about equity issues such as computer literacy, bandwidth, access—those sorts of things.

Dr Kingswell: The Hitnet program was actually interesting in that it was particularly targeted at people with low literacy levels and poor computer literacy as well. It was quite an interesting program. It is no longer funded by Queensland Health. It now runs as an independent social enterprise and it receives a bit of government funding, but it also gets its funding through leasing arrangements with the actual services in which it exists.

Ms BATES: Do these programs piggyback off the telemedicine capabilities that have since been funded across the state? Are they utilised at all?

Ms Chalmers: As I mentioned earlier, particularly for the COACH program we have combined telephone with videoconferencing to be able to do that. In terms of the barriers that you were talking about, without doubt some of that more face-to-face presence but via technology would overcome and create the rapport that is often needed to engage people in the process of change. However, that kind of technology is not commonplace in most homes. To help coordinate somebody to get to somewhere, it then starts to move into the challenges of transport and cost and those sorts of things.

The other one is often, particularly for targeted populations such as those from a non-English speaking background, being able to have that conversation style happening without a third interpreter. Having a workforce that has the health knowledge and the counselling skills as well as the language skills and those sorts of things can often be a challenge and a barrier.

The other barrier that we see in our environment is often the health literacy of an individual. That then starts to move into their readiness for change, so there is a longer educational component before you can really then sometimes assess somebody's readiness for change and then plan with them for that change and motivate them through it. Sometimes it is a bit of a longer start process.

Ms BATES: Thank you.

Mr KELLY: Thank you very much for your presentations. For me, reading through the submissions, what was interesting to note was that there is already quite a significant amount of work being done in this manner provided by government organisations, non-government organisations and the private sector. Is there, in your views, a role or a need for Queensland Health to start to map and coordinate the services being provided out there to ensure we are not actually duplicating and to ensure there are not areas of unmet need across-the-board?

Dr Kingswell: Again, I think the short answer is yes, that Queensland Health has a responsibility to ensure it is not duplicating a program provided by the Commonwealth, the non-government sector or the private sector. However, Queensland Health cannot control the behaviour of private organisations, the non-government sector or the Commonwealth, for that matter. Yes, we would strive to get a system that does not duplicate and replicate services.

Mr KELLY: I guess with that landscape now, where we have many non-government organisations pursuing the use of these technologies to deal with the issues they are trying to deal with and private providers obviously spotting opportunities to provide a service at a profit, is there any view around the need to start to, I guess, regulate what can be delivered and by whom it can be

delivered; ensure there is consumer protection; ensure that when I suddenly find myself with something presented to me on Facebook or Twitter as a health promotion activity it is in fact a health promotion activity and not the latest fad that somebody has set up with a website and is marketing at a cost but which will not do me any good and in fact, in some cases, may do me some harm?

Dr Kingswell: I would be inclined to think that is a responsibility of the Office of the Health Ombudsman, given that the Health Ombudsman has carriage over any activity that can be construed as a health service. I am not sure that it is a role for the department to comment on, but I am happy to take some advice from our legal department.

Mr KELLY: One final question: are the programs that are delivered by Queensland Health overseen and delivered by the health professionals or are they programs that can be delivered by trained staff that are not necessarily from a health professional background?

Ms Chalmers: It is a variety in terms of the response. With a lot of the programs that we deliver and elsewhere in Queensland Health, it is a multiskilled workforce, often delivered by nurses and/or counsellors, particularly for looking at early intervention and preventive health. A lot of it is about that whole behaviour change process, so cognitive behaviour therapy and those sorts of things. Certainly, a lot of the programs that we deliver through the Health Contact Centre are with a counsellor workforce, but for different opportunistic information provision opportunities certainly we have found it just as successful with a non-clinical workforce.

Mr DICKSON: First of all, I welcome you all to the meeting today. I really appreciate your time. On the face of it, I think this web based technology and telephone technology sounds absolutely fantastic. The couple of questions that I have for you relate to interdepartmental working relationships such as with Education and Sport. I used to be the minister for national parks, recreation, sports and racing. My director-general, John Glaister, was actually working with the health department and also with Education to further fight obesity, to use that as an example, because it leads to diabetes and other health problems such as heart disease. That is where I think there is a great opportunity, as those other departments already have a web base that can touch into a lot of people's lives.

I think intervention has to be targeted at young people. We have made mistakes. We are a little bit older and we are destined to end up in the ground a hell of a lot quicker than are our children, so we should be targeting those young people and going after them with the database that you already have, such as with our Get in the Game policy, where you could target individual children to assist them with this type of program. It is going to get down to the cost of food and the cost of the preparation, and it needs your ideas and suggestions to be put forward to those families as to how they do that. I know that you are going to get the best dollar value that you can possibly can, but how do we get to more people more often and get them on board with your program? While all this is just a suggestion and I think what you are doing is absolutely outstanding, it has the potential to do great things if you work interdepartmentally, united together. Are you looking to go down that path or not?

Ms Chalmers: In response, we have a few examples. Earlier we mentioned an initiative that we have started upselling prevention, which was an opportunistic engagement with individuals who had originally called for a particular health issue. We then engaged in a discussion around physical activity, nutrition and those sorts of things. That often resulted in providing individuals also with links to information about parks, walking paths, dog facilities and those sorts of things within the person's local area. We were not providing them with a mass site but trying to target them to their population. I think we do do it, yes, in a more coordinated fashion and perhaps being able to link a great deal of the information resources together to give a package to an individual and personalise it. It seems to be the strong evidence that you need to hear the individual, hear their circumstances and tailor it to their requirements, and that is what maintains the motivation and also starts that whole change-of-behaviour process. To make it generic loses the essence for the individual.

Mr DICKSON: You have said that you advise people about better food and healthier lifestyle. Are you finding that there is a big take-up, or is it cost prohibitive for people to buy healthier food, to join a sporting club or to become involved with health initiatives? Is that prohibitive for people? Is there any feedback in that area?

Ms Pulsford: The answer is mixed. What we are finding, for example, in the physical activity arena and in the Chief Health Officer's report, which is published every two years, where we do significant surveying of the population in terms of, for example, participation in physical activity, is

that there has been an increase in the proportion of the population in Queensland undertaking physical activity and that the gap between high socioeconomic and low socioeconomic around physical activity is closing slightly. Some of you were present this morning listening to the Heart Foundation representatives speak. Not everything has to be an organised activity, but you would know through some of the consultation that was done last year that there was some evidence that people absolutely want to adopt healthy lifestyles and that in some cases they do find it cost prohibitive.

To go to the member's question earlier about duplication of activities, the role of government is to provide activities which are at a cost that can be accessed by people who cannot perhaps afford other options. Weight Watchers, for example, has a very high membership and offers a certain product. It is offered at a very definite cost. Therefore, online recipes and online access to apps can perhaps balance that, provided people have computer literacy and the interest in pursuing that.

To answer your earlier question, if I might, about evidence across agency interaction, not necessarily in the area of personal health interventions or health promotions but, as I know you appreciate, personal promotion interventions, on their own they are not sufficient for population change. So there is a whole range of other activities that the department pursues with agencies—for example the education department, where we work with them around their guide to tuckshops around red, green and amber foods. I do not want to stray too far off your question. But we have also done work with the Department of Justice and Attorney-General in terms of workplace initiatives. People, as they said this morning, spend an awful lot of time in the workplace. So outside of the personal health promotion topic that you are looking at, there is a very broad range of activity that the government, together with other government agencies, is pursuing. It just does not fall into the focus of your inquiry.

Mr DICKSON: Thank you very much for your time. If you can take that on board, please do not ever become a silo. Work unilaterally because you will get so much more bang for your buck. I appreciate your time today.

Mr HARPER: Thank you very much for your time today. You mentioned Headspace and the 80 centres across the state. I am wondering if there is more scope for health promotion in that area. What good data exists? Is there good take-up there, particularly in the rural and regional areas? Can you comment on that?

Dr Kingswell: Headspace, I think you would be aware, is a federal program. Our department is not directly responsible for that. We do participate as co-provider, if you like, in most of the regions where Headspace exists.

Mr HARPER: Do you have any other interactions with that particular agency?

Dr Kingswell: We have interactions with Headspace nationally in that the state certainly has a view and an opportunity to help design what they provide. For instance, they have recently done an early psychosis expansion on the Gold Coast that reaches up into Logan and they certainly invited us into the tent to help identify the priority regions for that service for Queensland. Where the Headspace centres exist, there is a requirement that the Queensland public sector partners with them in that Headspace needs referral pathways for children that they identify as needing mental health care. So those sorts of cooperative relationships exist. But beyond that we do not control much of the activity within that organisation.

Mr HARPER: Some of the data I read identified not-so-successful health promotion areas in the rural and Indigenous areas and remote areas. Is there any way you think the department can better promote in those particular areas? I know that we are using web based programs and telehealth, but there does not seem to be good take-up or good data in those particular areas.

Ms Chalmers: I agree with you in terms of particularly nutrition, weight loss, physical activity and that sort of thing. In another domain of health prevention, around smoking cessation, we have had very good success in having identified counsellors who are really able to engage with clients around cultural aspects as well as language and those sorts of things. Perhaps if we learn from one kind of prevention program and want to shift that into others, I suspect that would be more of a success factor to the programs. But certainly evidence would say that technology is not so much the issue because the communities and individuals utilise that just as much anywhere across Queensland.

Mr HARPER: Finally, in the future, in what areas do you believe telephone or web based personal health promotion interventions will be used?

Dr Kingswell: I think this possibly cuts across your question, Ms Bates, about access and barriers to access. There was a 2014 Nielsen report that identified 69 per cent of Australians searching for health or medical related content in the past 12 months and 14 per cent searching weekly or more. When you got down to the younger age groups, it was 21 per cent of 16- to 24-year-olds and 25 per cent of 25- to 34-year-olds searching weekly or more often and they gather information about medically diagnosed disease or illness, they find more about alternative treatments, they get a second opinion, they seek support from other internet users or they find relevant patient support groups. Everyone has a smart phone—not everyone. But that is coming, so I think this has huge application.

Dr ROWAN: Thanks very much for the presentation this morning. My first question is about how the cost-effectiveness is being measured and quantified by the department in relation to these innovative technologies. Is that being publicly reported?

Dr Kingswell: Certainly the funding around the COACH program was publicly reported and the cost per intervention and the benefit that that provided was publicly reported.

Ms Chalmers: More broadly, in terms of the telephone program which comes under 13HEALTH, we have participated in benchmarking exercises which particularly do look at cost. It was not a final published report. Other participants needed to give agreement for that. There are evaluation studies which do include quite often a cost element. To be able to do the comparison, though, of apple to apple it does become very difficult because often they do not include the same elements to it. So it is often not just costs but really patient outcome. The evidence so far has shown often the higher need for the level of complexity of client and also the outcome that needs to be achieved for them. The scale is also increased in cost in terms of much greater participation with them, utilising more than just one channel of delivery, multiple channel—those sorts of things.

Dr ROWAN: I guess that was my specific question. If you have a particular community that is already costing a certain amount of money that the department is already investing into by providing a particular service—there are obviously clinical outcomes or patient outcomes that are being tracked—then these technologies are being brought in on top of that to augment what is currently existing and it is about how you quantify the material change from a cost perspective of adding that additional layer of support to those communities. So is that being tracked in any way and is that being published?

Dr Kingswell: We could take that on notice.

Ms Chalmers: Yes, I think we could probably take that on notice. Quite often the telephone based support programs are an alternative for people as opposed to a face-to-face delivery program. Can I just clarify as to whether that is the context you were meaning?

Dr ROWAN: It is really both in the sense that it is either/or. So either it is being added in and augmenting what is currently existing—so it is actually a value add to the current service which may be in operation in terms of actually rolling out some web based or telephone assistance to what has already been provided—or the alternative to that is that it replaces face-to-face programs or what was existing. So are there any measurements that are taking place in relation to the costs from that perspective and whether it is truly cost effective? And if it is truly cost effective then is that being reported back and being published in a public way?

Ms Chalmers: The upselling prevention initiative that we started earlier this year truly is an example of opportunistic interaction. The cost actually sat with the individual who made a call in the first place to inquire about something. It has had no dedicated budget or funding for it. The cost of the QUT evaluation is probably the greatest portion so far in delivering that. It will be interesting to see what level of follow-up and pathway we have started with the individuals in terms of changing their lifestyle patterns and routines.

Dr ROWAN: My second question is around coordinated service planning and mapping, which was alluded to before. My specific question is around the role of general practitioners and the primary health networks and what is happening in relation to engagement there to avoid duplication in relation to what is occurring from the primary health network's perspective.

Ms Pulsford: The Preventive Health Unit had a close relationship with all of the networks as they stood and we are starting to re-engage with the newly appointed networks. They are amongst our stakeholder group and we are looking to implement programs. They are often consulted around the role that GPs could play in referrals to programs et cetera. They are a key stakeholder group. We do work with them. We will work with the newly appointed networks. I think there is a much greater role that could be played.

CHAIR: I will come back to members who might have additional questions. I call the member for Greenslopes.

Mr KELLY: The Quitline program has clearly been an addition to a whole range of strategies to try to reduce smoking and has obviously contributed to the overall success we have had in getting smoking rights in a very positive direction. Are you aware of a similar approach that might be undertaken by Queensland Health or is being undertaken anywhere else in relation to using that type of approach for other substance abuse problems—alcohol or other drugs? Do you think it would be of value to try to take that approach in the management of those particular substance abuse problems?

Dr Kingswell: Certainly there is an online program that we funded as a result of the previous government's Safe Night Out Strategy. The acronym is DAAR. I cannot right at this minute tell you what that stands for, but it is an online counselling initiative. So if you commit one of eight prescribed offences while intoxicated, there is the option to refer you into this program that is underway. There was previously, and still is, the diversion that occurs through the courts for minor drug related charges, and there is face to face in ED departments the DABIT program.

Ms Chalmers: The Health Contact Centre delivers the Quitline service for Queensland. Our experience is that we often find individuals have a smoking habit as well as alcohol or other drug issues. It immediately becomes a lot more complex in terms of looking at the concept of self-management over the telephone. There is a limit to what can happen over the phone or via the web when you have a complex environment of addiction and often mental health issues as well. Sometimes some of the clients that we have are nearly developing respiratory difficulties and pulmonary issues. There is a limit and a point at which to further deliver services via the telephone really will not achieve the desired outcome. Knowing when that point is reached is not a standard formula. But often when there starts to be three or four comorbidities or complexities et cetera, you want to start looking at other means.

Mr KELLY: One of the points you made very early in your introduction was about partnerships. Are there any partnerships that Queensland Health is currently considering, either from a private sector provider or a non-government provider? Are there partnerships that you are looking to implement over the short to medium term?

Ms Pulsford: In terms of health promotion, apart from the 13HEALTH and the Healthier. Happier. campaign, the department delivers all of its other programs in partnership with other entities. Apart from those two that I have stated, we do not deliver programs ourselves. They are all through the engagement with other entities.

Mr KELLY: Thank you.

Ms BATES: As a former member of the Health and Community Services Committee I was involved in an inquiry into telehealth services in Queensland. I think this is probably the third inquiry that I have been involved in since I have been in parliament on this exact same issue. It did outline a number of successful telehealth services. It also identified a substantial underutilisation of existing telehealth equipment across the Queensland public health system. In particular, I remember a lot of the issues surrounded appropriate staffing for telehealth interventions—to have the right staff there, the same staff, so that people felt comfortable working with individual health practitioners; scheduling issues around having a room available somewhere in the hospital on a regular basis. Also, there was the reluctance of certain medical fields to utilise telemedicine and the complaints from the health professionals, particularly the doctors, was that there were no real clinical pathways that were appropriate to particular fields to encourage them to use it.

I know that, following on from that inquiry, the recommendation to the Minister for Health was to increase funding to telemedicine. I know that then Minister Springborg did commit another $30.9 million particularly for telehealth for rural and Indigenous areas. I know that the former Labor government invested some $30 million in rolling out hardware. Having been on many tours around Queensland hospitals, I noticed back then that a lot of the telemedicine machines were covered with black plastic and dust and were not being used. That is why we did the initial inquiry into telemedicine. So I am asking: since that injection of funding back in 2013, have you seen any improvement or uptake in the usage? On top of that, can you give me an example of what you would see as a successful health intervention by utilising the existing framework that we have now?

Dr Kingswell: I can certainly give you one example. I think the information that you want is quite detailed. We could take that question on notice and come back to you, because there has been an enormous investment and an enormous amount of activity in this space over recent years.

Ms BATES: Sure.

Dr Kingswell: Possibly one of the examples that you might be interested in—and a concrete example—is a virtual stroke clinic. People might be aware that somebody who presents to a major hospital having had a stroke has about a three-hour opportunity or window to have thrombolysis supplied in order to prevent significant disability. That sort of intervention has only been restricted to those stroke clinics where they exist. That can now be addressed through virtual stroke clinics through telemedicine intervention. I understand that is happening, but we are happy to get you some details on the extent and the increase in activity in that space.

Ms BATES: That would be great. I also went with the committee to Thursday Island and witnessed telemedicine firsthand with a lot of those remote islands. They certainly had the system down pat. They had worked out that they needed to have a particular room available and the same nurse so that the patients were quite comfortable dealing with the same professional each time and they had slotted in times so that the doctors were not turning up and the system was down or there were no patients waiting. So it would be great if you could give the committee some examples, because we did the review into it and the funding was allocated but since then we have not really had any feedback about what that injection of funds did—where the money went, how it was being utilised and if there is anything that we need to further investigate as a committee in that respect.

Dr Kingswell: We will come back to you with a detailed response to that.

Ms BATES: Thank you.

Dr ROWAN: Did the failed payroll system have any impact on the rollout of these technologies?

Dr Kingswell: I would have to take that on question on notice. I have no idea, I am sorry.

CHAIR: I have just one final follow-up question. I know that the health issues that we are talking about are multifaceted. Certainly, Ms Pulsford, you have gone to that. We are talking about a wide range of issues that these programs are trying to target. I just wondered from the point of view of the department—you are unable to be all things for all people—in just targeting some of these health measures, health promotions and the interventions: is the department clear on what it is trying to address and it is targeting? Is there a clear strategy in mind about where you are putting your resources, money and efforts in that regard?

Dr Kingswell: Do we know where the risks are in the community?

CHAIR: No. Is there a clear strategy within the department about what programs and what issues in the community we are going to target? Obviously, there is a wide range of programs. Clearly, you want to target smoking and that is why you have that service. I just wondered if there is a strategy internally about these health promotion initiatives.

Ms Pulsford: Yes, there certainly is. There is a health and wellbeing strategy that is developed. It is multi-intervention, as we have talked about. So it is the combination of policy and legislation, sector development, social marketing, personal skills development—which is where you are looking—risk assessment, early intervention and counselling and health surveillance research. The personal skills intervention, which is where you are looking, technologies are usually population based. So the COACH program and those sorts of things are broad population based. Some of the other personal skills development might be targeting, for example, a culturally diverse group. But then you might look to move that from a personal skills development program into a sector program. In other words, you begin to teach culturally appropriate language, tools, resources et cetera to the broader sectors so that they can better deal with those people. So, yes, we most certainly do.

CHAIR: Thank you.

Ms Pulsford: And we look at it. Not only that, there is the range of interventions but then there is also `are you looking at the individual and family?' and then, as I described outside of that, we look to workplaces and we look to community. Then we look to the engagement of other sectors. So there most definitely is.

CHAIR: Thank you. Are there any other comments? I think the committee has asked all the questions that they wanted to. Dr Kingswell, are there any other comments that you would like to make that you feel you did not get time to make in your opening statement? Or Ms Chalmers or Ms Pulsford?

Dr Kingswell: I think you have covered, through your questions, what we intended to present to the committee. Thank you.

CHAIR: Okay. Ladies and gentlemen, that concludes our briefing. I again thank our witnesses for coming before us this morning: Dr Kingswell, Ms Pulsford and Ms Chalmers. Thank you for the time and effort that you have contributed to this hearing this morning. I also thank the

committee secretariat and Hansard for being here today, my fellow committee members and, of course, the observers. A transcript of the proceedings will be available on the committee's parliamentary web page as soon as practicable. The secretary will be in touch with you about the timing of responses to the one or two things you took on notice. Otherwise, I declare this briefing closed. Thank you.

Committee adjourned at 12.39 pm