EDUCATION, EMPLOYMENT AND SMALL BUSINESS COMMITTEE

Members present:

Ms LM Linard MP (Chair)
Mr N Dametto MP
Mr MP Healy MP
Mr BM Saunders MP
Mrs JA Stuckey MP
Mrs SM Wilson MP

Staff present:

Ms S Cawcutt (Committee Secretary)
Ms M Coorey (Assistant Committee Secretary)

PUBLIC HEARING—INQUIRY INTO THE HEALTH AND WELLBEING QUEENSLAND BILL

TRANSCRIPT OF PROCEEDINGS

MONDAY, 1 APRIL 2019

Brisbane

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The committee met at 10.07 am.

CHAIR: I now declare open this public hearing for the Education, Employment and Small Business Committee inquiry into the Health and Wellbeing Queensland Bill 2019. I would like to acknowledge the traditional owners of the land on which we meet this morning and pay my respects to elders past, present and emerging. My name is Leanne Linard. I am the chair of the committee and the member for Nudgee. The other members here today are: Mrs Jann Stuckey, the member for Currumbin and deputy chair; Mr Bruce Saunders, the member for Maryborough; Mrs Simone Wilson, the member for Pumicestone; Mr Michael Healy, the member for Cairns; and Mr Nick Dametto, the member for Hinchinbrook.

The committee's proceedings are proceedings of the Queensland parliament and are subject to the standing rules and orders of the parliament. The proceedings are being recorded by Hansard and broadcast live on the parliament's website. The purpose of this public hearing is to hear evidence from stakeholders who made submissions as part of the inquiry into the Health and Wellbeing Queensland Bill 2019. The bill was referred to the committee on 28 February this year. The committee will examine the policies the bill gives effect to and the application of fundamental legislative principles set out in the Legislative Standards Act 1992. The committee must report to parliament by 18 April 2019. The program for today's hearing has been published on the committee's web page, and there are printed copies available from the committee staff.

WHITEMAN, Professor David AM, QIMR Berghofer Medical Research Institute

CHAIR: Thank you for your submission and thank you for coming along today. I know that you have made previous submissions with regard to this area which I know will bring great value to the committee. I invite you to make an opening statement.

Prof. Whiteman: I too would like to acknowledge the traditional owners of the land on which we meet and pay my respects to their elders past, present and emerging. I would like to thank the committee for the opportunity to present to the committee on behalf of the QIMR Berghofer Medical Research Institute.

This review comes at a very telling time. Life expectancy in Australia has increased over the past century. We enjoy the fruits of good health care and research into what prolongs life span, but we acknowledge that those benefits have not been distributed equally to all members of the population. I guess this is the objective of the committee that is meeting today. We know that the main threats to health and wellbeing in terms of the health system are the chronic diseases which account for a great deal of suffering, morbidity and mortality across the population.

We at QIMR Berghofer strongly support the establishment of the Health and Wellbeing Queensland statutory agency, particularly the efforts of that agency to reduce population exposure to risk factors that cause disease and to improve the health of Queenslanders. You will see from our submission that we have made a number of recommendations regarding the operations and objectives of that commission, but we strongly support the establishment of this statutory agency.

We particularly want to make recommendations around how the commission will work. We acknowledge that we know a great deal about exposures in the population that lead to poor health, but we do not know all of them and we do not measure all of them routinely. Our biggest challenge in the health field is knowing the difference between what works in theory and what works in practice, so the area of implementation science. In my own field we know that the sun causes skin cancer, but how we get the population to change their behaviours so they take the advice of reducing their exposure to the sun is an ongoing challenge. Until we have evidence to show what works and what does not work, our messages are not as effective as they might otherwise be.

We also would hope that the statutory agency is able to work with the expertise that resides in Queensland. Queensland is home to a great many excellent and outstanding institutions that conduct world-class health research, and many of those are in the room today. We would hope that the agency as a priority works with those existing networks that are out there.

We note that the agency will have the ability to distribute grant funding to promote research and for research to be done, so in our submission we have asked that the process of distributing grant funding be open, transparent and competitive to ensure that the money is invested in the most effective way possible.

We support the bill's focus on monitoring and evaluating the outcomes of the commission. We would hope that that is done in a way that reflects the long time lines that are involved in changing population exposure for chronic diseases, so ensuring that evaluation and monitoring is fit for the purpose of the agency.

In relation to the composition of the board, we strongly support the notion that there be four CEOs of government departments on it. That will promote interagency and interdisciplinary collaboration. We would also recommend that one of the board members have experience in research or public health, and we would strongly encourage consumer representation on that board.

We note that there are provisions in the bill for the agency to have a philanthropic foundation attached to it as part of its funding mechanism, and we would just note a word of caution there. We would like to think that this agency has the full support of government and that its activities are supported by government. We note that the activities associated with raising funds can consume energy and resources within an organisation, so there is a note of caution on that.

We want to make sure that the agency is given time to achieve its goals. We note that the bill contains provisions for monitoring the performance of the agency over time. We know that these sorts of agencies take time to really deliver health changes, so being mindful of how that evaluation will work is something that we would counsel. I would be very happy to take any questions that you may have.

CHAIR: Thank you for that summary of your submission. In your conclusion you make the point that the commission should identify gaps in the evidence. Do you or QIMR Berghofer have any particular views with regard to where those gaps are?

Prof. Whiteman: Not specifically, no. We all have our own personal areas of health research where we would prioritise certain things, but I think really the space of implementation science. We do know a lot about the aetiology and the causes of chronic diseases and we know a lot in theory about how those factors cause disease, but the complicated step of taking things out of the laboratory or out of academic studies and applying them to a population so that you can change the population's physical activity levels, reduce their obesity levels, change their diet or improve their use of sun protective measures is very difficult to do because the evidence base is quite thin as to what works in practice in Queensland.

A lot of the research literature is done in other settings, but those other settings do not have the same health systems we do; they do not have the same health literacy that we do; they do not have the same primary care networks that we do in Australia. It is very setting specific, so it is not always the case that you can take a finding off the shelf, even from other parts of Australia, and apply it in Queensland and expect the same size of effect. For me and for our institute it is that implementation side, of taking the research and applying it in practice, where the big gap is.

CHAIR: That segues beautifully into my next question around your comment in regard to implementation science. When you refer to implementation science, are you essentially referring to issues that are being raised—if my recollection is correct, it was raised in the last inquiry by QUT quite strongly in regard to social marketing and behaviour change. They were raising the point that, yes, we understand what is happening and we understand what effect it is having, but we do not necessarily invest enough into these other mechanisms to actually change that behaviour, and of course one size does not fit all. Is that what you are referring to when you talk about implementation science?

Prof. Whiteman: It is along those lines. One specific example would be: how can we use the modern technologies or the emerging technologies better to change the way people behave? I guess I am talking about the evidence base that underpins the activities of an agency like this. In clinical medicine we do clinical trials to say, 'This drug will change your blood pressure on average by 10 millimoles.' The equivalent kind of work in public health is to say, 'We've done a trial on 10,000 people. Presenting information in this way by these qualified people will change the BMI of that population over two years by one or two units.' It is about doing proper trials to say, 'We've measured the intervention, we've measured how well it is delivered in that population and we can see the effect in a period of time.' Knowing the effectiveness of those interventions is what implementation science is about. It is actually the hard research work of quantifying the changes in response to an intervention.

CHAIR: I should not infer that this is what you mean, but sometimes there are so many options and great ideas that people bring forward. Is your view that sometimes they are short-lived and we are not measuring their outcomes before we move to something else and it is more piecemeal? Is that essentially your view sometimes?

Prof. Whiteman: Yes, or I guess taking it back one step would be to say that often the evidence is based on observations that are not rigorously scientific. They would be almost akin to an anecdote. We do trials in public health, and I can give one example that was done in Queensland about 20 years ago. It was a sunscreen intervention trial randomising a town of people to receive or not receive sunscreen and apply it every day. It takes a long time. It took another 10 years to see the effects of that, but all the way through we could monitor the effect and use of sunscreen in one half but not in the other and could see lower rates of skin cancer by about 50 per cent in the arm that used sunscreen. We have always known or believed that sunscreen would work, but until you have done the trial you do not really know how sustainable that intervention is. Can you get people to wear the sunscreen? What about the people who do not wear sunscreen? What sort of cancers do you prevent and what sort do you have no effect on? We now know a lot more about how effective sunscreen is. Then you can model into the future to say, 'If we can shift the rest of the population by the same amount that we saw in that Nambour study, we could expect to reduce our expenditure on skin cancer excisions by X million dollars.' It is doing the trials—it is not the only issue that we face, but it is a very important one if we are making policy decisions. It is better to have good evidence than no evidence.

Mrs STUCKEY: You have made a number of recommendations in a very well documented submission and we have noticed that, overall, you do commend the objectives of this bill. However, you have mentioned a recommendation about a fixed percentage of the annual Health budget being allocated to these activities. Did you have any amount in mind when you wrote that?

Prof. Whiteman: That is a very challenging question.

Mrs STUCKEY: It is in your submission.

Prof. Whiteman: Yes. You will read different figures in the literature when people talk about these sorts of things. People would like to see one per cent of the Health budget spent on prevention activities. Even that is far in excess of what we currently spend on prevention. It seemed like a very modest ask. If I was being greedy on behalf of my constituency I would say that we should double that. It is really about the notion that we ascribe importance to prevention. Currently, it does not seem that it is visible in the health expenditure budget in the same way that treatment is. We spend all of our effort on treatment and diagnosis and a lot less on prevention. It was really just to start the conversation as to really thinking about this in a committed sense and commit to a long-term investment in prevention.

Mrs STUCKEY: Another recommendation was the establishment of a foundation. Could you briefly elaborate on how you see that working versus a charitable revenue?

Prof. Whiteman: It may be that the committee might have misread or we may have miscommunicated our advice there. We were being cautionary about the establishment of a foundation, saying that the philanthropic space is very crowded for a new entity to arise that is competing for funds in a fairly small market against long-term, existing players with recognised brands. It might take an awful lot of work on behalf of the commission to get visibility in that space. It could be an investment that may not bear fruit—at least for a long, long time. We were taking the view that, while the agency is being established, having the full support of government where it is fully funded to carry out its tasks, which is about changing the population and improving health—we would advocate that in the short to medium term that is a better use of the funds that would be directed towards it than trying to establish a new brand in a crowded marketplace of other philanthropic agencies. That is really not motivated by self-interest, even though we are in that space as well; it is just a very difficult space to work in. I think everyone in the room would say that it is getting harder and harder and we spend more money trying to bring in a little bit of money. It was really just to be cautionary about how realistic that might be.

Mrs STUCKEY: Another of your recommendations relates to reporting, acknowledging the fact that chronic disease can present after long latent periods of time and acknowledging that it will take time for HWQ to achieve this measurable change. How long do you envisage it will take and how do you think the outcomes can be measured in the short term?

Prof. Whiteman: In the short term I think the focus would have to be on process measures: how well has the commission implemented its action plans, what activities have taken place, be they educational or interventions in various settings. They are very much process measures. Our concern was that over many cycles of government people might look at this and say, 'Heart disease rates are still very high,' but having done the research we know that it takes sometimes decades for the primary prevention to bear fruit in terms of lower incidence of disease down the track. It is about building in performance measures that are relevant for the time scales that we are looking at. That is, in the short

term they have to be process measures. Is the agency delivering meaningful activities to the right populations in those time frames? The long-term benefits in terms of disease prevention will take a long time to be seen. If that would be the judgement in the early phase, I would say we will see no benefit of this commission in the short term, given the long lead time of many of these chronic disease interventions.

Mrs STUCKEY: There are some target goals to reach. I know that we could have that conversation all day, and there are other members waiting to ask questions.

Prof. Whiteman: In the short term you might want to see that there is an increase of five per cent per year of Queenslanders who are following the healthy eating guidelines or performing physical activity at a level that is sufficient to reduce cardiovascular disease. Those are good activity measures to have in the medium and short term, but how that plays out against a declining incidence of heart disease will take longer.

Mr HEALY: I like everything you say, love the organisation you work for and also appreciate what an impressive amount of evidence can do to your funding and your planning. Your submission was terrific. When you talk about the composition of the board, obviously we will have some ministers there, which will make it exciting and stimulating. You were talking about having the private sector involved. If you could extrapolate on that, it would be helpful.

Prof. Whiteman: I am not sure that we specifically mention the private sector; I think we were advocating more on behalf of having people with a research background or research training on the board to ensure there is oversight of the sorts of activities that are happening in that space. We also recommended that someone with public health experience be on the board to give it that perspective of how long these lead times can be. We strongly believe there ought to be consumer representation, which I think is covered in the bill but maybe it was not crystal clear to us. Having the consumers represented there is really important.

Mrs WILSON: You have made a number of recommendations within your submission. Have you had any meetings with the ministers or the department in regard to these recommendations that you have made?

Prof. Whiteman: I personally have not. Our director, Professor Frank Gannon, meets with the director-general periodically and occasionally with the minister as well, and these conversations have come up. It is not specifically with this agency in mind but more in the challenge of the burden of chronic disease and how we address that through research and prevention. Certainly in the broader scope of conversations it has come up.

Mrs WILSON: How hopeful are you that any of your recommendations will be included?

Prof. Whiteman: Having seen the submissions of the others in the room today as well, I would be very hopeful. It seems to me there is a great commonality of purpose in the public health community that there is support for this agency but a hope that the establishment of it is grounded in reality. It is not a big agency and it cannot fix everything, but if it is given the right guidance and the right environment then it can make a difference. My view is that I speak for many people when I say that it is supported, and we would like to see it evidence based and then allow it to do its work.

Mrs WILSON: Have you been disappointed with the delay in this bill, given we have been talking about this since 2015?

Prof. Whiteman: We recognise that processes take time. Of course, we would always like to see things done very quickly. I think it is really important to take the time to make sure that it is established correctly and sustainably and given the resources and the oversight it needs to succeed. In a perfect world it might happen quicker, but we live in the real world.

Mr DAMETTO: You were saying earlier that in relation to chronic diseases like skin cancer it can take a long time to see the effects of a treatment or a change in the way we do things. Can you please speak to the importance of a body or an agency like this having bipartisan support, from both sides of politics? We would hate to see something like this be set up and then at some stage another party sees that this is not something they want to support in terms of funding. Could you talk to us about how having that bipartisan support would ensure this agency achieves what it is trying to do in the long term?

Prof. Whiteman: I probably cannot speak specifically about bipartisan support. What I would say is that agencies like this do need to have a long life span. The work they do takes years to implement—just in general in similar organisations around the world. The programs they run and the interventions they offer take years to deliver and sometimes decades to manifest.

Mr DAMETTO: Literally generational?

Prof. Whiteman: Yes, it can be. We are talking about long time spans. Agencies like that do best when they are broadly supported by the community, broadly supported by the professional sectors that underpin them and supported by the parliament as well. I think these sorts of agencies typically enjoy that support because the work they do is valuable and people see the benefits. Yes, if you are talking about bipartisan support in the Queensland system, but I would hope that parliamentary support and community support would be necessary for this to have a long and productive life span.

CHAIR: Thank you very much for coming today. We appreciate it. All the best to QIMR. We thank you for the work that you do.

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

CHAIR: Thank you for coming today and thank you for the submission on behalf of the Public Health Association. I invite you to make a brief opening statement if you would like to add any comments to your submission and then we will open for questions.

Ms Del Fabbro: Thank you. I would also like to acknowledge the traditional owners of the land upon which we meet today and pay my respects to elders past, present and future. I am the president of the Queensland branch of the Public Health Association of Australia. The PHAA is recognised as the principal non-government organisation for public health in Australia, working to promote the health and wellbeing of all Australians. Our mission, as the leading peak body for public health, is to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population based practice in public health.

The PHAA congratulates the Queensland government on the expanded scope of the Health and Wellbeing Queensland Bill. We support the population-wide approach to addressing chronic disease and risk factors throughout the life course. We also appreciate the commitment to collaborate across sectors and the policy development role indicated by the bill.

I will now highlight a few points for further consideration. Firstly, the PHAA recommends using a health-in-all-policies approach to support effective intersectoral action. Intersectoral action for health has long underpinned health promotion in public health. The reason for this is that more can be achieved by organisations working together rather than working alone. In fact, without significant buy-in and commitment from sectors outside of health, the overall goals of the bill are unlikely to be obtained.

A health-in-all-policies approach is a whole-of-government approach that puts health on the agenda of policy developers in all sectors—from education to transportation, town planning, the environment and beyond. Health is produced in all settings. We become healthy by the characteristics of the settings that we live in, and a health-in-all-policies approach would enable health impacts to be monitored in these different settings and at different levels.

I will give you an example. The problem of overweight and obesity can be influenced by education policies, such as those guiding tuckshops in schools. It can also be influenced by main roads policies, including the walkability of our neighbourhoods. It can also be influenced by local government policies, such as the provisions for access to quality food in the context of mixed-use retail spaces in existing and greenfield suburban developments.

Secondly, as suggested by Professor Whiteman, embedded research with an overarching monitoring and evaluation framework will be key to understanding the impact of the bill. Furthermore, the role of the Health and Wellbeing Queensland agency in the development of policy and statewide frameworks will need to be made clear, especially given that many health promotion activities have been devolved to the regions and local governments - for example, water fluoridation.

Thirdly, the Public Health Association of Australia is particularly supportive of the focus of the bill on addressing inequities and social determinants of health. We think that including the community voice will be important to addressing those inequities.

Fourthly, effective public health and health promotion measures have prevented an extraordinary amount of ill health and death in our communities. This is outlined in this PHAA monograph on the top 10 public health successes in Australia which I will leave for you. Addressing complex problems such as obesity, nutrition, mental health and wellbeing and equity for Queensland's Aboriginal and Torres Strait Islander people will require really strong and sustained leadership, governance and a willingness to commit for the long term, as we have just heard - well beyond the state budget for 2019-20. I look forward to the next copy of this document that comes out and will hopefully include some initiatives from Health and Wellbeing Queensland.

I noted in the 27 March Queensland Health response to submissions that ongoing funding may draw on numerous sources. While we agree that an entrepreneurial approach to health is laudable, the PHAA does caution against the conflicts of interest that can arise with partnerships with industry and commercial partners when it comes to health.

To conclude, the PHAA appreciates the opportunity to contribute to this public hearing and to contribute to the health of Queenslanders. We look forward to partnering with Health and Wellbeing Queensland in this important area of policy and practice. We hope that the Queensland government commitment to health and wellbeing will be a long-term commitment.

CHAIR: We appreciate that. You mentioned that you wished to table something. Is leave granted to table that? Leave is granted.

Mrs STUCKEY: Thank you for your submission. I found it very interesting. I am married to a GP, who also finds this very interesting. He suggested we ask: of the many issues involved with suboptimal health and wellbeing, what does your organisation believe to be the No. 1 issue?

Ms Del Fabbro: The issue of obesity has really been central to the concern of this committee since the first iteration. That would be perhaps a logical place to start. Addressing the nutrition and physical activity of Queenslanders would be a good place to start. That will also lead to improvements in other areas.

Mrs STUCKEY: Thank you. That is exactly what he thought you would say. I will have to tell him that; he will be very happy. On the top of page 6 of your submission you mention the goal of increasing the number of Queenslanders with a healthy body weight by 10 per cent by 2026. Has this healthy body weight gone up or down over the years, as far as you can recall?

Ms Del Fabbro: I was reflecting on when I think Jeannette Young addressed that in the response to the public hearing, and she said that in some demographics it has gone up and in some it has stayed the same. If you look overall, there is a rise in BMI, body mass index.

Mrs STUCKEY: That is interesting, because I thought she was saying it is pretty much the same. I concur with you.

Ms Del Fabbro: There will be pockets of the population that have factors like socio-economic disadvantage that will be experiencing those health impacts more than others.

Mrs STUCKEY: I am just trying to get whether overall we have raised the BMI or lowered whatever, because we are all getting fatter as a nation. I guess that is what I was after. Finally, you did mention some projects that you felt could be used as innovative projects generated by the community partnerships that you have put in here. You have suggested a few of those already, but is there anything you would like to add—the type of innovative community partnership programs?

Ms Del Fabbro: I think the main thing we are interested in is making sure that that intersectorality is sustainable. Because of the long-term requirements of the goals that we are trying to address, maintaining that interest in all of the different sectors, maintaining their interest in achieving health goals, will be something that requires some work in innovation.

Mr SAUNDERS: Thank you for coming in today. I think you have been reading my correspondence because of your opening remarks about councils and town planning. One of my hobby horses is the placement of food outlets and supermarkets and aisles and things like that. It has to start there. Has your organisation had any work with the Local Government Association and councils to try to improve planning decisions?

Ms Del Fabbro: I could not say specifically. I am not aware of what specific relationships the PHAA has had with councils, but certainly we have made submissions in the past that have looked at the research around the location of food outlets to schools and within supermarkets.

Mr SAUNDERS: Is there any evidence to show that by doing the correct planning—like more walking paths, changing where our food outlets are and their proximity to schools and preschools and suburbs—there can be a change in people's health?

Ms Del Fabbro: I think there is evidence to support that the availability of healthy food will make it easier for people to make the decision to choose those healthier foods—providing a supportive environment for healthy choices.

Mr SAUNDERS: I particularly like getting to the children young in the schools, because I think that is the only approach we can take to continue. Thank you for your submission. It was good reading.

Mr DAMETTO: Thank you for coming along today and giving your evidence and your submission to the bill. Firstly, last week we got to enjoy catching up with Life Education. It was 40 years of operating in Australia and 38 years in Queensland.

Ms Del Fabbro: Is that Healthy Harold?

Mr DAMETTO: Yes, that is Healthy Harold, the giraffe. The work they are doing at that grassroots level to educate children is imperative for changing people's behaviour - changing not only their behaviour but also that of their parents. They can take that message home. When it comes to healthy eating, do you think the best way to address that at the supermarket or the grocery level is to increase the price of unhealthy food or to reduce the price of healthy food?

Ms Del Fabbro: I would probably have to take that on notice and take that to our nutrition special interest group. What I would say is that those kinds of interventions will require planning at all different levels and input from a lot of different people.

Mr DAMETTO: I am all for people still having choices in their diet. If someone wants to have a treat or they want to spoil themselves, they should not have to pay the exorbitant price of, say, a sugar tax that is put on something. That is what concerns me.

Ms Del Fabbro: There is evidence that placing a higher price on high-sugar foods and drinks does have an impact on the consumption of those items. There is evidence to support that.

Mrs WILSON: On pages 6 and 7 of your submission, under the heading 'Funds allocated to grants', you state—

The new bill does not provide an indication of the proportion of the overall budget that will be made up of grants paid in a financial year.

...

For transparency and accountability purposes for HWQ to demonstrate meeting its core functions, it would be preferable for the Bill to stipulate a minimum proportion of the funding to be committed to grants, and to other and existing prevention activities.

Can you elaborate on this? Do you have any figures in mind?

Ms Del Fabbro: Not necessarily a particular figure in mind, but what we are seeking is transparency about the allocation of those funds to new activities of the agency. We are mindful that there will be some transfer of activities from other preventative areas in Queensland Health, but I am reassured by the statements made on 27 March by Queensland Health addressing that particular concern. They did say that funds would also transfer with those prevention activities to the new Health and Wellbeing Queensland agency. I guess it would be nice to have a bit of transparency about that intention of the funds being spent.

Mrs WILSON: So you have no figure in mind that you would like to see whatsoever, or a percentage of the funds that you would like to see?

Ms Del Fabbro: I guess last time it was 55 per cent, in the last bill. The more the better.

CHAIR: Thank you for coming before the committee today. We thank you and the Public Health Association for the voice that you add to these important issues in our state.

BALDWIN, Ms Louise, Senior Research Fellow, Faculty of Health, Queensland University of Technology

YOUNG, Professor Ross, Executive Dean, Faculty of Health, Queensland University of Technology

CHAIR: Thank you for your submission and thank you for providing us with your expertise. Can I invite you to make a brief opening statement and then we will open for questions.

Prof. Young: I too would like to acknowledge the Turrbal and Jagera people, the traditional owners of the land on which we meet, and acknowledge elders past, present and emerging.

QUT welcomes the proposal by the Queensland government to establish an independent statutory authority focused on health promotion and the prevention of chronic disease and reducing inequity across Queensland communities. We also acknowledge that this is part of a broader body of work, including ministerial and Department of Health leadership and COAG, around obesity and things like Queensland Health's drinks forum, which are all part of the bigger picture. We see one of the greatest things about an agency is coordination of this activity in a more streamlined and well-articulated manner.

At QUT we also support building healthy communities throughout Queensland, in terms of both application of research evidence and building a workforce through our teaching and learning activities that help to deliver these outcomes. We welcome ongoing opportunities to collaborate with the government in building a healthier Queensland.

Importantly, this forms part of a global trend where we are shifting our focus away from established tertiary disease and beginning to look at emergent disease and how we can address this issue more comprehensively. We see similar commitments in the International Network of Health Promotion Foundations and the International Union for Health Promotion and Education. Importantly, the World Economic Forum talked about this in their last report as one of the top 7 most promising areas in increasing productivity and sustainability of the health system to predict and prevent ill health.

This is timely and indeed overdue, so we are glad to be here today to discuss this bill more comprehensively. We believe this is now urgent. We are glad to see that this has been tabled. It is particularly important to look at how we can look at the interface between chronic disease prevention and social inequity across Queensland communities.

As we heard earlier this morning, we have robust research that now helps to inform how we might progress down this path, but we need to do this in a coordinated and effective way. How we effectively deploy and implement these research findings is a crucial aim of this body, as is how we use what we already know much more effectively than we have to date.

Part of this is also about stratification of risk due to socio-economic status. That is a crucial part of this going forward. We need to look at an ecological perspective that exists beyond campaigns or individual elements. For example, if we are considering an issue like obesity, this view is much more than looking at campaigns. It also needs to consider obesogenic environments—which parts of our environment are stimulating overeating and obesity and looking at issues of affordability of food. We also see this as a crucial issue in rural and regional Queensland, where there are many costs that rural and regional people face that we also need to plug into our overall picture.

It needs to be a more sophisticated approach that makes the healthy choice the easy choice for Queenslanders wherever they live, work, play and learn. We know, too, that this is complex. It would be wrong of me to suggest that there are straightforward, linear answers to these problems. There are intersecting issues that we need to try to grapple with. Based on evidence, we see that this involves the environment, policy, the community, individual and collective action, personal skills, health literacy and reorienting the health and other systems towards prevention. One of our recent reports at QUT—a collaboration with the Wesley Medical Research institute—has clearly shown that adopting a healthy city approach and adapting that for rural and regional Queensland can have significant benefits for those communities.

In summary, we see that addressing the economic and social determinants of health requires a deep and abiding commitment. We are hoping that Health and Wellbeing Queensland will be part of this commitment. It is to collaborate both across and beyond government, to work more broadly to see how systems influence things such as income, housing, employment, transport and access to services. At QUT we believe we must commit to this in a collaborative manner, and Health and Wellbeing Queensland has a vital role to play to facilitate such collaboration beyond the health sector through community organisations, universities and other research institutions.

CHAIR: Thank you to QUT. Tertiary education institutes in Queensland have always made a significant contribution to the hearings and inquires we hold. I hope that continues for a long time. We appreciate access to your expertise, particularly during semester when I am sure it is in demand on campus. You just mentioned some research. Are we able to have access to that or a copy of that?

Prof. Young: Certainly. In fact, Louise Baldwin is one of the chief investigators in that research so I will hand over to Louise to give a response.

Ms Baldwin: Yes, sure. That is some work that we did particularly around Central Queensland. We are now expanding into North Queensland and more broadly across the south-west. It really looked at what are the chronic disease risk factors. They were very consistent across the regions and certainly consistent with other needs assessments across the state.

We really went to that next point and thought, 'How do we actually address this?' It was almost the case that we do not need to reinforce the problem anymore; we really need to know what works in regional areas, particularly knowing that we cannot necessarily pick up another program or initiative that has happened in other parts of Australia or globally. We can certainly take some learnings from that, but Queensland is such a unique state, geographically and with a diversity of communities and the way that they function.

We looked globally at what had worked elsewhere. The World Health Organization have a very strong program and set of recommendations around a healthy cities approach. They broaden that out to a healthy cities and towns and healthy communities approach. We looked at how that could work in Queensland. It is very much about building the capacity of the communities to take all that evidence and work out the `how' and how that is going to work in their local area.

The work we are doing now is working out the `how'—working with local governments, working with different health organisations, expanding into school areas and looking at how we can integrate these healthy activities into the way that communities already work. We know that if something new comes in and then the time runs out, it is going to fall away at the end. It is about integrating into the way the communities work. There is good guidance from the World Health Organization. We are able to manipulate that around to a Queensland situation at the moment.

CHAIR: That capacity building is something that a number of stakeholders have raised in their submissions. `One size fits all' will never work in such a decentralised state as Queensland. We have three regional members on the committee who are very passionate about that. It sounds like that is ongoing.

Ms Baldwin: Yes.

CHAIR: I was going to ask if we could have a copy. I would love to read your research.

Ms Baldwin: We absolutely have a copy of the initial reports. We can certainly send you something.

CHAIR: If you do not mind taking that on notice, we would love to have a copy for some light reading. I am also interested in the third dot point on page 3 of your submission. You mention that in the School of Public Health and Social Work there is a national research project on sustaining chronic disease prevention health promotion approaches. That is obviously different to the research that you have just commented on. Could you tell me where that is up to? It looks like the findings of the work are currently being prepared. Is that something we can also gain access to?

Ms Baldwin: We are just finalising the analysis of that work. That is also one of the things that I am working on. We have done a large national study across the key experts in health promotion as well as leading state and territory health departments and other settings. We are very conscious in our work that health sits much broader than the health sector. We have also worked across the education community in terms of local government and the workplace health and safety space and looked at what has worked in sustaining programs long term elsewhere and what we need to do for Australia in the future.

We have come up with a very nice framework, which is in the final stages of being assessed in front of an international panel to make sure that Australia is in line with those global guidances and that we also have the flexibility around it to, exactly what we were saying, implement it so that it is locally driven, locally owned and locally relevant so we potentially avoid some of the historic work where health promotion approaches may have stopped when other sources of funding have stopped—looking at how we can integrate it more broadly. We certainly can take that on notice and send you a summary.

CHAIR: QUT also can call on its significant business faculty, because I know that social marketing is a great strength. Rachel McAdams is the name that comes to mind. I think she made a submission on behalf of QUT in that regard. Public health or health prevention is something some people do not get. If you get money from this end then you will pay double that money at the other end. We really appreciate the work you are doing in this space and the advocates that you are.

Mrs STUCKEY: Thank you for your submission. As Professor Whiteman said earlier this morning, there are common threads through the submissions but each one has some great nuggets of their own. Given the stark and alarming contrast in health between urban, regional and rural Queensland communities, what are your thoughts about the focus and funding being equally divided between those three sectors?

Prof. Young: I would not want to place a percentage on it, but I think more importantly we thought, from the governance down, that we need to get rural and regional representation within this organisation and make sure that we make a strong claim about the need for investment in rural and regional areas to advance health promotion more effectively. In terms of individual projects, the work that Louise just talked about is a really good example of a model that is deployed in rural and regional Queensland. Encouraging engagement and encouraging people to apply for funds that will be made available is probably a more sustainable exercise to make sure that we have high-quality work that is being judged and evaluated in a comprehensive way rather than to set a fixed percentage, but I think the principle is a really important one.

Ms Baldwin: We certainly know from the Chief Health Officer's report alone, let alone the other needs assessments that have been undertaken by the hospital and health services and the primary networks, that there is a great need in rural and regional Queensland. We would welcome a focus in that space.

Mrs STUCKEY: Considering your submission's statement with regard to the board being comprised of up to four CEOs from relevant government departments, I was wondering which departments you think they should be. Health is obviously a given. Your submission explores the premise that you believe that other departments should also recognise and play an active role. Are you referring to outside the board? Perhaps we could have some suggestion from you for the board but also where you feel outside of the board would be of benefit.

Prof. Young: Certainly. More broadly indeed we noticed that the majority of representatives on the board were going to be government representatives. One of our messages was that, in terms of the collective ownership of these activities, that proportion may need to be re-examined.

As part of the sustainability of this, we also need strong accountability. As we heard from Professor Whiteman this morning, typically the focus on many of these investments in the past has been short term. That is why we have spoken in our submission about a 10-year action plan, to make sure we are giving a sufficient head of steam for benefits to be accrued. We see as part of that in government that we will need economic advice. We all need advice around housing. We will need advice around communities. I would say there is probably no government department that does not have a share of the responsibility in terms of making sure these activities work. That mix may change over time.

I hark back to one of the earlier points. When we are looking at socio-economic and social disadvantage, I think that departments that have a strong role in terms of addressing need there would be really obvious partners in terms of this going forward. We are concerned more broadly in terms of that long-term focus that we get the opportunity for really novel and good ideas to flourish. That should be not too directed from the minister downwards. We see there is a great opportunity here to get that engaged connection across communities, across the partners that you see presenting evidence here today - outside of government too. I would not like to be prescriptive in terms of which government departments. I think everyone has a stake in this.

Mrs STUCKEY: How realistic, then, is the 10 per cent by 2026 if we are talking about a 10-year plan?

Prof. Young: Clearly, in terms of any of these plans we have accountabilities going forward. We are not measuring the outcomes just then; we are looking at the kind of process measures that Professor Whiteman talks about. I think those issues can coalesce very happily together.

One of the issues we have seen in the past—this has been evaluated nationally as well—is that our short-term focus has meant that potentially good ideas have not been allowed to flourish. We had the Australian National Public Health Partnership. An evaluation of that partnership showed that it needed to be a longer investment. In fact, sadly, sometimes we are just beginning to see a return when the funding ceases and the potential ripple effects of that initial funding are never met.

Mr HEALY: First and foremost, I note your opening statement in relation to concerns around the effectiveness of this body in relation to its capacity to coordinate and the make-up of the board. That was my question to an earlier presenter. I come from Cairns. We are a very multicultural city, but we have a significant percentage of obvious challenges—the lower socio-economic end of the scale. What I am interested in—I think my two colleagues from regional areas would also be interested in this—is your thoughts on rural representatives and how they could be nominated or selected. It goes to something that was asked earlier—what area. It may be some NGOs. I am wondering what sort of composition you would see.

Prof. Young: We certainly saw that as essential. Over time, given that we have such a dispersed population across a large state, we would be interested in input from different regions - so how a board is refreshed and how that diversity of use gets represented. We saw it as absolutely essential in the first instance. As Louise has been saying, much of her work has involved local government. I think they are unsung heroes who deserve a stronger voice. They are often doing work that is well intentioned but not as well coordinated as it might be. In terms of all the different representation we might have, rural and regional local government would be a sensible place to look for such representation.

Ms Baldwin: I note that Queensland Health in its response to the submissions also highlighted the opportunity for committees to be developed as part of the governance for Health and Wellbeing Queensland so there is an opportunity to have a strengthened focus on rural and regional areas. Again, Queensland is a diverse state with different needs and different community compositions. What works in North Queensland may not be the same as what works in the south or south-west.

Mr HEALY: My final comment is that I love the submission - I thought it was terrific - but I agree, Ross, that it has not happened quickly enough. This is my first term here. I have been here only 14 months, but I will take everything from the Kennedy assassination all the way through to this as my responsibility as a politician. It does help when governments do not cut budgets to Health - and that is not what the Palaszczuk government is doing, so we are looking forward to seeing some positive outcomes.

Mrs WILSON: You mention on page 3 of your submission that the ongoing evaluation of short-, medium- and long-term outcomes of all projects should be integrated into Health and Wellbeing Queensland. What would you hope for in the short term?

Prof. Young: In the short term we would be looking at level of engagement and activities and, importantly, how the multiple benefits that may accrue from those activities might be measured and shared. One of the challenges we faced in the past was that, regardless of which metric we used to measure success, we did not share the outcomes of those very effectively. We thought that open, transparent, connected measurement was going to be the most important principle going forward. In addition to looking at what kind of work might be commissioned, how are learnings shared? Sometimes it might be well intentioned ideas that do not work out as we thought, and it is important when we have not had the engagement or impact that we like to look at what may have been gone wrong and to be much more open about that, too.

Ms Baldwin: I would agree. In reflecting back to David Whiteman's comments earlier around that implementation space, we have a wonderful opportunity to fill that gap and lead globally and fill in the gaps in the evidence of what does work. We also see an opportunity similar to the work of the Chief Health Officer's report, which is guided by the different regions across Queensland by the HHSs being able to similarly report what is working in those regions. If we are seeing improvements in particular risk factors, we can look at what is working on the ground to help those improvements and how that can work to inform other regional areas as we start to scale that up and sustain that across the state. Similarly, if things are not going so well we can look at what is happening in that community, what is influencing that and what we need to do. We would certainly see that overarching chronic disease prevention plan for Queensland as long term and the shorter term measures being able to report on the progress and those short-term successes along the way and being able to guide the long-term achievements there.

Prof. Young: We may need to be imaginative about what we are measuring. There is a study called the Habitat study. That started at QUT but the academic who has led that is now at Deakin University. It has looked at geospatial data as well as health data in Queensland communities and has found that issues such as perception of safety, of lighting, of footpaths—a whole range of issues—also contribute to poorer choices that people can make in their lives. They are already disadvantaged in multiple ways, but the environments in which they live exacerbate that disadvantage. We need to sometimes be careful of reductionist measures that do not capture the richness that we need to be looking at. Not to make that too complicated, but it may not be the usual suspects that we need to measure in some of these initiatives.

CHAIR: You mentioned something which stood out to me in the Queensland Fitness, Sport and Recreation Skills Alliance report too, so you are all singing from the same song sheet, which is not always the case.

Mrs STUCKEY: This question is perhaps a little provocative. I am wondering if you have done any studies that engage GPs in relation to sensitivities around the language they might use. Perhaps they might use soft talk to patients to encourage them to have a healthier lifestyle rather than being more direct. Have you done any work in that area? I was talking to somebody last week who signed up for a weight reduction course, and she said that if they had not pressured her so hard there was no way she would have got through it. I wonder if the health professionals who are dealing with these people tiptoe around some of those issues, particularly the obesity issue.

Prof. Young: I will try to give a brief response but the answer is, yes, we have. I have in terms of my own research background as well, looking at areas like motivational interviewing in terms of how we build commitment for individuals to act on advice. There is a large body of work around that. I guess it is one of those areas we talked about previously, where we know what we should be doing but putting out programs to make sure we are delivering health care in that manner is something that we continually need to work on. As I mentioned earlier, health workforce capability around these issues is an area we are deeply committed to, and there are bodies of work that look at communication and primary care and how that can tip people over into making healthier choices.

CHAIR: Good question, Deputy Chair, and my question for our next submitter too. Thank you both for your time. You have taken a number of questions on notice. Our secretariat will be in touch with you about that. That is providing some additional information which is very informative for us as a committee.

LINJAWI, Dr Sultan, Endocrinologist

CHAIR: Welcome, Dr Linjawi. Thank you for your submission to the committee. This is a topic you are very passionate about. We will provide you with an opportunity to make an opening statement and then we will ask you some questions.

Dr Linjawi: I would like to acknowledge the traditional owners of the land and pay my respects to the elders past, present and emerging. I would also like to thank the committee for this opportunity to appear before you and provide comments on the Health and Wellbeing Queensland Bill. I suspect I am unknown to you in the committee, so please forgive me while just for a moment I give you some background to who I am. I am a diabetes specialist and endocrinologist. I have spent 12 years living and working in regional Australia as a sole endocrinologist. For many years I was the only diabetes specialist between Newcastle and the Gold Coast. I moved to regional Australia, and I have always had a passion for health inequality.

Too often I think people in Australia outside of metropolitan cities do not have access to the level of health care they deserve. For the last two years I have been living in Brisbane. I have a profound passion for new, innovative diabetes treatments and, as a consequence, I am involved in many global clinical trials and have published numerous papers. I am asked to lecture globally many times a year and to date my publications have over 500 citations. I certainly have expertise in this area. Throughout my career in Australia and the United Kingdom, where I originally come from, I have treated people with borderline diabetes, over 10,000 people with type 2 diabetes and over 1,000 people with type 1 diabetes.

I have to say that helping this diverse group of people still excites me, despite the fact that I have been doing this for 15 years. That is because I think we can make a tremendous difference in their lives. In 2009 I developed a lifestyle modification program called Why WAIT for people at risk of diabetes. We were I think the first but certainly one of the first privately endorsed deliverers of this program by the federal government, and my team and I delivered the program to over 550 people across four geographical regions. The funding ceased for this program in 2011 and I think has been reinvigorated by Queensland Health in terms of a grant to Diabetes Queensland. We were proud of the fact that, of those 550 participants, 88 per cent of the group achieved significant weight loss of about six kilograms and 50 per cent lost more than eight kilos over the six-month period. We did not give anyone any dietary advice; we just explained things and persuaded people that change was worthwhile.

In the last five years I have taken all that I have learned as a medical specialist and I have used this to develop a personalised online diabetes program which is called myhealthexplained.com. We have worked with psychologists, diabetes educators, dieticians, award-winning filmmakers—because we believe it is about story telling—and technology experts who deliver education that is inspirational, scalable, outcome focused and specifically individualised for people with type 2 diabetes, borderline diabetes and gestational diabetes. The My Health Explained platform essentially delivers 45 videos over a 12-week program. What is particularly unique is that the content changes depending on an individual's needs. Part of that is what they request - they can customise the program - but we also look at their responses to questions and change the program based on what their medical need is. I will elaborate on that further later if necessary.

The program is designed to address this single issue, which is `why does diabetes matter?' So often when we look at programs that we deliver we forget the 'why'. We tell people that we are here to improve their health, but they do not necessarily understand that if you have diabetes and it is not controlled you will lose seven years of your life. For the majority of those years prior to your death you are going to be in ill health. Unfortunately, the traditional view for many people is to say, 'If I die, I die,' but it is a sustained period of ill health followed by an unpleasant departure.

As I said in my submission to the committee, I commend the government on establishing through this legislation a statutory body that can work across boundaries to promote health and wellbeing by funding and coordinated efforts. I sincerely believe that this body is one of the most exciting opportunities I have encountered in my work life. The fact is that what we are doing as health professionals, as elected governments and as a community is not working. We have had a number of submissions about things that can be done and the long time line and what we know, but the number of people with diabetes is increasing, the number of people with weight related issues is increasing, our outcomes are getting worse not better, and the only reason we are not in the disastrous situation of some other countries around the world is that we are spending profound amounts of money to keep people alive—profound amounts. Health and Wellbeing Queensland

suddenly has the potential to do this. I think too often our approach focuses on the role of the individual. We look at an individual and we think that the individual has to fix the problem. We ignore the aspect that society imposes on the individual. Addressing both is vital if we are going to have any chance of succeeding.

For the individual, the impact of diabetes and other chronic diseases is profound. The cost is huge. There are too many deaths, too many health complications in diabetes and too many amputations. I think it is imperative that we educate individuals but I also think we need to do it in a way that is sustainable. I will give you an example, if I may. When we think about the volume or the mass of a particular object, we look at the height, the length and the width, and if that was one by one by one that would have a mass of one. However, if we double that we have to double it in every direction. Doubling something increases the mass by eight. With respect to an apple—and here are two that I picked from a supermarket yesterday; they are both pink ladies—this is 2½ of that, even though size wise there is only a 20 per cent difference. By the time you weigh them, because of the fundamental aspect of physics and science that you cannot get away from - that is an issue. People need to understand that. Also, as a government we can look at portion control. We can say that if we can find ways to legislate and reduce the amount that people are served, that 20 or 30 per cent reduction in the food they eat may have an enormous impact.

I am making a TV documentary. We have filmed in 14 countries around the world. One aspect we worked out is that in Japan they have three per cent obesity rates—three per cent. If you go to a fast-food outlet that serves fried chicken in Japan, the size is 30 per cent smaller than it is here in Australia and you order one. As a specialist I know that looking at how the environment interacts with the individual is how the government's aspiration and commitment to increase the proportion of Queenslanders at a healthy weight range by 10 per cent will be achieved. I think we should be not only looking at that group at the lower end but also trying to reduce people in every segment. The statutory body also has the opportunity not just to look around funding models and try to find innovative ways to change things but also through legislation to perhaps change the way that organisations and companies behave with us. The reason I brought in Maltesers today was that, like you, I fancied a bit of chocolate the other day - and you are right: occasionally you do want a treat.

Mr DAMETTO: Absolutely.

Dr Linjawi: These Maltesers are worth $3.50. I thought that was a bit little for how I was—

Mr DAMETTO: They are getting smaller, aren't they?

Dr Linjawi: Yes, I was thinking that for how I was feeling. I thought, 'I'll look around,' and then the next packet I found were these, which were $6 and triple the weight. Another packet is five times the weight and was $5. We have an issue in this country around something called non-linear pricing. You never see a situation in supermarkets whereby things that are healthy cost less the more you buy. We never see that you can get 30 per cent free if you buy green beans. We never see that, but every single aisle, from the middle across the whole of the supermarket basically, is offering us `30 per cent extra', `get king size', `buy this', `buy that'. I think there are specific challenges. Individuals need to understand this, but I think the role of this body could actually influence things across the whole of society in a way that would be inspirational.

The challenge of dealing with the current model in terms of delivering education to people is based on train the trainer: we have a program that we like, we develop it, we prove that it works and then we roll it out across the state. The idea is that you train one group of people to deliver it across the state. The problem with those models is that we are consistently dealing with two things. The first is the variation between person—some people are great; some people are not—but also some days you have a good day and some days you do not. So we have interpersonal variations and intrapersonal variations that all lead to a reduction in the quality of the educational process that we can deliver. My Health Explained, essentially because it is an online program, is delivered and can be delivered right now to every single person in Queensland who has diabetes or borderline diabetes. It can be delivered with consistency, personalised to that individual's needs. They can watch it at a time that is convenient and helpful to them. They can see it as many times as they want and within three months we will know the outcome of that simple intervention of providing basic, simple diabetes education to everyone who deserves it.

The fact is that many members of our community are wedded to their phones. They want to do things at the times that are convenient to them. Yesterday I went on to the My Health for Life website and I phoned the telephone number, but it is only manned Monday to Friday between nine and five. If on a Sunday afternoon I had my moment where I decided I was going to change my life, there was

no-one to talk to, so that moment may have passed. We need to think about people's lives to try to find ways to engage with them in a sustainable manner. I think this bill, with the authority that it establishes, really does provide a chance to reshape obesity across the whole environment, and if we do that then I am sure Queensland will see the benefits for decades to come.

CHAIR: Thank you very much for your opening statement. You said many very interesting things and I know that the committee will have lots of questions for you, but of course we will be limited by time, as we always are. We thank you very much and certainly appreciate your expertise and passion and for coming today to share that with the committee and have a say on the authority.

I appreciate your experience in terms of delivering services in regional New South Wales. I am a city based member of parliament and I have never lived in regional areas, so I appreciate the expertise you bring in that regard. I take your point about the phone, too. It has made apps quite available. I am somebody who loves to be active and, to be honest with you, I almost feel overwhelmed sometimes by the amount of information and advice that is readily available. I think people can feel so overwhelmed that they almost think, 'I just don't know what to listen to or who to listen to or what I should be eating or what program I should be doing, so I just kind of won't.' How do you think the authority can effectively cut through some of that to create meaningful change?

Dr Linjawi: Yes, and I think it really is an issue. The inconsistencies across just the health sector are really quite profound in terms of what different nurses, doctors and dietitians say. If you talk to patients a lot, like I do, you will know that they are frustrated by the fact that they get completely different messaging. I think what we have to do is look at a certain region and try something, and if it works we go for it. In terms of my involvement with this app, when you talk to marketing people they say that you test a little a lot and when you work out that it is working you double down and you bet on it. Otherwise, you put your eggs in one basket and you go down a particular road and then five years later you realise that it did not work. You test a lot, and if it works you really then invest quickly and heavily into that strategy.

CHAIR: Thank you. You also talked about not only the individual but also the impact that society and the systems around that individual have on the individual, but ultimately it will come down to that individual making a choice. My husband is a health professional also and he talks with great sadness about some individuals who are not well managed, including those with diabetes, and the sad outcomes that that brings about. How is it that we can—and I do not use the word 'pressure' because I do not think that works, in the main; I think it makes people feel bad about themselves—empower people to, at the end of the day, make a choice to manage their condition or in fact to make decisions that maybe prevent them from contracting that condition? What is your view in that regard, particularly given that you have seen people in regional areas and they do not have the same choice that we might have in the city?

Dr Linjawi: Yes, they do not, but I will say something. I think one thing that we do really badly is—and this relates to a question you asked one of the other people—talk about the ideal body weight. It probably does not really matter. We really should be trying to get people to lose a little. People are overwhelmed. They go to the doctor and they will say, 'I'm overweight. How much do I need to lose?,' and the doctor will say, 'Thirty kilos.' They will think, 'That's it. I'm not going to do it.' In reality, the risk curve is exponential. In other words, if you are significantly overweight you have a really profound risk but, at the same time, if you lose 10 kilos you slide down the risk curve quite profoundly.

My concern with the aspect of the number of people who are in the healthy weight range increasing is that if we achieve that by getting people who are just a little overweight to be normal weight we are not helping in reducing the complication rate dramatically. It would be much more exciting to get people in the obese range to overweight range or the severely obese into the obese range. That is going to have a much bigger impact on health. I think we give them a challenge and an outcome that is achievable rather than saying, 'You're not going to be able to do this from the start.'

Honestly, I am speaking like a broken record, but truly I have seen so many people. They just need to believe it and generally they can make the small changes they need to. It is not huge stuff they need to do. Most people have not gained weight because they eat far too much every day. Most people have gained weight because they ate a little bit too much every day for the last 20 years and they need to eat a little bit too little for the next 10 and they will lose weight. It is not a huge change in direction to get a really great outcome.

CHAIR: Finally, you mentioned non-linear pricing and portion control as two significant impacts that the current environment has on individuals. Are there any other stand-out societal limitations or pressures? I would say overtime and amount that people work can prevent them from being able to exercise and pressure and all those sorts of things, but what would be some that you would mention?

Dr Linjawi: There are lots, but I will just raise one that really bothers me. I am a reasonably well paid doctor and I have two lovely kids and a lovely wife and we all try and do physical sport. I have to say, there have been times when I have not done sport because of financial considerations. If you think about it, to be a member of a sporting organisation—and this has evolved just because of the way it is—you need to join the club and then you need to join the local area and then you need to pay a fee to the state and then you need to pay a fee to the federal system. Because we have this `user pays' from the federal government all the way down, what ends up happening is each of these organisations is looking towards finding ways to get money. If you want to play soccer, it can cost $350 for five months plus you have to pay $10 per match. If you are doing that and you have two kids and they want to play two or three activities—I worked it out prior to coming to this meeting—a person in regional Australia who is on $60,000 to $80,000 a year may be expected to pay $4,000 to $5,000 a year for their children's sporting activities. Part of what these organisations need money for is to indemnify themselves, so each layer has a level of indemnity to indemnify the board. These are things that I think governments can deal with.

CHAIR: Thank you. We have the Queensland Outdoor Recreation Federation speaking later and they are very passionate about Nature Play and free outdoor movement and play which, as a parent myself, I think is the best form of activity. Thank you so much for your opening comments and for answering my questions.

Mrs STUCKEY: Thank you and welcome. I found some of the stats in your submission extremely sobering, particularly those around amputations from diabetic complications. I am very interested to follow up a bit more on that app. Have you had any meetings with the minister or the department regarding your My Health Explained app?

Dr Linjawi: Yes. I met with a representative of the minister and a representative of the Department of Health and we had an opening discussion. They were supportive. From my perspective with the app, I am looking for some support to do a reasonably large trial to be able to understand and stretch it. I know based on people who come in and interact what happens. I know that across the 45 videos we get about an 80 per cent to 90 per cent watch rate across all of those videos on average, so people are certainly engaged, but we need to test it in the real world. I am hoping that we will be able to do this. Maybe this is the kind of project that is shovel-ready for this statutory body when it is up and running, because I am ready to go.

Mrs STUCKEY: What sort of cost would there be to government for a pilot or a trial on something like this?

Dr Linjawi: At the moment we retail the program directly to people and we charge $144 per person, so it is a relatively inexpensive product. Some of that is challenging, because you want to make it cheap enough so that everyone can afford it but you need to advertise through Facebook and other mediums to be able to acquire them. I am sure if the Department of Health was looking to find a way, it would not be a lot of money - maybe a couple of hundred thousand dollars.

Mrs STUCKEY: Obviously the motivation is having that person who coaches you or motivates you to keep going through all of the videos, so if there is a price incentive there sometimes that is enough. I know that people get gym memberships and do not use them, but then some people think, 'I've paid for it. I'd better do it.' How many programs have you sold or how much of this is already out in the marketplace and when did you complete it?

Dr Linjawi: It is a relatively new project. We have been going about six months. Mostly what we do is short-term testing, so we make changes around words. We do short-term testing and then look at what happened. We have had about 100 people so far purchase it. They are all doing great. To put it in context, we have about 10 per cent of people who have been in more than 60 times, so they come back and watch.

Mrs STUCKEY: Sorry, but could you explain what you mean by 'been in more than 60 times'?

Dr Linjawi: They come back into the program—into the app—and actually watch the videos again.

Mrs STUCKEY: Okay, so it does not time out? Once you have it, you have it?

Dr Linjawi: No, they are in.

Mrs STUCKEY: That is good.

Dr Linjawi: It is a journey, but they can go backwards and look at previous videos as they build their levels of knowledge. There is a new diabetes treatment that came out a few years ago. We have proven that if you take people with diabetes and you give them this treatment and they have high risk for heart disease, which is about 30 per cent of the diabetic population, you can reduce hospitalisation

by 40 per cent within three months with this particular treatment and you can reduce death by about 30 per cent within three months. It is profound. Most doctors do not know about it. Most GPs do not know about it. Most patients do not have any idea that there are people at risk who would benefit. The way this app works is that we identify people who are specifically at very high cardiovascular risk and then we tell them that they are at high risk, we explain what that means, we tell them the drugs that can change their potential outcomes and we ask them to go and talk to their doctor about those drugs. These are pretty substantial numbers in terms of 35 per cent of admissions with cardiac failure when 20 per cent to 25 per cent of the people being admitted to hospital have diabetes.

Mrs STUCKEY: There are significant savings if you can keep them out of hospital and get them well.

Dr Linjawi: Profound.

Mr DAMETTO: Doctor, thank you very much for coming along and not only for your submission but also for the work you are doing in rural and regional Queensland and with your app. I will give a bit of context behind my question. I like to look after myself. I like to keep fit. I like to eat well. It is not hard; it is just being mindful of what you put in your mouth. I try to plan out my day, not by doing meal prep or anything but just having an idea of where I am going to buy my takeaway food, because we are all living very busy lives these days. What worries me when I go back to my small home town of Ingham is that I drive through Ingham on a Tuesday tonight and the only thing that is open is McDonald's, KFC or Dominos. It is cheap food and not very nutritious, but when you are hungry or you have not planned something else, that is all you have to eat. What do you think we could be doing better to enable businesses that do provide healthier food to stay open later and provide food in those rural and regional towns where there is not the large community base to fuel these businesses to stay open longer to provide that good quality food?

Dr Linjawi: I entirely understand what you are saying, but I would like to make a slight variation on your comment. I do not think it matters whether we are dealing with good quality or bad quality food if you are eating too much. It is like fruit. Fruit is really important, no doubt, but I can tell you that younger people in this country do not eat enough and the older age group eat too much. There are many people who I see with diabetes who are consuming a lot of a fruit in a day that is putting their blood sugars up enormously and contributing significantly to their weight. We achieve weight reduction by asking them to reduce the amount of fruit or change the types of fruit they eat.

Getting back to the point that I made earlier, I think we can legislate for smaller portions. It is then a person's individual choice whether they would like to eat two. No-one is stopping them ordering two Macca's, but at the end of the day I think it is reasonable that we look at ways of reducing the amount that is served to them. That is achievable. It may be that the economic model is not there in a small town like Ingham, but the reality is that if we are really going to make a big change across the whole state, and indeed the country, we really need to have that bigger vision interaction.

This is my other little thing that I brought today, which is disgraceful. This was purchased by me yesterday at a large national shop. It is two burgers, the equivalent of a soft drink, a large ketchup and chips. That is what we are going to get our kids to play with? My frustration is that I see that and I do not know who to tell. I would like the statutory body to be the sort of place that I can come and say, 'This is something we need to pick up and take and go and talk as a government to these people and say, "Is this really what we want to do as responsible Australian citizens? Do you really want to sell this?"' They also had vegetable options. Great, yes: let's get kids playing with vegetable options so they think, 'Yum, I quite like broccoli.'

Mrs STUCKEY: It does not look that appetising though, does it?

Dr Linjawi: No, but it is cheap. I didn't like it. It really upset me, so I brought it here to share it with you guys.

Mr DAMETTO: Thank you very much, Doctor. I appreciate your answer.

Mr HEALY: Sultan, you have probably created more questions than you have come with solutions. Your submission is fantastic. The stats are outstanding. I agree with everything you say. That is impressively appalling. It looks like you will be on the Maltesers for the next week at home which will be good - maybe not so good.

Dr Linjawi: I have had them for a month and a half so I am actually quite proud of myself.

Mr HEALY: I do not think they will be any different from the day you bought them, from a nutritional perspective. At the end of the day, we have bodies that ensure packaging is done the right

way and we are protected by statutory government bodies and government boards in a variety of ways to ensure the food is nutritional. You cannot ride a bike these days without having a helmet on your head. There are so many protections by all levels of government. Are you aware where there has been legislation relating to food portions?

Dr Linjawi: Yes, the United Kingdom. The United Kingdom has essentially put in a sugar tax. I am not a big fan of a sugar tax, and I am happy to elaborate if necessary, but they did put it in. What happened was that the food manufacturers decided that one way of dealing with it was to make their chocolate bars smaller. I think that was a reverse way of doing it. Mine would be, I think, to say that a chocolate bar is a certain size. Again, I go back to Japan. In Japan they are all 30 per cent smaller. It is at every level.

Mr HEALY: I agree. In somewhere like Japan, for some unique reason there is a culture. The discipline is impressively consistent and it has been there for a long time. If you look at what their natural food habitat is or where they are, it is a lot of seafood. The oldest people in the world all live in Japan, as we know.

Dr Linjawi: They do.

Mr HEALY: I get that, but there is no moral obligation. We have issues where I live in Cairns. You have been in regional New South Wales. The challenges would almost be identical.

Dr Linjawi: I know Cairns well.

Mr HEALY: I see you note some concerning figures there. There is no moral obligation for the people of Coles or Woolies or Kentucky Fried. Their obligation is to their shareholders to get a return.

Dr Linjawi: That is right, but we pay as a society. That is the trouble.

Mr HEALY: I totally agree. My father-in-law is a canefarmer, so a sugar tax would be interesting. I have lovely discussions with my learned colleague here, and no doubt certainly with the member down the end, but would you suggest that we look at introducing increases which make it harder for this sort of food, from a legislative perspective?

Dr Linjawi: My issue with a sugar tax is that, at the end of the day, it is going to be quite small; it is not going to be punitive. The example that is used is smoking. I have spoken to people at the World Health Organization who are very involved in the smoking issue, and they say, `Look what happened with smoking.' It is different. They are talking about Coke going up by 10 cents or five cents. It really is not an enormous amount of money.

If we have bodies that look at food quality to ensure we are providing safe food for people, I think it is reasonable that they also look at food amounts to ensure we are not overfeeding our population, because that is our current challenge that is only getting worse.

CHAIR: Thank you very much for your time. We appreciate it.

DURHAM, Ms Alison, Advocacy Manager, Heart Foundation Queensland

HAMILL, Ms Lyn, Program Director, Diabetes Queensland

McMILLAN, Ms Chris, Chief Executive Officer, Cancer Council Queensland

VINES, Mr Steven, Chief Executive Officer, Heart Foundation Queensland

CHAIR: We have a lot of expertise at the table. I know that time will not allow us, as it always does not, to ask the questions and have the time together that we would like. I invite each of you, if you would like—obviously we have your submissions—to make a very brief opening statement. If we can limit it to two minutes each so that we can have a discussion, that would be wonderful.

Ms McMillan: Thank you for the opportunity to be here this morning. A very salient point to make first off is that every 20 minutes a Queenslander will learn that they have cancer. That equates to 27,800 Queenslanders in this year that will be diagnosed with cancer; hence, at Cancer Council Queensland we work to reduce the burden of cancer. That is our main mission. We do that through research, patient care, prevention and early detection. Research shows that one-third of cancers can be avoided through a range of lifestyle changes. Furthermore, one-quarter of cancers can be avoided specifically through two things: changes to nutrition and physical activity. Cancer is just one of the chronic diseases that could be avoided if more Queenslanders were supported to make healthy choices. I am pleased to be here this morning with my colleagues from the Heart Foundation and Diabetes Queensland. We actually do a lot of work together in this space.

Communities across Queensland will benefit from a strong, independent agency to focus on health promotion and preventative health. All three of our organisations have expressed support for this within our submissions. In our view, this is a sensible model that should deliver real, positive impacts for the Queensland community. It has clear objectives and a commitment to reducing obesity and overweight. Its governance model is well designed to lead the organisation, including representation from across Queensland government departments, which will de-silo some of the preventative health efforts and allow a majority of board members to be drawn across the community, including Aboriginal and Torres Strait Islander communities. This will facilitate a skills based group to set the strategic direction of the agency.

Health and Wellbeing Queensland's success will rely on the execution of these strategies, and we welcome the bill's clear focus on working in partnership with not-for-profit organisations like ours. We think there are great opportunities for our organisations and those like ours to partner with the agency to develop its priorities and support the delivery of important services.

Mr Vines: I would like to thank the committee for inviting us to be here this morning to share some of the Heart Foundation's perspective on the Health and Wellbeing Queensland Bill 2019. I would like to acknowledge the traditional owners of the land on which we are gathered and to pay respects to elders past, present and emerging.

We are very pleased to be here alongside our fellow NGO colleagues Diabetes Queensland and Cancer Council Queensland. The Heart Foundation strongly supports the establishment of Health and Wellbeing Queensland, and we certainly urge this committee and all MPs to support the bill. We want to see the preventative health agency established now so that we can all work together to get on with implementing excellent health promotion interventions for all Queenslanders.

We support the intent of the changes to this new bill, especially the increase in budget, the improvements to its independence and a skills based board. The independence of the agency is essential so that it can be truly separate from political processes and continue to have bipartisan support. Certainly the budget commitment of $33 million for 2019-20 needs to be sustained at this level and grow in future years.

Certainly a healthy economic future for Queensland will be shaped by the health and wellbeing of our population, especially in keeping people productive in the workforce and in their communities. Therefore, prevention must be given a greater priority and funding, and we believe Health and Wellbeing Queensland will be well placed to do this. With 30 per cent of the total state budget consumed by health expenditure, we cannot continue on this trajectory. We need to do more than treat disease; we need to prevent it. Effective prevention to address the risk factors of cardiovascular disease can also help reduce the risks of other chronic diseases like diabetes and some cancers. These certainly include risk factors such as high blood pressure, high cholesterol, smoking, unhealthy diet, overweight and obesity and physical inactivity.

We also certainly emphasise the need for a multistrategy approach using evidence based interventions. For example, if there was a focus on a particular region or community, health promotion programs like Heart Foundation Walking and My Health for Life could be implemented alongside interventions that build supportive environments. This morning we have heard some examples of what supportive environments look like, which should include building infrastructure and legislative reforms that make the healthier choice the easier choice. Other examples include building connected pathways for walking and bike riding; improving access to public transport and healthier food options; banning junk food advertising around schools, sports grounds and public transport hubs; reducing speed limits to make it safer for pedestrians and bike riders; and reforming planning laws that support healthier living.

We would also like to emphasise that the grant allocations should fund programs and projects that can be sustained long enough to be evaluated and achieve outcomes in communities. We do not support one-off short-term grants, and we need to minimise the perpetual cycle of pilot programs. Again, I would like to thank you for your time today. I look forward to answering any questions you may have.

Ms Hamill: Diabetes Queensland welcomes the Health and Wellbeing Queensland Bill 2019 and the opportunity to speak to you today. As you would be aware, Diabetes Queensland represents its members and the 240,000 Queenslanders living with all types of diabetes—type 1, type 2 and gestational diabetes. Of course, working to prevent type 2 diabetes for the future is of great interest to us.

We see Health and Wellbeing Queensland representing a significant milestone in health promotion. As a coordinating and promotion body, Diabetes Queensland fervently hopes that it can achieve the strategic combination of effective chronic disease prevention, that being changing the language of chronic conditions to take away the blame solely at the individual level; to address the issues as a community and provide help where that is needed; to utilise resources effectively; to work strategically and consistently alongside existing funded actions where we could change community actions; to cross the boundaries between health outcomes and their social causes, making sure that those who are in need are assisted; and to use evidence and research to deliver results. We believe that Health and Wellbeing Queensland is designed to effectively tackle the task.

Many chronic conditions are strongly tied to socio-economic conditions and factors, and interventions identified by Health and Wellbeing Queensland can offer resources to communities of need that are otherwise not available. We know that health promotion works. When strategies are coordinated and aligned, health promotion can make a big change to our community on many levels. There are potential savings to the Health budget outlined in the bill and in many submissions, I am sure. There is the increase to economic productivity through decreased illness and disability and there is the increase to individual independence and quality of life.

I am the program director for My Health for Life, which is a chronic disease prevention program delivered by an alliance led by Diabetes Queensland but which includes the Heart Foundation, the Stroke Foundation, the Queensland Aboriginal and Islander Health Council, the Ethnic Communities Council and the seven primary health networks. We have been operating for three years and we are still talking. It would be one of the programs moved to operate within Health and Wellbeing Queensland and is an example of what could be possible when collaboration is encouraged. Our program works on reducing individual risk factors through encouraging behavioural change and, as outlined in our submission, the results from the thousands of people—as of today 5,100 people—who have been through our program and attended at least four or more sessions.

Just to round off my comments, I thought I would tell you about one of our participants. If you are a reader of the *Choose health* report, you may have read about Albert. Albert is from the Gold Coast and was on the hospital surgical waitlist for knee surgery. He had a complex medical history including a history of cancer. He was at 131 kilos, drinking nine to 12 beers daily for his pain management, not eating regularly and also not doing too much activity due to his knee pain. After six sessions with our telephone health coach he had lost 4½ kilos, had started eating breakfast and having regular meals. He had reduced his alcohol intake by half and was actually having two alcohol-free days. He completed his knee surgery and began cycling five days a week on his little tricycle for 30 to 90 minutes as well as doing some weights. We caught up with Albert in December just passed—six months after he had finished his last session. He has continued with his healthy lifestyle goals and reports good physical and mental health. He has lost another 6½ kilos, which is fantastic, and now weighs 120 kilos, aiming to achieve 110 kilos. He is eating breakfast, he is eating fruit and vegetables, and he is still having his two alcohol-free days. He is still cycling, he is in his pool doing exercises and he now thinks he is healthier than most people his age.

Diabetes Queensland strongly supports Health and Wellbeing Queensland as an independent health promotion agency that can garner the support of parliament, organisations and, most importantly, Queenslanders who want a healthier future for themselves and their families.

CHAIR: Thank you all for your opening statements and for your submissions. Given that this is our third inquiry process together, thank you for being with us along that journey. I know that you have had a number of different people come. I think, Alison, you have been at all of them. We really do appreciate the amount of time you give. We know that you are very passionate about your respective areas and about health promotion generally. We really appreciate the time that you put in to coming and helping the committees with these sorts of inquiries in the parliament. It certainly improves the outcomes, so thank you.

I have a question specifically in relation to the Heart Foundation submission. You make a very strong statement on page 3—

It is essential that HWQ be truly independent from political processes. What we want to see most of all is a strong agency with bipartisan support that can withstand any change in government and the political environment over time.

That is the issue—the elephant in the room. I know that it was raised constantly in Victoria when the original committee with this reference went there and looked at the different models across the country. One of the reasons they have been so successful is the length of time they have been able to remain relevant, funded and supported by both sides of parliament. I know where you will go in regard to how long-term change takes that sort of support, but can you speak to why you have made such a strong statement in your submission in that regard?

Mr Vines: Yes. As you say, it is very important as this is a long game. We are looking for long-term impact and long-term change. I think what is really important is that this body is also long term and therefore is not potentially subject to change with different changes in political parties. I think the VicHealth model, as you have referred to, is a good one in that it has stood the test of time. I think it might have been first established in 1987. It is now making some very good changes with its model. Certainly the independence that it has built in is not too dissimilar to what is proposed here with the Health and Wellbeing Queensland Bill. We see that this body needs to be independent to be able to make decisions based on the evidence of what needs to be done.

Ms Durham: We have seen preventive health agencies come and go. We had a national preventive health agency that was abolished. We want to see that that does not happen, that prevention is given a high priority in Queensland and that it does have the bipartisan support of all MPs. That is a really strong message that we want to put and that is why it is in our submission. We can lose this kind of momentum that we now have. It has taken many years for us to get here, as you say, Leanne. We strongly support it and we want to make it clear that it is our expert opinion that it should go ahead.

CHAIR: That segues into my second question. Given that Queensland Health and all of the professionals that they represent do an extraordinary job delivering services across a vast state, why is this authority so important as distinct from what is already happening, do you think, in regard to health promotion?

Mr Vines: We allude to this in other parts of our submission around the importance of a multisector approach and a whole-of-government approach. We certainly see the value in this body having across-government scope, certainly to increase the investment in prevention but also to make sure that it is a very comprehensive approach that is being taken. That is not to say that that is not happening in the Department of Health, but I think there is so much potential to really scale it up have that whole-of-government input. One of the elements is having DGs from other government departments on the board. I think there is value in that. As we have heard from other speakers this morning, this is quite a complex area—to address chronic disease—and it does take a whole-of-government, whole-of-sector approach. That is where I see this body substantially adding to that, as well as the additional investment in prevention.

CHAIR: I appreciate your point that it is not about Queensland Health not doing enough. I think what they do they do extraordinarily well, but perhaps an authority, it has been said—whether you agree or not—of this nature, as distinct from Queensland Health but working alongside them, will assist because they have independence, flexibility and that cross-sectoral ability that maybe a significant and large department in the everyday delivery of services does not have. Is that fair to say? Those on the committee are nodding.

Ms McMillan: Yes, I would agree.

Mrs STUCKEY: Thank you for coming along. It is nice to see that collaboration, isn't it? I think you were here for Dr Linjawi's very interesting presentation. Are any of you aware, particularly Diabetes Queensland, of his health app?

Ms Hamill: No, we are not. I will now find out more. There are a number of options. In fact, if you go to the app store you will find that there are many apps relatable to health, wellbeing and diabetes. None of them is right or wrong; it is about people's engagement with any kind of tool that assists them to understand their own disease state or their own risk. The challenge always is getting people to even look. We know that everyone can always identify someone else who is at risk of a chronic disease but it is a lot harder to acknowledge that they themselves are at risk and need to take action.

Mrs STUCKEY: I think it is great to see the collaboration but, as we have acknowledged, this budget will need to grow in future years. At the moment almost $33 million has been allocated in next year's budget. How do you feel about the competing interests? You have a limited bucket of money, which I know we always have, but there will be winners and losers. How do you think it should be divided up? There are other organisations apart from yourselves, of course. Have you thought about the competing interest factor?

Ms McMillan: Absolutely, we do. We sit here alongside of each other but we work together as well in this very tight space of the NGO area. I think realistically it will relate back to the immediate focal points that come in the early days of establishment and what particular areas. We have spoken this morning about obesity being one area that touches not just our organisations but also stroke organisations and many others in the sector. We are very good at putting our own focal points to the side and working together. Sometimes it is about one party taking the lead and the others being there as a secondary support. I think that is the intent of what this is all about. Being here today demonstrates that we, as an example of the NGO area, are really ready to do that.

Mrs STUCKEY: We all know that you are used to dealing with 'loaves and fishes' kind of money - in a very legal way!

Ms Hamill: Yes. The opportunity there is to leverage—if we do the work up-front and we are all on the same page, it is beholden to our organisations to work to find a way to support the agency to be successful; otherwise it will not be there and our conversations about having something strong and something to promote about Queensland and its role in prevention will be lost. It is very much in our best interest for this entity to be successful. We have seen already, even with the alliance within My Health for Life, the multiplier impact you can get by having parties who have not necessarily exactly the same interest but a very strong common interest that is core. When each contributes the basis of the rest of their organisation to the communications and to the resources that are available, you can get a significant multiplier. I think it is very much in our interests to make it work.

Mrs STUCKEY: Along budget lines, I note that Professor Whiteman was saying that ideally it would be great to get one per cent of the Health budget, or two per cent if he were being perhaps a little more optimistic. Do you have any figure in mind of what percentage of funding should be going to grants?

Mr Vines: In terms of funding for prevention more generally, we certainly say there always needs to be greater investment in prevention. If you compare Australia and Queensland to other countries like New Zealand and Canada, in terms of prevention as a percentage of the total health budget their investment levels are more like seven per cent in New Zealand and five per cent in Canada. In terms of the percentage of funding for this body to go towards grants, we have put forward in our submission that we would like to see close to 80 per cent of that funding budget go towards grants. In VicHealth it is about 67 per cent of their funding. In Healthway in Western Australia about 81 per cent goes towards grants, sponsorships and activities.

Ms Hamill: The other thing would be to not necessarily limit ourselves. If what we are doing has been shown through research or evaluation to be working, make sure it gets the funding—if not more—to keep doing more to make sure that you have equity across the entire state. Because Queensland is a very large state, the cost for my project to deliver in the Torres, the cape or the west is quite different to delivering down the road, and we need to make sure there is sufficient funding to apply equally across the state.

Mrs STUCKEY: If it is a new project and we are saying that we want sustainable ones, how do you know if they are going to be sustainable if you cannot give them a go and measure them?

Ms Hamill: Absolutely you need to do that, but if it shows value then make sure there is a health economist's eye over it before you start without trying to retrospectively work out whether it worked or not.

Mr HEALY: These are good submissions. Coming from me it does not mean a lot, but I think it is easy. I get it. Lyn, you talked about a seven-year relationship. The way you answered the earlier question, 'Well, you're all vested interests' - you handled it well. I am sure your relationship will continue to do quite well with the way that you handled that. All jokes aside, I think it is important that we do have a consolidation so it is easy to work with government. I also get the importance of the funding side of things. I am sure that as this organisation grows and becomes more important and more attention is allocated to preventative medicine as opposed to being reactionary we will start to see some changes.

Lyn, your submission highlights the recommendation of the Senate Select Committee into the Obesity Epidemic in Australia about the appropriate use of language to avoid stigma and blame in public health campaigns. Can you give us a highlight on your thoughts in relation to how that may impact Health and Wellbeing Queensland?

Ms Hamill: It is about being aware that there is language. What we are finding increasingly is that we talk about obesity, but in fact you have to talk about healthy weight, not obesity, because obesity now has negative connotations. We even find it with diabetes. Someone who is newly diagnosed with type 2 diabetes may not be quite so willing to talk about it because of the connotation that they got it because they eat too much, they are fat and they did not do the right thing. There are a whole pile of people with a whole range of reconditions who are going to get type 2 diabetes. If you are a male over 55 with any kind of history you have a one-in-seven chance of getting type 2 diabetes, yet three-quarters of the factors that make the difference are not your fault. There is this whole 'fault' discussion.

We have to talk about it. We have to talk about the difference between healthy weight and obesity or overweight in a way that is not casting blame or seen to be casting blame upon the individual and their decisions, because there is an obesogenic environment. We talked earlier about the size of Maltesers or McDonald's serves. If you ask someone to solely make decisions every day on their own about whether they take that small piece of cake or not, the reality is that people cannot do that on their own. It is just being very careful about language. Throughout the world everyone is trying to find a polite way to talk about it to engage people positively but still get the point across. I think the question was asked earlier about the role that GPs or allied health professionals play. It is very difficult to have a conversation with someone without seeming to place blame on people or them seeming to feel like it is blaming them. It is a challenge.

Mr HEALY: I get that it is about how people feel. If they are not comfortable, they will not come back and they are less likely to take medication. I accept that in the areas you represent there is a significant body of evidence to support that the real future of the country is in our classrooms right now and it starts with education. I asked the question earlier about the composition of the board. My personal view is that we would have to have somebody from education there. That would be important. The people that your groups are dealing with now are at the other end of the scale.

Ms Hamill: There are children who are five who have type 2 diabetes, so it is at all ends of the scale.

Mr HEALY: The composition of the board has been touched on and how everyone is going to compete, but you are right: it is just how that board sits and where the strong representation is. As I said, from my perspective I think that education has to be at the table. It is a key area. Do you all support that?

Ms Hamill: We agree.

Ms Durham: Education is one of the social determinants of health that we talk about. Yes, the education of young people is extremely important. It is important for future employment, housing and health outcomes. That is why, yes, education would be an important one to have at the table - equally, things like housing, transport and access to those things. Not everyone can be on the board, as long as there are cross-sectoral discussions and you have leadership, regional people, NGOs and people representing Queenslanders to get that change.

Mr HEALY: I agree, Alison, that if you have too many it becomes ineffective.

Mrs WILSON: Have you been disappointed with the delay in this bill, given that it was discussed and there was a parliamentary inquiry back in 2015? I note this was mentioned in the submissions of the Cancer Council and the Heart Foundation.

Ms McMillan: Not disappointed, per se, but I think with anything there needs to be time and effort put in to getting it right and getting the wheels in motion. We welcome that it is moving now. From our perspective, a delay in the process sometimes ends up with a better process in the end, so it is to be hoped that is the focus going forward.

Mr Vines: I certainly support that.

Ms Hamill: The whole conversation about prevention is one that has been around for the last 10 to 15 years, so we are just pleased to see something happening that we think will be positive with this board.

Mrs WILSON: Are there any improvements to the bill that you would recommend, from your points of view?

Ms Hamill: I think the bill is sufficient to get us going. It is about the implementation—who is formed onto the board—and then the steps that are taken to start to engage and get projects or programs underway that will make or break the organisation.

Ms McMillan: Certainly I think engagement is critical, and that will cut across all the different areas. We were just speaking about education being a primary part of it, but it is across all different areas. That really does need to continue and be emphasised.

Mr SAUNDERS: We were talking earlier about PHNs. My PHN under the federal government at the moment is larger than some countries in Europe, so how do we expect PHNs to work with this body if they are so big? Their funding has been cut. I work very closely with PHN members in my area, and they are trying to deliver the same amount of services with fewer and fewer dollars. Do you see any problems with this organisation working with these PHNs that are at the moment severely understaffed, underfunded and too large?

Ms Hamill: I can speak to my own experience. When My Health for Life was first set up we brought a representative of the PHN to the table who was representing all seven PHNs. We now have arrangements in place for all seven PHNs where I contribute the equivalent of about half an FTE to each PHN. It is fortunate that prevention is on their radar, so it is a very positive thing. The challenge they have is that, with general practice, many of the people they represent are busy people. Working with the Heart Foundation, we have identified a number of opportunities to find the early adopter - general practices that want to work in the prevention space - and use the PHN communication strategy, so there is a way to leverage through the PHNs. To date it has been very successful, and they are happy to continue with this. You have to acknowledge that their complex environment is a bit different to ours, their funding environment is different and the masters they report to are different, but we have been able to find a way to work collaboratively with them successfully. I think it is a case study of how it can work.

CHAIR: There being no further questions, I thank you all again for coming today. We really appreciate it.

FOX, Ms Melissa, Chief Executive Officer, Health Consumers Queensland

CHAIR: Would you like to make a brief opening statement? Then we will open for questions.

Ms Fox: It is really great to be here. My name is Melissa Fox, CEO of Health Consumers Queensland. I would also like to open by acknowledging the traditional owners of the land on which we are gathered and pay my respects to elders past, present and emerging and acknowledge the role that we all have to work together to improve the health outcomes of Aboriginal and Torres Strait Islander people.

Like my colleagues before me, having made three submissions we too have a keen interest in the success of this body. We are the statewide peak organisation for consumers and carers across the state. I would like to open with the caveat that we are not content experts in the area of prevention. We are not here to give strategic advice around what initiatives and mechanisms would be most effective for progressing this organisation's aim. Our focus is on consumer engagement. This is not about doing 'to' Queenslanders but doing 'with' us and not asking, 'What's the matter?' but asking 'What matters to you?'

As you would have seen from our submission, our core focus has been about embedding consumers, carers and the community right through the work of this organisation. We see that, similar to how the hospital and health services work, there would be benefit to ensuring this organisation has a consumer and community engagement strategy and implementation plan that demonstrates how consumers are involved in the identification of their needs, whether that be at a local level or a statewide level; to have the opportunity to have their capacity built to be able to share their innovative solutions, which are often cost effective, with other partnered organisations, whether they be condition-specific organisations like those who have just spoken, researchers, health service providers or other government departments; that consumers be involved in the selection of those initiatives; and that consumers are involved in the implementation of those and their ongoing monitoring and evaluation. We also see the importance of having diversity on the board, so consumers and carers involved through those activities. It is a skills based board, but we would like to see not just people working in the system but also community members sitting on the board.

CHAIR: That would have been my question to you. The comment has been made that it is important to have consumer representatives on the board, so thank you for picking that up. We have your first three submissions and the comments that you made to the first three inquiries. You do make the important point on page 4 that consideration needs to be given to ensure that the grant program does not unnecessarily disadvantage communities with strong demand for health promotion but low capacity to apply for or implement grants. I think that is often an issue, and it is an issue picked up by the stakeholders who are following you and other stakeholders who have appeared this morning.

Do you feel that some of the larger resourced—and I will not say 'well resourced' because the people on the panel before you would all say that they need more resourcing and of course they do, too—NGOs and organisations like that that have the capacity to deliver some pretty innovative programs negate that to some degree - not totally but to some degree - in that they might be able to deliver those effective programs in those areas? What are your thoughts?

Ms Fox: We are really excited about the opportunity that this body can bring to incubate community led innovation and to almost be, for want of a better term, a dating agency to connect those communities—often those who have the greatest need but who are often afforded the least opportunity to shape the health system to meet their needs—to give them the opportunity to partner with those organisations.

CHAIR: That is a very novel way of describing it. Thank you very much for that.

Mrs STUCKEY: Thank you for your submission. Recommendation 2 in your submission on page 4 states—

> If a grant program is run from ... (HWQ), that there is a transparent and reportable involvement of consumers and community in the governance of the program and in the decision making.

Public Health Association Australia made similar comments and would prefer a set proportion to be allocated to grants. Is your organisation of the same opinion?

Ms Fox: We were pleased to hear the statistics just mentioned around the 67 per cent to 81 per cent—

Mrs STUCKEY: The wish list.

Ms Fox:—across the country. We would definitely like to see the majority of funds go to those initiatives that are going to produce the best outcomes for Queenslanders, absolutely.

Mrs STUCKEY: Recommendation 3 of your submission is for a cross-government advisory group. You discussed having that diversity on the board. How would you see the cross-government advisory board?

Ms Fox: In terms of the departments that we would most like to see represented on that?

Mrs STUCKEY: Yes.

Ms Fox: We agree with Professor Ross Young that all government departments have an interest in this area. Definitely those that we could see should be most centrally placed would be Aboriginal and Torres Strait Islander Partnerships, Communities, Education, State Development and Planning, Treasury and also Corrective Services.

Mrs STUCKEY: And, of course, Health and Education. If there are four positions on the board—

Ms Fox: We would support what previous speakers have said. It is not just about the board but also about additional mechanisms. We would like to see the opportunity for other stakeholders to have the chance to interact with those other departments, whether it is a collaboration or a partnership—some kind of stakeholder engagement mechanism that could exist outside of the board to feed into the board and into operations.

Mrs STUCKEY: I asked this question earlier, and I know that you said you are not into the context, which is understandable. With the clientele you represent, would you be able to say that there is one health issue or chronic health situation that you see? Is it more diabetes? Is it more weight enlargement? Is it heart? Are you able to say that there is one larger cohort of a particular chronic disease than any other?

Ms Fox: I could not speak to that in terms of the condition, but the issues that we most frequently hear from our members are around access to health services and equity to those health services—so having access to the same kind of models that are going to deliver the best outcomes for them. Whilst I said previously that we would not give advice around what initiatives should necessarily be funded, we would be encouraging that they are cross-sectoral, that they are place based and that they involve consumers and carers in their development.

Mr HEALY: In your submission you talk about this body having the opportunity for a focus on health literacy and equipping people to understand. Earlier we had a doctor talk about his app, which I think is great, and we will be looking at that at the appropriate time. Can you elaborate a little on that? I am assuming that we know what it is, but is there something new that has not been canvassed or covered?

Ms Fox: Sure. We are excited about how this body could align with an increase in health literacy that is in the new National Safety and Quality Health Service Standards that all of our public and private hospitals are accredited against. The new version that came in at the start of this year has an increased focus on health literacy.

With reference to health apps to any particular initiative aimed at increasing consumers' health outcomes, we would caution that there is no one size fits all. Whilst a lot of us have access to smart phones and we will engage with apps, there will be many people in our population—again, those with the greatest health needs—for whom that may not be the best mechanism. It is about sitting down, talking to those communities and finding out what is going to work for them.

Mr HEALY: I visited my 89-year-old father on the weekend. He is in a nursing home. His capacity to interact with technology is impressively disappointing. Your point is not lost on me. Admittedly, he acknowledges that also. As he tells me on a regular basis, there is only so much time; he is in the tow-away zone. The capacity to interact changes with time. My father has all of his faculties. He will sit down and read, so he goes looking for that. Are you seeing anything outside of digital capacity? In schools?

Ms Fox: Sure.

Mr HEALY: Written materials?

Ms Fox: And also models of care. We have the healthcare homes that are looking at breaking down those current funding barriers to providing a model of care that means that someone is walking alongside someone with a chronic condition. We are excited by that. It would mean that we are funding for outcomes rather than volume and activity. That is really one of the challenges within our current system—that we need to be funding for outcomes, funding for prevention—and this body really sits in that.

Mrs WILSON: Welcome. I notice your recommendation No. 4 relates to the partnership framework and clear protocols and criteria to ensure there is no conflict of interest. Have you ever seen this happen before?

Ms Fox: The best way that we would like to look to that is flipping it and having any initiatives analysed for what is best for consumers. When we talk about vested interests or those partnerships that we see this organisation should avoid where it may have happened in the past, that might be around engagement with fast-food chains, alcohol, tobacco, supermarkets. We want this body to be able to influence the behaviour and the practices of those companies but exercise caution in any kind of arrangements that may have either an actual or a perceived conflict of interest.

Mr DAMETTO: Thank you very much for coming along and giving your evidence today. I noticed at the start of your address to the committee this morning that you acknowledged the traditional owners of this country, which was brilliant. We love how you did that. My question is more about how we are closing the gap. We are failing to close the gap on so many different fronts, including health. In your opinion, what can we be doing better to get better health outcomes in our rural, regional and remote traditional owner communities?

Ms Fox: This organisation absolutely needs to have a focus on both of those parts of our population. Again, it is listening to them. They know what the problems are and they want to work alongside health agencies and all the other partners—

Mr DAMETTO: Have we not been listening for 10 or 15 years? Is that what is happening here?

Ms Fox: Listening and acting and funding and implementing these initiatives in a really effective way - and not just pilots but, if they work, then upscaling them and continuing to support them.

CHAIR: Thank you, Melissa, I appreciate your time.

COURTNEY, Mr Dom, Executive Officer, Queensland Outdoor Recreation Federation

CUMMISKEY, Mr Peter OAM, Chief Executive Officer, Sports Federation of Queensland—QSport

REEVES, Mr Phil, Executive Chairman, Queensland Fitness, Sport and Recreation Skills Alliance

CHAIR: Phil, I respectfully acknowledge you as a former serving member of the House, whether you would wish me to or not. I appreciate that you are on the other side of the table here, but you have served in this place and I acknowledge you as such. Thank you all for coming and I thank you for making a submission. I have mentioned this morning that this is the fourth time I have looked at this issue. It is really lovely to have a panel of sporting and fitness sector representatives. It is not something that we have had in our previous inquiries, so I am really looking forward to hearing your views today. We will move through the panel, like we have with those before you, and give you about two minutes to make a quick opening statement, if you would like to.

Mr Courtney: Thank you. I would also like to acknowledge the traditional owners of the land where we gather. I acknowledge elders past, present and emerging. That is particularly relevant for us because of the connection between land and the places and spaces where outdoor recreation activities take place across our state.

QORF is the peak body representing the interests of the outdoor recreation sector across the state. That incorporates nature based and outdoor recreation, outdoor education activities, adventure tourism, adventure therapy and adventure racing. We are a member based not-for-profit association and we are charged with representing and advocating on behalf of the coalition of outdoor recreation groups and individuals.

Queenslanders highly value and enjoy experiences in the outdoors, and QORF acts to protect the legacy of participation in outdoor activities for our current and future population. We welcome the establishment of Health and Wellbeing Queensland as a statutory body contributing to the objectives of the bill. Health and Wellbeing Queensland has the potential to play a key role in the health and wellbeing of all Queenslanders, but Health and Wellbeing Queensland cannot do that on its own. We believe that outdoor recreation opportunities and locations provide Queenslanders with positive quality-of-life choices, experiences and social connections. Outdoor recreation spaces and activities connect people to place, self and others and enable communities to lead healthier and more fulfilling lives.

With support from the Queensland government, since May 2014 QORF has been running the Nature Play Queensland project, which is aimed at making outdoor play a normal part of childhood again for Queensland children. As part of the Nature Play Queensland project, we have come to the realisation that a healthy world comes from a complete and balanced childhood incorporating outdoor free play. Similarly, a healthy Queensland comes from a balanced life incorporating outdoor activities. We call for an alignment between Nature Play and Health to strengthen Queenslanders' health and the health of their families, neighbourhoods and communities.

QORF looks forward to developing a close partnership with Health and Wellbeing Queensland once it is formed, including partnering and collaborating on projects about improving the health and wellbeing of Queenslanders. We also note that the Health and Wellbeing Queensland Bill includes an amendment to the Hospital Foundations Act 2018 to have the effect of accommodating the possibility of a foundation being set up to support and promote the objectives of preventing illness and improving the health and wellbeing of the Queensland population. We support that amendment as a means of funding the programs and actions and as a way to appropriately fund some of the outcomes and outputs of Health and Wellbeing Queensland.

We have also recently made submissions to the development of the Queensland Sport and Active Recreation Strategy 2019-2029 and the Queensland Walking Strategy 2019-2029. Those two strategies are being developed by the Department of Housing and Public Works for Sport and Recreation and also the Department of Transport and Main Roads through their cycling programs and teams. We take the view that each of those strategies needs to be read together as part of the bigger picture regarding physical activity across Queensland. That applies just as much to Health and Wellbeing Queensland. QORF also supports the submission made by the Queensland Fitness, Sport and Recreation Skills Alliance regarding the Queensland Health and Wellbeing Bill, which I am sure Phil will speak more to in a moment.

CHAIR: Thank you.

Mr Reeves: Thank you. I, too, would like to acknowledge the traditional owners and appreciate the committee for this invitation. It is good to be back—for a little while. Today, we would like to take this opportunity to place on record our support, as key bodies of the Queensland fitness, sport and active recreation industry and the industry workforce, for this bill. Our organisation is a key voice in the industry in relation to skills and training needs and other workforce development. We work in conjunction with two of my colleague organisations here—with QORF and QSport—and Fitness Australia through their Queensland manager and the community recreation sector as well. We are the whole industry.

Our organisation supports the establishment of a health promotion agency. If the committee and the parliament support the bill, we wish to partner in the delivery to make the new agency a success for the people of Queensland. We support the bill, because we believe in the objective of improving the health and wellbeing of Queenslanders and reducing the risk factors associated with chronic disease and addressing the social inequalities in the health system. We believe that there are worthy objectives in keeping with our sector's desire to contribute to physical activity, social inclusion, mental health and the job readiness of Queenslanders.

As Queensland Fitness, Sport and Recreation Skills Alliance outlined in its submission, we believe that Queenslanders need a health promotion agency but, importantly, we believe that the agency needs to be dedicated and focused on physical activity.

Put simply, we believe that the proposed Health and Wellbeing Queensland agency must be mandated to ensure the agency is responsible for funding fitness, sport and active recreation and is involved in setting the agenda for health promotion. As a representative of the sector that helped deliver fitness, sport and active recreation opportunities to Queenslanders, we stand ready to be partners on this exciting agenda. We hope there will be a partnership between our sector and the new agency so that a large investment of public funds in public health and physical activity is done in a strategic and connected way.

Our submission has outlined our belief that the government support for fitness, sport and active recreation should be tied to measurable health, social inclusion and employment outcomes and that a trained and skilled workforce is needed to help the sector operate. We suggest the proposed Health and Wellbeing Queensland agency have a charter which entrenches the concept we call Get Active Queensland, which is a model inspired by the Victorian Health Promotion Foundation, and have a dedicated focus on a physical activity as part of the overall health system. We are not suggesting that the delivery of overall government support for sport and recreation be merged into the proposed agency, because the existing agency still plays a strong role in partnering with the sector and we want to see it retain its existing focus. We do want to see it actively partner with Queensland Health in rolling out some of its program through Health and Wellbeing Queensland.

The committee would have seen our submission. We proposed concepts such as Health and Wellbeing Queensland local plans, health and activity plans, and providing GPs with the resources to provide physical activity options for their patients. We also made three recommendations in our submission: recommendation 1, to establish place based health and activity plans; recommendation 2, creation of a network of Health and Wellbeing Queensland community facilitators; and recommendation 3 in regard to investing in facilities and spaces.

In summary, we support the bill and the practical delivery of services the proposed new agency would deliver. We believe that physical activity must be enshrined in the charter of the agency to be specifically included in the legislation that will be considered by the Queensland parliament. We encourage you to follow the Victorian model mentioned earlier and recommend it to the committee for consideration. Thanks for giving us the opportunity to have a say.

CHAIR: Thank you, Phil. Peter, welcome. Would you like to make an opening statement?

Mr Cummiskey: Thanks very much for the opportunity to attend today. Much of what I could say about the rationale for QSport's support of the bill and what it proposes to do has already been said by my colleagues. QSport, as the peak body for organised sport in Queensland—QSport is the Sports Federation of Queensland; that is its exact name—comprises 70 state sporting organisations out of something like 80 that could be members. The great majority of participation in sport is covered by our membership. Our role is to assist the development of sport for the reasons that have been stated in relation to why it is proposed that the Health and Wellbeing Queensland Bill be put into place.

Two of the objects—improving the health and wellbeing of Queenslanders and reducing the risk factors associated with disease—are part and parcel of what sport has been doing for decades and will continue to do. The point I want to make is that, in terms of organised sport in Queensland, there are 70 state sporting bodies and 7,000 clubs spread across a very decentralised state. If there were more support to assist those at the grassroots level on the ground, that would not go astray. My experience over many years of being involved with other state jurisdictions—there are health promotion agencies in Victoria and Western Australia, which will be known to the committee—is that sport has been used as a vehicle, and that is the key thing. Organised sport at a state and local level can assist the delivery of the HWQ objects and functions over time.

The key thing I would like to say, having listened to earlier comments in the last half an hour, is that sporting organisations have been innovative. They have had to be over at least the last couple of decades to survive in many cases. I think the potential for sport to be involved as a potential audience, potential target for assistance or their ability to convince the organisation of what it can do is worthy of support. I understand that resources will always be finite and there will never be enough to do the job we would all like to see done. That is a fact that we all understand. Sports use competitive approaches, and organisations that have resources to assist them can do so, and sports in turn can assist the organisations with their objectives. The arrival of a Health and Wellbeing Queensland that engages with sport and supports mutually beneficial outcomes should be a positive development, coming as it will in due course with a new sport and recreation strategy, in the not-too-distant future.

CHAIR: Thank you all for your opening statements and submissions. As I mentioned before, in the first reference that the House gave the former health committee, a lot of the submitters were health and research institutes. I think the fact that you have all submitted some way down the line in the inquiry—you have submitted and you have come—and the nature of your submissions really speaks about people understanding the purpose of the commission and how it has to be cross-sectoral. Personally, it is very exciting to me that you have all submitted, and I think all your submissions speak so strongly to the fact that obviously Sport and Recreation have an incredibly important role to play in terms of the grants they have given every member of this House—and this committee would say we love those grants to our local community sporting groups. However, that is not the only place where your voice is so important; there needs to be a strong voice from your sectors with regard to how the commission operates and the outcome, so thank you. It is really great to have you. Peter, you mentioned 7,000 clubs. With so many sporting options and clubs, in your experience, why do you think that a large percentage of our population and an estimated quarter of our children are still struggling with weight as an issue in the community and in health?

Mr Cummiskey: There are all sorts of reasons individuals are struggling to find the time, in the world in which we live today. The year 2019 is not 1989 and it is not 1969. The world we live in is very different. The pressure on individuals and families is much greater. We have seen that the ability of people to find the time in a much busier lifestyle has had an impact on them doing what they would like to do. I have one in my family who would like to do more and just does not make it to the degree that they would like. It is about ensuring that experiences and examples of how people can get involved in physical activity, in sport and in other forms of recreation—there needs to be promotion of those examples.

We are all capable of seeing how what someone else does acts as a catalyst for individuals. You can have campaigns that suggest to people you need to move to become more active and therefore to increase the level of health and wellbeing. Sport, particularity the more team oriented sports, gives people community engagement; it gives them a place where they can be encouraged by others. If you have to do it on your own, sometimes you do not do it. If you realise you are part of a group and you have some sense of obligation, you may well keep at it.

The fact that there are 7,000 clubs just reflects that in this country and in this state sport is a big part of our whole way of life and we should make sure there is the ability to encourage people to be active and to use the examples that come from that. That is what I think part of this exercise will be about: finding those examples where people are active both individually and in sport. In groups it leads us to encourage others to make that move to overcome those barriers that might exist, be it time, money or whatever.

CHAIR: Do you feel that there are potential barriers, other than time, to families or individuals in the community accessing those clubs and those sporting opportunities? You mentioned money, which I think is a well understood one.

Mr Cummiskey: Most people lock onto cost as an inhibitor. We have been acknowledging that in 70 sports—they are not all the same—there are some sports that require greater investment in not just time but also money to participate. That is a choice. We live in a country where if you want to ride

a horse for your engagement you probably need to have one, and if you want to get involved in certain sports that require equipment then you accept that is part of it. Then we get down to the more populous sports where the cost is less. That is why there are lots of people in some of those sports, because the cost of participation is not the great barrier that it is to some other sports.

There have been various looks at this over time—tax rebates for children in sport going back over 12 years and vouchers that now exist. Around four or five jurisdictions in Australia now have some sort of support that is aimed at assisting families. The thing I want to say to this committee—and I think most of you, if not all, would know this—is the committees that run sporting clubs are usually dominated by parents because their children are there. They do not actually make these things up to make it more expensive than it needs to be. They do have to cover essential costs. They do have to have insurance. They do have to make sure that they provide a safe environment. They do have to make sure that the quality of the instruction of those who line up and sign up to play sport is of a quality that will keep them there. There is a lot of talk about governance being required, and I would not argue with that. In reality, the quality of the coach and the quality of the team manager in many sports, particularly obviously team sports, is the critical determinant, and I can speak with experience.

CHAIR: Phil, on page 12 of your submission you talk about this idea of a potential Queensland government HWQ passport. Can you talk a little bit about that and where the vision came from?

Mr Reeves: It is either a passport or a referral document. We use the term 'passport' when looking at other areas. If a person goes to a GP and the GP realises that person, whether it is a child or a senior or someone in between, needs to get active, similar to the voucher system for getting kids active in clubs these days, it would be a situation of a referral or a passport to go and get involved in an activity. Then we would have those local area providers who coordinate the different activities who maybe work with health groups and fitness centres. For example, in the case of a mature age person who has non-work time as they are still at home and need to be active, gyms are pretty well empty from nine to three in a lot of places, so they could work with the fitness providers. It is not just about working with sport and active recreation; it is also the fitness and the whole lot. The referral has to come from the best people who would know that, and that would be the local GP. It encourages people to get health plans, and part of the health plan is an activity plan or a passport.

CHAIR: Sorry to cut you off: it is an innovative idea and it struck me that the deputy chair made a comment earlier, which I think is very true, that it must be quite an uncomfortable and difficult conversation sometimes to have between a medical professional or a GP and someone they are seeing. The way I read your idea was quite a positive or lovely thing to say: 'Here's a way that we would love to encourage or enable you to be a part of the process.' We will not get into the subject of private health insurers because that is not a good subject. I know that the initiatives many of them were pushing some years ago were for people to access a subsidised Fitbit and things like that that made them feel a bit more positive and encouraged with their fitness. Is that the concept as well?

Mr Reeves: That is right. Government funding through Health and Wellbeing Queensland is probably going to be focused on those target groups - those place based, lower socio-economic circumstances. That is why they can get a voucher for a set amount, whether it is $300 or $500, to go and link with the industry, and with industry being partners it could really be effective.

Mr Courtney: Can I add to what Phil said. Under the Nature Play Queensland project we have been running we have passports which we call a 'passport to an amazing childhood'. We have given out over 400,000 of these in the last almost five years. We have done some place based ones where it might be '15 things to do on the Gold Coast' or in Logan. Different councils have got on board and they want to personalise that for their communities. It could be a similar thing across the community for different healthy, active things that you could do, whether it is to go to a specific gym in their neighbourhood or a different place. It is all about just giving people ideas of how they can get started and get more active. I think that is how it can really work. There is definitely a lot that can be done in that space.

CHAIR: Thank you, and thank you for the way that you encourage people to engage with their natural space, because all of the research shows that that assists in mental health as well as physical health and that is just so important.

Mrs STUCKEY: Thank you for coming in. It is good to see you again, Phil and Peter, and it is nice to see you too, Dom. It brings back lots of fond memories of the Get in the Game initiative that we brought in and the Nature Play and the passports. Those sorts of innovative ideas are what you have been led to do, but I think it is a fairly natural progression. I think it is fantastic to have your involvement in this new HWQ.

There will be a limited bucket of money—there always is—and you know very well how to make the most of that. Are you concerned about the competing interests from so many other organisations? Would you like to see a specific percentage or amount allocated to sports and activities?

Mr Courtney: Personally, I do not think it is really about us as a sector here for it to be a cash grab of a certain percentage of this. I think realistically what we need to have is more engagement with the health side of the world. At QORF we have worked with the Heart Foundation in the last couple of years in relation to the Walk at Work campaign that they were running. We helped promote that for them. Those sorts of things are just ideas that there is no reason not to support. I think it is more about collaborations across the sector. When you are targeting a community, it is about considering all aspects of that community and the different elements that make up that whole healthy lifestyle. We are definitely part of that solution to that process.

I am not sure how you would put a specific percentage on how much of it should be for physical activity or sport or outdoor recreation or fitness if we call it all physical activity. I am not sure how you would do that, because there might be a program which specifically needs an education campaign as the key part to get to that next step. I think it is more about the collaborative nature and how Health and Wellbeing Queensland can bring those different parts together.

Mrs STUCKEY: I do not think you were here for some of the earlier witnesses, because that is where that question came from. They actually were not talking about it as a cash grab; they were talking about it as a percentage of the funding to be allocated just to grants. Given the number of people who will be looking to secure some of that, I was just interested to see if you wanted to be guaranteed that you were in the game for it.

Mr Courtney: I misunderstood.

Mr Reeves: It probably depends on how it is set up. One of our recommendations is the concept of a place based health and activity plan which would involve Health, ourselves, Education, whatever—whether it is a grant program itself within that or whether funding is given to that. You might pick a target area originally so the money goes for that area. It is hard to put a percentage on how much will be grants, because you do not know whether it is just going to be funded or whether it is going to be grant.

What I will say is: if it is a grant program, it is often mistaken that the grant program should go 100 per cent to a particular organisation or centre to do. Part of that grant funding has to be for evaluation, coordination and management, because you have to get that done. If you do not get the evaluation done, you are not going to see the success of it. If you do not have the money to manage or coordinate it, it will not be able to be delivered.

Mr Courtney: In terms of the overall funding of the organisation, I completely support a large proportion of that going to that sort of grant direction, if it goes out to the communities, rather than it being for covering the internal costs of the organisation. I think I misunderstood.

Mr Cummiskey: I do not think there should be a straitjacket on the group that is going to come into play to put this in place, oversight it, monitor it and evaluate it. At the end of the day, I think you want the best propositions to come forward and I think you want the best propositions to be successful. Sport is used to competing within itself, let alone with other sectors. I think 40 per cent of the volunteers in community are involved in sport. There are people out there who, while they are hard-pressed for time between jobs, family and all the other things they have to do, are on their local sporting club committee or on the board of a state sporting organisation. You can rest assured there is enough quality in there that they will think of innovative ways to try to respond to this positively. I do not think we should try to straitjacket it in the first instance, until you have some track record to look at.

Mr SAUNDERS: Thank you for coming in. Peter, earlier we heard from Dr Sultan Linjawi, who was talking about the cost of sport. I know that in my own community this is a big factor for why kids are not playing sport. Do you have any evidence to show that the cost is stopping kids getting out and playing sport? Is there any evidence from QSport across the whole of the state?

Mr Cummiskey: Most of the information is anecdotal. I do not run 70 sports; the organisations themselves are autonomous. They have basically said things to us, as have others in the community—led by the media in the third week of February every year when there is a question that turns up in the *Courier-Mail* about the cost of sport. They go to the same seven sports and they get the same answers. There are a variety of responses, and it highlights the fact that the further down the line in terms of the financial capacity of individuals and families, parents and guardians of children—particularly if the kids want to play more than one sport—that is a factor. I do not know too

many people who do not wince when they get a bill for hundreds of dollars for anything. When push comes to shove, it affects the choice that parents and guardians make for their children in particular. Adults can make those decisions in their own right.

The point was made earlier that the kids of the day are the future of tomorrow. We need to make sure that we do all we can to get children into an active lifestyle earlier rather than later. If we get those sorts of traits embedded in their psyche then clearly they will go forward understanding that.

The question of cost, which is a perennial, is one where it gets back to what I said before. There are different sports that require different levels of support. We have an exercise underway at the moment looking at the cost of sport from the point of view of the sports that provide funding down to grassroots and others that basically are being asked at grassroots to fund upwards, including those sports that have significant international dimensions.

In that sense, the cost of participation is a reality. Those who realise it is a factor are constantly trying to find ways to keep the costs contained. It is very difficult, because other aspects of running a sporting activity impact on those people who are making those decisions. The local club dimension has responsibilities to governments for the leasing of facilities and the costs of utilities. The whole issue of what it costs to put a youngster out to play sport for a normal 20-week activity is something that we are all looking at all the time.

Mrs WILSON: Peter, is there anything in the bill that QSport would like to see added or amended, or was your submission more based on the need to align the government's preventive health strategy across all government sectors and agencies?

Mr Cummiskey: I think the answer is the second. I do not pretend to tell parliamentary draftsmen exactly how they should say these things. The reality is that the fundamental principles here are to put in place something that promotes health and wellbeing. Physical activity brings mental health benefits, and that is the crunch here. This is an opportunity with some resources, limited though they might be - but they are limited everywhere and we understand that. I do not have a problem with what is basically being proposed at this point.

CHAIR: I thank each of you for coming along today. We really appreciate your contribution. That concludes the hearing. Thank you to all stakeholders who have participated today. Thank you to our Hansard reporters. A transcript of these proceedings will be available on the committee's web page in due course. I declare this public hearing on the Health and Wellbeing Queensland Bill 2019 closed.

The committee adjourned at 12.54 pm.