Inquiry into the establishment of a Queensland Health Promotion Commission

Report No. 21, 55th Parliament
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
June 2016
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HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

June 2016
HEALTH, COMMUNITIES, DISABILITY SERVICES AND
DOMESTIC AND FAMILY VIOLENCE PREVENTION
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Mr Joe Kelly MP, Member for Greenslopes
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Ms Ros Bates MP, Member for Mudgeeraba (until 10 May 2016)
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¹ Mr McArdle was appointed Deputy Chair on 11 May 2016. Dr Rowan was Deputy Chair from 24 February 2016 to 10 May 2016. Ms Bates was Deputy Chair from 1 April 2015 to 24 February 2016.
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<td>Australian Association of Social Marketing</td>
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<td>AHPC</td>
<td>Australian Health Policy Collaboration</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>AMAQ</td>
<td>Australian Medical Association Queensland</td>
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<td>ANPHA</td>
<td>former Australian National Preventive Health Agency</td>
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<td>CHETRE</td>
<td>Centre for Health, Equity, Training, Research and Evaluation</td>
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<td>CHO</td>
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<td>HoRSCH</td>
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<td>NSW</td>
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**Glossary**

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Chair’s Foreword

This Report presents a summary of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee’s inquiry into the establishment of a Queensland Health Promotion Commission.

In undertaking the inquiry, the Committee was required to consider the potential role, scope and strategic direction of a Queensland Health Promotion Commission, the effectiveness of collaborative, whole-of-government, and systems approaches for improving and sustaining health and wellbeing including models used in other jurisdictions and population-based strategies.

The Committee sought written submissions, held a public departmental briefing, a public hearing, and travelled to Perth and Melbourne and had a teleconference meeting with the South Australian Department of Health and Ageing to consider comparative health promotion arrangements.

This report sets out a summary of the evidence provided to the Committee. The Committee found that there is strong support for the establishment of a Queensland Health Promotion Commission. The establishment of a Health Promotion Commission in Queensland presents an opportunity to provide strategic leadership and direction on whole-of-government initiatives and partnerships with industry and community organisations to address the social determinants of health and reduce risk factors of chronic illness. The Committee was unable however to recommend a particular model.

On behalf of the Committee, I would like to thank those individuals and organisations who lodged written submissions, met with the Committee and provided additional information during the course of this inquiry.

In particular, the Committee would like to thank representatives from the Western Australian Department of Health, Healthway, the Victorian Department of Health and Human Services and VicHealth who met with the Committee in Perth and Melbourne. The Committee would also like to thank the representatives from the South Australian Department of Health and Ageing who met with the Committee via teleconference. The Committee found the information provided to be invaluable in understanding the comparative schemes.

I would also like to thank the Department of Health for their cooperation in providing information to the Committee on a timely basis. The Committee also wishes to acknowledge the assistance provided by the Queensland Parliamentary Library and Research Service, Hansard and the Committee Secretariat.

I commend this report to the House.

Leanne Linard MP
Chair
Summary of recommendations

Recommendation 1

The Committee recommends that a Queensland Health Promotion Commission be established but could not determine what model.
1. Introduction

1.1 Role of the Committee

The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (the Committee) is a portfolio committee of the Legislative Assembly. The Committee was formerly known as the Health and Ambulance Services Committee which commenced on 27 March 2015 under the Parliament of Queensland Act 2001 (POQA) and the Standing Rules and Orders of the Legislative Assembly. On 16 February 2016, the Parliament agreed to amend Standing Orders, renaming the Committee and expanding its area of responsibility.

The Committee’s primary areas of responsibility include:

- Health and Ambulance Services;
- Communities, Women, Youth and Child Safety;
- Domestic and Family Violence Prevention; and
- Disability Services and Seniors.

Section 92 of the POQA provides that a portfolio committee is to deal with an issue referred to it by the Legislative Assembly or under another Act, whether or not the issue is within its portfolio area.

1.2 Referral

On 16 September 2015, the Legislative Assembly agreed to the following motion:

1. That the Health and Ambulance Services Committee inquire into and report to the Legislative Assembly by 12 May 2016 on:
   a) the potential role, scope and strategic directions of a Queensland Health Promotion Commission,
   b) the effectiveness of collaborative, whole-of-government and systems approaches for improving and sustaining health and wellbeing including:
      i. models used in other jurisdictions (including specific agencies or whole-of-government policy frameworks); and
      ii. population based strategies other than personal interventions delivered by telephone or ICT.

2. That, in undertaking the inquiry, the committee should consider:
   a) approaches to addressing the social determinants of health;
   b) population groups disproportionately affected by chronic disease;
   c) economic and social benefits of strategies to improve health and wellbeing;
   d) emerging approaches and strategies that show significant potential;
   e) ways of partnering across government and with industry and community including collaborative funding, evaluation and research; and
   f) ways of reducing fragmentation in health promotion efforts and increasing shared responsibility across sectors.

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1 Parliament of Queensland Act 2001, section 88 and Standing Order No. 194
2 Queensland Legislative Assembly, Hon SJ Hinchliffe MP, Leader of the House, Parliamentary Debates (Hansard), 16 September 2015: 1850
3
4
Establishment of a Qld Health Promotion Commission

On 18 February 2016, the Legislative Assembly agreed to a motion that the Committee report back on its inquiry into the establishment of a Queensland Health Promotion Commission by 30 June 2016.

1.3 Inquiry process

The Committee’s consideration of the referral included calling for public submissions, a public departmental briefing and a public hearing. The Committee also sought additional written advice from Queensland Health (the Department).

The Committee travelled to Perth and Melbourne from Monday 29 February to Wednesday 2 March 2016. The Committee met with representatives from the Western Australian Department of Health; the Western Australian Health Promotion Commission (Healthway); Dr Sharyn Burns from Western Australian Centre for Health Promotion, Curtin University; Ms Janine Freeman MLA representing the Western Australian Parliament’s Education and Health Standing Committee; the Victorian Department of Health and Human Services; and the Victorian Health Promotion Foundation (VicHealth). A list of representatives who met with the Committee is contained in Appendix D.

The Committee also met with representatives from the South Australian Department of Health and Ageing via teleconference on Wednesday 22 June 2016.

1.4 Submissions

The Committee advertised the inquiry on its website and wrote to stakeholders and subscribers to inform them of the inquiry and invite written submissions.

The closing date for submissions was 27 November 2015. The Committee received 43 submissions. A list of those who made submissions is contained in Appendix A. Submissions authorised by the Committee have been published on the Committee’s webpage and are available from the committee secretariat.

1.5 Public departmental briefing

The Committee wrote to the Department seeking written advice on the referral. The Committee received this written advice on 24 November 2015.

The Committee held a public departmental briefing with officers from the Department on Wednesday 20 April 2016. A list of officers who gave evidence at the public departmental briefing is contained in Appendix B. The transcript of the briefing has been published on the Committee’s webpage and is available from the committee secretariat.

1.6 Public hearing

On Wednesday 25 May 2016, the Committee held a public hearing with individuals and representatives from organisations who provided submissions. A list of representatives who gave evidence at the public hearing is contained in Appendix C. A transcript of the hearing has been published on the Committee’s webpage and is available from the committee secretariat.

1.7 Outcome of committee considerations

The Committee agreed that there was strong support from stakeholders for the establishment of a Queensland Health Promotion Commission (QHPC). The Committee agreed on a recommendation to establish a QHPC but could not determine what model.

**Recommendation 1**

The Committee recommends that a Queensland Health Promotion Commission be established but could not determine what model.
2. Health Promotion

2.1 Ottawa Charter

The first World Health Organisation (WHO) International Conference on Health Promotion was held in Ottawa, Canada, on 21 November 1986. The conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialised countries, but took into account similar concerns in all other regions. The Conference established a Charter (Ottawa Charter) with the following pledge:

- to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;
- to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;
- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
- to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being;
- to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and, most importantly, with people themselves;
- to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

A copy of the Ottawa Charter is contained in Appendix E.

Subsequent to the establishment of the Ottawa Charter in 1986, the WHO has held a further seven global conferences on health promotion:

- Adelaide, Australia (1988)
- Sundsvall, Sweden (1991)
- Jakarta, Indonesia (1997)
- Mexico City, Mexico (2000)
- Bangkok, Thailand (2005)
- Nairobi, Kenya (2009)
- Helsinki, Finland (2013)

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5 http://www.who.int/healthpromotion/conferences/previous/ottawa/en/
6 http://www.who.int/healthpromotion/conferences/previous/ottawa/en/
7 http://www.who.int/healthpromotion/conferences/en/
2.2 What does health promotion mean?

According to the Ottawa Charter health promotion is:

…the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.  

The Ottawa Charter sets out five key ways to promote health, which are to:

- build healthy public policy by putting health on the agenda of policy makers in all sectors and at all levels;
- create supportive environments at home, work and leisure. The built and natural environments are particularly important;
- strengthen community actions by empowering communities to take control of their health by providing information, learning opportunities and funding;
- develop personal skills by enabling people to learn, throughout life, to cope with chronic illness and injuries. This should be facilitated at home, school, work and in the community; and
- reorient health services to ensure the sector promotes good health as well as treats ill health. More attention should be given to research, while services should focus on all of a person’s needs.

The WHO defines prevention as:

…approaches and activities aimed at reducing the likelihood that a disease or disorder will affect an individual, interrupting or slowing the progress of the disorder or reducing disability.

There are three types of prevention: primary, secondary and tertiary. Primary prevention involves taking action before a problem arises in order to avoid it entirely, rather than treating or alleviating its consequences. Secondary prevention is a set of measures used for early detection and prompt intervention to control a problem or disease and minimise the consequences. Tertiary prevention focuses on the reduction of further complications of an existing disease or problem through treatment and rehabilitation.

2.3 Why focus on health promotion?

The Australian Institute of Health and Welfare (AIHW) in its report on Australia’s Health 2014 noted that a person’s health and wellbeing are influenced by a number of intrinsically related biological, lifestyle, societal and environmental factors, many of which can be modified to some extent. Therefore, an important part of disease prevention is health promotion which impacts on these modifiable factors.

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8 [http://www.who.int/healthpromotion/conferences/previous/ottawa/en/](http://www.who.int/healthpromotion/conferences/previous/ottawa/en/)
9 [http://www.who.int/healthpromotion/conferences/previous/ottawa/en/](http://www.who.int/healthpromotion/conferences/previous/ottawa/en/)
10 AIHW, Australia’s Health 2014, May 2014: 344
11 Trust for America’s Health, Prevention for a Healthier America: Investments In Disease Prevention Yield Significant Savings, Stronger Communities, February 2009: 6
12 AIHW, Australia’s Health 2014, May 2014: 160
With regard to health promotion, they stated:

This describes activities which help individuals and communities to increase control over the determinants of their health. Health education and social marketing can be used to promote health, as can policy and structural changes such as taxation, legislation and regulation.  

They noted that programs that promote and protect health, and prevent illness, are undertaken and funded, by many agencies including all three levels of government (federal, state and local), non-government organisations, academia, the private sector and community groups. They also noted that other government sectors such as education, urban planning, and sport and recreation, also play an important role in promoting good health.

The Ottawa Charter identifies that prerequisites and prospects for health cannot be ensured by the health sector alone and health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by non-governmental and voluntary organisations, by local authorities, by industry and by the media. It also notes that health promotion strategies and programs should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

The AIHW noted that the ongoing need for prevention has been brought into sharp focus by the increase in chronic diseases, with the large associated health, social and economic burdens. The focus of health promotion is on the prevention of chronic diseases.

In 2012, the AIHW published a report examining the risk factors contributing to chronic disease. That report defined chronic diseases as:

...illnesses that are prolonged in duration, do not often resolve spontaneously, and are rarely cured completely. Chronic diseases are complex and varied in terms of their nature, how they are caused and the extent of their effect on the community. While some chronic diseases make large contributions to premature death, others contribute more to disability. Features common to most chronic diseases include:

- complex causality, with multiple factors leading to their onset
- a long development period, for which there may be no symptoms
- a prolonged course of illness, perhaps leading to other health complications
- associated functional impairment or disability.

The AIHW report found that the development of chronic diseases is strongly associated with the behavioural risk factors of smoking, physical inactivity, poor diet and the harmful use of alcohol and these behaviours can contribute to the development of biomedical risk factors, such as high blood pressure, obesity and high cholesterol.

The report identifies that that prevention is better than cure is still applicable for preventing chronic disease and reductions in lifestyle risk factors will result in a decrease in the incidence of some chronic diseases, which, in turn, can cause a decrease in premature deaths resulting from those conditions.

13 AIHW, Australia’s Health 2014, May 2014: 344
14 AIHW, Australia’s Health 2014, May 2014: 344
15 http://www.who.int/healthpromotion/conferences/previous/ottawa/en/
16 AIHW, Australia’s Health 2014, May 2014: 343
17 Australian Institute of Health and Welfare, Risk factors contributing to chronic disease, 2012: 5
18 Australian Institute of Health and Welfare, Risk factors contributing to chronic disease, 2012: 12
19 Australian Institute of Health and Welfare, Risk factors contributing to chronic disease, 2012: 8
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The report also identifies that behavioural risk factors are health-related behaviours and although an individual’s actions can be influenced by other factors, for example, personal preferences, family influences, culture, financial resources or climate, in most cases control over these behaviours lies with that person. Therefore, behavioural risk factors are those that are most open to change by individuals, and are often the main focus of primary health control and health promotion activities.\(^{20}\)

The Commonwealth House of Representatives Standing Committee on Health (HoRSCH) recently tabled its report on Chronic Disease Prevention and Management in Primary Health Care. That Committee found that:

> Chronic disease is not a unique problem to Australia; it is a global health concern. Chronic disease is placing a heavy burden on Australia’s health care system and more broadly on Australian society. Recent societal and lifestyle changes have had profound effects on the illnesses that beset the population. While medical advances have served to increase life expectancy and decrease mortality rates, the increase in sedentary workplaces and lifestyle factors such as diet, exercise and habitual behaviour such as smoking and excess alcohol consumption has seen the incidence of chronic disease skyrocket, both domestically and internationally.\(^{21}\)

The report identifies that the financial cost of health care for chronic disease in Australia is extensive noting:

> Of the total 2015-16 Federal Budget expenditure of $434.5 billion, health expenditure totalled $69.4 billion, or just under 16 per cent of total federal expenditure. Health expenditure has also grown faster than the broader economy, with the ratio of health expenditure to GDP increasing from 6.8 per cent in 1986-86 to 9.5 per cent in 2011-12. Over a third of this expenditure is incurred by the four most expensive disease groups, all of which are chronic diseases: cardiovascular diseases, oral health, mental disorders, and musculoskeletal.\(^{22}\)

However, in its submission to the HoRSCH inquiry, the Public Health Association of Australia (PHAA) noted that the cost to the healthcare system is underestimated due to not all healthcare expenditure being allocated by disease, particularly those that are managed in the primary healthcare setting. They noted that the associated costs of chronic disease, such as residential care, would increase significantly if these costs were included.\(^{23}\)

Queensland University of Technology (QUT) advised the Committee that, whilst Queenslanders enjoy a good quality of life and are amongst the healthiest in the world, an increasing and/or high incidence of several risk factors are leading to increased chronic disease, poorer health outcomes and increasing health system costs. They advised that health promotion is an important driver of prevention of risk factors and can contribute to the reduction of risk by invention programs targeted at individuals, settings or whole communities.\(^{24}\)

They noted that best practice requires that health promotion is embedded in all aspects of society as part of everyday life. They advised that as responsibility for most of the major determinants of health lie beyond the health sector, cross-agency partnerships and whole-of-government approaches are needed to better promote population health.\(^{25}\)

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\(^{22}\) House of Representatives Standing Committee on Health, *Report on Inquiry into Chronic Disease Prevention and Management in Primary Health Care*, May 2016: 31-32

\(^{23}\) PHAA, Submission to House of Representatives Standing Committee on Health, Inquiry into Chronic Disease Prevention and Management in Primary Health Care, August 2015: 7

\(^{24}\) Submission 3, QUT: 4

\(^{25}\) Submission 3, QUT: 4
QUT also advised that health promotion is essential to identify the unique risk profile of communities, and can contribute to the reduction of risk by intervention programs targeted at individuals, settings and whole communities. They noted that enhanced cooperation and coordination of effort could potentially be effective in ensuring that the health system is sustainable and contributes to better health for all Queenslanders. It will also reduce fragmentation and increase shared responsibility for health outcomes.

The Chief Health Officer (CHO) advised the Committee that preventable chronic diseases impact on the health and wellbeing of the community and the economy. The CHO also confirmed that some Queenslanders have worse health than others advising:

Socioeconomic disadvantage, remoteness and being Indigenous all bring higher rates of disease and lower life expectancy.

Queensland Health advised that chronic diseases accounted for more than two-thirds of the $147.4 billion in national health expenditure in 2012-13. Health expenditure costs in Queensland associated with chronic diseases were estimated to be $9.6 billion in 2011-12.

The HoRScH inquiry noted that there is a strong distinction between prevention and management of chronic diseases. That Committee noted that prevention and management of chronic disease requires different policies and approaches. They stated:

Prevention of chronic disease, especially those diseases that have strong lifestyle contributory factors, requires very different policies, programs and approaches to management of those conditions. While they share a common care and treatment goal, the funding, providers and resources required have very different focuses and requirements.

Prevention of chronic disease requires education, monitoring and engagement with the community to ensure that contributory lifestyle/risk factors are avoided, or at least monitored and controlled before conditions can manifest or have irreversible contributions.

The report concludes that:

Chronic disease within the Australian context, as it is internationally, is an increasing burden on the health care system, as well as the social and community bonds around care and support for those with chronic disease.

The increasing prevalence of chronic disease within Australian society is a clear indicator that the system of prevention and management needs to adapt to the pressures and care needs of that portion of the Australian population and the support required by their families and support networks.

The Australian Medical Association Queensland (AMAO) advised the Committee that public health is an issue of vital importance to if Queenslanders are to live health, productive lives. They advised that:

Sadly, growing health inequality and unhealthy lifestyles in both Queensland and Australia, especially in children, and an ageing population are increasing problems that are jeopardising the ability of our healthcare system to provide adequate care for Queenslanders.
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The CHO advised that making the healthy choice is not always easy. The CHO advised:

Individuals may not have the right information or they may face a number of social, environmental or other barriers. Individual efforts are often not enough, especially for those in our communities with fewer resources. It is increasingly understood that the lifestyle related behaviours that cause chronic health problems are caused by a complex mix of societal, environmental, socioeconomic and biological factors that are embedded into everyday life.  

The CHO confirmed that:

Health is created outside the health system. Stakeholders from across the community, industry and all spheres of government can contribute to creating a healthier Queensland. Champions for health and wellbeing are needed across all sectors. A number of approaches and tools can facilitate a more comprehensive collaborative approach to achieving health improvements.  

The Heart Foundation agreed that positive health outcomes mostly come from outside of health because where people live, work and play is the biggest impact on their health, as is whether they have education, whether they have employment or whether they are socially connected.

Professor Fleming from QUT advised the Committee that changing attitudes and behaviours is complex and requires a variety of strategies that result in changes. Professor Fleming advised that successful changes in behaviour are the result of multiple strategies across multiple government departments and community organisations over a long period of time.  

The Cancer Council supports the consideration of a dedicated Health Promotion Commission on the basis that one-third of cancers are preventable through healthy lifestyle. They consider that ongoing investment and commitment to preventable health are essential for effective cancer control.  

They advised:

Effective health promotion is based on the principles of the Ottawa charter to develop healthy public policy, to create supportive environments, to strengthen community action, to develop personal skills and to reorient health services. The Ottawa charter also highlights the need to influence the social determinants of health in order to address the root cause of illness and improve the health of disadvantaged populations. Finally, the Ottawa charter acknowledges that many of the levers for good health lie outside the health sector, meaning that the enhancement of health is dependent on action from a broad range of sectors and settings.

The Heart Foundation advised the Committee that health promotion works if it is multi-strategy, multi-sector and sustained. They advised:

What we have seen in the past is it not being sustained. We have seen campaigns working; we see them pulled. We see people working together; we see it stop. We have not had that continuation, and we have seen successes beyond tobacco. We have seen childhood immunisation. We are, according to the Chief Health Officer, seeing a halt in the rise of obesity.

33 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 4
34 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 4
35 Ms Foreman, Heart Foundation, Public hearing transcript, 25 May 2016: 10
36 Professor Fleming, QUT, Public hearing transcript 25 May 2016: 2
37 Ms Border, Cancer Council, Public hearing transcript 25 May 2016: 9
38 Ms Border, Cancer Council, Public hearing transcript 25 May 2016: 9
39 Ms Foreman, Heart Foundation, Public hearing transcript, 25 May 2016: 10
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The PHAA advised the Committee that:

A healthy population is a key requirement for the achievement of society’s goals. Reducing inequalities and the social gradient improves health and wellbeing for everyone. The issues promoting healthy communities are complex and multifactorial.  

Diabetes Queensland advised the Committee that the growth of chronic and preventable conditions has largely replaced infectious and infant mortalities as the primary cause of death. They advised that 90 per cent of deaths are now attributable to chronic diseases and most of these deaths are caused by comorbidities of chronic conditions. They advised that chronic conditions are increasingly present in conjunction with each other. 

The Cancer Council noted that, with the exception of UV exposure, the same four behaviour risk factors cause chronic diseases. They noted that whilst there are differences once a person has a particular disease, the same behaviours can lead to various chronic diseases. The Heart Foundation agreed advising that it is not about particular chronic diseases but the shared risk factors.

Overall, submissions highlighted the strong commitment from many different organisations to the promotion of health and wellbeing and stakeholders generally agreed that there is a need to focus on health promotion as a means to address chronic diseases and illnesses. Submissions also generally agreed that there is a need for the government to respond to this issue.

Queensland Health advised that the financial benefits to the Australian economy of realistic reductions in the prevalence of chronic disease risk factors have been conservatively estimated to be $2.3 billion over the lifetime of the 2008 population. Two-thirds would result from reduced health sector costs, and one-third from financial benefits associated with reduced workforce productivity losses and household costs.

Queensland Health also suggested that focusing on health promotion can provide broad benefits of improved health across the community. They advised:

The gains are shared between individuals, employers, communities, all spheres of government, health, business and other groups. Co-benefits of an effective health promotion agenda may accrue to other policy areas including transport, housing, sustainable development, education and employment. For example, healthier people are more likely to be in paid employment and to take fewer sick days, with benefits flowing to their employers. Improving and sustaining the good health and wellbeing of all Queenslanders therefore has a number of important economic and social benefits. It leads to a stronger economy, increased productivity, reduced demand on health and social services, improved local environments, reduced health inequalities and a better quality of life.

The Queensland Nurses’ Union (QNU) noted research that has found that the ‘health and wealth’ agenda is based on the scientific evidence that health is an investment, not just an expenditure. Healthier populations are more productive, participate more actively in the labour market and gain higher incomes.

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40 Dr Gardiner, PHAA, Public hearing transcript, 25 May 2016: 16
41 Ms Naranjo, Diabetes Queensland, Public hearing transcript, 25 May 2016: 9
42 Submission 6, Diabetes Queensland: 2
43 Ms Border, Cancer Council, Public hearing transcript, 25 May 2016: 14
44 Ms Foreman, Heart Foundation, Public hearing transcript, 25 May 2016, 15
45 Correspondence from Queensland Health to Committee, dated 22 February 2016: 1
46 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 4
47 Submission 7, QNU: 8
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With regard to investment in health promotion activities, VicHealth has noted that:

_Health promotion and disease prevention efforts are essential to sustainable change, and investment is highly cost-effective and can create real and lasting improvements benefiting the health of all Australians. Without a strong focus in these areas, the Government risks reducing the benefits of existing successful approaches and creating additional burden on the economy now and into the future._  

VicHealth has identified that changing people’s health-related behaviours is complex. They noted that:

_While individuals make their own lifestyle choices, governments play a critical role in ensuring every Australian can access and understand the healthy choice, and has the opportunity to actively improve their own health. This is influenced by their family, community, school, workplace, industry, income, social norms and beliefs, and a range of other factors. These influences mean that health and risk behaviours vary between areas and groups of individuals, often causing the greatest burden of ill health to be experienced by those with the most disadvantage._

VicHealth has also advocated for long term sustained commitment to health promotion activities. They noted that evidence has shown that programs such as reducing tobacco use, increasing immunisation and preventing road trauma, have benefited from sustained commitment from successive governments.

They noted:

_While there will always be debate over the best way to implement health promotion and disease prevention activity, there is a clear case for significant and sustained investment in the area. Generational change requires generational commitment, and irrespective of the structures through which they were implemented, Australia’s strongest achievements have enjoyed ongoing support from federal and state governments. VicHealth believes that this is an essential factor in ensuring the success of future preventive efforts, as without it, major investments will be an ineffective and inefficient use of taxpayers’ money due to inconsistent support and delivery._

PHAA cited US research advising the Committee that:

_For every $1 you spend on prevention, you are saving $5 on treatment. It is a really worthwhile investment in making the Health budget go further._

That US study, undertaken by Trust For America’s Health (TFAH), in 2009, found that an investment of $10 per person per year in proven community-based disease prevention programs could yield net savings of more than $2.8 billion annually in health care costs.

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48 Victorian Health Promotion Foundation, *Submission to Senate Standing Committee on Community Affairs*, June 2014: 1
49 Victorian Health Promotion Foundation, *Submission to Senate Standing Committee on Community Affairs*, June 2014: 2
50 Victorian Health Promotion Foundation, *Submission to Senate Standing Committee on Community Affairs*, June 2014: 1
51 Victorian Health Promotion Foundation, *Submission to Senate Standing Committee on Community Affairs*, June 2014: 5
52 Dr Langbecker, PHAA, Public hearing transcript, 25 May 2016: 19
The TFAH report notes:

With this level of investment, the country could recoup nearly $1 over and above the cost of the program for every $1 invested in the first one to 2 years of these programs, a return on investment (ROI) of 0.96. Within 5 years, the ROI could rise to 5.6 for every $1 invested and rise to 6.2 within 10 to 20 years. This return on investment represents medical cost savings only and does not include the significant gains that could be achieved in worker productivity, reduced absenteeism at work and school, and enhanced quality of life.\(^{54}\)

The study also found that prevention efforts that involve direct medical treatment or pharmaceuticals often have higher direct costs. These tertiary measures are aimed at trying to reverse a condition or prevent it from getting worse. Secondary prevention efforts are more effective if they are targeted to at-risk populations.\(^ {55}\)

2.4 Approaches to addressing the social determinants of health

Health Consumers Queensland (HCQ) advised that focusing on the social determinants of health has the potential to reform healthcare. They advised:

By focusing on the social determinants we have the potential to re-think and re-design the way in which health promotion is planned and delivered. If done well, it has the potential to revolutionise healthcare in Queensland by addressing the social determinants of health first, rather than meeting the needs of the institutions who provide ‘health care services’.\(^ {56}\)

2.4.1 What are the social determinants of health?

The AIHW noted that in recent years there has been increased understanding of the importance of social determinants of health – a term that encompasses not only social, but economic, political, cultural and environmental determinants.\(^ {57}\)

The WHO defines the social determinants of health as follows:

The social determinants of health (SDH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.\(^ {58}\)

The WHO considers that these circumstances are shaped by the distribution of money, power and resources at global, national and local levels and that the social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries.\(^ {59}\)

The WHO has established a Social Determinants of Health unit focusing on four key areas: better governance, reducing health inequalities, environmental and social health determinants and monitoring social determinants of health and health equity.\(^ {60}\)

\(^{54}\) Trust for America’s Health, Prevention for a Healthier America: Investments In Disease Prevention Yield Significant Savings, Stronger Communities, February 2009: 3

\(^{55}\) Trust for America’s Health, Prevention for a Healthier America: Investments In Disease Prevention Yield Significant Savings, Stronger Communities, February 2009: 6

\(^{56}\) Submission 26, HCQ: 6

\(^{57}\) AIHW, Australia’s Health 2014, May 2014: 6

\(^{58}\) World Health Organisation, Social determinants of health, (accessed 11 January 2016)

\(^{59}\) http://www.who.int/social_determinants/sdh_definition/en/

\(^{60}\) World Health Organisation, Social determinants of health, (accessed 11 January 2016)
Numerous studies have been undertaken into the impact of the social determinants of health over the past decade. These studies conclude that non-medical factors play a substantially larger role than do medical factors in health. A US study in 2015 stated that research estimates that access to quality medical services may prevent less than 20 per cent of avoidable deaths and the remaining 80 per cent are attributable to genetics (20 per cent) and social, behavioural and environmental determinants of health (60 per cent). The study suggested that added investment in social services such as housing, nutritional assistance, education, public safety and income supports, can result in improved health outcomes and measurable health care cost savings.  

The AIHW has identified that some health determinants have positive effects on health and others have negative effects. They developed a framework, Figure 1, which divides determinants into four major groups whose main direction of influence goes from background factors through to more immediate influences. The framework shows how the first main group—the broad features of society and environmental factors—can determine the nature of another main group. Both these main groups also influence people’s health behaviours, their psychological state and factors relating to safety. These in turn can influence biomedical factors, which may have health effects through various further pathways. 

Figure 1: A framework for the determinants of health

Source: AIHW, Australia's Health 2014, May 2014: 5

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62 AIHW, Australia’s Health 2014, May 2014: 4
The National Rural Health Alliance Inc noted that the social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries. Regional Australians are subject to the same types of social disadvantage as what can occur in cities (such as lower educational attainment, job uncertainties and unemployment, poor access to appropriate housing etc). However, in rural and remote communities the health effects of this disadvantage are compounded by poor access to communications (such as high speed broadband, mobile phone coverage, public transport) and environmental challenges (such as drought, floods and bushfire).

Diabetes Queensland concluded that this means that those who are facing greatest social disadvantage are most likely to be exposed to circumstances which create worse health outcomes for them, in turn increasing social disadvantage.

This issue is discussed further in section 2.5 of this report.

2.4.2 Approaches to addressing the social determinants of health

Submissions highlighted that there are various mechanisms designed to address the social determinants of health. Stakeholders generally agreed that many of the conditions for health and wellbeing lie outside the health system.

The Heart Foundation acknowledged that it is often government’s actions outside the health sector that can most significantly reduce health inequities. They advised that addressing inequity in health outcomes requires engagement with other policy sectors, such as housing, education, employment, and social policy. They advised that siloed departments of government require social determinant advocates to design their policy proposals to work within these departments, rather than expecting silos to be swept aside. They consider that social determinants action will deliver both on social justice and enabling a growing and more productive economy.

The Australian Association of Social Marketing (AASM) advised that hard to reach, or disproportionately affected groups often require more intensive approaches to facilitate health behaviour change and to improve health outcomes. They advised that, top down, expert driven approaches with such groups often fail. They suggested:

> It is often key to harness and facilitate ownership within such communities of health behaviour change efforts so that people feel that their ideas, priorities and realities are being acknowledged.

Professor Russell-Bennett advised the Committee that there is a significant evidence base in the last decade that demonstrates that communication and awareness on its own cannot change behaviour. She advised that:

> ...awareness and communication are the first steps and they create motivation. Without the opportunity and without the ability, all you have is a highly motivated person and it goes nowhere.

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64 Submission 6, Diabetes Queensland: 4

65 Submission 34, Heart Foundation: 7

66 Submission 36, AASM: 4

67 Professor Russell-Bennett, QUT, Public hearing transcript, 25 May 2016: 7
Professor Russell-Bennett cited a study by Carins and Rundle-Thiele in 2012 which reviewed social marketing effectiveness for healthy eating behaviour. That study found that social marketing incorporates a mix of strategies and relying heavily on advertising or communication should be avoided due to the limited efficacy of this approach when compared with programs utilising more of the marketing mix. The study also suggested that consideration must be given to the changes that can be made to social and environmental influences on behaviour as part of an integrated social marketing program.68

The former Australian National Preventive Health Agency (ANPHA) noted that effective preventive health action requires an enabling infrastructure to function including research, monitoring and evaluation, information, a strong workforce and leadership. In response to this issue it developed a framework (Figure 2) depicting elements of and contributions to, achieving and maintaining a systematic approach to preventive health.69

Figure 2: A preventive health system framework

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2.5 Population groups disproportionately affected by chronic disease

The AIHW noted that in 2012, 30 per cent of the Australian population lived in regional and remote areas and that Australians in regional and remote areas tend to have shorter lives and higher rates of disease and injury than people in major cities. The AIHW report on Australia’s Health 2014 states:

Poorer health outcomes in regional and remote areas may reflect a range of social and other factors that are detrimental to health. People living in more remote areas are often disadvantaged with regard to educational and employment opportunities, income, and access to goods and services. They may face more occupational and physical risks, for example, from farming or mining work and transport related accidents, and experience higher rates of other risk factors associated with poorer health, such as tobacco smoking and alcohol misuse.

The CHO noted in her The Health of Queenslanders 2014 Report (CHO Report) that socioeconomic disadvantage is widespread across the state and is particularly prevalent among Indigenous Queenslanders and in areas outside cities. The report noted:

Communities and populations with higher levels of disadvantage experience higher rates of death for many conditions. These include the major causes of death such as cardiovascular disease, cancers and respiratory conditions. Disadvantaged people die at younger ages, with some stark sex related socioeconomic differences, for example, a 20-year gap in median age of death for injury for females in disadvantaged areas compared to advantaged, while the male gap was only two years.

Those diseases and conditions which show the most marked socioeconomic differences are often the most preventable. These include coronary heart disease, stroke, diabetes, lung cancer, melanoma, COPD and injuries such as road transport, falls and suicide.

The causes of poorer health are evident in higher rates of the two most disabling risk factors, obesity and smoking. The large differential in prevalence of smoking that has been evident in the past decade has not changed, with the smoking rate in disadvantaged populations about double the advantaged rate. Obesity has a similar socioeconomic difference which has not changed. Reducing health inequalities will require a focus on reducing the risk factor gap.

QUT noted that significant disparity exists across the state in terms of health outcomes. They noted that poor health outcomes are faced by indigenous people, people experiencing socioeconomic disadvantage and those living in rural and remote communities.

The Northern Queensland PHN noted that a higher burden and risk of chronic disease is carried by older people, males, socioeconomically disadvantaged populations, Indigenous Queenslanders, and those in remote areas. They advised:

NQ PHN has a diverse population and landscape – making up almost one-third of Queensland’s land area. Two-thirds of Local Government areas in our catchment have people living in very remote areas, and 9.5% of our population identify as Aboriginal and/or Torres Strait Islander. Of the 31 LGAs in the region, 12 are with 100% of the population in the most disadvantaged quintile. The leading causes of burden for Indigenous Queenslanders were...

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70 AIHW, Australia’s Health 2014, May 2014: 186
71 AIHW, Australia’s Health 2014, May 2014: 186
72 Queensland Health, The Health of Queenslanders 2014 – Fifth report of the Chief Health Officer Queensland, November 2014: 152
73 Submission 3, QUT: 5
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mental disorders (17% of total), cardiovascular disease (15%), diabetes (10%) and chronic respiratory disease (9%).\textsuperscript{74}

The Apunipima Cape York Health Council noted that while lifestyle factors contribute directly to risk of chronic conditions, there is sound evidence that the lifestyle choices people make are profoundly influenced by the circumstances of their lives. They noted that whilst good nutrition is fundamental, poverty is a key driver of food choice. They advised that the reality is that most Aboriginal and Torres Strait Islander people living in remote communities are in the low income bracket, yet basic food costs them 30 to 40 per cent more than urban centres.\textsuperscript{75}

Apunipima Cape York Health Council advised that there is no entity responsible for coordinating health promotion efforts across Cape York and that it is unrealistic to expect South East Queensland representatives to establish and maintain relationships and networks across sectors in rural and remote communities.\textsuperscript{76}

The Torres and Cape HHS advised the Committee that they have a lack of access to culturally-safe health promotion and prevention programs specifically targeting lifestyle diseases (smoking, nutrition, communicable diseases) and men’s and women’s health and they have no capacity to initiate local health promotion activities.\textsuperscript{77}

2.6 Economic and social benefits of strategies to improve health and wellbeing

Queensland Health noted that an important aim of any health system is to prevent disease and reduce illness so that people remain as healthy as possible for as long as possible. Rising levels of chronic diseases represent one of the biggest health challenges.\textsuperscript{78}

Queensland Health identified that chronic diseases remain the leading cause of death in Queensland and impact on the health system, the health and wellbeing of the community and the economy.\textsuperscript{79}

They also noted that:

The financial benefits to the Australian economy of realistic reductions in the prevalence of chronic disease risk factors have been conservatively estimated to be $2.3 billion over the lifetime of the 2008 population. Two-thirds would result from reduced health sector costs, and one-third from financial benefits associated with reduced workforce productivity losses and household costs.\textsuperscript{80}

The CHO noted in the CHO Report that:

Preventing disease and addressing risk factors in the population has dual benefits. It will reduce the burden of ill health both now and in the future. It will also improve wellbeing and reduce the incidence of chronic disease, providing economic benefits through savings in the health system and improved productivity:

\begin{itemize}
\item Promoting healthy lifestyles will improve the health and wellbeing of the population. Queensland adults with the least number of risk factors report the highest levels of quality of life and satisfaction with their health. In 2012, with each additional chronic disease risk factor a person carried, there was a 70% reduction in quality of life, self rated health and satisfaction with health, irrespective of socio demographic variables.
\end{itemize}

\textsuperscript{74} Submission 10, NQPHN: 4
\textsuperscript{75} Submission 38, Apunipima Cape York Health Council: 7
\textsuperscript{76} Submission 38, Apunipima Cape York Health Council: 8
\textsuperscript{77} Submission 25, Torres and Cape HHS: 1
\textsuperscript{78} Queensland Health, \textit{Health and Wellbeing Strategy – 2015 to 2020}, April 2016: 6
\textsuperscript{80} Queensland Health, \textit{Health and Wellbeing Strategy – 2015 to 2020}, April 2016: 6
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- **Reducing the prevalence of risk factors is achievable, and will deliver significant health improvements.** One-third (31%) of burden in Queensland and 43% of premature deaths are associated with 13 modifiable risk factors. Cardiovascular disease, as the largest cause of death and the most expensive to treat, is important to prevent. Gains will come from a renewed focus on treating and preventing high blood pressure, high cholesterol, high blood glucose, obesity, smoking and physical inactivity.

- **Reducing the incidence of disease has the potential to lower health system costs and improve productivity.** Productivity losses from obesity comprise 44% of the $8.3 billion in financial costs nationally. For heart attacks and chest pain, productivity losses are 50% higher than the $4.3 billion healthcare system costs. The recent slowing of the decline in deaths due to coronary heart disease in younger age groups in Queensland and nationally, is likely to jeopardise future gains in healthcare cost reduction and productivity improvement.81

The CHO advised the Committee that Queensland Health has been working steadily to improve the health of Queenslanders and data now shows that progress has been made in the areas of smoking and obesity rates. The CHO advised that adult and youth smoking rates are at their lowest recorded levels and the age of first trying a cigarette has increased from 14 to 16 years. The CHO also advised that the adult and child obesity rate is no longer increasing which is the first step before the increasing trend can be reversed.82

The Heart Foundation advised the Committee that the health of the economy depends on having a healthy population. They advised that the continuing focus on acute care is unsustainable. They advised that 27 per cent of the state budget is devoted to health and within that only two per cent is devoted towards public health and most of this is spent on cancer screening and immunisation.83

The ‘Cost of Inaction on the Social Determinants of Health’ report was commissioned by Catholic Health Australia, in 2010, to provide an indication of the extent of the cost of Government inaction in developing policies and implementing strategies that would reduce socio-economic differences within the Australian population of working age (25-64 years) that give rise to health inequities.84

This study found the cost of government inaction on the social determinants of health leading to health inequalities for the most disadvantaged Australians of working age is substantial. The study found there were substantial differences in the proportion of disadvantaged individuals satisfied with their lives, employment status, earnings from salary and wages, government pensions and allowances, and use of health services between those in poor versus good health and those having versus not having a long-term health condition. The report considered that improving the health profile of Australians of working age in the most socio-economically disadvantaged groups therefore would lead to major social and economic gains with savings to both the government and to individuals.85

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81 Queensland Health, The Health of Queenslanders 2014 – Fifth report of the Chief Health Officer Queensland, November 2014: ix
82 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 2-3
83 Ms Foreman, Heart Foundation, Public hearing transcript, 25 May 2016: 10
84 University of Canberra, National Centre for Social and Economic Modelling, The Cost of Inaction on the Social Determinants of Health, June 2012: 2
85 University of Canberra, National Centre for Social and Economic Modelling, The Cost of Inaction on the Social Determinants of Health, June 2012: ix
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The study’s findings suggest that if the WHO’s recommendations on social determinants of health were adopted within Australia:

- 500,000 Australians could avoid suffering a chronic illness;
- 170,000 extra Australians could enter the workforce, generating $8 billion in extra earnings;
- Annual savings of $4 billion in welfare support payments could be made;
- 60,000 fewer people would need to be admitted to hospital annually, resulting in savings of $2.3 billion in hospital expenditure;
- 5.5 million fewer Medicare services would be needed each year, resulting in annual savings of $273 million;
- 5.3 million fewer Pharmaceutical Benefit Scheme scripts would be filled each year, resulting in annual savings of $184.5 million each year.86

The report’s authors noted:

These remarkable economic gains are only part of the equation. The real opportunity for action on social determinants is the improvements that can be made to people’s health and well-being.87

The WHO has identified that no single organisation or group is likely to have sufficient resources to tackle the complex health issues related to the prevention and management of chronic diseases. They suggested that partnerships are required to bring together different parties to achieve a shared goal. They suggested the most effective health partnerships work within an overall framework for prevention and control determined by government. They noted that working in partnerships ensures synergies, avoids overlapping and duplication of activities, prevents unnecessary or wasteful competition and provides a means of spreading potential benefits beyond what individual partners would achieve on their own.88

2.7 Emerging approaches and strategies that show significant potential

The AIHW has noted that no single approach works for everyone, as people have complex needs and personal circumstances differ considerably. They identified:

Experience from key approaches suggest that prevention activities appear to work best with a combination of universal and targeted approaches and with multiple strategies and interventions. Efforts to reduce smoking, for example, have relied on universal approaches incorporating: restrictions on how tobacco products can be promoted and sold; graphic health warnings on packages and in the media; increased tobacco excise; public education programs; support for smokers who are trying to quit; and selective prevention approaches that target at-risk populations such as pregnant women and Indigenous Australians.

Preventive action is undertaken in different settings, from the home to urban spaces, schools and workplaces, with each playing a role in creating healthy, sustainable communities. Effective action also requires enabling infrastructure, involving research, information, monitoring and evaluation.89

86 University of Canberra, National Centre for Social and Economic Modelling, The Cost of Inaction on the Social Determinants of Health, June 2012: vii
87 University of Canberra, National Centre for Social and Economic Modelling, The Cost of Inaction on the Social Determinants of Health, June 2012: vii
88 WHO, Preventing Chronic Diseases – a vital investment, 2005: 149
89 AIHW, Australia’s Health 2014, May 2014: 346
They noted that well-planned prevention programs have made contributions to a better quality of life and increased life expectancy. Successful prevention reduces the personal, family and community consequences of disease, injury and disability and allows for the better use of health system resources, producing a healthier workforce, which in turn boosts economic performance and productivity.90

Professor Russell-Bennett from QUT, advised the Committee that there are three factors that bring about significant behaviour change. She advised:

"You need to be motivated to change, and that is where the health promotion/communication side comes in; you need the opportunity to change; and you need the ability to change. "...unless you take a broad approach, a systems approach, to the problem, you are really not going to bring about significant change."91

Professor Russell-Bennett advised that in the past emphasis has been on education and awareness. She advised that whilst this is important, a lot of problems in health do not necessarily need more knowledge or more information but rather they need enablers.92

She provided the Committee with an example of the Red Cross Blood Bank. She advised that their research has found that the single biggest factor that determine whether a young blood donor returns to donate of not is convenience and not about altruism. She advised that they have worked with the blood service to develop an app that allows people to pop in when it is convenient to them rather than working with the systems that they have which are based on a medicalised environment.93

Professor Fleming agreed that not everyone has the ability to make changes for themselves without supports around them. She advised that a campaign increases awareness but it does not necessarily change behaviour. She provided the example of wearing seatbelts in cars. She advised:

"...when seatbelts were first introduced into cars the police were monitoring that but they were not fining anyone. Eventually you were required to wear your seatbelt. There were advertising campaigns, community interventions, conversations in schools with kids asking, ‘Are your mum and dad wearing their seatbelts?’ There were multiple strategies across multiple levels. It was not just about what you hear on television or hear on the radio."94

Professor Russell-Bennett noted that there is a lot of work going on in health that occurs outside the health professional area. She suggested that when it comes to preventative health there are areas where a legislative change would not work.95

The Australian Health Policy Collaboration at Victoria University (AHPC) has stated:

Too often, the claim is made that we don’t know ‘what works’ in preventing chronic diseases. While it is true that there are fewer published studies evaluating the impact of preventive interventions than curative interventions, there is now a solid (and growing) core of robust evidence about cost-effective preventive interventions.96

There have been a number of research studies undertaken examining health investment. For example, a study undertaken by researchers at the University of Queensland assessed the cost-effectiveness of a suite of prevention measures. This study evaluated 150 preventative interventions and found that a large impact could be attained by implementing a small number of cost-effective interventions.97

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90 AIHW, Australia’s Health 2014, May 2014: 347
91 Professor Russell-Bennett, QUT, Public hearing transcript, 25 May 2016: 3
92 Professor Russell-Bennett, QUT, Public hearing transcript, 25 May 2016: 3
93 Professor Russell-Bennett, QUT, Public hearing transcript, 25 May 2016: 6
94 Professor Fleming, QUT, Public hearing transcript, 25 May 2016: 7
95 Professor Russell-Bennett, QUT, Public hearing transcript, 25 May 2016: 3
96 AHPC, Chronic diseases in Australia: Blueprint for preventive action, June 2015: xviii
97 Vos, T, et al, Assessing Cost-Effectiveness in Prevention, September 2010
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The assessed interventions included both population-based and high-risk group preventive interventions covering areas such as mental health, diabetes, tobacco use, alcohol use, nutrition, body weight, physical activity, blood pressure, blood cholesterol and bone mineral density.\(^{98}\)

The AHPC prepared a paper in 2015 paper identifying what they consider to be strategic priorities for taking action to prevent chronic diseases. They identified seven core principles to be adopted to reduce the impact and incidence of chronic diseases as follows:

1. Systemic approach: focus on common risk factors and determinants, not individual diseases.
2. Evidence-based action: act now using best available evidence and continue to build evidence.
3. Tackling health inequity: work to improve and redress inequities in outcomes.
4. National agenda with local action: build commitment and innovation with local action.
5. A life course approach: intervene early and exploit prevention opportunities at all ages and across generations.
6. Shared responsibility: encourage complementary actions by all groups.
7. Responsible partnerships: avoid ceding policy influence to vested interests.\(^{99}\)

2.8 Ways of partnering across government and with industry and community including collaborative funding, evaluation and research

Professor Russell-Bennett suggested to the Committee that a health promotion commission could partner with universities to provide an objective lens to generate evidence. She also suggested that a health promotion commission, if it wants to make significant change, needs to do things differently. It needs to think about creative ways it can involve all stakeholders in the system.\(^{100}\)

Professor Russell-Bennett advised that typically service delivery and health promotion or communication are kept separate. However, she considers that there needs to be integration across service delivery as well as communications.\(^{101}\)

She advised:

> You cannot tell people to do something without having the systems that sit around and support it. It is a bit like saying, ‘Make sure you exercise, make sure you eat plenty of fruit and veg and then we will give you a completely different experience if you come to the hospital’—if you do not do that, if you have preventive health clinics that do not link into that. You need to have that broader approach where everybody is working together. It is also a better return on investment. Instead of having everybody doing their little campaigns and possibly even working against each other, you have this consistent approach and everybody is doing their bit to work together.\(^{102}\)

The Committee explored the issue of research and development and the role of universities with stakeholders. The PHAA suggested that the commission could identify gaps when it was setting its agendas and commission appropriate research. They advised that if the commission identified areas it wished to focus on, universities could step up to fill that gap.\(^{103}\)

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\(^{98}\) AHPC, Chronic diseases in Australia: the case for changing course, October 2014: v

\(^{99}\) AHPC, Chronic diseases in Australia: Blueprint for preventive action, June 2015: i

\(^{100}\) Professor Russell-Bennett, QUT, Public hearing transcript, 25 May 2016: 4

\(^{101}\) Professor Russell-Bennett, QUT, Public hearing transcript, 25 May 2016: 4

\(^{102}\) Professor Russell-Bennett, QUT, Public hearing transcript, 25 May 2016: 4

\(^{103}\) Dr Langbecker, PHAA, Public hearing transcript, 25 May 2016: 18
The PHAA also noted that:

*The nature of universities is that, particularly with research, you always need funding to have a job and to generate research. There is not a lot of funding in Australia for translational programs, as we have been told before. Perhaps there is a role for the commission to play in terms of making better links between programs that work and implementing them into the community. They may not need a lot of money, but if we have programs that work there is no point in them sitting in an academic publication somewhere.*

The Mental Health Commissioner advised that there is a need to ensure processes are put in place that allows collaboration across departments which takes into account funding accountabilities and responsibilities. She advised that there are different processes if agencies are retaining funding control or if funding is to be contributed to a pool. The Mental Health Commissioner also suggested that there was a need for appropriate oversight of the commission.

The Northern Queensland PHN suggested that there is an opportunity to utilise alternative funding arrangements which foster innovation, called Social Impact Investment (SII). They advised that this is an emerging approach to tackling social challenges that brings together capital and expertise from across the public, private and not-for-profit sectors. SII is a financial mechanism in which investors pay for a set of interventions to improve a social outcome that is of financial interest to a government commissioner. If the social outcome improves, the government commissioner repays the investors for their initial investment plus a return for the financial risks they took. If the social outcomes do not improve above an agreed threshold, the investors stand to lose their investment.

SII seeks to generate social impact alongside financial return and can be used to financial social services and social infrastructure with payments normally made based on achieving agreed social outcomes rather than on inputs or activities.

In 2013, the NSW Government established the Office of Social Impact Investment. It pioneered Australia’s first two social benefit bonds, seeking to deliver better services and results for families at risk. It has also released two requests for social impact investment proposals, with the first focused on improving outcomes for vulnerable young people and offenders on parole, and the second on improving outcomes for people with chronic or mental health conditions.

### 2.9 Ways of reducing fragmentation in health promotion efforts and increasing shared responsibility across sectors

Submissions noted current fragmentation around preventive health and the importance of the Commission in promoting alignment between federal, state and local jurisdictions and acknowledging the role of other sectors including non-government organisations. They identified that the value of reducing fragmentation in the delivery and funding of health promotion initiatives by working across government departments, enhancing coordination, undertaking collaborative research and developing partnerships with many different sectors.

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104 Dr Gardiner, PHAA, Public hearing transcript, 25 May 2016: 18
105 Dr van Schoubroeck, Mental Health Commission, Public hearing transcript, 25 May 2016: 27
106 Dr van Schoubroeck, Mental Health Commission, Public hearing transcript, 25 May 2016: 27
107 Submission 10, NQPHN: 5
Professor Fleming advised the Committee that VicHealth and Heathway are examples of a whole-of-strategy approach. She advised that in South Australia they have tried to get a whole-of-government approach but have not been quite as successful, primarily because politicians and senior bureaucrats need to be committed to this approach. She noted that a lot of activity has to be in communities because people’s behaviours will not change unless there is a real buy-in by the community themselves. She advised that this also has to be supported at a policy level by government.110

Professor Fleming advised that activities and commitment must come from whole-of-government, including local government, which play an important role in the development of community inventions that meet the needs of particular communities.111

Professor Fleming also advised that they have found in their research that in some communities there are many health groups trying to provide similar services and some of them did not know that there was another service doing the same thing.112

Professor Russell-Bennett suggested that there is a need to provide incentives, such as reward systems and performance appraisals, which encourage individuals within departments to work collaboratively to ensure that mixed messages are not being delivered.113

The Heart Foundation highlighted that fragmentation often occurs due to a lack of continuous funding. They advised:

...we do have some great powerhouses and research that is happening. What we do not see then is the translation of that into practice at a population level, so we have an RCT, a randomised control trial, and then the funding finishes for that research. We might have some great publications, but then the application of that research to the population is where it often falls down.114

Diabetes Queensland agreed and added that the resources are available but what is required is the ability to harness the information and target it in the right places.115 They consider that in order to reducing fragmentation, the commission could create multi-tiered partnerships between multiple agencies, including departments, HHS, and several non-government agencies in a bid to offer more comprehensive and streamlined responses. They consider that by aligning relevant agencies to contribute collectively to a targeted community, programs can be delivered with more depth and success and it would be the role of the Commission to identify the need, coordinate the partnerships, and evaluate the outcomes.116

The AASM noted that reducing fragmentation can be a positive outcome from the creation of stakeholder networks and facilitating stakeholder dialogue and consensus building on health issues.117

The Committee noted that the Mental Health Commission plays a role around coordination of organisations and what they deliver, in both government and non-government organisations. The Committee sought the Mental Health Commissioner’s advice regarding involving consumers in the process of the planning and development of services and the identification of need. The Mental Health Commissioner identified that one of the challenges they have faced is trying to get the right consumer groups. They have worked with peak groups but increasingly they are working through providers for any research and are getting involved on the ground.118

110 Professor Fleming, QUT, Public hearing transcript, 25 May 2016: 4-5
111 Professor Fleming, QUT, Public hearing transcript, 25 May 2015: 5
112 Professor Fleming, QUT, Public hearing transcript, 25 May 2015: 5
113 Professor Russell-Bennett, QUT, Public hearing transcript, 25 May 2016: 6
114 Ms Foreman, Heart Foundation, Public hearing transcript, 25 May 2016: 11
115 Ms Naranjo, Diabetes Queensland, Public hearing transcript, 25 May 2016: 11
116 Submission 6, Diabetes Queensland: 6
117 Submission 36, AASM: 5
118 Dr van Schoubroeck, Mental Health Commission, Public hearing transcript, 25 May 2016: 27
3. **The effectiveness of collaborative, whole-of-government, and systems approaches for improving and sustaining health and wellbeing**

3.1 **Current Queensland model**

Currently, in Queensland, health promotion is the responsibility of the Preventative Health Branch within Queensland Health. Queensland Health has adopted a Health and Wellbeing Strategy\(^\text{119}\) which outlines the strategic approach, targets, priority action areas, deliverables, and rationale for effective prevention.

The department advised the Committee that it is implementing initiatives to improve and sustain the health and wellbeing of the Queensland population. The department currently funds prevention programs and services, excluding activities undertaken by Hospital and Health Services (HHSs), to address the following key health issues:

- Obesity prevention;
- Smoking cessation;
- Prevention of alcohol-related harm;
- Oral health;
- Sun safety;
- Immunisation;
- Population-based cancer screening initiatives;
- Sexual health; and
- Aboriginal and Torres Strait Islander Health.\(^\text{120}\)

The department has also developed the ‘Health and Wellbeing Strategy – 2015-2020’ which provides a framework for the identification, delivery, and progress reporting of priority actions over the long term. The strategy seeks to promote integrated and complementary action across areas proven to make a difference and to deliver best value for every dollar spent on prevention.\(^\text{121}\)

The strategy identifies six priority areas for action by the Preventative Health Branch and forms part of a larger whole-of-government and community response which is needed to reduce chronic diseases and their modifiable risk factors—unhealthy eating, physical inactivity, risky drinking, unsafe sun exposure, and smoking.\(^\text{122}\)

The priority areas identified in the strategy are:

- Public policy and legislation—creating environments that make it easier to lead healthy lives;
- Sector development—supporting sectors to integrate prevention into their business;
- Social marketing—raising awareness, motivating, and influencing healthy behaviours;
- Personal skills development—empowering people with the skills and knowledge to make healthy choices;

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\(^{120}\) Correspondence from Qld Health to Committee dated 17 November 2016: Attachment 2


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- Risk assessment, early intervention and counselling—identifying and helping people at greater risk to take early action to improve their health; and
- Health surveillance and research—proving timely and robust information to inform policy and practice.\(^{123}\)

The CHO Report notes that:

*The health of Queenslanders continues to improve, and compares well nationally and internationally. However, as in many developed countries, the burden of disease in Queensland is shifting towards greater disability and away from early death. In addition to an ageing population, the drivers for a longer, but not necessarily healthier life are:*

- increases in chronic diseases
- shifts towards disabling conditions and away from fatal causes
- changes in risk factors, particularly the influence of obesity.\(^{124}\)

The CHO advised the Committee that Queenslanders are aware that their lifestyle choices are not necessarily healthy and want to lead an active and healthy life and see a role for government in preventing and reducing lifestyle related diseases.\(^{125}\)

QUT’s submission noted that prevention and early intervention programs in Queensland are currently provided by a range of service providers including government, non-government organisations, local councils, businesses, private health insurance companies, universities and community groups in a range of settings. They advised that the effectiveness of these programs is often limited by short-term funding constraints.\(^{126}\)

QNU identified the most serious gaps in the current primary health system exist for patients requiring highly specialised and diverse health care such as patients experiencing mental illness, particularly in the category of child and youth, disability and domestic violence. They consider that these service gaps are more prominent in indigenous communities as demonstrated by the limited progress against the life expectancy target. They also considered that access to appropriate primary health services for culturally and linguistic diverse communities and refugee communities remains an issue as does the ability to sustain the presence of primary health in regional, rural and remote areas.\(^{127}\)

They consider that reasons for service gaps in the primary health care system include:

- Lack of health service integration;
- Limited patient coordination;
- Inability for clinicians to work to full scope;
- Limited access to the Medical Benefits Scheme (MBS) for nurses/midwives;
- Inadequate health workforce planning;
- Ineffective health policy/strategic direction;
- Insufficient funding/prioritisation;

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125 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 3
126 Submission 3, QUT: 6
127 Submission 7, QNU: 5
• Minimal evaluation and public reporting; and\textsuperscript{128}
• Geographical location.

The Northern Queensland PHN advised the Committee that, in recent years, they have seen a noticeable fragmentation of health promotion services and a lack of state-wide strategic direction, with state-wide efforts focusing on social marketing as its core health promotion strategy. They consider that while social marketing strategies hold value in mass-reach of key messages, it is important to consider hard-to-reach populations and environmental change through a multitude of strategies, to create long-term sustainable change in population health outcomes. Their experience is that community based health promotion interventions, involving the creation of supportive environments for health, policy, regulatory frameworks and legislation, have a strong history of producing favourable, cost-effective behaviour change at a primary and secondary prevention level.\textsuperscript{129}

The AMAQ advised that successive governments have attempted to curb the rate of chronic lifestyle related diseases with limited success. They believe that part of the reason for this is a lack of a coordinated, overarching, whole-of-government policy that tackles the best way to manage public health in a state as large and decentralised as Queensland. They suggested that each government department formulates their own policies without tying their work into the efforts of other departments and the work of departments not typically associated with health issues is ignored.\textsuperscript{130}

The AMAQ also opined that whilst many local governments also take an active role in protecting and improving public health, it is not apparent that the state government policy development process feeds into or works with the local government sector in any meaningful way.\textsuperscript{131}

3.2 Models used in other jurisdictions

Evidence provided to the Committee suggested the models used in Western Australia, Victoria and South Australia could be used in the Queensland context. These models are considered in further detail below.

3.2.1 Western Australia – Healthway

The West Australian Health Promotion Foundation, known as Healthway, was established in 1991 under Section 15 of the *Tobacco Control Act 1990* (WA) as an independent statutory body reporting to the Minister for Health. The original purpose of Healthway was largely to provide funding to replace tobacco sponsorship. Healthway provides grants to a range of organisations in WA to support programs which encourage healthy lifestyles. This includes grants for health promotion projects and campaigns in the community as well as research funding to support studies that add to the knowledge-base around what works in health promotion.

However, there have been recent changes to the legislation relating to Healthway. The *Western Australian Health Promotion Foundation Act 2016* (WA) received Royal Assent in March 2016, which provides for changes in the structure and composition of the Healthway Board and nomination process for Board membership.

The new Act states that Healthway must be led by a seven-person board. One board member is the presiding member, appointed by the Minister on the nomination of the Premier. The Premier must consult with the parliamentary leader of each party in the Parliament before nominating a presiding member. The Minister must appoint the other six members, one of which must be the deputy presiding member. The board can appoint a chief executive officer, but while the changes arising from the Act are implemented, Healthway is run on a day-to-day basis by an Acting Executive Director.

\textsuperscript{128} Submission 7, QNU: 5  
\textsuperscript{129} Submission 10, NQPHN: 6  
\textsuperscript{130} Submission 30, AMAQ: 2  
\textsuperscript{131} Submission 30, AMAQ: 2
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Until 1997, Healthway’s funding was based on hypothecation linked to tobacco taxes. Following a successful High Court challenge to the States’ powers to impose business franchise fees on the sale of tobacco, this source of funding was no longer available. Healthway’s appropriation was then allocated from the consolidated fund and this continues to be the case. Funding provided to Healthway is determined by the government based on historical funding levels. Figure 3 table sets out Healthway’s appropriation from consolidated funds for the past five years and for the next four out-years.132

Figure 3: Healthway’s appropriation from consolidated funds from 2011/12 to 2019/20

<table>
<thead>
<tr>
<th>Year</th>
<th>Appropriation from Consolidated Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>$20,674,000</td>
</tr>
<tr>
<td>2012/13</td>
<td>$21,420,000</td>
</tr>
<tr>
<td>2013/14</td>
<td>$21,783,000</td>
</tr>
<tr>
<td>2014/15</td>
<td>$22,118,000</td>
</tr>
<tr>
<td>2015/16</td>
<td>$22,492,000</td>
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<td>2016/17</td>
<td>$23,037,000</td>
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<tr>
<td>2017/18</td>
<td>$23,614,000</td>
</tr>
<tr>
<td>2018/19</td>
<td>$24,204,000</td>
</tr>
<tr>
<td>2019/20</td>
<td>$24,809,000</td>
</tr>
</tbody>
</table>

Source: Correspondence from WA Education and Health Standing Committee, dated 15 June 2016: 2-3

Healthway advised that:

Consistent with the Tobacco Products Control Act 2006, Healthway’s appropriation is prescribed in the Tobacco Products Control Regulations which are periodically amended to reflect the appropriation for future out years. The most recent amendment was approved by the Executive Council in April 2016 for the periods 1 July 2016 to 30 June 2019 as per the figures in the above table. The appropriation for 2019/20 is reflected in the State Government’s budget papers, but will require a further amendment to the regulations, which will be sought in 2018/19.133

Healthway’s major activity is to fund sponsorships to sports, arts and community organisations to encourage participation in healthy activities, to promote health messages and to create healthy environments. It also provides grants for health promotion projects and health promotion research.

Evaluating the effectiveness of sponsorship projects and determining where to invest sponsorship funding has been an integral part of this program. It established the Graduated Project Evaluation system to evaluate the effectiveness of Healthway’s sponsorship activities. A review of this program was undertaken in 2008 by academics from Edith Cowan University.134

It is a founding member of the WHO’s International Network of Health Promotion Foundations.

3.2.2 Victoria – VicHealth

VicHealth was formed in 1987 as part of the Tobacco Act 1997 (Vic). It was initially formed to promote health generally, but had a particular emphasis on cutting smoking rates. It did this by paying sports and arts organisations not to renew tobacco sponsorships as they ended. Tobacco sponsorships were replaced by sponsorships from health agencies to promote health messages.

VicHealth states that their primary focus is on promoting good health and preventing chronic disease and they do this by creating and funding world class interventions, conducting vital research to advance Victoria’s population health, producing and supporting public campaigns to promote a healthier Victoria and provide transformation expertise and insights to government.135

132 Correspondence from WA Education and Health Standing Committee, dated 15 June 2016: 2-3
133 Correspondence from WA Education and Health Standing Committee, dated 15 June 2016: 3
134 Health Promotion Evaluation Unit, Edith Cowan University, A Review of the Evaluation of Healthway Sponsorships, September 2008
135 Victorian Health Promotion Foundation, Submission to Senate Standing Committee on Community Affairs, June 2014: 1
They also state that they:

...seek to make health gains among Victorians by pre-empting and targeting improvements in health across our population, fostered within the day-to-day spaces where people spend their time, and with benefits to be enjoyed by all.\footnote{Victorian Health Promotion Foundation, Submission to Senate Standing Committee on Community Affairs, June 2014: 1}

VicHealth’s work in health promotion and disease prevention focuses on those areas that represent the greatest burden of disease and disability, and where there is the most potential for health gains: promoting healthy eating, encouraging regular physical activity, preventing tobacco use, preventing harm from alcohol and improving mental wellbeing.\footnote{Victorian Health Promotion Foundation, Submission to Senate Standing Committee on Community Affairs, June 2014: 2}

They advised that their approach is informed by international health promotion frameworks, particularly those led by the WHO and encapsulated in the Ottawa Charter. Their approach is based on the knowledge that health is influenced by a myriad of complex and interrelated factors including individual behaviours and beliefs, family environments, community and work cultures, practices and policies and broader socioeconomic factors.\footnote{https://www.vichealth.vic.gov.au/about/health-promotion}

VicHealth reports to the Minister for Health and is governed by a 14 member Board. The Minister appoints 11 members and three are nominated by the Victorian Parliament from the major political parties. VicHealth actively engages with a range of political views by including on the VicHealth Board an elected representative from each of the Victorian parliamentary party. The tri-partisan nature of VicHealth’s Board has been identified as one of its greatest strengths.\footnote{Correspondence from Queensland Health to Committee, dated 22 February 2016: 6}

In 2014-15, VicHealth employed 72.4 full-time equivalent employees. Figure 4 sets out funding from 1996-97 to 2014-15 and its full-time equivalent (FTE) staff from 1999-00 to 2014-15.\footnote{Funding is classed as money received from the Victorian Government, excluding any other sources of income such as one-off grants and interest received on cash reserves.}

Figure 4: VicHealth’s annual funding (\$m) and full-time equivalent staff

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure4.png}
\caption{VicHealth - Funding (\$m) and full-time equivalent staff}
\end{figure}

Source: VicHealth, Annual Reports, multiple years.
Establishment of a Qld Health Promotion Commission

VicHealth receives its core funding from the Department of Health and Human Services (DHHS) to deliver its objectives. In 2014-15, this funding was $36.9 million. It also periodically receives special funding from various other government agencies to deliver specific programs.

Under section 33 of the Tobacco Act 1987 (Vic), VicHealth must use at least 30 per cent of its budget on payments to sporting bodies and at least 30 per cent of its budget to bodies for the purpose of health promotion.

VicHealth’s Board also sets targets for spending on particular areas, some of which are shown in Figure 5\textsuperscript{141}.

**Figure 5:** VicHealth’s expenditure on selected health promotion areas\textsuperscript{142}

![Graph showing VicHealth's expenditure on selected health promotion areas](image)

Source: VicHealth, *Annual Reports*, multiple years.

VicHealth runs a wide range of health promotion programs, such as programs to encourage people to stop smoking, reduce their alcohol consumption and increase their physical activity. It also invests in research and runs training and events. It engages with all levels of government, across political parties and across a range of portfolios. It also has relationships with health promotion practitioners and the media as well as partners in the sports, research, education, arts and community sectors. It is a founding member of the WHO’s International Network of Health Promotion Foundations.

VicHealth funds health promotion research. It commissions a mix of investigator-led research, strategic research and evaluation research to build evidence for health promotion interventions.

In 2014-15, its investment in research projects, fellowships and scholarships, and centres of excellence in research and practice was over $5 million\textsuperscript{143}. It has invested over $65 million in over 400 public health research projects over the past 15 years.\textsuperscript{144}

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\textsuperscript{141} Some spending schemes are omitted from Figure 2 because they no longer run or have changed over time.

\textsuperscript{142} Note: ‘Improving mental wellbeing’ and ‘Research and evaluation’ have only been listed as separate activities for the final two years.


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VicHealth advised that:

Research is essential to build knowledge and encourage innovative solutions. At VicHealth, research complements all of our health promotion investments. We support a mix of investigator-led research, strategic research and evaluation research to build evidence for health promotion interventions.

By supporting excellent research, improving the overall skills of researchers, providing networking opportunities for researchers and connecting research to policy and practice, we increase the impact of health promotion and public health programs.145

VicHealth also runs programs to improve Victorians’ health and systematically evaluates these programs. Some examples of the findings of its evaluations of some of these programs are below:

- Changing people’s views of alcohol – The Alcohol Cultural Change Project
  
  In partnership with the State Government, VicHealth embarked on a project to change the culture of alcohol consumption in Victoria and to reduce the acceptance of drunkenness among young people.
  
  The project was delivered in two phases, with the second phase based on the findings of the first. The first phase was ‘NameThatPoint’, which was an online forum for 16-29 year-olds to discuss the role of alcohol in their culture. The campaign ran a competition offering $5,000 to the person who could name the point in a night out where they cease to think clearly and continue drinking.
  
  Phase 2, ‘No Excuse Needed’ then followed with a social marketing campaign to persuade people that it was acceptable to drink moderately.
  
  The views of participants in both campaigns were sought to evaluate the campaigns. After the NameThatPoint campaign, around 30% of respondents drank less alcohol and people thought the campaign had realistic aims, was non-judgmental and entertaining.
  
  Participants in the ‘No Excuse Needed’ campaign were more likely to agree that moderate drinking was acceptable and excessive drinking was unacceptable compared with non-participants.146

- Encouraging increased water consumption – The H30 challenge

  In 2014, VicHealth launched the H30 challenge, encouraging Victorians to swap sugary drinks for water for 30 days, with the aim of encouraging people to choose water as their beverage of choice.
  
  Of the 5,500 participants, VicHealth found that 76% claimed they would continue to drink water after the challenge. VicHealth plans to run the campaign again in 2015-16.147

- Encouraging children to walk more – Walk to School 2014

  In 2014, VicHealth ran its annual ‘Walk to School’ campaign for the tenth time. The campaign encourages primary school children to walk to and from school during October. The scheme supports children and their families to establish routines incorporating walking.

VicHealth gave grants, resources and support to 52 local councils to help achieve the campaign’s aim. A record 78,628 students from 499 schools participated. VicHealth’s evaluation indicated that participants walked significantly more after the campaign than children who did not take part.148

Professor Fleming advised the Committee that the VicHealth model is a good example of a broad approach.149 QUT noted that VicHealth funds innovative research projects and fellowships, as well as research conferences and seeks to keep the health promotion workforce strong and engaged across the health sector, communities and industries. It provides advice to government and complements and contributes to the efforts of various government portfolios.150

QUT also considers that VicHealth ensures that the brightest health promotion minds work together on strategic directions. VicHealth focusses on creating the conditions in which good health can flourish – from better public policy and healthy urban environments to more inclusive and respectful communities and their work is underpinned by robust evidence, and is integrated with evaluation, practice and dissemination.151

The Heart Foundation advised that VicHealth has provided a strong and successful model for promoting good health and preventing chronic disease and Queensland would do well to emulate this. However, they considered that if this model were adopted it would need a significant increase in funding to provide the following four key functions undertaken by VicHealth:

- Create and fund world-class interventions
- Conduct research to advance population health
- Produce and support public campaigns
- Provide transformational expertise and insights to government152

3.2.3 South Australia – Health in All Policies

Health in All Policies (HiAP) is about promoting healthy public policy and is based on the understanding that health is not merely the product of health care activities, but is influenced by a wide range of social, economic, political, cultural and environmental determinants of health. It aims to address complex, multi-faceted problems such as preventable chronic disease and health care expenditure require joined-up policy responses. 153

The policy was established in 2007 and has been supported by a high level mandate from central government, an overarching framework which is supportive of a diverse program of work, a commitment to work collaboratively and in partnership across agencies, and a strong evaluation process. 154
HiAP was adopted in response to recommendations made by Adelaide Thinker in Residence Professor Ilona Kickbusch. The HiAP approach is coordinated by a small team who work in a dedicated unit within the SA Department of Health and Ageing. HiAP work is linked strongly to South Australia’s Strategic Plan (SASP), which calls for ‘joined-up’ government approaches that work across departments to achieve specified targets and objectives. Defining features of the SA HiAP model include working on the basis of a co-operation strategy, central governance and use of a Health Lens Analysis (HLA) process. Central governance from the Department of the Premier and Cabinet provides clear direction, accountability and an across-government mandate for inter-sectoral collaboration.155

The HLA process provides a mechanism for examining the connections between policy and health in a systematic and collaborative manner, which results in evidence-based recommendations to guide policy strategy. The HLA process and the ways in which it fits into the SA HiAP model are shown in Figure 6.156

Figure 6: South Australia’s HiAP Model

![South Australia’s Health in All Policies (HiAP) Model](image)


The model seeks to build strong inter-sectoral relationships across government and facilitate policy work of mutual benefit to the health sector and the partnering sector. By incorporating a focus on population health into the policy development process of different agencies, the government is able to better address the social determinants of health in a systematic manner.157

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HiAP is an approach to generating public policies across sectors which systematically takes into account the health implications of decisions and seeks synergies and avoids harmful health impacts in order to improve population health and health equity. It provides a foundation for policy makers from the health sector to work with those in other government sectors to consider the potential health impacts of policies as they are developed and implemented. A HiAP approach is intended to ensure that policies from all sectors have positive, or at least neutral, impacts on population health, wellbeing and health equity.\(^\text{158}\)

The following elements were identified as critical in adopting the HiAP:

- A cross government mandate;
- Leadership from the centre; and
- A dedicated strategic HiAP team within SA Health.\(^\text{159}\)

The Joint governance structure includes:

- ExComm Chief Executives Group
- SA Department of Premier and Cabinet
- South Australia's Strategic Plan
- SASP / HiAP priority setting process

Central leadership for HiAP is provided by a high level government leadership group called the Executive Committee of Cabinet Chief Executives Group (CEG).

They report to the Executive Committee of Cabinet, a sub-committee of the SA Government Cabinet. This Committee is charged with overseeing the development, implementation and evaluation of HiAP across government. A Memorandum of Understanding has been developed to describe the relationship, roles and functions.\(^\text{160}\) A copy of the Memorandum of Understanding is contained in Appendix F.

A study by Flinders University academics published in 2014 comparing the Health Impact Assessment (HIA) approach in NSW and the HiAP approach in SA found that:

\textit{The alignment of the HiAP approach with the systems of the SA Government increases the likelihood of influence within the policy cycle. However, the political priorities and sensitivities of the SA Government limit the scope of HiAP work. The implementation of the HIA approach from outside government in NSW means greater freedom to collaborate with a range of partners and to assess policy issues in any area, regardless of government priorities. However, the comparative distance from NSW Government systems may reduce the potential for impact on government policy. The diversity in the technical and tactical strategies that are applied within each approach provides insight into how the approaches have been tailored to suit the particular contexts in which they have been implemented.}\(^\text{161}\)


\(^{159}\) \url{http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+reform/health+in+all+policies/governance}


The study found that the areas that are selected and the recommendations that are made are bound by the priorities, agendas and political sensitivities of government and politicises the conduct of work under the HiAP approach. The study also found that this approach puts constraints on who can collaborate to undertake the work, with little community input being possible.162

The NSW HIA model was developed in 2003 and has predominantly been developed and applied by the Centre for Health Equity Training, Research and Evaluation (CHETRE) at the University of NSW who use HIA in partnership with both government and non-government collaborators.163

A further study by Flinders University, also published in 2014, evaluated the concept, theory and application of HiAP. This study was part of a longer term study. The authors identified the following four basic HiAP strategies:

- **Health at the core:** Health objectives are at the centre of the activity, for example tobacco reduction policies or mandatory seat belt legislation.
- **Win-win:** The aim is to find policies and action that benefit all parties, such as providing healthy school lunches that promote learning and health.
- **Co-operation:** Emphasis is on systematic co-operation between health and other sectors which benefits the government as a whole. Health seeks to help other sectors meet their goals as a central aim and health is advanced through systematic, ongoing co-operative relationships.
- **Damage limitation:** Efforts are made to limit the potential negative health impacts of policy proposals, such as restricting the sale of alcohol in a new urban development.164

The study identified the following factors that have contributed to HiAP remaining on the policy agenda in SA since 2008:

- HiAP is promoted as a strategy to address complex problems. Initial residency and subsequent return visits of a high profile health theorist who promoted HiAP as a strategy to manage rising rates of chronic disease, ageing population and resulting budgetary pressure, giving it an international context. HiAP was positioned as an innovative means of reducing demand for health care.
- HiAP is positioned as an integral and integrated part of the SA policy context. Executive Committee of Cabinet mandated the application of HiAP approaches across strategic projects linked to the SASP and able to be adapted to key policy drivers. Focus of HiAP work shifts with changing political circumstances in order to maintain relevance and currency.
- HiAP requires only a small investment with the potential for a significant policy and health impact.
- HiAP is supported across government and in particular by the SA Premier.
- HiAP is more acceptable because it works within the existing structures of government rather than creating new structures.165

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The study concluded that:

...early findings indicate that the SA HiAP approach has been successful in developing robust policy processes to bring about action on the determinants of health and has navigated a fast changing and complex policy environment and proved sustainable for over 5 years. 166

A number of stakeholders championed the HiAP approach used in South Australia. The Brisbane North PHN advised the Committee that this an exemplar model for health promotion which elevates the importance of accountability for health impacts of policy at all levels of government and is ideally structured to address the social determinants of health.167

The PHAA advised:

This approach has been developed and tested in a number of countries. It assists leaders and policymakers to integrate considerations of health, wellbeing and equity during the development, implementation and evaluation of policies and services. To advance this health-in-all approach, the health sector must learn to work in partnership with other sectors, jointly exploring policy innovation, novel mechanisms and instruments, as well as better regulatory frameworks. 168

The QNU also recommended that the Commission consider the HiAP approach. They noted that South Australia’s Strategic Plan seeks to enhance the state’s prosperity, sustainability and quality of life for its citizens, and has been described as a blueprint for action on the social determinants of health.169

They noted:

Many of the targets contained in South Australia’s Strategic Plan are important social determinants of health. Action on the targets aims to produce positive health and wellbeing outcomes for the population, and contribute to longer term reduction in health care expenditure. The plan recognises the need for concerted and cooperative action across multiple sectors of South Australian society to achieve the targets.170

QNU also noted that the HiAP approach has also been adopted in countries in Europe.171

The Australian Health Promotion Association (AHPA) advised that the HiAP framework addresses inequity through initiatives and interventions addressing behaviour change within disadvantaged communities, as well as addressing structural changes of the social, economic, cultural and environmental settings that impact on the health and wellbeing of these populations. They consider that this framework should underpin the deliverables of the commission.172

The Northern Queensland PHN believes that adopting a HiAP framework underpinning the commission, will support investment and show real action into addressing health inequality and social determinants of health.173

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167  Submission 24: BNPHN: 1
168  Dr Gardiner, PHAA, Public hearing transcript, 25 May 2016: 16
169  Submission 7, QNU: 6
170  Submission 7, QNU: 6
171  Submission 7, QNU: 8
172  Submission 43, AHPA: 3
173  Submission 10, NQPHN: 3
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The University of the Sunshine Coast (USC) advised the Committee that there are few government policies that consider these socially determined inequalities in health outcomes; and the approaches required to undertake this work is a much needed priority. They noted that the WHO has endorsed the approach of HiAP as a systematic and sustainable way of integrating health and wellbeing into the policy process of all sectors of government, whether they are transport, housing or economic development. They considered that the policy review process across sectors in place in South Australia is an example of where this can work in practice.174

3.2.4 Former Australian National Preventive Health Agency

The Australian National Preventive Health Agency (ANPHA) was established on 1 January 2011, following the commencement of the Australian National Preventive Health Agency Act 2010 (Cwlth). The Agency was abolished effective of 30 June 2014 and its essential functions were transferred to the Commonwealth Department of Health.175

The ANPHA was established, as a statutory authority, in the Health portfolio, for the purpose of providing national capacity to drive preventive health policy and programs. It was intended to provide policy leadership and establish partnerships with Commonwealth, state and territory governments, community health promotion organisations, industry and primary health care providers.176

The ANPHA was Council of Australian Governments (COAG) initiative which agreed at its meeting in November 2008 to a Health Prevention National Partnership. This agreement provided funding to support the following elements:

- increased access to services for children to increase physical activity and improved nutrition;
- provision of incentives for workplaces and local communities to provide physical activity and other risk modification and healthy living programs;
- increased public awareness of the risks associated with lifestyle behaviour and its links to chronic disease;
- a national social marketing campaign; and
- enabling infrastructure, including a national preventative health agency, surveillance program, workforce audit, eating disorders collaboration, partnerships with industry and a preventative health research fund, leading to better oversight and research into prevention, leading to improved outcomes.177

The ANPHA Act provided for the Minister to appoint an advisory council of up to 11 members comprising individuals with a breath of experience and expertise, including members representing the States and Territories and the Commonwealth. The Act also allowed for the appointment of Expert Committees to assist and provide advice to the CEO on preventative health research, healthy lifestyle and tobacco related issues.178

ANPHA had six high-level strategic goals as follows:

- GOAL 1: HEALTHY PUBLIC POLICY: Promote and guide the development, application, integration and review of public, organisational and community-based prevention and health promotion policies.

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174 Submission 14, USC: 2
175 http://health.gov.au/internet/anpha/publishing.nsf/content/home-1
177 Council of Australian Governments, Communique, 29 November 2008: 17
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- **GOAL 2: HEALTH RISK REDUCTION**: Provide policy advice and program leadership to support the development, implementation, evaluation and scaling up of evidence-informed health promotion and health risk reduction strategies for population groups across the lifespan and in a range of settings, with an initial focus on obesity, tobacco and harmful alcohol consumption.

- **GOAL 3: KNOWLEDGE MANAGEMENT**: Drive the development of dynamic knowledge systems that enable evidence-informed policy and practice in prevention and health promotion across Australia.

- **GOAL 4: INFORMATION AND REPORTING**: Guide improvements in national surveillance systems for prevention and health promotion and ensure that information on the progress of prevention and health promotion strategies is made readily available and regularly reported.

- **GOAL 5: CAPACITY BUILDING**: Build broad and comprehensive prevention and health promotion capacity.

- **GOAL 6: ORGANISATIONAL EXCELLENCE**: Establish ANPHA as an innovative, reliable, transparent and accountable organisation, highly regarded by governments, partners, staff and the community with a strong national identity.\(^{179}\)

Its role included responsibility for providing evidence-based advice to governments on the development of preventive health policy and, in particular, managing the Preventive Health Research Fund to gather the information needed to develop new preventive health policies and programs, with a focus on translating research into practice.\(^{180}\) It also funded grants for research programs for other initiatives.\(^{181}\)

It was also required under the Act, every two years starting in 2013, to publish a report on the state of preventative health in Australia. Its first report was published in July 2013.\(^{182}\)

As at 30 June 2012, ANPHA had 39 staff and as at 30 June 2013 it had 42 staff. Initially ANPHA staff were seconded from the Department of Health and Ageing and then transferred to the Agency effective from 29 August 2011.\(^{183}\)

On 15 May 2014, the then Minister for Health and Minister for Sport, introduced the *Australian National Preventive Health Agency (Abolition) Bill 2014*. The purpose of this bill was to abolish the ANPHA. The Minister stated that this abolition would:

\[
...streamline and better coordinate public health efforts that are currently spread across two agencies and remove duplication and unnecessary costs.\(^{184}\)
\]

The Minister also noted that there was a lack of clear demarcation of responsibilities between ANPHA and the Department of Health which had led to a fragmented approach to preventive health and inefficiencies through duplication of administrative, policy and program functions.\(^{185}\)

\(^{182}\) ANPHA, *State of Preventive Health 2013*, July 2013: e
\(^{184}\) House of Representatives, Hon P Dutton MP, Minister for Health and Minister for Sport, *Parliamentary Debates (Hansard)*, 15 May 2014: 3833
\(^{185}\) House of Representatives, Hon P Dutton MP, Minister for Health and Minister for Sport, *Parliamentary Debates (Hansard)*, 15 May 2014: 3833
The Senate referred the Bill to the Community Affairs Legislation Committee. That Committee called for submissions and reported in July 2014. The Committee’s report notes:

While the majority of submissions received by the committee expressed concern at the proposal to abolish ANPHA, a number of submissions acknowledged the benefits of minimising duplication of functions. A consistent theme throughout the submissions was the importance of preventive health and the on-going savings to the community through reductions in chronic disease. Most submissions emphasised the importance of preventive health programs and recommended that preventive health programs and policy should continue when the responsibilities are transferred to the Department from ANPHA.\(^\text{186}\)

The Committee was satisfied that the transfer of ANPHA’s roles and responsibilities to the Department should not result in any diminution of the commitment to preventative health programs and policies and recommended that the Bill be passed.\(^\text{187}\)

A number of commentators were critical of the decision to abolish the ANPHA. Professor Stephen Leeder, Emeritus Professor of Public Health and Community Medicine at the University of Sydney noted that:

Australia faces major problems with potentially preventable disorders such as obesity, diabetes, and heart disease due to problems such as smoking and alcohol abuse. These are national problems demanding national solutions.

ANPHA was a move in that direction. It was not manufacturing iron lungs for polio victims. It was up to the minute. So abolishing it was a pretty dumb thing to do.

The functions of the ANPHA were to act as a clearinghouse for information about preventive programs that work, to foster research and the trial of new ideas, to promote the use of social marketing and social media as ways of communicating preventive messages to the community (modern-day Grim Reapers for example) and advocating nationally for changes that need to be made nationally, say to food, and that cannot be done at state level.

Although a creature of government, it was meant to have independence. It raised hopes that, for once, we might have an institution to support prevention, rather as universities have lecture halls, research workers have laboratories and clinicians have hospitals.\(^\text{188}\)

Professor Leeder also stated:

The politics of prevention are what made ANPHA so important to our health future and so hated by those who, like the tobacco barons of yore, want free rein to push their wares no matter the health costs.

Of course, a new institution will take time to reach its full potential – five years as a minimum. Many people expected too much from ANPHA. Naturally there are things that could have been done better and many of these could still be affected by adjustment if ANPHA had been allowed to live.\(^\text{189}\)

\(^{186}\) Senate Community Affairs Legislation Committee, *Australian National Preventive Health Agency (Abolition) Bill 2014*, July 2014: 4


\(^{188}\) Leeder, Prof S, Centre for Obesity Management & Prevention Research Excellence in Primary Health Care, Seminar, Whither Preventive Health – the Legacy of ANPHA, August 2014


\(^{189}\) Leeder, Prof S, Centre for Obesity Management & Prevention Research Excellence in Primary Health Care, Seminar, Whither Preventive Health – the Legacy of ANPHA, August 2014
3.2.5 Other models

The Committee sought advice from stakeholders on other international models that have been implemented successfully. Professor Russell-Bennett advised:

*I have seen it in the UK, in the national centre for social marketing. That was set up just under a decade ago. It was a joint venture between the Department of Health and a consumer lobby group. They put in a significant amount of money looking beyond health communications to go into more of a systems approach. It has incorporated some behavioural economics, it has incorporated health and it has incorporated business principles and psychologists. There is quite a substantial evidence base, with case studies now sitting around it, that that broader discipline approach works.*

*...the principles of that multidiscipline approach have now been completely embedded in a whole-of-government way. It is making a significant impact on changing the welfare of British citizens.*

QUT’s submission highlighted that the governance models in place at the Queensland Mental Health Commission and the Australian Commission on Safety and Quality in Health Care could be adapted for the commission.

The Queensland Mental Health Commission (QMHC) was established on 1 July 2013 as a statutory body under the *Queensland Mental Health Commission Act 2013*. The Act identifies that the QMHC’s purpose is to drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system.

They consider that the Commission’s job is to:

- Develop a whole of government strategic plan by working together with consumers, families, carers, government and non-government stakeholders and to then facilitate, support and report on their work and the work of others who put the Strategic Plan into action;
- Carry out, support and contribute to reviews, research and evaluation;
- Facilitate and promote awareness, prevention and early intervention strategies; and
- Establish and support mechanisms to improve system governance, such as the Mental Health and Drug Advisory Council and promoting consumer, family and carer engagement and leadership.

The QMHC’s focus is on increasing knowledge, understanding and information sharing through partnerships, public reports and community awareness activities. They work closely with the community, government, and industry in areas including health, employment, education, housing and justice.
3.3 Population based strategies

The WHO has identified that:

Population-wide approaches seek to reduce the risks throughout the entire population. They address the causes rather than the consequences of chronic diseases and are central to attempts to prevent the emergence of future epidemics. Small reductions in the exposure of the population to risk factors such as tobacco use, unhealthy diet and physical inactivity lead to population-level reductions in cholesterol, blood pressure, blood glucose and body weight.\(^{195}\)

However, they also noted that population-wide and individual approaches are complementary and should be combined as part of a comprehensive strategy that serves the needs of the entire population and has an impact at the individual, community and national levels. They also noted that comprehensive approaches should also be integrated and cover all the major risk factors and cutting across specific diseases.\(^{196}\)

There are a broad range of prevention and early intervention strategies. Population based strategies target the whole population and by their nature there is not allowance for targeting specific populations. Population based strategies include: legislation; mass media strategies and education strategies.

For examples population-based strategies for a drug and alcohol program might include:

- Legislative changes, such as licenced premises trading hours, pricing regulation and bans on smoking in specific places.
- Media-based strategies, including mass media campaigns and reduction in the advertising and promotion of health hazards such as alcohol and tobacco.
- Drug education, including school drug education.\(^{197}\)

QUT advised that population-based prevention and early intervention strategies target whole populations with no allowance for targeting specific populations. They provide two examples – a mass-media anti-smoking campaign which aims to reduce the prevalence and take-up of smoking in the entire population or Australia’s Sun Smart initiative to reduce the incidence of sun cancer in the general population.\(^{198}\)

QUT advised the Committee that they have been involved in research and evaluation of population-based strategies which have been developed in Queensland.\(^{199}\)

The Cancer Council advised that population based strategies play a particularly important role in monitoring and evaluation. They provided the example of the Australian Secondary Students Alcohol and Drug Survey which is a cross-sectorial collaboration to collect data from students and focuses on the behavioural aspects of smoking, alcohol, drug use and other lifestyle factors. The information from this longitudinal study is used to inform strategies to change unhealthy behaviours.\(^{200}\)

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\(^{195}\) WHO, *Preventing Chronic Diseases — a vital investment*, 2005: 90

\(^{196}\) WHO, *Preventing Chronic Diseases — a vital investment*, 2005: 91


\(^{198}\) AHPC, *Chronic diseases in Australia: Blueprint for preventive action*, June 2015: xviii

\(^{199}\) Submission 3, QUT: 13

\(^{200}\) Submission 4, Cancer Council: 5
4. **A Queensland Health Promotion Commission**

Queensland Health advised the Committee that there is a commitment to establish a state-wide QHPC as an independent statutory body under a Queensland Health Promotion Commission Act. They advised:

*The Commission will direct whole-of-government initiatives and partnerships with industry and community organisations to address the social determinants of health and reduce risk factors of chronic illness. It will provide strategic leadership and make health improvement a whole-of-government priority, not just the responsibility of our hospitals and health services. It will seek to engage community organisations, businesses and other levels of government in a common purpose of creating and sustaining healthier Queenslanders.*

All of the submissions received by the Committee supported the creation of a QHPC. Some submissions identified agenda items for the commission to consider. Some submissions also identified ways their organisations could contribute. These included:

- Pharmacy Guild of Australia, particularly through its community pharmacies.
- Northern Queensland PHN, through their Health Action Co-ordinators and established relationships with their community.
- South East Queensland Refugee Health Partnership Advisory Group, through their community engagement model.
- Apunipima Cape York Health Council, through its model of care emphasising local leadership and family centred approach and combining the full spectrum of interventions from prevention to protection.
- Australian College of Nursing, through expanded roles for nurses’ in health promotion and illness prevention.

There were a number of common themes apparent in the submissions received by the Committee. The most common theme was the need for the commission to work collaboratively with government departments and a range of stakeholders such as health and hospital services and universities. Submissions suggested that the Commissioner needed to be able to convince other departments, such as transport, housing and education, to include health considerations in their decision-making processes.

By working collaboratively, submitters suggested that the Commission would be able to access a range of government and non-government data to analyse itself or to publish and allow others to analyse.

Another common suggestion was that the Commission needed to provide vision and strategic direction to the health sector and beyond, and needed the credibility and resources to be able to do this.

Many submissions suggested that the Commission would be well placed to identify and eliminate duplication of services in the health sector.

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201 Correspondence from Queensland Health to Committee, dated 22 February 2016: 2
202 Submission 1, Bicycle Queensland; Submission 9, Optometry Qld & NT; Submission 11, RANZCO; Submission 12, Positive Ageing Cairns Inc; Submission 18, RCPA; Submission 21, Palliative Care Qld Inc; Submission 23, Dietitians Association of Australia; Submission 27, NAQ Nutrition; Submission 37, Brisbane CBD Bicycle User Group;
203 Submission 8, Pharmacy Guild of Australia
204 Submission 10, Northern Qld PHN
205 Submission 17, SEQ Refugee Health PAG
206 Submission 38, Apunipima Cape York Health Council
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The Committee sought a response from the department on the issues raised in submissions. Queensland Health supported the consideration of a HiAP approach that includes strong leadership, political will for decision making and sustainable implementation together with the development of governance structures, tools and mechanisms to facilitate collaboration between stakeholders. However, whilst recognising that VicHealth a leader in the field of health promotion and has a significant role in funding health promotion initiatives and providing sponsorships for sporting or cultural activities, Queensland Health identified that the current budget allocation does not allow for significant funding of health promotion initiatives.

Queensland Health highlighted that the advantages and disadvantages for the commission in having the ability to administer government funds for health promotion initiatives to be:

Advantages – increased profile, status and awareness, and that it could enable the targeting of resources to meet government priorities. The ability to administer limited flexible funds to support innovation or research could enhance the strategic objectives of the commission and its partners and help avoid accountability obstacles associated with whole-of-government initiatives, for example access to funding outside existing program structures.

Disadvantages – being perceived as a major funding body include the potential for attention and focus to shift away from more strategic and cross sectoral or systems approaches; resources to be directed towards procurement and administration processes; and relationships to be focused on purchaser or provider motivations rather than collaboration and collective impact. This power and relationship imbalance is also likely to impact on stakeholders' willingness to jointly fund or consider alternate funding arrangements.

4.1 Potential role, scope and strategic directions of a Queensland Health Promotion Commission

Queensland Health advised the Committee that a QHPC could operate as a catalyst for change and provide leadership across and beyond the health sector. They advised that it could also ensure that the diverse perspectives and experiences are recognised and understood.

Queensland Health suggested that a QHPC could:

...support actions to address the social determinants of health and reduce health inequity;
provide a focal point that identifies key leverage points outside the health system to facilitate long-term change; and facilitate coordination by identifying synergies, connections, redundancies and new opportunities.

They also advised that a health promotion commission could:

...ensure community ownership, engagement and participation; engage key stakeholders across community, industry and government and cultivate strong relationships and participation; and encourage a common language that helps to generate support and facilitate collaborative working leverage from rich networked relationships within government, across sectors and with regional, remote and urban Queensland communities.

207 Correspondence from Queensland Health to Committee, dated 22 February 2016: 4
208 Correspondence from Queensland Health to Committee, dated 22 February 2016: 4
209 Correspondence from Queensland Health to Committee, dated 22 February 2016: 4
210 Correspondence from Queensland Health to Committee, dated 22 February 2016: 5
211 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 3
212 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 4
213 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 4
214 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 4
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Queensland Health advised:

The health promotion commission could: deliver an agreed vision for a healthier Queensland with early wins and longer-term outcomes; encourage evaluation and data sharing; and support knowledge sharing of what works, why and how things have changed. 215

The AMAQ advised that the commission could strengthen Queensland’s efforts to improve public health by coordinating collaboration and partnerships between government departments and external stakeholders. Where such partnerships already exist, the QHPC could strengthen these linkages and help normalise them, making them an intrinsic part of how Government does public health policy development. The QHPC would help ensure that health becomes a key consideration in most, if not all Queensland Government policies. 216

However, the AMAQ identified that the difficulty for any organisation that is trying to bring together every government department and external stakeholders is that without sufficient authority to bring these organisations together, the commission could fail before it even begins. As a new government body, it would lack much of the authority and imprimatur it would need to drive reforms across government and although Queensland Health is a large and powerful organisation, they are not sure that even it wields sufficient strength to help ensure that the commission is successful. 217

The AMAQ has strongly recommended that the commission be established as a statutory body that reports to DPC itself. They consider:

This level of authority would ensure that other Government Departments would feel compelled to contribute in a positive and proactive manner. Given that the DPC would be required to contribute to a whole-of-government plan, it makes sense that it be the lead agency in the development of the Commission, the setting of its strategic scope and the development of the whole-of-government plan. 218

The Heart Foundation advised that they consider the commission is well placed to provide the leadership to help increase the workforce capacity to have a focus on health and wellbeing, to work in partnership, to have the knowledge and expertise, and to provide adequate resourcing, monitoring and evaluation. 219

The PHAA advised that they consider that the commission has an important role to play in addressing the social determinants of health and needs to be adequately funded, be established within key frameworks, engage with partners and have a health for all policy. They also consider that the commission needs to have a strong independent identity and it needs to have a sustained approach. 220

The Chiropractors’ Association of Australia (QLD) considered that there is a need for revision and assessment of current models of health promotion and education. They advised:

The health environment is one of amazing information and technological advancement, however the cost of health care is increasing, and our communities are unhealthier. Government and health care providers, can not keep doing the same things and expect different results. 221

215 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 5
216 Submission 30, AMAQ: 5
217 Submission 30, AMAQ: 5
218 Submission 30, AMAQ: 6
219 Ms Foreman, Heart Foundation, Public hearing transcript, 25 May 2016: 10
220 Dr Gardiner, PHAA, Public hearing transcript, 25 May 2016: 16
221 Submission 28: CAA(QLD): 4
With regard to how the commission can make a difference compared to the current processes, the Brisbane North PHN provided the following analogy:

...there are a whole bunch of buttons that can be pressed to effect change. There is a button that says ‘educate the individual and motivate them to undertake an activity’ and there is a button that says ‘change the law’. There are a whole bunch of buttons that we can press and they all have, hopefully, a positive effect on health promotion. The problem is that those buttons are being pressed randomly at the moment. You press a button over here, a button over here and a button over here, and we hope magically that things will work out best for the Queensland population.

What this commission needs to do is bring some strategy to the button pushing so that the buttons are pressed in the correct sequence and the buttons that need to be pushed together are pushed together. If, on the one hand, we are saying that we want to promote walking because that is healthy but, on the other hand, we are not addressing street lighting and we are not preparing the pavement or the walkway, then we need to press those two buttons together and that is what is not happening. That is what the commission needs to do.\(^{222}\)

### 4.1.1 Relationships

Queensland Health advised the Committee that the prerequisites of an effective partnership include:

- having a common agenda;
- shared measurement systems;
- mutually reinforcing activities; and
- continuous communication.\(^{223}\)

They advised that it is important to have clear delineation of roles and scope of work for each stakeholder, including the Department of Health and the commission, as this would enhance the partnership in order to maximise opportunities and reduce duplication.\(^{224}\)

They consider that it is important that:

...all government departments have the ability to contribute to a shared agenda for health promotion. This includes capacity within the Department of Health to promote health and wellbeing and to support collective action. Collaborative work presents opportunities to explore pooled or alternative funding models as well as changes to financing structures and incentive mechanisms.\(^{225}\)

The CHO advised the Committee that she considers that much of the work of the Commission will be about unlocking and supporting the ‘doing’ potential of many different sectors, organisations and groups.\(^{226}\)

\(^{222}\) Mr Martin, Brisbane North PHN, Public hearing transcript, 25 May 2016: 20
\(^{223}\) Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 5
\(^{224}\) Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 5
\(^{225}\) Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 5
\(^{226}\) Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 5
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The CHO considers:

An effective commission would operate as a catalyst for change whose success is measured by the impact of the actions of a diverse array of organisations and groups. This is a great opportunity for increased leadership in health promotion through: delivering stronger governance with a broad mix of expertise at the highest level; ensuring credibility and buy-in across government, community, industry and academia; using a strategic systems approach to collectively understand how best to make a difference and to measure collective impact; efficiently and effectively using human and financial resources; and having a realistic scope and focus on preventable chronic disease and the social determinants of health. 227

The Heart Foundation advised the Committee that there is a need for coordination of effort across government. They provided an example of the Department of Transport and Main Roads (TMR) ‘Active Towns’ program. They advised that this pilot program around active travel but they did not engage with other agencies, such as Sport and Recreation or Health. The Heart Foundation also was critical that a health and social impact assessment was not included in planning bills or regulations. They advised:

What we know is that if the planning that is done today is done badly, the health of people in five, 10 or 20 years will be negatively impacted. 228

The Heart Foundation also expressed the view that Hospital and Health Services (HHSs), whilst wanting to focus on people being healthy and well and on better chronic disease management, they have difficulty engaging with appropriate bodies. They consider there is a huge opportunity to incentivise both HHS and Primary Health Networks (PHNs). 229

The PHAA supported the view that the commission appropriately engage with government at all levels, including local government and with organisations outside of government, including the university sector, non-government agencies, industry and professional associations. They encouraged multi-partisan support for the establishment of a commission. 230

The Brisbane North PHN considers that engagement with GPs and other allied health staff is also crucial. They advised that GPs and allied health staff are often the first port of call for people about health issues and they are a very highly trusted source of information in the community. The Brisbane North PHN considers that GPs and allied health staff are a gateway for a range of other services and supports. 231 The AMAQ agreed that GPs should have a pivotal role in health management. 232

The Mental Health Commissioner advised the Committee that there will be a need for clear definitions of respective roles of agencies as part of the process and there will be a need for agencies to work together to achieve the best outcome. 233

The Mental Health Commission advised that their experience in the first years of operation that there has been a continued need to review its scope particularly in relation to the roles of Queensland Health in differentiating between strategy development and advocating for change, and responsibility for the implementation of programs. They consider that this is to be expected and is a necessary part of minimising the gaps between strategy development and implementation without creating overlap and duplication. 234

227 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 5
228 Ms Foreman, Heart Foundation, Public hearing transcript, 25 May 2016: 12
229 Ms Foreman, Heart Foundation, Public hearing transcript, 25 May 2016: 12-13
230 Dr Gardiner, PHAA, Public hearing transcript, 25 May 2016: 16
231 Mr Martin, Brisbane North PHN, Public hearing transcript, 25 May 2016: 17
232 Dr Boyd, AMAQ, Public hearing transcript, 25 May 2016: 22
233 Dr van Schoubroeck, Mental Health Commission, Public hearing transcript, 25 May 2016: 25
234 Submission 19, QMHC: 7
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The Mental Health Commission noted that a similar problem can occur between commonwealth and state, particularly in relation to population health initiatives in the absence of a national strategy that articulates clearly agreed roles, and also provides mechanisms for on-going partnerships to link locally led and locally funded initiatives to the overarching strategy. 235

Queensland Health agreed that clear role delineation between the commission and the department will facilitate effective collaboration and engagement with stakeholders. Queensland Health considers that a way to create clarity in the division of roles is for the Commission to influence the environments in which health is created and support actions to address the social determinants of health, while the department concentrates on individual behaviour change and health monitoring and surveillance. 236

The Mental Health Commissioner also advised that credibility for the organisation is important. She stated:

*If your major lever for change is influence, then the credibility is so important. If your major lever for change is they have the funding, then it is not quite so hard. Certainly, in your first year you are still trying to work out who your stakeholders are. It takes a while. You have to build that personal trust before you get the organisational trust. My stakeholders say that it takes at least five years to really get a whole-of-government traction. I think at three years you are starting to see it, but certainly in the first year you cannot expect too much.* 237

The Mental Health Commissioner also suggested that managing stakeholder expectation is important. 238

4.1.2 Potential role

QUT’s submission identified the role the commission should involve the following core functions:

- guiding whole-of-government initiatives and partnerships to implement programs promoting health and wellbeing, based on the best available evidence
- commissioning, conducting, supporting and contributing to reviews, research and evaluation
- facilitating and promoting awareness, prevention and early intervention strategies using contemporary and innovative media
- guiding improvements in health promotion monitoring and surveillance systems
- building prevention and health promotion capacity and strengthened standards of practice
- consulting with priority groups to develop targeted strategies to address health inequalities
- facilitating and supporting cross-sectoral partnerships
- long term planning of the health promotion and prevention workforce. 239

Professor Russell-Bennett advised the Committee that the role of the QHPC should be to facilitate action. She advised that the government does not have the resources to make it happen on its own. 240

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235 Submission 19, QMHC: 7
236 Correspondence from Queensland Health to Committee, dated 22 February 2016: 3
237 Dr van Schoubroeck, Mental Health Commission, Public hearing transcript, 25 May 2016: 26
238 Dr van Schoubroeck, Mental Health Commission, Public hearing transcript, 25 May 2016: 27
239 Submission 3, QUT: 4
240 Professor Russell-Bennett, QUT, Public Hearing transcript, 25 May 2016: 5
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She suggested:

*If you can imagine a wheel and you have a hub in the middle. The hub is connected to all the bits around it. It makes everything happen. It supports the structure, but it does not necessarily bear all the weight. For instance, the Mental Health Commission needs to do its job and you do not need to take that off it. However, if you position your role as thought leadership, as innovation, and you engender or encourage all the activities, you do not need to do it all yourself. In fact, if you encourage people to work together with communities, you just need to facilitate it. ‘Build it and they will come.’ It is the same way that the eBay model and the Airbnb model leverage the consumer-sharing economy. They do not provide any of the rides. They do not have the manpower for that. They provide the system that allows people to come together and help each other. That creates an exponential effect in terms of the number of people actually working for the common good. I think that is something that the government could do and it would be resource efficient, but it would be more effective because you are getting people to work together. It is about facilitating rather than controlling.*

The Brisbane North PHN suggested that, because the commission needs to influence a whole range of different sectors, both within and outside government, it is not going to be able to have a control and command structure. They advised that:

*If it has good processes to agree what the strategy is and those processes are based on evidence and have extensive involvement of those sectors and communities, if we can generally agree what we want to do then, yes, there will be some winners and losers, to put it that way, as things change. However, if the commission has respect and it does its work well, then hopefully the negative impacts of that will diminish.*

The Cancer Council articulated the view that the establishment of a QHPC applies the five principles of the Ottawa charter and will lead the preventative health agenda in Queensland. They consider that the Commission will require the following core functions:

- Strategic leadership;
- Systems advocacy;
- Extensive stakeholder engagement;
- Research, monitoring and evaluation; and
- The coordination of health promotion activities across the state.

The Cancer Council advised that they consider that the Commission can play a role in identifying and then disseminating best practice information in health promotion and practice. They considered that an important role of the commission will be to be a central body to look across the state and see what health promotion health promotion activities are happening and support the evaluation and continuous monitoring towards targets, the impact of those initiatives and then being able to look at which ones are working the best so they can constantly be refined to improve practice.

The Cancer Council recommended that the commission focus on the following key areas:

- Addressing social disadvantage and supporting at-risk population groups.
- Continuing the pace of progress on tobacco control.
- Tackling Queensland’s overweight and obesity crisis.

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241 Professor Russell-Bennett, QUT, Public hearing transcript, 25 May 2016: 6
242 Mr Martin, Brisbane North PHN, Public hearing transcript, 25 May 2016: 21
243 Ms Border, Cancer Council, Public hearing transcript, 25 May 2016: 9
244 Ms Border, Cancer Council, Public hearing transcript, 25 May 2016: 11
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- Promoting healthy diet and lifestyle habits.
- Encouraging SunSmart behaviour.
- Incentivising innovation through collaborative research and translational initiatives.\(^{245}\)

They consider that these focus areas must be informed by evidence on the social determinants of health, forming a key plank in the Queensland Government’s response to chronic illness and disease through the examination of regulatory levers, programmatic initiatives, social marketing, and service-based responses.\(^{246}\)

Metro North HHS suggested that potential roles for the commission could include:

- providing state wide leadership;
- formalising collaborative arrangements between stakeholders;
- analysing relevant data to guide priorities and action;
- facilitating increased funding for service delivery to be invested in priority areas;
- evaluating programs to ensure ongoing strategies are based on evidence; and
- developing common language around health promotion and prevention.\(^{247}\)

With regard to the role the commission will perform, Diabetes Queensland advised that they would like to see the commission play a role in the mapping of needs and resources and then implementation is done at the local level. They consider that this model will be most effective in achieving behavioural change.\(^{248}\)

The Cancer Council confirmed that this type of model will require a lot of engagement with community based organisations. They consider that the commission needs to have a high-level strategic guidance, planning, coordination, policy role and then engage with the right sectors. They advised that a settings based approach is required to engage with health organisations and other sectors such as education, schools and workplaces and engaging with people where they live, play and learn.\(^{249}\)

They also consider that monitoring and evaluation are critical in assessing the effectiveness of health promotion programs, informing research policy development and service provision.\(^{250}\)

The Brisbane North PHN suggested that the commission should use a matrix model in terms of organising and prioritising its work. They also consider that the state-wide policies of the commission should be operationalised at a regional level so that the framework is set at a state level but the actions driven by local communities.\(^{251}\)

The PHAA suggested that there is a strong role for the commission to make sure there is equity across the state.\(^{252}\) They also consider that the commission should not be in the area of delivering programs.\(^{253}\)

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\(^{245}\) Submission 4, Cancer Council: 6
\(^{246}\) Submission 4, Cancer Council: 6
\(^{247}\) Submission 5, Metro North HHS: 1
\(^{248}\) Ms Naranjo, Diabetes Queensland, Public hearing transcript, 25 May 2016: 12
\(^{249}\) Ms Border, Cancer Council, Public hearing transcript, 25 May 2016: 12
\(^{250}\) Submission 4, Cancer Council: 4
\(^{251}\) Mr Martin, Brisbane North PHN, Public hearing transcript, 25 May 2016: 17
\(^{252}\) Dr Gardiner, PHAA, Public hearing transcript, 25 May 2016: 17
\(^{253}\) Dr Gardiner, PHAA, Public hearing transcript, 25 May 2016: 18
Establishment of a Qld Health Promotion Commission

The Brisbane North PHN agreed that the commission should not be in the area of delivering programs but act as a facilitator for local delivery needs. They provided an analogy of an air traffic controller advising:

_I will use the analogy of an air traffic controller. Planes can come into an airport. They know each other exists. They can communicate with each other. They can relate to each other. They could probably manage an airport kind of okay, but they probably would not use it very efficiently. There would be a 10-minute gap there and a 20-minute gap there and they might come a bit closer to each other and might overlap, and in airport terms that is pretty tragic. What an air traffic controller does is help to manage that system more effectively. They could do it on their own, but they do it better because there is an air traffic controller helping to facilitate the system. That is the additional resource that we need at the local level—that is, someone who is resourced to facilitate bringing the partners together and working locally to figure out how do we achieve the directions that are set at the state level by the commission._

The PHAA also suggested that there was also a role for the commission to play in ensuring the promotion of messages which are evidence based.

The Committee noted that Healthway has a model where the foundation allocates funding for grants and sponsorships. It sought advice from stakeholders regarding whether Queensland should adopt this type of model.

The Brisbane North PHN advocated against this approach on the basis that there is a danger that the focus will be on the small amount of money available to the commission and not on the bigger picture. They advised that the commission needs to influence funding decisions and not just a small amount of funding that it has at its own disposal. They consider that should this approach be taken, there is a risk that the organisation as a whole focuses its attention on how it distributes and manages the funding appropriately. The focus is then taken away from the strategic vision and the idea of bringing partners together. They consider that funding for behavioural interventions should remain with other funding sources.

4.1.3 Potential scope

The Committee questioned the department about what a health promotion commission would add given the existing health promotion activities currently being undertaken by Queensland Health. They advised that a health promotion commission would further Queensland’s interests because health outcomes are dependent on a whole range of areas and Queensland Health does not necessarily have access to all the levers required.

They further noted that:

_It is about bringing all those other organisations closer together and facilitating that dialogue on a more even playing field. I think sometimes it is difficult seeing Health as the leader in this space because it is not; it is about all of these organisations. I think that is what the commission could achieve._

Queensland Health advised that they would continue to do the work they are doing which is about individual change and providing funding to organisations undertaking health promotion media campaigns.

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254 Mr Martin, Brisbane North PHN, Public hearing transcript, 25 May 2016: 18
255 Dr Gardiner, PHAA, Public hearing transcript, 25 May 2016: 20
256 Mr Martin, Brisbane North PHN, Public hearing transcript, 25 May 2016: 18
257 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 6
258 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 7
259 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 7

48
The CHO acknowledged that extensive work has been done in government bring people do get together across government agencies. However, the proposed health promotion commission would be a different vehicle to provide leadership to more easily bring all groups together and involving government agencies, the NGOs and the community.\textsuperscript{260}

The CHO advised that they would not like to see the Health Promotion Commission weighed down with taking on the work the department currently does. The CHO advised that it takes significant resources to undertake this type of operational work. The CHO advised that she considers that the Health Promotion Commission should focus on the:

\textit{...intellectual aspect of bringing people together and finding out the ideas and what strategies we should use, rather than the operational side of going out and doing things that are pretty standard for a department—whatever government department it is.} \textsuperscript{261}

The CHO agreed that the focus of the proposed health promotion commission should build an evidence and research base and have a coordination role.\textsuperscript{262} The CHO also agreed that the commission should work closely with Queensland Health and all other government agencies. The CHO advised:

\textit{If it does not do that, it will not succeed. It cannot just sit there as an independent organisation making pronouncements. It has to engage with all of government but also all of the NGOs, community sectors and academia. It really has to have that major facilitation engagement role, listening to people across the whole breadth of the community and all organisations. It cannot work independently in isolation. That would not progress the agenda.} \textsuperscript{263}

Queensland Health also advised that the commission would need to engage with the Commonwealth and the various agencies within the Commonwealth and would need to work with all three levels of government – state, local and the Commonwealth.\textsuperscript{264}

Diabetes Queensland consider that the key objective of the commission should be to change the health behaviour of the general community and this begins with influencing the behaviour of targeted communities. They consider that to deliver its objective, the Commission should be the key point of coordination for health promotion projects and it should work with communities, through HHS, PHNs and non-government organisations to ascertain local needs and risks.\textsuperscript{265}

Diabetes Queensland advised the Committee that most preventative health programs are aimed at those people who are already in the high-risk category. They consider that a QHPC can have the potential to stem the flow of people into that high-risk category by changing behaviours and outcomes from a much earlier stage. They consider that the commission will have the ability to implement generational change by reacting to the social determinants, targeting messages and having authority across portfolios. They advised that the commission has the capacity to enact real change, isolate the most effective areas of progress and increase the awareness beyond health terminology.\textsuperscript{266}

Diabetes Queensland considers that the Commission should utilise existing networks and resources to help defragment the current responses and use its overview to challenge the embedded behaviours.\textsuperscript{267}

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\textsuperscript{260} Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 9
\textsuperscript{261} Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 6
\textsuperscript{262} Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 6
\textsuperscript{263} Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 6
\textsuperscript{264} Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 11
\textsuperscript{265} Submission 6, Diabetes Queensland: 5
\textsuperscript{266} Ms Naranjo, Diabetes Queensland, Public hearing transcript, 25 May 2016: 9
\textsuperscript{267} Ms Naranjo, Diabetes Queensland, Public hearing transcript, 25 May 2016: 9
\end{flushleft}
Establishment of a Qld Health Promotion Commission

They advised that the formation of the Health Promotion Commission needs to bestow it with the authority of knowing the health needs of Queenslanders, access to inter-departmental information, partnerships with on-the-ground non-government organisations, and the ability to coordinate resources to target localised need. They consider that, for it to be to be effective, the Commission needs to be credible and listened to by other departments, and governments, including around the Cabinet table. It cannot be isolated, and it needs to utilise and cooperate with existing networks to allow it to reach across communities, conditions, and departments. They consider it needs to be a true partner with the existing networks and resources to develop coordinated campaigns in communities across the state.268

The Heart Foundation advised the Committee that there is a need to prioritise and resource and coordinate approaches at a system level with a focus on health and wellbeing.269

The Cancer Council noted that there is currently a lot of duplication, and whilst they encourage as much participation as possible, they consider there is a need for much better coordination and oversight of who is doing what and where, what groups are not being reached, what is best practice, and what models could be used to suit different communities. They consider that there is a need to be efficient with the use of funds to ensure the best value for money.270

The Heart Foundation added that large proportions of charities funds are used covering administrative costs. However, they consider the biggest opportunities for the commission are in the area of enhanced coordination and the social impact of issues being considered across sectors. They advised that at the moment there is very little coordination and therefore there are gaps rather than duplication.271

PHAA consider that the commission should be allowed the freedom to highlight areas where policies may be harmful to health. They suggested that staff of the commission should be invited to early discussions or agenda setting across all areas of government in the formation of policy and legislation to ensure that a health lens is applied to the problem in a co-design process.272

HCQ considered that during its initial phase of development the commission should give equal weight and importance to all stakeholders including health consumers and health consumer organisations, community groups, business, all levels of government as well as health professionals and providers and universities. They advocated that the process must look beyond the typical players involved in health policy and planning to capture all the different perspectives to ensure the commission develops a social model rather than a medical or health model.273

Apunipima Cape York Health Council recommended that there needs to be a mechanism identified which allows for strong regional representation to ensure that the commission can fully represent the whole of Queensland, including equitable resource distribution.274

4.1.4 Potential strategic direction

QUT suggested that the commission’s strategic directions should include the following:

- support implementation of strategies that engage individuals and communities and are designed to prevent illness, reduce hospitalisation and enhance the health of individuals;
- the ability to translate, implement and embed policy and practice research;

268 Submission 6, Diabetes Qld: 1
269 Ms Foreman, Heart Foundation, Public hearing transcript, 25 May 2016: 10
270 Ms Border, Cancer Council, Public hearing transcript, 25 May 2016: 13
271 Ms Foreman, Heart Foundation, Public hearing transcript, 25 May 2016: 13
272 Dr Gardiner, PHAA, Public hearing transcript, 25 May 2016: 16
273 Submission 26, HCQ: 6
274 Submission 38, Apunipima Cape York Health Council: 8
• being innovative in its approach to health promotion activities, including the use of technology, and promoting innovation in health promotion teaching, practice and evaluation;
• alignment with national health priorities and focus on unique Queensland challenges; and
• appropriate funding to ensure long-term success and the improved health of Queenslanders.\textsuperscript{275}

Models in other jurisdictions, including Western Australia and Victoria, have as one of their tasks, funding to community organisations for programs that fit within the health objectives they are trying to achieve. The Committee sought the department’s views on whether a QHPC should be involved in this type of activity.

The department advised that this type of activity is very time consuming for a small organisation to undertake. The CHO advised:

\textit{I think it can become overwhelming and so that is where all the energy of that organisation goes into, rather than into that much more important strategic discussion and facilitation of ideas. I really think the commission should come out with the strategy and the advice about what should happen and then leave it up to other bodies. They need to say, 'Sporting organisations need to be funded to do X and Y and we think this should happen,' but I do not think they need to do that. That is just my view. Otherwise you would need a much bigger organisation than the one that has been suggested to date. I think you would have to look at it quite differently if they are going to get involved in actually funding different groups.}\textsuperscript{276}

Queensland Health advised that they support a commission with a realistic scope and a focus on primary prevention of chronic diseases. They advised that experience suggests that a focus on too many issues will overwhelm the resources of a commission and mean that efforts are spread too thin to achieve results across all issues.\textsuperscript{277}

Queensland Health suggested that the model used for the Queensland Mental Health Commission could be helpful. The CHO advised that the mental health commission has been very strategic in its direction and has engaged with the community.\textsuperscript{278}

Queensland Health advised that in their view, the commission should facilitate and work with a range of different groups and develop a strategic plan. It could examine where duplication is occurring.\textsuperscript{279} It considers that a whole of

Queensland Health also suggested that whilst there is scope for a health promotion commission to be involved in primary, secondary and tertiary prevention, there needs to be consideration of what the organisation can do so that it can succeed rather than giving it too broad a remit.\textsuperscript{280} They support the exclusion of secondary and tertiary prevention from the scope of the commission.\textsuperscript{281} They also suggested that the scope could be broadened as the organisation evolves. The CHO advised:

\textit{I think we have to be careful we do not give any new body an enormous amount of work that is not easily doable.}\textsuperscript{282}

The CHO cautioned against overwhelming a new organisation early on but giving it a defined remit to enable it to ‘have those early wins’.\textsuperscript{283}

\textsuperscript{275} Submission 3, QUT: 4
\textsuperscript{276} Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 7
\textsuperscript{277} Correspondence from Queensland Health to Committee, dated 22 February 2016: 2
\textsuperscript{278} Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 8
\textsuperscript{279} Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 9
\textsuperscript{280} Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 9
\textsuperscript{281} Correspondence from Queensland Health to Committee, dated 22 February 2016: 2
\textsuperscript{282} Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 9
\textsuperscript{283} Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 11
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However, Professor Russell-Bennett suggested to the Committee that they would like to see the remit of the commission being fairly broad to ensure that no area is underemphasised and is inclusive. 284

Professor Fleming agreed advising the Committee, that in her view, the health promotion commission should have a broad remit around a range of strategies. She provided the example of the mental health commission. She advised that:

With the mental health area, you are looking at medical service delivery all the way through to community interventions that prevent mental illness. The health promotion or public health commission can provide some of those strategies, but there are a whole range of other things that a public health commission can look at that do not necessarily have a mental health focus but could contribute to preventing mental illness in the community. 285

Both Professor Fleming and Professor Russell-Bennett agreed that there is no existing model that can be picked up and brought to Queensland. Professor Fleming advised that whilst the models in Western Australia and Victoria are efficient and effective and have been modified over time with different governments they do not coordinate a broader range of strategies. 286 Professor Russell-Bennett advised that if Queensland wants to be a global leader, it means having to take a risk. She advised that:

If Queensland wants to be a global leader and be innovative, it means you have to take a risk to a certain extent. You draw on the evidence to give you the confidence in what you are doing, but ultimately you have to be the first one to do this. I guess that comes down to how much of a difference you want to make. How far are you willing to go in order to make that change? The more you hang on to the way that we currently do it, the more incremental the innovation, the less the impact and the longer it will take. It comes down to the risk propensity of the government, but you do not have to jump blindly. There is a lot of evidence if you put it together that says, ‘This is how to do it,’ but ultimately innovation does require a level of risk and you have to be willing to do that if you want to be a leader. 287

QIMR Berghofer Medical Research Institute recommended that the commission should focus not only on primary prevention of disease (i.e. reducing population exposure to causal factors), but should also promote secondary prevention (i.e. early detection) and tertiary prevention (i.e. promoting a healthy life course after diagnosis, in recognition that an increasing proportion of Queenslanders are living with one or more chronic diseases). 288

The Brisbane North PHN noted that the Ottawa Charter was developed in 1986 so it has been known for decades how to successfully approach health promotion issues. However, what the health promotion area has suffered from is pendulum swings—for example sometimes governments are keen on prevention and at other times acute care takes priority. They noted that there has never been a consistent long-term approach to health promotion. They stated:

That is why we need the commission to have a 10-plus-year outlook so that we agree as a state on what our approach will be and then stick with it so we can achieve some outcomes and not change it every time the minister changes or the government changes, both at the federal level and at the state level. 289

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284 Professor Russell-Bennett, QUT, Public hearing transcript, 25 May 2016: 4
285 Professor Fleming, QUT, Public hearing transcript, 25 May 2016: 5
286 Professor Fleming, QUT, Public hearing transcript, 25 May 2016: 8
287 Professor Russell-Bennett, QUT, Public hearing transcript, 25 May 2016: 8
288 Submission 13, QIMR Berghofer: 2
289 Mr Martin, Brisbane North PHN, Public hearing transcript, 25 May 2016: 19
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The PHAA agreed stating:

*If we want to stop that pendulum swing, we need to be focused on the underlining issues which are the social determinants of health. If we focus on those, that will address issues across-the-board and we will not be swinging between specific conditions or specific behaviours. We will be addressing it across-the-board.*

With regard to the impact of health promotion activities, the AIHW has noted that:

*Sometimes prevention is a long-term prospect, since behavioural and structural change leading to lower rates of disease or premature death can take time. But long-term investments address deeply rooted social factors, or issues beyond the control of individuals or specific sectors, are as important as strategies that focus on shorter-term clinical prevention and other direct services.*

### 4.1.5 Potential structure and governance structures

QUT advised that the commission should be an independent statutory authority established under an Act of Parliament in the Department of Premier and Cabinet (DPC), to ensure a cross sectoral approach. They consider that the statutory authority model will enable the commission to engage in commercial activities, control its own funds, conduct a policy and coordination role, and potentially undertake a regulatory role to determine standards and to allow for specialist, scientific and research expertise.

They also consider that there should be a Queensland Health Promotion Commissioner appointed and there should be a representative advisory body or decision-making board reporting to the Commissioner.

They advised that the board should consider advice on the range of delineated activities of the Commission and assist to prioritise policy and activities. The key terms of reference for the board should be to consider advice and strategic direction on health promotion and prevention measures. They consider that the board should include representatives with expertise in health promotion principles and methods and also those with policy, practice and research expertise in priority risk factors such as obesity prevention, nutrition and physical activity promotion, smoking and alcohol programs. They consider that this body should also include members with an appropriate mix of other expertise such as legal, risk management and accounting/finance, consistent with best practice for managing boards.

Metro North HHS advised the Committee that a critical role for a QHPC would be to investigate and provide clarity to boundary issues affecting the whole of system implementation of strategies to address the determinants of health. They consider that the commission must recognise that these determinants lie in systems outside of health such as housing, education, transport and economic systems as examples. They consider that in order to achieve this, the commission should be independent of government departments, but not the government itself.
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The QNU agreed that the Commission be independent from Queensland Health advising:

*In our view it is essential the Commission operates independently from Queensland Health and has a broad focus beyond the traditional health portfolio area. Its sphere of activity should explore the key social determinants of health and recommend innovative strategies for improvement.*

The Heart Foundation considered that commission would be best established as an independent company limited by guarantee with a separate board of directors. They consider that greater visibility through a well-resourced independent body, strongly supported across government, industry and the community, will help give the issue status and reduce the vulnerability of this priority area from government processes. This governance structure will also allow for additional funding to be sourced via innovative methods.

Queensland Health’s response to this suggestion was to advise that this model is not reflective of the election commitment and would need further exploration of the different accountabilities required by a Commissioner and a Board of Directors and the level of independence from government.

Queensland Health advised that:

*Governance structures can enhance collaboration and leadership and facilitate collaborative problem-solving. Diverse membership provides access to critical knowledge, skills, expertise and diverse perspectives, including those from regional and remote Queensland and Aboriginal and Torres Strait Islander people.*

They consider that the health promotion commission could establish a governance structure that ensures access to critical knowledge and skills for timely advice, flexibility and innovation and provide leadership to facilitate collaborative working.

QUT advised the Committee that governance structures and administrative processes for decision making should be clearly articulated to ensure accountability, probity, ethics and to avoid conflicts of interest.

The Committee sought the views of Queensland Health regarding the governance structure around an independent statutory board. Queensland Health advised that they consider that it would be useful to have the department represented on any governance structure purely so that there can be a shared understanding of what is happening. The CHO advised that, whilst she considers that health outcomes are determined outside the Health department, the department has an enormous role in working information through and understanding what data is available.

With regard to the potential role and structure of the commission, the Mental Health Commissioner advised that it is necessary to articulate what function is to perform before deciding its form. She advised that if it is proposed to get achievement through the achievement of others, with a policy and persuasion function, then a structure similar to the QMHC would be appropriate. The Mental Health Commissioner advised that it needs to be clear how independent it is of government.

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297 Submission 7, QNU: 3
298 Submission 34, Heart Foundation: 2
299 Correspondence from Queensland Health to Committee, dated 22 February 2016: 6
300 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 5
301 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 5
302 Submission 3, QUT: 9
303 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 6
304 Dr van Schoubroeck, Qld Mental Health Commission, Public hearing transcript, 25 May 2016: 25
The QMHC noted that there are many theoretical models for establishing collaborative whole-of-government approaches. Their submission highlighted three different examples, including Healthway, themselves and beyondblue. They noted that for Heathway, the major lever for change is through allocation of funds with parameters specified by its legislation. For the QMHC, the key lever for change is the provision of high quality advice to government. beyondblue is an Australian public company, limited by guarantee. The members are the Commonwealth and each state and territory government.\(^{305}\)

The Mental Health Commissioner advised that having a statutory body, unlike a department which can have machinery-of-government changes at any time, provides ongoing robustness so that it can be agile when required. The independent statutory body gives it the capability of ongoing survival whilst remaining responsive.\(^{306}\)

Queensland Health advised the Committee that the proposed health promotion commission will initially have 15 staff.\(^{307}\) They advised that five new positions will be created and approximately 10 positions will be transferred from Queensland Health. They advised that the transfer of some but not all ten staff from Queensland Health with the remainder from a range of other departments would enhance the capacity of the commission to work across government and achieve organisational objectives and decrease the impact of reduced capacity within Queensland Health.\(^{308}\)

The Heart Foundation advised that they do not agree with the proposal to take 10 staff from the Preventative Health Unit in Queensland Health because there is a need to rebuild capacity in that unit to work across sectors and not be in essence diminishing it as well.\(^{309}\)

The Mental Health Commissioner also cautioned against transferring staff from Queensland Health to the commission suggesting that it needs to be a ‘green field’. She advised:

> Irrespective of which staff you have, there is a perception they will keep doing what they were doing if you transfer them across. I think those sorts of establishment principles are really important.\(^{310}\)

QUT’s submission identified that there is a need for a sustainable health promotion workforce in order to enable capacity building, training, mentoring and building innovative solutions suited to Queensland. They noted that while global frameworks are important to set high level and long term goals, adaptation to local circumstances is essential to ensure acceptability and relevance of health promotion programs for the population. They provided examples of the impact on mental health of drought and the impact of flooding on vector borne diseases.\(^{311}\)

The Cancer Council advised the Committee, that in their view, in order to perform its core functions and have a sustainable impact on the health of Queenslanders, the proposed commission will require bipartisan support ensuring protection from political cycles. They consider that the commission should also be granted the mandate to engage with the whole of government and have the ability to influence policies and sectors beyond health to encourage a health in all policies approach. They believe that the commission can provide a common agenda for preventive health, uniting government, academia, industry and community based organisations in a collaborative approach to advance the health of Queenslanders.\(^{312}\)

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\(^{305}\) Submission 19, QMHC: 9  
\(^{306}\) Dr van Schoubroeck, Qld Mental Health Commission, Public hearing transcript, 25 May 2016: 25  
\(^{307}\) Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 11  
\(^{308}\) Correspondence from Queensland Health to Committee, dated 22 February 2016: 7  
\(^{309}\) Ms Foreman, Heart Foundation, Public hearing transcript, 25 May 2016: 11  
\(^{310}\) Dr van Schoubroeck, Qld Mental Health Commission, Public hearing transcript, 25 May 2016: 25  
\(^{311}\) Submission 3, QUT: 7  
\(^{312}\) Ms Border, Cancer Council, Public hearing transcript, 25 May 2016: 9
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Professor Fleming and Professor Russell-Bennet also agreed that it is important that the proposed commission should be above politics. 313

The Heart Foundation also agreed that the commission should be above government. They advised that:

*It should have teeth, it should be independent and it should be above the political processes to provide that leadership both within and beyond the health sector, and it needs to be able to provide that independent and expert evidence across it.* 314

They noted that it is important to recognise that prevention will take time to show results and the benefit will come beyond a term of government. 315 They advised that the commission will need bipartisan support to be established and maintained and it cannot afford to be at the whim of whichever government is in power. 316

The Brisbane North PHN considers that the commission needs to be an independent statutory authority that reports to the Premier so that it is able to influence government and also have a long term vision and strategy. 317

The AMAQ agreed recommending that the horizons for the commission be lifted away from the three year cycle and subject to regular change. 318 They advised that if the commission is to survive the electoral cycle, it will require bi-partisan support. 319

The Northern Queensland PHN also believes that the commission needs to be a long-term investment, without the destabilising influence of political climate and include a strong evaluation framework to showcase results and outcomes. 320

With regard to the suggestions that the commission report to the DPC and/or the Premier, Queensland Health advised that this approach has the advantage of a potential for greater authority required for other departments to engage and respond in a positive manner. However, the attention of the Premier may be more diffuse given the significance of their responsibilities and the whole-of-government arrangements short lived, rather than the lengthy timeframe required for sustainable health improvements. Reporting to the Minister for Health may provide greater Ministerial access and attention, with a longer and more sustainable timeframe. 321

4.1.6 Commission name

The Committee notes that the names of similar bodies in other jurisdictions include West Australian Health Promotion Foundation (Healthway), the Victorian Health Promotion Foundation (VicHealth), and the Australian National Preventive Health Agency (ANPHA). The Committee also notes that the Queensland Mental Health Commission performs similar role, in regard to mental health, as that proposed by the QHPC.

The PHAA suggested that the name of the commission should be reconsidered. They advised that the name of the Health Promotion Commission implies service delivery. They suggested that it could be called a ‘health and wellbeing commission’. 322

313 Professor Russell-Bennett and Professor Fleming, QUT, Public hearing transcript, 25 May 2016: 8
314 Ms Foreman, Heart Foundation, Public hearing transcript, 25 May 2016: 10
315 Ms Foreman, Heart Foundation, Public hearing transcript, 25 May 2016: 10
316 Submission 34, Heart Foundation: 2
317 Mr Martin, Brisbane North PHN, Public hearing transcript, 25 May 2016: 17
318 Dr Boyd, AMAQ, Public hearing transcript, 25 May 2016: 24
319 Submission 30, AMAQ: 6
320 Submission 10, Northern Queensland PHN: 2
321 Correspondence from Queensland Health to Committee, dated 22 February 2016: 7
322 Dr Gardiner, PHAA, Public hearing transcript, 25 May 2016: 16
QUT also suggested that a change of name be considered. They advised:

We have provided evidence that a multi-disciplinary systems approach to improving health and wellbeing is needed to achieve the goals stated in the inquiry brief. For this to be achieved, the name of the commission cannot be the Queensland Health Promotion Commission. By definition this will limit the scope of activities to communication, education and awareness programs that are guided by health promotion frameworks. A health promotion oriented commission will deliberately exclude other approaches such as behavioural economics, psychology and social marketing which will reduce the effectiveness of any activity undertaken to address complex health issues such as obesity. Likewise the evaluation approaches will not reflect multiple-disciplines and will be headed in the direction of past failures.  

They recommend that a name adopted that reflects a multi-disciplinary and inclusive vision to encourage a systems approach across whole of government to improve the health and wellbeing of Queenslanders.

The AASM agreed that health promotion refers to communication of expert defined information and education messages to influence health behaviours—primarily drawing from public health and some limited promotion and communications ideas. They advises that research has consistently shown that health promotion alone is often ineffective—for example people already know that smoking is harmful to their health but some people still smoke. They considered that the commission should have a broader scope and strategic orientation and that name should reflect this. They suggested a more suitable title would be Queensland Health Behaviour Change Committee.

4.2 Health Promotion Commissioner

Many submitters suggested the Commissioner should play a key role in collaborating with a wide range of stakeholders to convince them to embed health considerations in their everyday work, which for some organisations would presumably require a fundamental change in how they work. In order to achieve this, most submitters stated that it was crucial for the Commission to be independent. Other submitters suggested that the Commissioner should report directly to the Premier, to show the importance of the role.

Submissions stressed the importance of the Commissioner and any advisory board having the necessary skills, background and experience to carry out their roles, to deliver strategic vision and leadership to the sector, and to work collaboratively.

Queensland Health advised the Committee that:

A large part of the commission’s ability to achieve its objectives will come from a combination of the status of a commissioner and the ability and credibility of the person serving in that role. The health promotion commissioner should be an individual who is well-respected in the field of public health and has the leadership abilities required for complex multi-stakeholder problem-solving. A clear mandate and the appropriate authority to act will enhance the ability to drive change.

Queensland Health advised that the people and engagement are the most critical components leading success of a health promotion commission.

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323 Submission 33, QUT: 16
324 Submission 33, QUT: 16
325 Submission 36, AASM: 1
326 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 5
327 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 7
Establishment of a Qld Health Promotion Commission

With regard to the sort of skill set required for the head of a commissioner, the CHO advised:

_I think it would be good if we were able to recruit someone with experience in the space so that they do not have to get up to speed. Many commissioners can have good, solid generic skills in engagement and facilitation but I think in this one if we want them to really get going quickly they need to have some experience and actual involvement in health promotion initiatives, whether it be from a research angle or a delivery angle. That does not concern me. They cannot be content free. I think they have to have some key knowledge in the area._ \(^{328}\)

Queensland Health advised the health promotion Commissioner should be an individual who is well respected in the field of public health and has the leadership abilities required for complex, multi-stakeholder problem-solving. Selection of a Commissioner is critical as much of the benefit of the commission comes from the ability of the Commissioner to influence, access decision makers and drive change in a collaborative manner. A large part of the Commission’s ability to achieve its objectives will come from a combination of the status of a Commissioner and the credibility of the person serving in that role. \(^{329}\)

The Heart Foundation advised the Committee that they consider that the commissioner needs to have expertise in public health, health literacy, social determinants of health and health equality. They consider that the commissioner will also need to be politically savvy to be able to navigate high-level decision making, be able to influence and be able to coordinate. They consider that the commission will require expert advisers with cross-sector expertise in transport, health planning, equity, housing and education. \(^{330}\)

They also advised that the commission will need expertise regarding the risk factors rather than individual chronic diseases. They advised that those experts will need to understand what the triggers are and what the evidence is showing could make a difference. \(^{331}\)

The AMAQ consider that it is the commission will need strong intellectual leadership. Their preference is for someone with a medical background to lead the commission in its work. They suggested that the role should be entitled Chief Public Health Officer and should be supported by a strong council comprised of health workers from other fields such as nurses, allied health and stakeholder organisations. \(^{332}\)

The Dietitians Association of Australia recommended that a Commissioner should be appointed and report directly to the Premier. They considered that the Commissioner should have a health qualification and experience and expertise in the preventative health space. They also supported the appointment of an advisory board to provide advice to the Commissioner. They suggested that the board should include:

- Consumer representative;
- Aboriginal and/or Torres Strait Islander representative with experience in working in the preventative health area;
- Culturally and Linguistically Diverse representative with experience in working in the preventative health area;

\(^{328}\) Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 11
\(^{329}\) Correspondence from Queensland Health to Committee, dated 22 February 2016: 6
\(^{330}\) Ms Foreman, Heart Foundation, Public hearing transcript, 25 May 2016: 11
\(^{331}\) Ms Foreman, Heart Foundation, Public hearing transcript, 25 May 2016: 15
\(^{332}\) Submission 30, AMAQ: 6
Establishment of a Qld Health Promotion Commission

- Practitioners or academics in nutrition, physical activity, alcohol, tobacco and drugs, sexual health, communicable disease, non-communicable disease, health promotion theory, epidemiology, social marketing; and
- Members with expertise in legal, accounting/finance, Risk management.\(^{333}\)

HCQ also advocated for an on-going advisory group with stakeholders from the health sector, health consumer and community groups and private providers to collaborate on and inform key campaigns and mechanisms.\(^{334}\)

With regard to the make up of the Commission, the Cancer Council advised:

> *Members of the Commission must be passionate about improving the social, emotional and physical well-being of people in Queensland. Members should be selected on a basis of skills and experience, reflecting the interests of the community as a whole, including women, people of culturally diverse backgrounds, Aboriginal and Torres Strait Islander peoples, people with a disability, and young people. Appointees should not be selected on the basis of membership of any external representative group. Members must possess the personal and professional competencies to provide leadership and strategic vision of health promotion in Queensland.*\(^{335}\)

QIMR Berghofer Medical Research considered that the commission should include members with expertise in health research, as well as practitioners and community representatives.\(^{336}\)

### 4.3 Funding

Funding of $7.5 million over four years (including $600,000 in 2015-16) to establish a state-wide Health Promotion Commission was provided for in the 2015-16 Queensland Budget. The Queensland Health Service Delivery Statements that the Commission is:

> …to provide strategic leadership for whole-of-government initiatives aimed at maintaining and improving health and wellbeing of Queenslanders by preventing and slowing the increase of chronic illnesses such as diabetes, heart disease and cancer\(^{337}\)

The 2015-16 Budget also provided for additional funding for specific health promotion activities including:

- Health for Life! Taking action on Diabetes community based prevention program;
- 10,000 stems program to increase incidental exercise and encourage participation in the Heart Foundation Walking Program; and
- Go for 2&5 multimedia program to increase fruit and vegetable consumption.\(^{338}\)

Queensland Health advised the Committee that the fixed commission budget suggests a more targeted scope and strategic focus rather than a significant funding of health promotion activities.\(^{339}\)

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333 Submission 23, Dietitians Association of Australia: 5-6
334 Submission 26, HCQ: 7
335 Submission 4, Cancer Council: 6
336 Submission 13, QIMR Berghofer: 2
339 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 5
They advised that:

*Adequate resources, including financial and human resources, are critical for effective collaboration.*

Some submitters saw the Commission’s role as providing funding and/or assistance to collate data and commission research or specific health projects.

Metro North HHS advised that a key issue in any progress will be commitment to an investment in a service delivery model and a long-term funding model that acknowledges the workforce required and the time that it takes for outcomes to be realised.

The University of Queensland School of Public Health advised that given the longer timeframes needed to embed and see benefit from health promotion initiatives, the commission should be established as a statutory body with bi-partisan support and recurrent funding, to safeguard, as much as possible, its sustainability. The advised that without access to recurrent funding and the ability to direct the allocation of a portion of the health promotion and disease prevention resources the commission would remain aspirational and the risk of detracting from, rather than value adding to, the current Queensland Health directed health promotion initiatives and activities.

The Cancer Council advised the Committee that adequate government funding is vital to the effectiveness of population-wide health promotion strategies. They consider that the proposed establishment funding must be underpinned by funding to build health promotion capacity and enable the delivery of integrated programs and services which include prevention, protection and promotion. They consider that funding should be proportionately allocated against Queensland Health’s operating budget.

QUT also considers that the proposed funding is insufficient to address the overarching aims of the commission. They suggested that additional funding would be required to ensure the long-term success of the commission and the improved health of Queenslanders. The advised that funding is needed to support the innovation in health promotion and the appropriate implementation and evaluation of health promotion programs and policies. They consider that this will ensure that data are available to the QHPC to support its strategies and that they can direct the workforce towards the most pressing needs and at-risk areas of the state.

The Australian Health Promotion Association (AHPA) advised that they anticipate that the current allocated budget will not allow for direct health promotion service delivery or funding contributions for health promotion initiatives to be delivered by other parties. Therefore, they consider it is essential that the commission lead and advocate for the reinigoration of health promotion across Queensland and drive policy agendas amongst all relevant sectors to ensure that health promotion is acknowledged and considered an elevated priority on policy agendas.

With regard to the issue of the proposed budget for the Commission, the PHAA suggested that if the proposal is for the Commission to deliver services, the budget is insufficient. However, if a model similar to South Australia is adopted, which has a small team that works across sectors of government, a smaller amount of funding is required and delivers value for money.

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340 Dr Young, Qld Health, Public departmental briefing transcript, 20 April 2016: 5
341 Submission 5, Metro North HHS: 2
342 Submission 20, University of Qld School of Public Health: 1
343 Submission 4, Cancer Council: 4
344 Submission 3, QUT: 11
345 Submission 43, AHPA: 2
346 Dr Gardiner, PHAA, Public hearing transcript, 25 May 2016: 19
## Appendix A – List of Submissions

<table>
<thead>
<tr>
<th>Sub #</th>
<th>Submitter</th>
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<tbody>
<tr>
<td>001</td>
<td>Mr Damian O’Sullivan</td>
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<td>002</td>
<td>Bicycle Queensland Inc</td>
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<td>003</td>
<td>Faculty of Health, Queensland University of Technology (QUT)</td>
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<td>004</td>
<td>Cancer Council Queensland (CCQ)</td>
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<td>005</td>
<td>Metro North Hospital and Health Service</td>
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<td>006</td>
<td>Diabetes Queensland</td>
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<td>007</td>
<td>Queensland Nurses’ Union (QNU)</td>
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<td>008</td>
<td>The Pharmacy Guild of Australia, Queensland Branch</td>
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<td>009</td>
<td>Optometry Queensland &amp; Northern Territory</td>
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<tr>
<td>010</td>
<td>Northern Queensland, Public Healthcare Network (NQPHN)</td>
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<td>011</td>
<td>The Royal Australian and New Zealand College of Ophthalmologists (RANZCO)</td>
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<td>012</td>
<td>Positive Ageing Cairns Incorporated</td>
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<td>013</td>
<td>QIMR Berghofer Medical Research Institute</td>
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<td>014</td>
<td>University of the Sunshine Coast, School of Health and Sport Sciences</td>
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<tr>
<td>015</td>
<td>Mr John Brown</td>
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<td>016</td>
<td>The Central Queensland, Wide Bay, Sunshine Coast PHN</td>
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<td>017</td>
<td>South East Queensland Refugee Health Partnership Advisory Group</td>
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<td>018</td>
<td>The Royal College of Pathologists of Australasia</td>
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<td>019</td>
<td>Queensland Mental Health Commission</td>
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<td>020</td>
<td>University of Queensland School of Public Health (USQ)</td>
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<td>Palliative Care Queensland Inc (PCQ)</td>
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<td>023</td>
<td>Dietitians Association of Australia</td>
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<td>024</td>
<td>Brisbane North Primary Healthcare Network (PHN)</td>
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<td>025</td>
<td>Torres and Cape Hospital and Health Service</td>
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<td>026</td>
<td>Health Consumers Queensland Ltd (HCQ)</td>
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<td>027</td>
<td>Nutrition Australia Queensland (NAQ)</td>
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<td>028</td>
<td>Chiropractors’ Association of Australia (Queensland) Limited (CAAQLD)</td>
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<td>029</td>
<td>Stroke Foundation - Queensland</td>
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<td>030</td>
<td>Australian Medical Association Queensland</td>
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<td>031</td>
<td>Joint Submission - MDA; Queensland Council of Social Service (QCOS); Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT); Health Consumers Queensland; Organizations aligned to the South East Queensland Refugee Health Partnership Advisory Group (PAG)</td>
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<td>032</td>
<td>Public Health Association of Australia</td>
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<td>033</td>
<td>Joint Submission - Professor Rebekah Russell-Bennett; Professor Judy Drennan; Dr Rory Mulcahy; Professor Neil King; Dr Josephine Previte</td>
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<tr>
<td>034</td>
<td>Heart Foundation Queensland</td>
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<td>035</td>
<td>University of Southern Queensland (USQ)</td>
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<td>036</td>
<td>Australian Association of Social Marketing (AASM)</td>
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<td>037</td>
<td>Brisbane Central Business District Bicycle User Group</td>
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<td>038</td>
<td>Apunipima Cape York Health Council</td>
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<td>039</td>
<td>Dr Anne Maree Baldwin and Dr Andrew Langley</td>
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<td>040</td>
<td>Ms Giselle Olive</td>
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<td>041</td>
<td>Australian College of Nursing (ACN)</td>
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<td>042</td>
<td>Gold Coast Hospital and Health Services (GCHHS)</td>
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<td>043</td>
<td>Australian Health Promotion Association (AHPA)</td>
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### Appendix B – Officers appearing on behalf of the department at the public departmental briefing – Wednesday 20 April 2016

<table>
<thead>
<tr>
<th>Department of Health</th>
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<tbody>
<tr>
<td>Dr Jeannette Young, Chief Health Officer and Deputy Director-General, Prevention Division</td>
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<tr>
<td>Ms Kaye Pulsford, Executive Director, Preventive Health Branch, Prevention Division</td>
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<tr>
<td>Mr Mark West, Senior Director, Preventive Health Branch, Prevention Division</td>
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Establishment of a Qld Health Promotion Commission

**Appendix C – Witnesses appearing at the public hearing — Wednesday 25 May 2016**

<table>
<thead>
<tr>
<th>Queensland University of Technology</th>
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<tr>
<td>Professor Rebekah Russell-Bennett, Professor-Marketing; QUT Business School; Co-editor Journal of Services Marketing; Adjunct Professor National University of Ireland</td>
<td>Professor Rebekah Russell-Bennett, Professor-Marketing; QUT Business School; Co-editor Journal of Services Marketing; Adjunct Professor National University of Ireland</td>
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<tr>
<td>Professor Mary Lou Fleming, Head of School, Public Health and Social Work</td>
<td>Professor Mary Lou Fleming, Head of School, Public Health and Social Work</td>
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<th>Cancer Council Queensland</th>
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<td>Ms Nicole Border, Policy and Advocacy Manager</td>
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<th>Diabetes Queensland</th>
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<tr>
<td>Ms Rebekah Naranjo, Policy and Advocacy Manager</td>
<td>Ms Rebekah Naranjo, Policy and Advocacy Manager</td>
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<tr>
<th>Heart Foundation Queensland</th>
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<tr>
<td>Ms Rachelle Foreman, Health Director</td>
<td>Ms Rachelle Foreman, Health Director</td>
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<tr>
<td>Ms Deanne Wooden, Nutrition Manager</td>
<td>Ms Deanne Wooden, Nutrition Manager</td>
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<th>Public Health Association Australia</th>
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<tr>
<td>Dr Paul Gardiner, President, Queensland Branch</td>
<td>Dr Paul Gardiner, President, Queensland Branch</td>
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<tr>
<td>Dr Danette Langbecker, Vice President, Queensland Branch</td>
<td>Dr Danette Langbecker, Vice President, Queensland Branch</td>
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<th>Brisbane North Primary Health Network (Brisbane North PHN)</th>
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<td>Mr Paul Martin, Manager Partners in Recovery</td>
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<th>Australian Medical Association Qld – by teleconference</th>
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<td>Dr Bill Boyd, Deputy President</td>
<td>Dr Bill Boyd, Deputy President</td>
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<th>Queensland Mental Health Commission</th>
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<tr>
<td>Dr Lesley van Schoubroek, Commissioner</td>
<td>Dr Lesley van Schoubroek, Commissioner</td>
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Appendix D – Representatives who met with the Committee in Perth and Melbourne – Monday 29 February 2016 and Wednesday 2 March 2016

<table>
<thead>
<tr>
<th>Monday 29 February 2016 – Perth</th>
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</thead>
<tbody>
<tr>
<td>Ms Maree De Lacey, A/Executive Director, Western Australian Health Promotion Foundation (Healthway)</td>
</tr>
<tr>
<td>Dr Jo Clarkson, Director, Health Promotion and Research, Western Australian Health Promotion Foundation (Healthway)</td>
</tr>
<tr>
<td>Ms Denise Sullivan, Director, Chronic Disease Prevention, Public Health Division, Western Australia Department of Health</td>
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<table>
<thead>
<tr>
<th>Tuesday 1 March 2016 - Perth</th>
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<tbody>
<tr>
<td>Professor Di Twigg, Dean, School of Nursing and Midwifery, Edith Cowan University</td>
</tr>
<tr>
<td>Ms Janine Freeman MLA, representing Education and Health Standing Committee</td>
</tr>
<tr>
<td>Dr Sharyn Burns, Co-Director, Western Australian Centre for Health Promotion Research and Director, Health Promotion, Curtin University</td>
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<table>
<thead>
<tr>
<th>Wednesday 2 March 2016 – Melbourne</th>
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<tbody>
<tr>
<td>Ms Judith Abbott, Director, Prevention, Population, Primary and Community Health, Victoria Department of Health and Human Services</td>
</tr>
<tr>
<td>Mr Colin Sindall, Director, Population, Health and Prevention Strategy, Victoria Department of Health and Human Services</td>
</tr>
<tr>
<td>Mr Darryl Kosch, Victoria Department of Health and Human Services</td>
</tr>
<tr>
<td>Ms Jerril Rechter, Chief Executive Officer, Victorian Health Promotion Foundation (VicHealth) and other members of VicHealth executive team</td>
</tr>
</tbody>
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Appendix E – Ottawa Charter for Health Promotion
The Ottawa Charter for Health Promotion
First International Conference on Health Promotion, Ottawa, 21 November 1986

The first International Conference on Health Promotion, meeting in Ottawa this 21st day of November 1986, hereby presents this CHARTER for action to achieve Health for All by the year 2000 and beyond.

This conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialized countries, but took into account similar concerns in all other regions. It built on the progress made through the Declaration on Primary Health Care at Alma-Ata, the World Health Organization's Targets for Health for All document, and the recent debate at the World Health Assembly on intersectoral action for health.

Health Promotion

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

Prerequisites for Health

The fundamental conditions and resources for health are:

- peace,
- shelter,
- education,
- food,
- income,
- a stable eco-system,
- sustainable resources,
- social justice, and equity.

Improvement in health requires a secure foundation in these basic prerequisites.

ADVOCATE

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

ENABLE

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

MEDIATE

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and
voluntary organization, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

**Health Promotion Action Means:**

**Build Healthy Public Policy**

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

**Create Supportive Environments**

Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socioecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment - particularly in areas of technology, work, energy production and urbanization - is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

**Strengthen Community Actions**

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities - their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

**Develop Personal Skills**

Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

**Reorient Health Services**

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments.
They must work together towards a health care system which contributes to the pursuit of health. The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services which refocuses on the total needs of the individual as a whole person.

**Moving into the Future**

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

**Commitment to Health Promotion**

The participants in this Conference pledge:

- to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;
- to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;
- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
- to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being;
- to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and, most importantly, with people themselves;
- to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

The Conference urges all concerned to join them in their commitment to a strong public health alliance.

**Call for International Action**

The Conference calls on the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion.

The Conference is firmly convinced that if people in all walks of life, nongovernmental and voluntary organizations, governments, the World Health Organization and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, Health For All by the year 2000 will become a reality.

**CHARTER ADOPTED AT AN INTERNATIONAL CONFERENCE ON HEALTH PROMOTION**

*The move towards a new public health, November 17-21, 1986 Ottawa, Ontario, Canada.*

* Co-sponsored by the Canadian Public Health Association, Health and Welfare Canada, and the World Health Organization.

**Health Promotion Emblem**

A brief explanation of the logo used by WHO since the First International Conference on Health Promotion held in Ottawa, Canada, in 1986. Select an element of the logo for the specific explanation of that part or simply read on for the complete explanation.
This logo was created for the First International Conference on Health Promotion held in Ottawa, Canada, in 1986. At that conference, the Ottawa Charter for Health Promotion was launched. Since then, WHO kept this symbol as the Health Promotion logo (HP logo), as it stands for the approach to health promotion as outlined in the Ottawa Charter.

The logo represents a circle with 3 wings. It incorporates five key action areas in Health Promotion (build healthy public policy, create supportive environments for health, strengthen community action for health, develop personal skills, and re-orient health services) and three basic HP strategies (to enable, mediate, and advocate).

The main graphic elements of the HP logo are:

- one outside circle,
- one round spot within the circle, and
- three wings that originate from this inner spot, one of which is breaking the outside circle.

a) The outside circle, originally in red colour, is representing the goal of "Building Healthy Public Policies", therefore symbolising the need for policies to "hold things together". This circle is encompassing the three wings, symbolising the need to address all five key action areas of health promotion identified in the Ottawa Charter in an integrated and complementary manner.

b) The round spot within the circle stands for the three basic strategies for health promotion, "enabling, mediating, and advocacy", which are needed and applied to all health promotion action areas. (Complete definitions of these terms can be found in the Health Promotion Glossary, WHO/HPR/HEP/98.1)

c) The three wings represent (and contain the words of) the five key action areas for health promotion that were identified in the Ottawa Charter for Health Promotion in 1986 and were reconfirmed in the Jakarta Declaration on Leading Health Promotion into the 21st Century in 1997.

More specifically:

- the upper wing that is breaking the circle represents that action is needed to "strengthen community action" and to "develop personal skills". This wing is breaking the circle to symbolise that society and communities as well as individuals are constantly changing and, therefore, the policy sphere has to constantly react and develop to reflect these changes: a "Healthy Public Policy" is needed;
- the middle wing on the right side represents that action is needed to "create supportive environments for health";
- the bottom wing represents that action is needed to "reorient health services" towards preventing diseases and promoting health.

Overall, the logo visualises the idea that Health Promotion is a comprehensive, multi-strategy approach. HP applies diverse strategies and methods in an integrated manner - one of the preconditions "for Health Promotion to be effective" (Jakarta Declaration 1997). Health Promotion addresses the key action areas identified in the Ottawa Charter in an integrated and coherent way.

The term Health Promotion (HP) was, and still today is sometimes, narrowly used as equivalent for Health Education (HE). But HE is one of several key components and action areas of HP as illustrated by the HP logo (see the key action area of "develop personal skills").

The HP logo and approach were reinforced at the second and third conferences on Health Promotion that took place in Sundsvall and in Adelaide.

In the light of the venue of the Fourth International Conference on Health Promotion, that was held in Jakarta, Indonesia, in July 1997, the design of the Ottawa logo was slightly modified to reflect culture and atmosphere of the host country of the conference, making sure that the shape and elements of the original logo were preserved, together with its inner meaning.

The Jakarta Conference logo is a more open and slightly more abstract version of the original HP logo from Ottawa. The three wings, that are now in brick-red colour, still represent the key HP action areas. The outside circle and the inner spot of the Ottawa logo are merged into a unique blue spot from where the three wings originate. This still symbolises that HP addresses its action areas with an integrated multi-strategic approach. Overall, the design of the HP logo adapted for the Conference in Jakarta is more open and lively; all the wings are now reaching out of the circle. This, visualizes the fact that the field of HP has grown and developed, and that today and in the future HP is outreaching to new players and partners, at all levels of society, from local to global level.
Appendix F – South Australia Health in All Policies Memorandum of Understanding
MEMORANDUM OF UNDERSTANDING
Between
THE DEPARTMENT OF THE PREMIER AND CABINET
and
THE DEPARTMENT FOR HEALTH AND AGEING
for
Systematising Health in All Policies

Rationale

Community health and wellbeing are largely influenced by measures that are often managed by government sectors other than health.

Meaningful and sustainable improvement in health outcomes requires a systemic and coordinated approach across government and the community.

Considering the direct and indirect impact of government plans, proposals and policies on the health and wellbeing of the population will improve overall population health outcomes, reduce the growing economic burden of the health care system, and improving the productivity of South Australia.

Health in All Policies provides a methodology for inter-agency collaboration and partnership in planning and policy development to support non-health sectors in contributing to the improvement of broader health outcomes.

Objectives

This Memorandum of Understanding sets out the basis for collaboration between the Department of the Premier and Cabinet (DPC) and the Department for Health and Ageing (DHA). It aims to systematise the Health in all Policies principles, practices and processes which are now incorporated in the partnership approach of the South Australian Public Health Act 2011 (the Act). The key objectives of this Memorandum of Understanding are to:

- embed Health in All Policies principles, practices and processes in government policy and planning
- establish governance arrangements to support implementation
- align implementation with the government’s strategic policy priorities.

Agency Responsibilities

Under this Memorandum of Understanding, DPC and DHA will have responsibility for the following functions.

DHA will:

- incorporate Health in All Polices principles, practices and processes in implementing the Act and State Public Health Plan.
- develop procedures and protocols, under section 17 of the Act, for inter-agency collaboration on policy development based on Health in All Policies principles, practices and processes.
- provide assistance to state and local government agencies to build capacity for cross-sector collaboration on the development of policy that positivity impacts on health and wellbeing.
MEMORANDUM OF UNDERSTANDING

- contribute to the evidence base of the Health in All Policies approach by monitoring and documenting the implementation and outcomes of systematising the partnership approach.

Where appropriate, DPC will:
- identify opportunities to promote Health in All Policies principles, practices and processes in across government policy development and decision making, consistent with section 17 of the Act
- support DHA in developing and implementing procedures and protocols for inter-agency collaboration on policy development based on Health in All Policies principles, practices and processes, consistent with section 17 of the Act.
- advocate and promote the benefits of the partnership approach at the state, national and international level
- provide advice on opportunities to add to the evidence base of the Health in All Policies approach.

Review and Evaluation

The Memorandum of Understanding will be reviewed, and where required amended, on an as needs basis by DPC and DHA to ensure that it is delivering on the shared objectives and meeting the needs of both departments.

DPC and DHA will continue to collaborate to support the NHMRC project Evaluation of the SA Health in All Policies approach, and where relevant, evaluations of identified initiatives.

David Swan  
Chief Executive  
Department for Health and Ageing  

Jim Hallion  
Chief Executive  
Department of the Premier and Cabinet  

25/3/14
Statement of Reservation – Government Members

The Government Members of the Committee noted that there was strong support from stakeholders for the establishment of a Queensland Health Promotion Commission (QHPC).

The establishment of a Health Promotion Commission in Queensland presents an opportunity to provide strategic leadership and direction on whole-of-government initiatives and partnerships with industry and community organisations to address the social determinants of health and reduce risk factors of chronic illness. Addressing the social determinants of health, that is the social, economic and material factors surrounding people’s lives, such as housing, education, employment, and public transport, goes beyond being just the responsibility of our hospitals and health services and requires a broader approach.

Over the course of the inquiry, the Government Members were very appreciative of meeting with and hearing from representatives from the Western Australian Department of Health and Healthway, Victorian Department of Health and Human Services and VicHealth, and South Australian Department of Health and Ageing who outlined their HiAP approach. Each jurisdiction spoke strongly of the importance of having a coordinated, strategic focus on health promotion and prevention efforts in addressing the social determinants of health, reducing risk factors of chronic disease, and in so doing the cost of tertiary healthcare to the community. Each jurisdiction is employing a very different model to deliver on these health promotion and prevention efforts, from specific standalone agencies to whole-of-government policy frameworks.

While the Committee agreed that there is strong support for the establishment of a Queensland Health Promotion Commission, the Committee was unable to agree on a particular model to recommend for establishment in Queensland. The Government Members of the Committee saw great merit in the VicHealth model and the significant body of investigator-led, strategic and evaluation research their Foundation has built to support evidence based health promotion interventions in Victoria. The Government Members consider that incorporating these types of activities into the functions of the QHPC would be of benefit to both the QHPC and government as a whole.

The Government Members noted the multi-faceted approach of the HiAP model which aims to bring together different agencies within government to enable the impact of policies and programs on health to be a key consideration. The Government Members expect that facets of this approach could be adapted for use by the QHPC.

The Committee and a number of submitters also saw merit in the governance models in place at the Queensland Mental Health Commission and the former Australian Commission on Safety and Quality in Health Care, which could be adapted for the Queensland context. The QMHC model focuses on increasing knowledge, understanding and information sharing through partnerships with government and non-government stakeholders.

The Committee heard evidence that high-level policy support, coordination and leadership are essential elements of effective health promotion activities and that the government is in a unique position to provide these elements. There were a number of common themes apparent in the submissions received by the Committee. These are, that a Queensland Health Promotion Commission will require:

- a high level mandate from central government;
- bi-partisan support, so that any agenda is long term and not at the whim of election cycles;
- a high level strategic, planning and coordination focus, particularly in ensuring the elimination of duplication and/or gaps;
- a framework which articulates the roles and responsibilities to be undertaken by both the QHPC and government departments;
- a commitment to work collaboratively and in partnership with both government agencies and other bodies, including local government, academic institutions and non-government agencies;
- a commitment to building strong relationships;
- a determination to build community engagement and capacity;
- a strong commitment to building knowledge and skills, particularly in the areas of health promotion strategies and addressing the social determinants of health; and
- a strong commitment to evaluation of strategies, programs and the work of the Commission.

Stakeholders, and the Government Members of the Committee, agreed that the QHPC should play a high level strategic role. Overall, the establishment of a Health Promotion Commission in Queensland presents an opportunity to provide strategic leadership and direction on whole-of-government initiatives and partnerships with industry and community organisations to address the social determinants of health and reduce risk factors of chronic illness in Queensland.

Leanne Linard MP  
Chair and Member for Nudgee

Joe Kelly MP  
Member for Greenslopes

Aaron Harper MP  
Member for Thuringowa
Non Government Members’ Statement of Reservation

Inquiry into the Establishment of a Queensland Health Promotion Commission

The House on the 16th September 2015 referred to the Committee an Inquiry in relation to the establishment of a “Queensland Health Promotion Commission” and provided terms of reference.

The timeline for reporting to the House is 30 June 2016.

Whilst agreeing to the need for a “Commission” we are concerned about critical details as to how that body would look and operate across the Government/non-Government/University and other entities that have a relationship with the Health Sector in Queensland.

These concerns need to be addressed before a Commission should be put into “the field” and have the potential to produce desired outcomes.

The issues we have include the following;

A) The process of undertaking the investigation for the need for a Commission lacks expert oversight.

We note that in South Australia the investigation took up to 12 months before it reached recommendation status. Professor Ilona Kickbusch was invited by the Government of South Australia to assess and then determine what recommendations she believed would assist the Government in developing their plan. Those recommendations were then placed before Parliament. It would appear to us that involvement from such an expert would have been of great assistance in determining a model that would apply in Queensland.

B) Additionally there should be an assessment of the following-

a. The Health needs of Queenslanders

b. Where the current approach to Health promotion is failing and

c. What has been the historical trend in regard to Health outcomes in Queensland these would produce a starting point

Non Government Members’ Statement of Reservation
We note the evidence by the Chief Health Officer is that “The adult and child obesity rate in Queensland is no longer increasing”. Though that is not to be taken that we don’t support a Commission it raises a point of whether or not further evidence of chronic disease rates should have been placed before the committee.

C) Attempts to consider models in other jurisdictions though of benefit are also fraught with danger. Often Queensland comment that we are unique given its geographical size and diverse population. Whilst considering other jurisdictions we must understand the unique nature of Queensland.

The unique nature must be weighed against adopting the model of another state.

D) The Terms of Reference refer to considering other “models used in other jurisdictions”. Again care must be taken as the complexity of models in other jurisdictions vary from state to state. It became obvious particularly as the inquiry progressed that whilst at face value other models appeared to offer benefits that could be adopted in this state there were layers within each jurisdiction that were unique to that state.

E) One further concern is that there appears to be a lack of assessed outcomes by states that have a Commission. This may well be because of the relative youth of these bodies. However it would be beneficial to consider pre and post outcomes of jurisdictions that have a Commission in place. This allows Queensland to assess whether or not they have been “successful” and if so to what degree.

F) Debate also focussed on where the Commission should be placed. It included sitting with the Department of Premier and Cabinet, some with the Health Department, some believe it should be totally independent of Government and there was a suggestion that the Commission should sit with this Committee. Opinions were divided. One of the overriding factors is the necessity for “buy in” by all relevant Departments on a day to day basis at the commencement of the Commission. The South Australian model refers to a Memorandum Of Understanding between DPC and their equivalent of our Department of Health. It appears that the role of DPC is to facilitate engagement by other Departments thus ensuring compliance with policy and the overriding principles of the Commission.

G) One further consideration is whether or not a “Commission” in the sense we are considering is required. The South Australian model appears to have a lose configuration where a small number of people sit with the Health Department but as we understand it is not a formal Commission. In fact, when looking at that
model it appears that it is not unlike the current Health Model in this state but with the oversite and the imprimatur of DPC.

H) There was much debate as to whether or not the ultimate model should be funding/policy, non funding/policy or limited funding/policy in makeup. This needs to be resolved. Similarly so does the issue of the level of policy development i.e. is it research, promotion, education, or merely setting the broad agenda by way of very high level policy development leaving departments to compliment the terms.

I) One matter that is not understood is the staffing numbers required and how that figure will grow over time. We note that in the 15/16 year the number of public servants employed by the Government exceeded their target by in excess of 4000 and that in the next financial year the wage bill will increase 4-8%. Depending upon the model and the role of the Commission this could be a major question and needs to be considered carefully.

J) The longevity of the body is also a question. Commissions of any type can be dissolved or evolve by a change of Government. If the body is to have a long-term focus that needs to be addressed.

K) The question of how we assess the success or otherwise of the Commission was not properly addressed. There does need to be a review by an independent university or other facility. Critically it cannot be self-assessing nor can an assessment be undertaken by the Government. There is an immediate need for KPI’s to be established and outcomes benchmarked against best practice.

L) Finally, there are many agencies outside of Government that are part of the Health system. One of the most important is Local Government.

We note the involvement of Local Government in South Australia is very important. In their case study dated June 2013 it states;

“Each local Government is required to develop a public health plan with regard to the state plan and outlines action to protect and promote the health of their local communities, recognising social detriments on health and wellbeing”

In no circumstances do we advocate legislation in relation to Local Government involvement but the question of Local Government involvement is critical.
M) It is fundamental that there be an investigation into federally funded programs regarding health & Lifestyle choices to ensure a duplication of both funding and messaging does not occur

As stated while there are a number of serious questions that need to be addressed and a significant body of work undertaken before a Commission, whether it be a new body or a reinvigorated existing body can be launched.

Dated this 29th June 2016

Mark McArdle

Tarnya Smith

Sid Cramp

Non Government Members’ Statement of Reservation