EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO THE ROLE OF DIET IN TYPE 2 DIABETES PREVENTION AND MANAGEMENT

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 28 NOVEMBER 2018

SESSION ONE

Members

Ms J.M. Freeman (Chair)
Mr W.R. Marmion (Deputy Chair)
Ms J. Farrer
Mr R.S. Love
Ms S.E. Winton

_____

Hearing commenced at 10.02 am

Dr ANDREW GEOFFREY ROBERTSON
Acting Assistant Director General, Public and Aboriginal Health Division, Department of Health, examined:

Dr DUNCAN JAMES WILLIAMSON
Assistant Director General, Clinical Excellence Division, Department of Health, examined:

Ms DENISE SULLIVAN
Director, Chronic Disease Prevention, Public and Aboriginal Health Division, Department of Health, examined:

The CHAIR: On behalf of the committee, I would like to thank you for agreeing to appear today to provide evidence in relation to the committee's inquiry into the role of diet in type 2 diabetes prevention and management. My name is Janine Freeman and I am the Chair of the Education and Health Standing Committee of the Parliament. To my right is Bill Marmion, who is the Deputy Chair; Josie Farrer, member for Kimberley; Sabine Winton, member for Wanneroo; and Shane Love, member for Moore. It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege. However, this privilege does not apply to anything that you might say outside of today's proceedings. We have our two research officers here, and Hansard taking the record. Before we begin, do you have any questions about your attendance here today?

The Witnesses: No.

The CHAIR: Would you like to make an opening statement or do you want us to head into questions?

Dr Robertson: I think we will head straight into questions if we can.

The CHAIR: You have put in a submission with respect to these things. I will go straight into the fact that there is a strong link between obesity and type 2 diabetes. Obviously, obesity is a lifestyle–diet disease, if you can call it that. The Department of Health recently hosted the Obesity Collaborative Summit, which brought together people within the health sector to workshop ideas on tackling obesity. During the summit, how much acknowledgement was there of the impact of type 2 diabetes on the health system? Do you want to take us through some of the outcomes of the summit, if that is possible?

Dr Robertson: I might pass to Dr Williamson.

Dr Williamson: Thank you. We will probably share this because it was a combined effort between our two divisions, to be honest. It followed on from the Preventive Health Summit that took place earlier in the year. There were a number of outcomes. We have determined that we are going to develop quality standards for obesity management services. We are going to create an evidence hub to support policy development, clinician education and decision-making around pathways for people with obesity. We are going to create mechanisms for easier referral and coordinated care. We are going to support consumer education, in particular by translating evidence into consumer-friendly language and resources. In collaboration with WAPHA—the WA Primary Health Alliance—

the Health Consumers' Council and ourselves, we are developing some media guidelines to try and give common messages and use common language to reduce ambiguity and improve our message. We are also going to support staff education, particularly around communication with people who have got problems with their weight. We are also going to look for sustainable funding options, and obesity in general was identified, specifically childhood obesity, through the Sustainable Health Review, the report of which is pending. It has been a major issue in Western Australia and it is going to be important to determine not just a plan of action, but how that might be funded in a sustainable way. We are going to work with our staff to enhance workplace food choices—improve those—and support healthy lifestyles. We are going to build on this collaborative by future meetings to determine whether or not we are tracking according to our proposed time line and pathway, and to ensure that we are maintaining best practice.

The CHAIR: They are all global; do you want to drill down into some of those? We had the primary health alliance in here to give us evidence, and other evidence that we have taken in submissions would indicate that there is a real issue around general practitioners and their capacity to treat effectively type 2 diabetes or prediabetes and have these conversations. You have talked about clinical education. What does that mean for the health department?

Dr Williamson: The first thing to say is that we are not education providers. We will work with the education providers to look at what the needs are of general practitioners and other clinicians.

The CHAIR: Is that the universities or —

Dr Williamson: Partly is it universities and partly it would be the postgraduate education through WAGPET, for instance, which is responsible for post-graduate education for general practitioners.

The CHAIR: Do they currently do anything in this area?

Dr Williamson: Yes, I imagine that they would, absolutely. For instance, training programs are organised through WAGPET for the College of Rural and Remote Medicine and for the College of General Practitioners. All of those programs would have a significant component addressing this. When WAPHA says that they are not sure about the capacity of their general practitioner workforce to deal with this, I am not sure exactly what they are referring to. I did not read their submission, but one of the problems that they are facing is a significant shortfall in GP numbers, and this is particularly acute in remote and rural areas. The health department is certainly trying to address that. We are looking at training pathways for general practitioners and ways in which we might encourage more graduates into general practice, and facilitating, through the HSPs, pathways to general practice vocational training programs. There are a number of things that we are doing to try and improve the capacity of the general practitioner workforce. Other things that we are looking at—again, in response to the interim report of the Sustainable Health Review—would be to look at alternative workforces that might have a contribution to make, in particular in Aboriginal health, but also around the nurse practitioners, diabetic educators and potentially a new type of role, which is referred to in the report as the "health navigator". They assist people who have chronic disease and multiple conditions who often have to see several different specialists at different sites on different days, to navigate the system and coordinate care.

[10.10 am]

The CHAIR: It sounds like you have a number of points that you have hit upon but there is no overall strategy. In my notes, there is some information in terms of there being a federal strategy around diabetes. There was a state one but that is now out of its time line; I cannot find the particular information with respect to that. Is the intention to do an overall strategy? We have the Australian

National Diabetes Strategy 2016–2020, but there does not appear to be a current Western Australian framework for action on diabetes and the standards.

Dr Williamson: There are a couple of things. There is obesity and there is diabetes.

The CHAIR: Yes, we are doing diabetes.

Dr Williamson: They are very closely linked. You are quite right, I do not think there is a national strategy around obesity, for instance. There is a national strategy around diabetes. Minister Cook has been a strong advocate for developing a national strategy for obesity, and clearly that would be one of the priorities for us, too. With respect to diabetes, I think Tim Davis and Mark Shah presented to this group. Back in the early days of the networks—I should say that the network directorate falls within my division—a model of care for type 2 diabetes was developed and subsequently a framework. I think they both indicated that they were working on some key performance indicators related to that framework, but that at the time they referred to it, it seemed to have stalled. I think that is where we are at the moment.

Mr W.R. MARMION: Why has it stopped?

Dr Williamson: I am not very sure; you would have to ask them. I am afraid I do not know.

Mr W.R. MARMION: We did ask.

Dr Williamson: I do not think they were clear in their submission either because I just read it. The development of the KPIs can be very tricky. They indicated in their evidence that there was also a national effort to do so and that they similarly had come across difficulties in terms of definitions and what one might reasonably expect to change in certain time frames et cetera.

The CHAIR: We have a chronic health issue and everyone is going: "It's hard to do KPIs. It's hard to get a framework together." We have all these nice—excuse the terminology—motherhood statements, but what are we actually doing on the ground that is effective?

Dr Williamson: Are you talking about prevention or treatment?

The CHAIR: I am happy for you to talk about prevention, and then I am happy for you to talk about treatment, but I really would be pleased if you talked about something that gave me confidence that we are addressing what is a chronic health issue.

Dr Williamson: Recently, Tim and Megan Burley, who is the director of networks, attended a forum in the east to look at the progress of each of the jurisdictions against the national diabetes strategy. I have a presentation of that. It refers to quite a lot of the things that we are doing and we are actually, in comparison with other jurisdictions, quite well placed. But I will hand over to the experts on prevention to allow them to address it and then if there are issues around treatment, I will come back to talk about that.

Dr Robertson: I might get Denise to talk about prevention. We are in a reasonably good place from a prevention point of view. There is still a lot we can do. We obviously had the Preventive Health Summit in March this year, which had both an obesity and alcohol focus, but we have had a number of frameworks in place and a number of programs that are addressing prevention, particularly in the obesity area. I will ask Denise to respond.

The CHAIR: When you are talking about it can you just comment on the fact that there is a national chronic health conditions framework but the WA one expired in 2016, and where we are going with that or is that more to do with your post —

Dr Robertson: It is probably more to do with—the health promotion strategic framework goes through to 2021. It is a current framework at this stage.

Ms Sullivan: The overarching framework when it comes to the prevention of chronic diseases such as diabetes type 2 is the WA health promotion strategic framework. That takes a risk-factor approach. It looks at the risk factors that are common to most preventable chronic conditions such as physical inactivity, unhealthy diets and unhealthy weight et cetera. Through the public health division, we do fund a number of statewide programs. They do not specifically address diabetes type 2, but the intent is to address factors that contribute to a range of chronic conditions such as diabetes type 2. The flagship campaign for the department would be the LiveLighter campaign, which is now delivered by Cancer Council WA. That is very much around elevating the issue of obesity as a significant public health problem and setting out what are some clear steps that could be taken both in terms of policy measures that it would be good for government to support, but also steps that can be taken at an individual level to try to address and manage the issue of unhealthy weight. In addition, we fund the Foodbank WA program, which delivers the school breakfast program which is a statewide program. It has a strong focus on schools where there are issues around food insecurity and quite a large number of schools and children benefit from that. Foodbank also delivers the Food Sensations program, which is specifically directed towards low-income families and individuals. It is based around improving knowledge and understanding of healthy eating and how to get the best buy for the limited funds that are available to you. In addition, we have the Better Health program. The Better Health program is specifically for families with children in the seven to 13-year-old age range where there are issues around unhealthy weight and it is about promoting healthy eating and a healthy lifestyle at a family level.

The CHAIR: Do you do reviews of all of these programs?

Ms Sullivan: Yes, all of the programs have research and evaluation that informs both their development and the evaluation of their performance. The evaluation would cover a whole range of things from participation in programs where you are looking at the number of services that are provided, but also the impact. We have seen changes in knowledge, attitudes and behaviours, and in some cases we are seeing reductions in BMI, for instance. Those sorts of measures are certainly included as part of the Better Health program, for instance. Most of these programs have been funded for a number of years now, although of the suite of programs, LiveLighter is probably one of the newer ones in that it has only been around for six years or so, which is not really a long time in terms of looking for major health impacts out of a health promotion program. The work that we fund in terms of state-level programs is also complemented by programs that would be delivered by health services, which are independent statutory authorities; other programs that would be delivered separately by non-government organisations such as the Cancer Council—they have their own programs and are independent of things that are funded by the health department—and also programs that would be funded through other government agencies. Healthway, for instance, funds the WA School Canteen Association to provide support to sporting and community organisations around healthy food service options within their facilities. Lotterywest—I am certainly aware of recent announcements around funding for SecondBite, which is a food relief program. Then you also have other government agencies like the Department of Transport where you have seen an increased focus on expanding the cycling network, for instance, which is around encouraging people to be more physically active and to use active transport rather than the car to get around.

The CHAIR: Our interest is around diet. How are you feeding into the public health plans that are coming through that are now required to be done by local governments?

[10.20 am]

Ms Sullivan: Public health plans have not become mandatory yet, but obviously local governments are keen to get ahead of the game and look at how they can better incorporate health and wellbeing

as part of their forward planning. It has been dealt with in a number of different ways. I would probably have more direct dealings with WALGA, the peak body, around information advice as to what would be appropriate from a health and wellbeing perspective outside of the usual regulatory things that fall on local government health services. Then, on the ground, the metropolitan and country health services would be dealing directly with individual local government organisations. Part of the support we provide would be around information to give them a sense of what is the overall health status of their particular communities for that local government, and also providing expert advice around what would be good practice in terms of programs where they may be looking to start up something new but equally ensuring that they are linked up with existing programs that may be delivered by the community services organisations, for instance.

The CHAIR: With all your funding and the outsourcing of all your funding and contracting out to other people, do you have an emphasis on the hotspots in terms of chronic diseases and the prevention of chronic diseases or their hotspots, or are you just targeting the low-hanging fruit—people who can change. Are you looking at it as an individual thing or are you looking at it as more of a systemic thing where you can actually have the greatest capacity to see change?

Ms Sullivan: It is a combination of both. When it comes to prevention, my area has particular responsibility for funding the universal statewide programs, but the emphasis in terms of the service agreements we have with the NGOs is to ensure that there is a skew towards low SES and that they are also ensuring reach and relevance to particular populations where there is high levels of overweight—obesity, inactivity et cetera. At a health-service level, our metropolitan and WA country health services would be working more directly with communities within their catchment areas. I am probably not that well-placed to comment on individual programs, but I am certainly aware that the north, south, east metropolitan and country health services do have specific programs around food, nutrition and activity including work with local government and, in some cases, this may be targeted programs where they are working more directly with Aboriginal communities within their catchment area, for instance.

The CHAIR: Someone once told me that for the amount of money that we pay after people get sick, we would almost be better off taking them shopping on a regular basis so that they had good diets and we would save money for the public health system. Is that just a myth?

Ms Sullivan: It is a bit hard to comment; I am not quite sure of the background to that. Certainly part of the statewide programs that we fund around food and nutrition include how to shop for healthy foods, how to ensure healthy foods are more affordable —

The CHAIR: Does it take people shopping?

Ms Sullivan: My understanding is that there is an element of that in the Food Sensations program that Foodbank WA provides.

Dr Robertson: I think where the comment may have come from is, broadly, if we could change even a percentage of the population's eating habits into more healthy habits, then the flow-on effect over time would be to reduce a number of these diseases, including —

The CHAIR: Do we not change anyone's habit by money, by the economies of scale? Is that how we make it an economic benefit? Part of the issue for people in the hotspots, and the community that I represent is in a hotspot, is the issue around healthy food and food that is supposed to be discretionary and that the discretionary "sometimes" foods are far less expensive than the other foods and far more convenient and so that becomes one of the reasons why they access that food. Sorry, Shane has to leave. How do we change that on a systems-basis, instead of going in and

individually trying to do stuff? Maybe that was too broad a question and you need to pick out of that that whole —

Ms Sullivan: Janine, are you sort of referring to some of the policy measures that need to be considered at a whole-of-government level?

The CHAIR: I suppose, yes.

Ms Sullivan: Are you referring more to the social determinants of health? So what are some of the other factors that impact on people's ability to make healthy choices? Certainly, that was a strong theme that came out of the preventive health summit that was held earlier this year in March, and a need to look more closely at what could be done at a whole-of-government level, so to what extent do other state government agencies, policies and actions have an impact? Certainly, a key recommendation in terms of policy options for government to consider was looking at planning legislation, standards and policies and the extent to which, in many respects, they probably look after the interests of developers but do not necessarily take into account community concerns that might relate to health and wellbeing issues. Certainly, we are aware through requests that come to the department from time to time that there will be communities that are concerned about the intent to place a McDonalds next to a primary school, for instance, and not feeling that there is a great deal of power and ability to object even when the local government is on side. Certainly, that has flagged a need to look at planning legislation. We are certainly aware that there are some other states—Queensland and Tasmania, for instance—where there have been changes made to planning legislation where community health and wellbeing needs consideration. I am certainly aware from work that we do with other government agencies such as planning around the Liveable Neighbourhoods framework, for instance, and the extent to which that is around promoting the sorts of communities in which people want to live and work, the factors that need to be considered beyond infrastructure, the services that need to be available and how neighbourhoods are plotted and developed in such a way that promotes health and wellbeing.

Mr W.R. MARMION: Can we just explore that area a little bit? I have done some work on Liveable Neighbourhoods in the past. Liveable Neighbourhoods actually encourages us to have open space in a liveable neighbourhood. The trouble for a developer—taking up your point about developing—is that for a high school, you need to have a certain sized oval, which is an AFL-sized oval. This is a problem for schools, and certainly for infill development because you do not have that. You need to look at a cluster of Liveable Neighbourhoods and in that cluster—apparently, you need four—you need to have perhaps more space. The trouble is that a developer will look at their liveable neighbourhood and another developer will look at theirs, and so you will not get a big enough developer that is looking at four liveable neighbourhoods that they own and actually being told by the government, "We want a large space." Are we missing out on spaces because we are just looking at a liveable neighbourhood and not the bigger picture?

Ms Sullivan: I do not know that I am the best person placed to respond. It is almost a question that probably needs to be put to the department of planning. Certainly, I am aware that there is some work happening around—was it population three million for the review of planning —

Mr W.R. MARMION: Maybe it is a bottom-level question. The big question is that even if you had that space, you want people to use it. We want the community to use it. How do you get people to use that space if you have the space? I suppose that is a better question.

Ms Sullivan: It is important to make that space as attractive as possible—shade, green spaces, sporting facilities, ensuring that there is ease of access for the local community in terms of being able to get to that space, lighting —

Mr W.R. MARMION: Let us keep going up the tree. We have done that and we are still not getting a result. What interventions do you need to do—an advertising campaign—to get people to do that?

The CHAIR: This is about exercise, not diet though.

Mr W.R. MARMION: I know. I do not mind you including diet as well. In terms of changing behaviour, is it up to the individual to work it out themselves or is there a government responsibility to actually try to influence the general system or is it up to everyone —

The CHAIR: He is asking about nudging.

Ms Sullivan: It is both. Obviously, you want individuals to make changes, but there is also a need to provide prompts and also the tools and information from resources to enable that.

Mr W.R. MARMION: But how far do you go? Do you regulate? Do you make it compulsory in schools?

The CHAIR: Are there any plans to remove promotions from state assets such as government-owned billboards, sporting facilities and events?

[10.30 am]

Ms Sullivan: Not that I am aware of. Obviously alcohol advertising is in the process of being removed from government public transport assets. Certainly, the issue of junk food advertising was raised as part of the preventive health summit, but that is a matter for government to consider.

The CHAIR: What is the position of the Department of Health around that?

Ms Sullivan: If you asked me personally, I would be in strong support of it. I am certainly aware that that is an action that has been taken by ACT, for instance. Most recently it has been announced that the Mayor of London is looking to remove junk food advertising from a whole range of assets that are either owned or controlled by the City of London.

Mr W.R. MARMION: What is the definition of "junk food"?

The CHAIR: "Sometimes foods".

Ms Sullivan: High in salt, fat, sugar—those types of foods.

Mr W.R. MARMION: Is there a definition, because if you do not have a definition, someone will put up an advertising thing and say, "No, this is not junk food under the definition provided by the Department of Health"? Is there a definition that defines junk food?

Ms Sullivan: There is a definition of what are called "discretionary foods" that is provided as part of the Australian Dietary Guidelines. In addition to that, an obesity working group is working with the COAG Health Council and is looking at a number of issues that relate to the marketing of unhealthy foods to children. One of the pieces of work that that group has been working on is defining the types of foods that should not be marketed or promoted to kids. That has only recently been endorsed by the COAG Health Council. I do not have that with me, but I am very happy to provide that to the committee.

The CHAIR: Yes, that would be great.

Mr W.R. MARMION: I have five kids. I have noticed over the decades that the advertising from Hungry Jack's and all those fast food outlets that advertise junk food has changed. They are now advertising salads and wraps and things —

The CHAIR: They do not sell them, though.

Mr W.R. MARMION: They take a long time to get made.

The CHAIR: They sell them to the parents. The discretionary foods are sold to the kids.

Mr W.R. MARMION: They take a bloody long time when you go through the drive-through because, you are right, they do not have them ready. The premise of my question—which is probably a good outcome as they might change the way they sell their products, but I am not the expert. I am interested in —

The CHAIR: Just to add to that, we had a hearing with the CSIRO and one of the things they said is that they believe that actively working with the organisations and the food industry—that is a big broad term—is actually a much more effective way than trying to battle against the food industry. As public health practitioners, how would you assess that view?

Ms Sullivan: There is a need to work with the food industry and the food industry is not all bad. There is quite significant diversity within that body. That being said, I would not want the food industry to be setting the health agenda because there is a commercial imperative that they need to serve. At a commonwealth level, you also have the Healthy Food Partnership—I am not too sure I have given the correct name there. Part of the role of that partnership is to try to encourage food reformulation.

The CHAIR: So that it becomes more low GI?

Ms Sullivan: Yes; so it becomes a healthier choice by comparison. You also have the Health Star Rating System. Unfortunately, that is voluntary, not mandatory, but what we are seeing is some of the effects of that. We are starting to see some reformulation of some foods because clearly they are seeing that the greater the number of stars, the better a marketing tool it is for different food products.

The CHAIR: You talked about the Australian Dietary Guidelines. One of the things that seems to be coming out through submissions and evidence is how controversial those guidelines are and whether they are still contemporary and reflecting what good dietary practices are for people. There are some people who have come out and said quite categorically that the Australian Dietary Guidelines are part of the problem in terms of what we have, what we are promoting and what we are educating for. Are you aware of that?

Ms Sullivan: I know that there are different diets that people promote. The Australian Dietary Guidelines were developed as part of an extensive peer-review process. They remain contemporary. The reality is probably that the majority of Australians do not eat a diet that necessarily aligns directly with the Australian Dietary Guidelines, but if anything, that just illustrates the task for health organisations and others in terms of encouraging a healthier diet.

The CHAIR: You talked about the Mayor of London. My understanding is that the British dietary guidelines are under review at the present time. Are you aware of that?

Ms Sullivan: They may be, yes. Sorry, I was not aware of that.

The CHAIR: We are still at the beginning stages of looking at all the evidence and we do not expect our report to be in until April, but there is a real concern around the level of carbohydrates that are recommended under the Australian Dietary Guidelines. Does the health department have a view on that?

Ms Sullivan: The health department's view is that the dietary guidelines are appropriate and they remain contemporary. They promote a diet that would suit most Australians, unless you had some other chronic condition where there was some need for special dietary arrangements.

The CHAIR: According to your —

Dr Williamson: Can I interrupt for a second? This is not my area of expertise, but I am just trying to work out where these issues are coming from. Clearly, there are some vested interests that might like to cast doubt on existing guidelines, but also there is a genuine concern among the scientific community about the whole area of nutritional science and its standing. Some of the commentary around this is from Professor John Ioannidis from Stanford and there is now quite a body of literature beginning to question how we develop some of these standards. I think there is a legitimate area of inquiry here, but we should not let it detract from some fairly commonsense guidelines that we do have in place.

The CHAIR: I suppose the issue is that the Australian Dietary Guidelines were last updated in 2013 and for us, the particular question is—I probably have not put it properly: are they suitable for type 2 diabetes or people with prediabetes in terms of a framework for being able to do either prevention, if you have prediabetes, or treatment?

Dr Williamson: As I say, I am not an expert in nutritional guidelines. I imagine that the guidelines that you are referring to are there for the general population, so of course there would then be dietary advice on top of that for people who have either got prediabetes or diabetes. I think that is a slightly different context.

The CHAIR: But the diabetes association still recommends them. They still have this primacy in terms of that area. If we are looking at what is a chronic disease, my understanding is that a major issue with the Department of Health's waitlist in terms of treatment—I am happy to be told if it is different—is diabetes related. We are looking at trying to treat that for the purposes of having healthy individuals but also being able to deliver a cost-effective health system. Are they the appropriate guidelines to assist people with type 2 diabetes? That is really the question. I am happy if you want to take that on notice.

Dr Williamson: I think the experts would have to address that rather than us necessarily—certainly rather than me. I notice that this was touched on by Tim Davis in his presentation and Michael Mosley indeed. There are a number of potential diets that might be used, including the "5 and 2 diet" that Michael Mosley has put forward and which I think, according to Tim Davis, might have been adopted by the national Heart Foundation as being a legitimate diet to follow. I think we would all have to take that question on notice. I am not sure that we would be able to resolve that without expert opinion.

[10.40 am]

Mr W.R. MARMION: Can I continue exploring this area? When you go to the doctor's surgery and they measure your blood pressure, they have a matrix on your age and your blood pressure and as you get older your blood pressure stays the same and you are actually getting better—that is my situation. The problem people have taking advice from people—telling you "this is how you eat"—is that if you are a fit person and you are young and you play sport, you do not even take any notice. You think, "I don't care what I eat because I do a lot of exercise", but as you get older, you probably are not doing as much but you still have that thought in your head that you are still pretty fit. Should the dietary guidelines actually be not just one thing for the general population but a matrix? People are sedentary, they do not do any work, and then there are those that actually do a bit of exercise and those who do a massive amount of exercise, but you have to quantify it. This is a suggestion; I want advice on this. We are talking about carbohydrates.

The CHAIR: They have already said they are not nutritional experts, though.

Mr W.R. MARMION: But I am talking about a general philosophy or a strategy, and your expertise has been around for more than five years in the area. Do you think people might take more notice of that? If someone is an Olympic rower, they can eat as much carbohydrates as they like.

The CHAIR: The question I think he is trying to say is that in terms of your public health prevention and your chronic health, how are you addressing those sort of things? We understand that you are not nutritionists.

Dr Williamson: I am not a nutritionist, but —

Ms Sullivan: There is a different diet for the well population versus somebody who has a pre-existing chronic disease.

Dr Williamson: Correct.

Ms Sullivan: They would be seeing a specialist dietician and a diet would be developed that is specific to their needs. The Australian Dietary Guidelines are for the general population and they suit most people and they are a commonsense set of —

Mr W.R. MARMION: But before you become a diabetic, you want people to be eating the right stuff so they do not get there.

The CHAIR: Let us talk about access to dieticians in the public health system: what is that like? I am prediabetic. I should have been following the Australian Dietary Guidelines. Clearly, that was commonsense. Clearly, there are a whole bunch of people who are not because we have an obesity issue. Either they are too difficult or whatever, but clearly a whole bunch of people are not following them. How do I get access to a dietician in the public health system?

Dr Williamson: If you are attending one of the public clinics, then you can be referred by a diabetes specialist or indeed any specialist to the dietetic department.

The CHAIR: But that is post-diabetes, is it not?

Dr Williamson: Well, it might be someone who, for instance, is overweight and going to the cardiology clinic who does not have diabetes. We generally do not see fit and healthy people in the public health system. I will leave that again to our public health experts here, but for the group that is actually in the system, whether they have diabetes or not, they have access to nutritional experts—dieticians. Obviously, what we see in the public hospital system is a small subset of everybody who has diabetes. I know that the greater proportion would be managed in primary care, so access to dietetic advice there would be by referral from a general practitioner to a private dietician. If you have a chronic disease and you have a care plan, then, as you are probably aware, you would have access to five allied health consultations per annum, some of which can be dietetic advice. That would be the normal way in which you would access it. I presume there would probably be some gap payments, perhaps, but not if you are a pension card holder. That would be a normal way in which you would access dietetic advice in the community.

The CHAIR: What is the waiting list for dieticians in the public health system?

Dr Williamson: I do not know. I would have to take that on notice if you wish that information.

The CHAIR: That would be great.

Ms S.E. WINTON: I just want to go back to Healthy Options WA, the food and nutrition policy. There is an audit underway at the moment. Can we get a little bit more information on that?

Ms Sullivan: One of the initiatives of the minister post the preventive health summit in March was to write to all chairs of the health services to essentially say that he wanted to see full compliance with the Department of Health's food and drink policy by 31 October. Subsequent to that there

would be an audit to ensure that there was compliance and, if not, what changes needed to be made. The audit is underway at the moment. About 25 sites are being audited, both in metropolitan and regional WA. The fieldwork will not be completed until just before the Christmas–New Year break. Obviously, there will need to be some analysis of the data that comes out of that and we are looking at a final report that should be ready around February or early March at the absolute latest. The findings from that will feed into a review of the food and drink policy with the intent to see a more strengthened policy, particularly when you look at what has happened in some other jurisdictions in terms of strengthening of their food and drink policies in their health services. I should say that subsequent to correspondence from the minister, we have seen elevated focus on catering and food services within our health services and quite a big effort being put in by health services to ensure that there is a bigger range of healthy food options and less healthy ones are less prominent.

Ms S.E. WINTON: What is your view of what the audit will show in terms of support or actions on the existing policy? Any sense of —

Ms Sullivan: It is a bit soon to call. I think it will show that there has been a good effort put in to improve compliance with the policy, but I suspect it will probably show where there is some need for improvement.

Ms S.E. WINTON: Do you think it will highlight perhaps the possible need for changes to the policy as well? Can you elaborate on what might be some of the blockers? I know there was that instance —

Ms Sullivan: There are certainly some issues with changes in terms of catering within the health services, particularly where they have been locked into long contracts with private providers. But there are things that can be done that mean that the red foods, for instance, are given less prominence. The other is the extent to which there has been awareness of the policy when it comes to tendering for new service providers within the health services. There is a need to ensure that that is given greater prominence as part of any changes in service providers. Also, we are aware of criticisms around the provision of sugar-sweetened beverages within health services, for instance. We are certainly aware of other jurisdictions where there has been a ban on the provision of sugar-sweetened beverages within particular health services.

The CHAIR: In the submission, the Department of Health is currently investigating the feasibility of mandatory kilojoule labelling on menus at quick-service food outlets in WA; where is this at? It sounds great. When is it going to happen?

Mr W.R. MARMION: I will use it.

Dr Robertson: As you are aware, there is already some self-regulation in this area and a number of outlets are already starting to do it. I suppose they have seen that this may well be a step that we would want to take. Certainly, we are progressing it, but there is still ongoing discussions as to how we actually put that in place.

The CHAIR: How can we help?

Dr Robertson: Probably by supporting it as a measure.

The CHAIR: Why is it a good measure?

Dr Robertson: People have no idea as to what the actual kilojoules are for most of the foods, particularly fast foods. Being able to actually make a decision—to use your Hungry Jack's example—people probably know that a salad should hopefully be a bit less, but they may not actually have any idea how much less.

The CHAIR: That is right, and if it has a dressing on it that has lots of sugar in it, that might not be the case.

Dr Robertson: Exactly. Some of the other food offered may actually be considerably less but people just do not know. They may make assumptions that are not based on reality.

The CHAIR: We have had submissions about glycaemic index and the view that it is not necessarily the kilojoules in the food but the glycaemic index. If it is low, then it has a longer benefit for you in terms of not necessarily refuelling yourself. Does that measure go with the same measure that you are looking at here with mandatory kilojoules? How does that interplay with the glycaemic index?

[10.50 am]

Dr Williamson: No, it is not quite the same thing. It is the way in which the kilojoules are delivered, really, and the rate at which the glucose is released into the bloodstream. Again, I think there was a lot of work done on the glycaemic index, in particular in the context of type 2 diabetes. Some people held strong opinions on it; there was a lot written on it and food choices were based on it. Again, going back to my earlier comment, I think some of this literature has been questioned recently and people are going back to review it, and I refer to the investigator whose name I mentioned earlier, John Ioannidis, who has drawn attention to this.

The CHAIR: He is from the United States?

Dr Williamson: Yes. His area is in evidence-based medicine at Stanford.

The CHAIR: And he is questioning the glycaemic index?

Dr Williamson: He is not specifically talking about that. He is a methodologist; he is a clinical trialist. His area of expertise is in evidence-based medicine. I suppose one of the difficulties about doing some of these studies is that they are not necessarily randomised controlled trials. Attempts have been made with a few dietary interventions to do such trials, which are the gold standard, if you like, for evidence, but they are not usually like that. They are usually cross-sectional studies, where you look at the sort of foods that some people are eating in comparison to others.

The CHAIR: It just seems to me that there is a high level of competing views on how to treat type 2 diabetes and diet. On the one hand, you have someone who says that if you had low GI foods that would be an effective treatment and prevention; then you are saying that there are now questions in terms of that. How do you resolve these things in terms of the public health system in Western Australia? We do not have an obesity coalition like they do in Victoria. Where is our strategic aspect of being able to take these into account and give good advice to people? Because one of the things that you talk about here is education for customers, as such.

Dr Williamson: Again, I might defer to my public health colleagues, but from a clinical perspective, I think there are some basics. I mean, fruit and vegetables are good, and there is some basic dietary advice that one can give. I think we have drawn attention to the need to have, in the case of patients with diabetes, specific dietetic advice that is tailored to their situation, whether they be an Olympic rower or a rather sedentary couch potato. But I think that it is fair to say that the area of nutritional science is extremely difficult. It is very difficult to do controlled studies in this area. Usually the studies are cross-sectional in nature, and they do not necessarily therefore indicate that your intervention—or where there is no intervention, those situations—is effective.

The CHAIR: Is that because they are all individualised interventions instead of a global systemic intervention, like basically restricting access to something?

Dr Williamson: There are lots of different types of interventions that have been done. Some of them have been combined. I mean, there is the multiple risk factor intervention trial, for instance, where

lots of risk factors were dealt with simultaneously, but quite often these intervention studies—which are very hard to do—are small, and the large studies that have been done are cross-sectional and are not randomised. So those are general problems about nutritional science that I just draw attention to. But I do not want to muddy the waters, because in a practical instance, if somebody with diabetes came in to my clinic tomorrow, I would not debate the state of nutritional science. I would be giving them very clear advice about what I think is a healthy diet based on the guidelines and advice that currently exists.

The CHAIR: So you send them off to a dietician. How do you monitor them and assist them so that they can continue on? Or do we just send them to the dietician and say, "There you go, off you go, change your dietary habits"?

Dr Williamson: Again, this gets back to behavioural economics and nudge and all these sorts of things: how do you influence people's behaviour, because that is really what we are talking about here. Giving them an information sheet, patting them on the back and saying "Here is a list, off you go" is clearly not going to work. There has to be ongoing contact. I think there is a large amount of interesting research that can be done about how one can have sustained benefits. That being said, we know that dietary interventions are effective. They are effective in people who have prediabetes; they are effective in people who have diabetes and wish to lose weight. There are current systems in place out there which are effective.

The CHAIR: In terms of assisting vulnerable communities and vulnerable populations, though, like Aboriginal or culturally and linguistically diverse and those in the country, the Department of Health submission states that addressing the social and cultural determinants of health that contribute to poor dietary choices and poorer health outcomes for Aboriginal people is vital. You go on to talk about the requirement for a comprehensive coordinated approach across all sectors and longer term commitment to address the social and environmental determinants of health. The Department of Health says that it has a leadership role in this. What does that mean in practice? How are you taking that on? Do you convene meetings around this? What is the process for that leadership role?

Ms Sullivan: In terms of more broadly around obesity prevention—not specifically diabetes prevention—we have overarching frameworks like the Health Promotion Strategic Framework, which is a fairly high level document that sets out some clear priorities and strategies for addressing obesity, unhealthy weight and inactivity as an issue. We also work quite closely with a range of other government agencies, so it is looking to what extent our public policies are mutually reinforcing. For instance, if transport is updating an active transport policy, or planning is updating one of its key planning policies, we will be looking at to what extent some of the changes that they are wanting to support helps reinforce a healthy lifestyle, but equally, as part of our own policies, how do changes in our transport planning environment enable people to live much healthier lifestyles, for instance. So there is a lot of work that happens at an officer level, which is not necessarily very visible, and it is not necessarily through formal senior officers groups, for instance. Certainly, through clinical excellence, there is also the health networks, which bring together groups from a whole range of sectors both from within health and other state government agencies where there is an opportunity both to share information around their activities and policies and where we need to be finding synergies or leveraging off one another's policy work.

The other is also the advent of a national obesity strategy—that has obviously been recently endorsed by COAG Health Council at its meeting on 12 October—and there is now some background work happening around the process by which that will be developed, although that is still many months away, given you have a number of jurisdictions that have elections coming up, and to what extent that may slow and disrupt the process.

The CHAIR: Is it worthwhile our having a state obesity coalition organisation like they do in Victoria? In my understanding that is funded by the Victorian health department. Is that the case?

Ms Sullivan: If you are referring to the Obesity Policy Coalition that Jane Martin leads, my understanding is that they get some funding through VicHealth, and it is a group that brings together a number of key NGOs and has a very strong advocacy role and a very important advocacy role. Its role is very much around niggling and reinforcing what are some of the bigger, bolder policy measures that government should be considering. We do not necessarily have a formal coalition as such here in WA, although there are a number of NGOs that probably play a leadership role in that space, so Cancer Council WA would be one. Also Telethon Kids Institute has a strong particular interest in this, and the two groups work together quite well. Heart Foundation clearly has had a strong leadership role around obesity prevention for some time too, although that has gone through some recent changes, so I am not too sure to what extent and where that sits within their work program here in WA. So there is quite a lot of working together that happens at an NGO level, as well as linking in with government, but probably not as—

[11.00 am]

The CHAIR: Does it happen with diabetes, though, or is it just on obesity?

Ms Sullivan: It is just on obesity, on the understanding that by addressing obesity, you are also addressing a biomedical risk factor that is linked to a range of other chronic conditions, be it type 2 diabetes, heart disease, and some cancers, for instance.

The CHAIR: But out of all of that, is type 2 diabetes not one of the most preventable and also one of the chronic diseases that lead to some of the biggest waitlists in Health? I keep thinking: how do you eat an elephant? You eat one bite at a time. We keep looking at obesity. If we concentrated on one of the outcomes of that, would we not have better outcomes? I am just interested. I suppose the question is: should we have looked at obesity—which is an enormous issue—instead of type 2 diabetes, which seems to be, in terms of this committee, value-adding something into health that both assists people in our community but also the health budget?

Mr W.R. MARMION: Can I just add to this? We can actually help the policy in this: that is why we are doing it. What would also help would be actually the cost. Have you got some data around the actual cost of diabetes 2 or 1, or even combined, per patient or total to the health department of Western Australia? It would be very handy to have that. Also, following on from that, the reduction in the costs if you actually did things like bariatric surgery or some intervention; also the cost of what you are doing now in terms of having diabetes centres throughout the state; which hospitals have facilities or have capacity to actually assist people with diabetes; do all public hospitals have that, or do you have to be sent? What costs are we actually incurring anyway in the health system?

Dr Williamson: I would have to take it on notice to provide the exact details.

Mr W.R. MARMION: Sure, I do not expect you to have them off the top of your head.

Dr Williamson: I have seen, if you have a patient with diabetes and complications, then they probably cost around $15 000 per patient per annum in the system.

Mr W.R. MARMION: That is for lifetime?

Dr Williamson: Once they have developed complications. We have actually done some fairly sophisticated modelling around this, and we would be able to provide more information on it.

The CHAIR: PwC in 2015 did a "Weighing the cost of obesity: A case for action". My understanding is that they did some modelling as well and, with a set of interventions, found a benefit–cost ratio

of 1.7 if you addressed diabetes. So anything in terms of the Western Australian aspect of that would be really appreciated.

Mr W.R. MARMION: I think Tim Davis mentioned that his wife does economic data around that, so it would be handy if we could get hold of some of that stuff.

Dr Williamson: I do not know that she has specifically done this. She has recently done an evaluation of the metro south program in Queensland.

The CHAIR: Yet that has not been continued in Western Australia. Why was that?

Dr Williamson: When I read that transcript, I was shocked, because I spent two years in Queensland at Princess Alexandra, working alongside a chap who set up the Inala clinic. It was funded by NHMRC and it seemed to me an extremely successful program. It was news to me that it had been discontinued.

The CHAIR: And your view is that it should have not been discontinued?

Dr Williamson: Yes.

Ms S.E. WINTON: I just wanted to revisit the KPIs for the Department of Health. We were earlier talking about diabetes type 2 and obesity not being—can you explain to me why that is the case, and what your view of that is, because it seems to me such an obvious thing that needs to occur?

Dr Robertson: Just so I am clear on the question: we do have KPIs.

Ms S.E. WINTON: Yes, you do, but specifically around our area of interest.

The CHAIR: Diabetes.

Dr Robertson: Our current KPI measures are around premature mortality.

The CHAIR: And you die from diabetes.

Ms S.E. WINTON: That is what I am trying to say.

Dr Robertson: You do not die from diabetes.

The CHAIR: No, that is right, you do not die from diabetes.

Dr Robertson: And that is the problem. You do not die from diabetes; you die from heart disease or similar. That is not to say that —

Ms S.E. WINTON: We cannot have those as measurable because —

Dr Robertson: No, and they are measurable. Certainly, when we look at them as measurables —

Ms S.E. WINTON: But are they measured in terms of the KPIs in terms of the department's performance?

Dr Robertson: No, because the particular KPI that we are looking at there is premature death, and it is not the principal cause or one of the top five causes for premature death.

The CHAIR: Is there a problem with having it as a KPI? That is what we want to know.

Dr Robertson: We measure it as a KPI anyway, it is just not one of the top. You have seen only a small number of KPIs that we measure. Our epidemiology area measures a whole range of KPIs in different areas. For example, for deaths where diabetes was listed as the underlying cause, the median age of death was 80, so it is not actually going to show up on a premature death model. We do measure it as a KPI, and we can provide that information. It is not necessarily a KPI that is one of our main principal ones up-front, but it is measured.

Ms S.E. WINTON: Where would we find that information, then, in terms of a KPI, the department responding?

Ms Sullivan: There is a whole range of reporting that government does, both at state and national level, and diabetes is reported in that. One example would be reporting on government services, which is put out by the federal government, so all jurisdictions contribute to that. Part of that reporting, you give what is the current data, what are the trends, but also what is being done at a jurisdictional level to address that issue. It is also reported on as part of reporting by the Australian Institute of Health and Welfare, and also as part of the "Burden of Disease Study". It is not overlooked as a condition, if that is the concern, but clearly it does not feature as part of that single KPI around premature deaths.

Ms S.E. WINTON: I guess that is my question: why does the department not have it as a KPI?

Dr Robertson: I suppose the question is —

The CHAIR: What would you get from it?

Dr Robertson: — what would you measure? Are you looking at deaths?

The CHAIR: No; we are looking at helping out the public health budget so that you do not have one of the major —

Ms S.E. WINTON: Yes, if it is not a KPI, then —

Dr Robertson: We do report a lot of these nationally. For example, in the Australian Institute of Health and Welfare's data —

Ms S.E. WINTON: But the KPIs report to the state government, correct?

Dr Robertson: Yes, they are.

Ms S.E. WINTON: I am not interested in reporting anywhere else. I am interested in reporting to government on the department's performance.

Dr Robertson: We release that information nationally, so we can look at it in comparison to other jurisdictions, and when we look at the prevalence, how we compare for hospital care.

The CHAIR: And the money spent on it?

Dr Robertson: And the money spent; some of that will be picked up separately. Money spent, I would have to look at.

The CHAIR: That would be good. If we could find out the sort of cost that is involved in treating a preventable disease in our community, that would be really helpful. If you think about it —

Dr Robertson: It is a very good question.

The CHAIR: There is a PwC analysis that says there is a cost benefit for us to actually focusing on reducing type 2 diabetes in our community. Now, think about it: in the period of time that you have been medical practitioners and working in the health department, you have seen an increase in type 2 diabetes. I get that we are going to blame the food industry and we are going to blame sugar in drinks, and we are going to blame all of that sort of stuff, but if you are someone like me, who is a policymaker, who has one of those hotspots in their area, and you go, "My goodness, we have had this preventable that is costing the health system and impacting on people, how are we measuring that so that we know we can get better?"

[11.10 am]

Dr Robertson The one challenge here, though, is if we are looking at obesity, it obviously contributes to a lot of other diseases.

The CHAIR: I am not looking at obesity. I am looking at type 2 diabetes.

Dr Robertson: Just teasing that out, because there are often a lot of comorbidities. People with diabetes may well have heart disease as well. We have some estimates of the cost, so in 2011, for example, overweight and obesity was responsible for around $240 million in inpatient hospital and emergency department costs in WA.

The CHAIR: That is overweight and obesity.

Dr Robertson: That is overweight and obesity. An element of that will be type 2 diabetes, but it will also include heart disease and a number of other conditions. That is around 5.4 per cent of all of our hospital costs at that stage in 2011, and that is expected to more than double. That gives you a ballpark figure of the kind of cost, but it does not isolate it down to type 2 diabetes. We certainly will be able to get some idea of those costs.

Ms S.E. WINTON: If I can just drill down a bit further. If my understanding of this is right, with the department's KPIs, like outcome 2, it has at point 5, "Loss of life from premature death due to identifiable causes", and it lists a whole heap of them. It does not include type 2 diabetes. What I am trying to say is the national health priority areas has diabetes listed on it.

Dr Robertson: Yes, premature mortality is more the issue here, and the recording of how people die. They are not generally recorded as having died from type 2 diabetes. It is often an associated cause, but the cause of death and the recording of the cause of death is primarily coronary disease or the like. That is why you are not getting that figure. It is how it is recorded on a reporting of death.

The CHAIR: We have someone else waiting outside to talk to, but do you have the responses to our bariatric questions that were sent?

Dr Williamson: Yes, somewhat caveated, I would have to say, but we certainly have the information.

The CHAIR: That is excellent. Thank you so much. If you could hand that to the researcher, that would be greatly appreciated.

Ms J. FARRER: Just on information sharing, because you know in the Kimberley we have all these different areas of health. There is Aboriginal medical health, and I guess that comes under NACCHO with National Aboriginal Health. With some of the findings or the research work that has been done, are they shared with the public health system, or individually they would have to go and ask for it? Considering people come under the practice of the local GPs and some are not able to come under, or work with, or able to get the information from the Aboriginal medical services.

Dr Robertson: Certainly our publications are readily available to both public and private. Generally our publications are released online.

Ms Sullivan: What sort of information is it —

Ms J. FARRER: The health information that sometimes GPs report. Aboriginal people are from remote areas. They get dealt with by all these different health services, like Kimberley health services, WAC health.

The CHAIR: It is about their personal information.

Ms J. FARRER: Yes.

The CHAIR: That is supposedly going to get fixed with the—they are talking about your patient information.

Ms Sullivan: So patient records?

The CHAIR: Yes, patient records.

Dr Robertson: With the My HR, that is one element —

The CHAIR: My Health Record.

Ms Sullivan: "My Health", not "My HR". That is our payroll thing.

Dr Robertson: Yes, My Health Record, sorry. I will just make that clear: My Health Record, yes.

The CHAIR: Josie just said that many of the Aboriginal people are not computer literate, and many of the people I represent are not computer literate as well, so whether there is some work being done on being able to assist people in the health department. We might send you a few questions, if that is okay. Thank you very much.

Hearing concluded at 11.15 am

_____