EDUCATION AND HEALTH STANDING COMMITTEE

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

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
FRIDAY, 1 MARCH 2019

Members

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

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Hearing commenced at 1.40 pm

Ms JOANNE MARIE BURGES
Executive Manager, People and Place, Western Australian Local Government Association, examined:

Ms KIRSTIE DAVIS
Policy Manager, Community, Western Australian Local Government Association, examined:

The CHAIR: Thank you for coming and seeing us today. I have a bit of an opening statement to go through. We are very appreciative of being able to chat to you. On behalf of the committee, 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. The other members of the committee are Mr Bill Marmion and Mr Shane Love. Ms Josie Farrer and Ms Sabine Winton are not present, and send their apologies. Also, Sarah and Jovita are our research people, who are very valued by the committee. 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. Before we begin, do you have any questions about your attendance here today?

The WITNESSES: No.

The CHAIR: We are looking into the role of diet in type 2 diabetes and we are really keen to speak to local government about this because of the implementation of the Public Health Act 2016, and local health plans. Our committee is due to report in early April, but we are glad to make a time so that we could all get together. Did you want to make a brief opening statement at all?

Ms Burges: I can probably just provide a short opening statement, Chair. Probably the best way to start is to outline that we really are guided in local government under a legislative and compliance framework and, particularly in relation to this subject matter, under the Local Government Act and, more broadly, under the Public Health Act 2016. As you just mentioned about local public health plans, as a requirement of the new Public Health Act 2016, local governments will be required to prepare a local public health plan by one year after the commencement of stage 5, so we are talking, at the very earliest, probably 2021 for that stage 5 implementation. I just thought it was useful to have that frame there, notwithstanding that we have a significant number of local governments that have already prepared those plans.

WALGA is active in working with local governments around local public health plans through the provision of leadership and sector representation, and the representation of views of local government both at the federal level and in situations such as this and in submissions. We have been working very, very closely with local governments all along the way of the implementation of the Public Health Act 2016, and particularly all the regulatory reviews et cetera that have been involved in that. We recognise that stage 5 is a significant stage of the implementation. The Department of Health has worked with both us and elected members and officers of local governments in the lead-up to this stage. We worked very closely with the previous Chief Health Officer, Tarun Weeramanthri, to help provide some insight into local governments' role and the necessity for a long lead time with local public health plans. Thus, with the interim state public health plan emerging from that, I am sure that he, at that time, was not keen to have it out in the

realm as soon as it was. By bringing that to local governments' attention, it was able to now include some of the guidance we are looking for, notwithstanding the health and wellbeing aspects that probably lead into this discussion today, but also the inclusion of mental health, among other matters. We work to our strategic framework in local government—the integrated planning and reporting framework under the Local Government Act. This is where public health planning fits within that act as an informing strategy to the long-term strategic view of local governments.

The association certainly advocates very regularly on behalf of the local government sector and is also part of several partnerships. In particular, we have been involved with the Sustainable Health Review subcommittee, which is now completed; public health planning, with membership that includes the Department of Health, health service providers and us; the North Metropolitan Health Service providers network; and the health and wellbeing advisory group, which has WALGA, local government public health officers and the Department of Health. They are just some of many. We also liaise with Diabetes WA. On this particular matter, we would defer generally, if there are specific matters, to Diabetes WA. There are strong relationships, in particular with planning aspects of local government, with the Heart Foundation, and in particular Healthy Active by Design features. We have worked very closely with them in providing both an environment and information for them on where the target audience really sits. Just to clarify that, there was very early thought that influencing planners at a local government level was the way to influence the design of what was going to occur in that local area, whereas we were able to assist in guiding that it is actually the community and the influence of elected members that have a huge impact on that.

The CHAIR: How did you do that?

Ms Burges: We worked right through the framework. It is like with anything we work with: you can only be guided by the frameworks, policies, legislation and regulations et cetera that are in place, so design and amenity within the community is only as good as the local planning scheme.

The CHAIR: So how are you working with local councillors? The reason I ask that is that what you are basically saying is that that will matter to the local elected councillors. In the case of working with local councillors in this space around the implementation of public health plans, if you say that you made people aware about amenity and bringing in Healthy Active by Design. I assume that you really had to go and educate councillors: is that what you did? Did you effectively go and educate councillors about Healthy Active by Design, or did you just say to the Department of Local Government, Sport and Cultural Industries, "It's not us; you have to talk to councillors"?

Ms Burges: No, we hold a significant role in that area both by speaking to the Heart Foundation and working with their group to assist in understanding where the target audience was. For instance, there was some further work undertaken with the healthy built food environments—a significant piece of work with Edith Cowan University.

That helped build their website. When they were going out to the community, they being the Heart Foundation—this is when they were targeting an audience of planners—we were saying, "Actually, we want to assist you with making sure that the actual target audience is elected members." We were able to help communicate that on behalf of the Heart Foundation and also our role —

The CHAIR: What happened after you communicated it?

[1.50 pm]

Ms Burges: We ensured that they —

The CHAIR: Did you have a forum or did they go out and see them? What actually happened on the ground?

Ms Burges: This is usually how we do it. At that time, because this was only towards the end of last year, we assisted in communicating that, encouraging the involvement of both officers and elected members to be au fait with that, and the Heart Foundation were holding workshops around that. We would not duplicate that usually; we would usually work with the agency, in this particular instance the Heart Foundation, to ensure that we could get those people to the table, those people being the elected members and officers, to ensure that the —

The CHAIR: That was just the end of last year. I would have thought, with the local government conferences coming up, this would be something you could have slotted into the local government conference agenda? Did you put it into a local government conference agenda?

Ms Burges: Certainly, in the local government convention of August 2018 we had a planning session. I would have to take it on notice as to the exact basis around that. Did we cover health and wellbeing in the last convention? I do not think we did in this last convention, but certainly from a planning point of view, Healthy Active by Design is brought to the attention of those elected members that are at themed conference concurrent sessions. Further to that, with any of the regulation that is happening around the Public Health Act, we are working closely with the Department of Health and collectively, instead of them going out and doing one set of consultation, we work out basically across the spectrum of IAP2 public participation, so there is a spectrum of that.

The CHAIR: What is IAP2?

Ms Burges: It is an association, an International Association for Public Participation.

Mr W.R. MARMION: I have never heard of that one.

The CHAIR: That is right. We have to have an association of public participation.

Ms Burges: It is a community engagement. One that you might be familiar with is IAPP, which is the state government, where you would go for some level of training.

The CHAIR: No. We just go doorknocking. That is how we get our public participation.

Ms Burges: Certainly part of the spectrum of that—it goes to everything from inform right through to empower and everything in between. We take everything around the regulation and anything to do with the Public Health Act very seriously. It is very much an engagement process. We work side by side with the Department of Health to ensure that at every opportunity we can bring people together, and that includes elected members and officers, information sessions and workshops.

The CHAIR: I am just going to throw something in here that is probably left field, but when we talk about engagement and stuff like that, we just went to the UK, and one of the things that was really interesting for us in terms of the current movement in the UK is that on-the-ground engagement with people in diabetes, and most importantly that people with diabetes can put their diabetes into remission, which was something that when I say that to people now—people say to me, "What did you learn in the UK?" And it is like, it is now starting to become much more a public policy position that you can put diabetes into remission. For such a chronic disease—I am just looking at the "Public Health Plan" from the City of Wanneroo, in their health plan, the City of Wanneroo say that the leading chronic health conditions are diabetes, heart disease and mental health problems. When you are talking in that way about how you enter into those conversations, I am just wondering how you weave it in so that it is that on-the-ground consultation of people, in terms of delivery through the health plans.

Ms Burges: I think the best way to answer that question is in the way that local governments themselves—we as the association can assist in knowledge access capacity building for those that are going to undertake this work. With those close relationships with the metropolitan health

services, you would be quite aware of where information would have fed into such things as that City of Wanneroo "Public Health Plan", is one of the first places they would start. I have the City of Cockburn's here, about their health and wellbeing profile, from which would have been drawn that information. I think when we look at health and wellbeing from that broader angle, type 2 diabetes is an end thing. That is the disease, whereas we are probably trying to work on the preventive part across a whole broad range of things that probably fit more under obesity, being more active, those kind of things. Definitely type 2 diabetes is part of a risk factor. The risk factors could lead to type 2 diabetes. At a broader level, the public health plans are going to look at what can we do from a preventive point of view? What can we do to address that amongst many other risk factors that we have in our community?

The CHAIR: What have they done in other jurisdictions like Victoria or the UK around this? Do you know? You are looking at Cockburn and the City of Wanneroo, but they were done in isolation of and are very new. Have we gone and looked at—to be able to equip them with—what has happened in particularly the UK? When we went to the UK we went to Newcastle and as part of their public health campaign they did a big project on Newcastle being active. It had a catchphrase, the Newcastle Can program, which was very on-the-ground, working with people. It had some particular pretty steep targets that it tried to meet, in terms of weight loss. But when you look at the sort of priority areas and stuff like that, they are health promotion and they are, you know, smoke-free stuff and healthy food, beverages and stuff like that. I suppose I am thinking that if it is such a chronic disease and figures so highly in both the plan you have got and the plan I have got, have you looked at anything else, and have not looked at it in that really global sense of, you know, "We are going to put 'eat three veg, two fruit' type signs everywhere" and actually be on-the-ground active participants in this sort of stuff? That is an around about question, sorry.

Ms Burges: No, it is excellent. I may call on my colleague, Kirstie, as well to add to this. We look right across the board. I mean, even this morning, we cannot dismiss the influence of champions, and Jamie Oliver has just been in town. Of course he is resending his messages about the focus on children. I can say that from a national level the Australian Local Government Association, for instance, in their submission and appearance before the select committee into obesity, recognised that children is where we start. If I refer back to Jamie Oliver, some of his stuff, we know the work that he has done in the UK—I am just picking one.

The CHAIR: Yes, that has worked!

Ms Burges: I think one of the challenges we have, Chair, and this is only a personal opinion, is how normalised obesity has become in Australia.

[2.00 pm]

The CHAIR: You do not have to be obese to have type 2 diabetes.

Ms Burges: I have personal experience with that, Chair, so I do know that. I do also know about the ability to turn the tide on that and to take it out of your life. That is about education around food, education around exercise, and lifestyle choices. I think what you will see and the examples—you have the Cities of Wanneroo and Cockburn and we have several examples here—where there are healthy eating programs that are introduced that local government not only informs our community about, but asks them to participate in.

The CHAIR: Do you reckon local government—in schools we have got the traffic light system, which, when we introduced it I had just become elected. The amount of times that P&Cs would meet with me to tell me that the traffic light system was terrible and was going to kill their canteen and stuff like that was pretty amazing. Do you reckon that local governments could do something like that

with seniors clubs? I go to seniors clubs and see what seniors eat. Could you do some of that—they fund, they support, they provide the facilities for those things. At the risk of being called a nanny state, which is the risk.

Ms Burges: I think it is very interesting you bring that up. I was very interested to read some of the research that we have undertaken into what some local governments are doing. Some local governments are working very closely with the WA School Canteen Association. Maybe you will think that is only going to influence schools, but as I read in, some of the requests from the canteen association could very much flow into recreational facilities—and do, those that are under the ownership of local government. It could be as simple as the catering facilities and the catering that comes into a local government and some of their events could be influenced in this way. I think that with many of these matters the challenge for yourself as a committee is going to be—does this need a regulated function? Does it need something from the top that says, "You will"? From the association and then also for our local governments, is it about something around sugary drinks? Is it about education?

The CHAIR: We cannot do sugary drinks.

Ms Burges: No.

The CHAIR: I suppose we could say, "You will not have sugary drinks in local government facilities." That will be an interesting one to put. You are right. You could regulate—I am not sure. Could you regulate local government facilities not to have sugary drinks in their facilities? Could the state government regulate and say to local government, "You can have other sugary drinks, but you cannot have this level of sugary drinks at the local aquatic centre"?

Ms Burges: I think it would be interesting to do that.

The CHAIR: My question is not whether it is interesting or not.

Ms Burges: I would not think you would be able to do in isolation. I would have to check and get back to you.

The CHAIR: Given that the discussion about local government reforms is currently out there, it would be really good to know: Is it possible? Is there a mechanism that you could actually do that?

Ms Burges: I would have to take that on notice.

The CHAIR: That would be great.

Ms Burges: My initial response would be that I think it would only be able to be done across the board, but I would not know the exact answer. We could seek that out.

Mr W.R. MARMION: Could I ask a few questions a little bit more on process and then coming down? I did some work for WALGA decades ago. WALGA is an organisation that most local governments in Western Australia are members of so it is a convenient tool. Especially with a smaller local governments, I see it as being able to do a lot of ground work for them and perhaps come up with pro forma stuff, a system and they can ring you up. What we are talking about now—health plans for local government. I would be very interested in your comments on the implementation of this. You have given some assistance in some of the answers to questions so far. For large councils like Stirling, for instance, and Wanneroo, that have resources that they can put a particular person on that might be able to look at this area, actually write a plan and then work out through the community service–type people how to engage with some aspects within the community that they have some sort of influence over and develop something that may make a difference, as opposed to in England where they have a much larger role to play. They actually have a budget for health—specifically for certain areas. We are in a different regime. I would be interested in your comment

on how this implementation is going to work in Yalgoo—I cannot remember the number of people that live in Yalgoo, but I know that it is very hard to even find a councillor to sit on the thing—how is this working and how do you see your role at the moment. Or how it is going to work if it is something they have even started?

Ms Burges: One of the early conversations with Tarun Weeramanthri was around being able to do things at a regional level. This was called upon from our local governments. It was not about—part of it was about that we are resource poor, but the other part was that this kind of information that is quite easy to get hold of for areas in the metropolitan area and some of those larger areas, but it is a very difficult to drill down. You quite rightly bring up somewhere like Yalgoo.

Mr W.R. MARMION: It is a little one, but Shane might bring up other ones.

Ms Burges: To be able to get the information down to an area that is significant enough—can we, without identifying actual places and people, say what the smoking levels are, what the levels of type 2 diabetes are et cetera. There was a call very early for us to say: is there an ability for us to produce local government public health plans at a regional level? We are very conscious of the fact that very early there was a little bit of pushback. You have got the environmental health officer who was previously—public health was their realm. Very much what we are looking at here is an across-the-organisation process, going into community development, the community development officers and these kinds of things. As we know, some of those smaller local governments do not have that level of resourcing. If I refer back to the Local Government Act, in that we refer to scalability. Is there a way of being able to scale, if there was going to be a compliance level around it, for instance? The interesting part is that size does not necessarily relate to—you have a large issue with this issue because you are large. We know that some of our smallest local governments in this area probably have the highest risk.

Mr W.R. MARMION: In the Kimberley, for instance.

Ms Burges: The Kimberley, lands, even in the wheatbelt. We know that some of these figures are coming back at astonishing rates. I could not profess to know the percentage of people that have type 2 diabetes in these specific areas. It would not take us long to find out. I am sure that the committee is probably fully aware of those. Do you have any comments that you wanted to add, Kirstie?

Ms Davis: On process, I can provide some. In addition to what Jo has already said, we do have a strong working relationship with the Department of Health and other key stakeholders and an advocacy plan for how we would like to address that. With the changing over of the Chief Health Officer and other key staff, we need to sit back down with them and see where we all are with that. What we have already committed to doing is continuing with those partnerships, to look at the appropriate acknowledgement and resourcing of the strategies that are required. All of our local governments that are engaged in the space acknowledge that having an outcomes measurement framework and health and wellbeing indicators at a local government area is what is required so that they can effectively develop their public health plans.

The CHAIR: Does that mean something like you could say here is your percentage of diabetes—in the case of the City of Wanneroo it is 67 per cent are overweight or obese and we want to reduce that to 65 per cent—or two per cent or whatever?

Ms Davis: This is how much it is costing council to implement this project and how successful that project is.

The CHAIR: So that is not what you are talking about.

Ms Davis: And redesign the program, work with the stakeholders, redesign a plan, a program, strategy or an initiative and implement that and re-cost it over time.

The CHAIR: So it is not so much about having it as a strategy of—what Newcastle Can did was to say that we have this percentage of people who are overweight and we want to decrease it by this percentage. You are not talking about that as being the targets. You are talking about how much does it cost us to deliver a healthy food initiatives into our council, how effective it is in terms of delivering that and how many people do we get coming along, and how we can get more people to come along. That is what you are talking about, is it not?

[2.10 pm]

Ms Davis: Essentially, but the second part of that would be to aim towards healthier communities, so that would indicate a reduction.

The CHAIR: If you could get excited about this, what would you like to see?

Ms Davis: I would like to see an outcomes measurement framework for local governments and health and wellbeing indicators in place across the whole of local government, and for our advocacy plan to be resourced and all the work that has gone into that with the Department of Health and other key stakeholders acknowledged.

The CHAIR: When you say resourced, what sort of resourcing are you talking about?

Ms Davis: We have got three different scenarios that we have put out there that we will lift off to the Department of Health when the dust settles a little bit, which might be appropriately resourcing WALGA or another identified organisation with, say, an FTE so we can start to roll out a lot of the resources that we have been developing—public health planning guides for local governments, "Pathway to a Healthy Community" and other training packages—and use that resource to support local government to operate in that space, through to a high-end scenario model which states that those resources are allocated through to local governments specifically or to the health services providers themselves to do that.

The CHAIR: Is that a public document?

Ms Davis: No, not at this stage.

The CHAIR: Can you give it to us in camera?

Ms Burges: It is just a work plan we are working on. I have no problem with that—in camera.

Ms Davis: Yes.

Ms Burges: I think the other side of things is that when we look at this matter I think it is very difficult and/or problematic for a local government, through their local health plan, to suggest that, as much as we would dearly love to—when you say if I was passionate about something, would I want to put this target market—of course. But that would set local government in isolation from the other partners within the remit of trying to address this matter. I would suggest that local government is but one component of how this can be addressed. You may have a local health plan that may have the target as a collective from an array of stakeholders, of which local government is one. And collectively we would like to see the target reached. But without the Department of Health and others on the ground providing information and building capacity of individuals along with those that can put programs in place, I think that it would be problematic to place that responsibility. I am not stepping back from it, but I would struggle if it was only a target from a local government. It is a community target.

Mr W.R. MARMION: This is the area I would like to keep exploring. Local government has certain powers. It comes under the local government act. It started off building roads—it was the roads board. Over time it has grown to almost whatever the capacity can be. You will get some councils, like Nedlands, that will go to China and come back and like to tell you about how they have developed international relations with China and that the state government should be involved. They are getting involved in international relations even. Here we are getting involved in health. You have to say, "What are you accountable for?" You touched on the health department having some responsibility here. Local government, in terms of your planning, there are mechanisms that you can influence. You can step out of influencing things like planning roads and bicycle things, which you can argue are good for fitness, and recreation which is all important. Then you start talking about specific diseases that might be prevalent in a certain council area.

It may be that that accountability or responsibility for that particular disease has got nothing to do with local government; it just happens to be that you have a whole lot of people with a certain disease that live in that council area, and it is a health department virus matter or something. I am just a council person here, but you are having to deal with this. Councils must be talking to you about how the hell they do this. Some will be geared up to be able to do it. I am interested in your comment on that.

Ms Burges: I think that we can bring forward a very real example from just this morning. This morning we launched a "Managing Alcohol in our Communities" resource—a guide—that complements a planning guide put out a few years ago around managing alcohol in our communities. That was not a singular effort. That was brought about by a partnership between the association, the Mental Health Commission, PHAIWA and our local governments.

Mr W.R. MARMION: What is PHAIWA?

Ms Burges: It is the Public Health Advocacy Institute of Western Australia. It is a very good organisation, who I can tell you —

Mr W.R. MARMION: So the "PH" makes the "F" sound.

Ms Burges: Correct. I was told by their director this morning that they are currently producing some obesity advocacy targets. It is very handy to know that. In the local government space, many things come past our door. I think you quite rightly pointed out that it used to be roads, rates and rubbish. We recognise that we are far broader than that. We have many local governments that I am sure would really like to just bring it back to those. However, local government often fills the gap which either other levels of government—state or commonwealth—or private business cannot fill. In this particular space, I think we have been in it for a very long time. Many years ago I was in local government as an elected member, back in the 90s, and we had Be Active officers who would be coming in and doing all sorts of activities to ensure that people became more active. These are all things that we know about. There are other examples that you have probably heard about yourselves when there have been other hearings about what local governments are doing—if you had said 20 years ago that you were going to be running a program to teach people how to shop for healthy fruit and vegetables, how to put menus together, how to grow vegetables, how to work together to get your own community garden, or how to influence the amenity of how the spaces in your community might look now and into the future. What is the best way? Do we have cul-de-sacs or do we have through pathways, so that we can enjoy our activities rather than go round and round? I think we have been in all these things for a very long time. I think the sector recognises that they have a key role. However, I think it will always be in partnership. I think that even with the local health plans, they will have a partnership approach.

The CHAIR: But they are not required to have a partnership approach; you are just required to do the public health plans.

Ms Burges: Correct.

The CHAIR: As a compliance-based aspect of things, you are required to identify the health risks in your community and have a health plan about how to address those. You can do them as personal compliance, which says, "We will make sure there is safety of water and that any food served at an event is healthy", because that would fit within the old model, but this model, depending on what the regulations say, is going to take you beyond that, isn't it?

Ms Burges: It is.

The CHAIR: It could just leave you to say it is your job now.

Ms Burges: It could. However, I think that there is a desire, albeit there was quite a bit of pushback right at the start, which I will not deny, from some local governments, because from a resourcing point of view, they might have only a shared environmental health office. They were going, "How the heck are we going to do this?" The association then comes in and we would help do things. We would ask: What is it that you need? What are the gaps that you need filling? Do we need to advocate to say that this needs to be on a scalable level? Do we need to assist you with templates, with resources or with where to get money from to provide programs? On the line of programming, it would be great to see that if programs are funded, there was an ongoing nature to those successful ones. I think this is where it comes to outcomes based, where the measurement might be about the cost, but that would be alongside someone else's measurement that you would be able to report which may have a target of reduction of type 2 diabetes, for instance.

[2.20 pm]

The CHAIR: Yes. Ongoing funding is always a problem. When you pass it down the line, the question is: Who funds it? Is it just as important to the ratepayers that they have people who are really healthy in their community and therefore that comes out of rates, as it is to the health department? Part of the issue with type 2 diabetes is that acute health goes into the state costing system, but preventive health is a federal government thing because it is a primary health issue in effect. What sort of relationship do you have with the primary health sector in this process? Are there any partnerships in that sort of area? One of the most powerful partnerships you are going to be able to establish, for us, around type 2 diabetes is when they are in their doctor's surgery having discussions about this. In the UK now, they talk about social prescribing and link workers. The question is: how do we ensure that you have those sort of aspects, where if they walk into a GP, the GP knows that the City of Wanneroo has a program that helps them go shopping and helps them with cooking and all those sorts of aspects, instead of saying to them, "Here is metformin. Off you go"?

Ms Burges: There are a couple of aspects that I can speak to on that one. From a primary health aspect, the association is a member of WAPHA—the WA Primary Health Alliance—and works very closely with them, and also on a broader aspect with Rural Health West. From a rural and regional point of view, we sit on a broad advisory group. The main essence of that is about the attraction and retention of doctors. I do know that many of the local governments—I will speak particularly in the metropolitan area—have close relationships through their health service units et cetera with the doctors that are there. We know that in rural and regional Western Australia, local government is inherently involved with doctors in particular and allied health through their attraction and retention where they can. That gets right down to the provision of infrastructure. So there is close alignment with that. I imagine that it is at varying levels, dependent upon need.

Mr W.R. MARMION: I can just envisage a regional council doing a plan and seeing type 2 diabetes as being one of their primary issues. One of the plans is, "We want this. We haven't got a bloody doctor, we haven't got a dietician, we haven't got this, and that's what we want to do." If you are going to that level of KPIs and objective-based planning, you might say, "Perhaps we should be funding." They do not do that, although perhaps with doctors they do. They might need to work out how to fund these people to be flying up regularly. You might be diverting funds from your rubbish collection to that. You could have a priority issue there.

Ms Burges: Absolutely. There are probably two fronts that I can speak to that the association is currently working on. From a rural and regional point of view, we have been undertaking, since early to mid-last year through some discussions that came out of the Murchison region, a health services review. I think the initial piece of work had over 109 local governments representing 120-odd submissions speaking to all aspects of regional health. That piece of work is ongoing. We have established partnerships. We ran a forum in the last couple of weeks where we had WAPHA speaking, we had the Aboriginal Health Unit, St John and WACHS—the WA Country Health Service. I think that was all the main ones we had covered. We are working with them. St John in particular has a pilot project occurring in Kambalda that is based on need. That is across the board. It is initially about the provision and retention of a doctor, but it is much broader than that and covers right through to volunteering and many of the touchpoints. You are right—there could be the situation where we have not got this or that, so that comes into: how do you become a resilient community based on the fact that you may not have some of these in place? Thus the other piece of work that we are working on that sits in the community area, which is about bringing all those people who have those touchpoints, which is usually community directors. Sometimes that person, as we know, if you are looking after anything in the community-development area, may well be the CEO, because there is no-one underneath you doing that work. We are working with those. In our current state council agenda, we have a request to set up a reference group to continue that work. We do recognise that this more broadly does encompass such risk factors and matters as type 2 diabetes. We need to be encouraging. We need to be finding ways to build the capacity of our decision-makers and also of the administrations of those trying to find where they place themselves in these serious matters.

The CHAIR: We are booked to 2.30 and we ran a bit late, so we apologise for that. Thank you so much. If you can send us that document that shows those three aspects of how you think implementation of the public health plan in an effective manner could be done, that would be really handy for us. There are two criticisms in the UK. One is that funding for public health sometimes gets used for roads, because preventing accidents is a public health issue. One of the others is that there is a shortage of public health workers in that broader public health aspect of workers, so it would be good to see your document. Thank you so much for coming. I apologise that we are finishing right on time. Thank you so much for your assistance today. It was really good to know that you are working on it. From our point of view, we think that focusing on type 2 diabetes down at that public health level in local government is one of the tools that we can talk about in our report or think about for our report. Thank you very much.

Hearing concluded at 2.28 pm

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