

**A report commissioned by the Department of Health
Government of Western Australia**

Review of Public Health in Perth, West Australia

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Executive Summary

This review of public health in Perth, West Australia (WA), was motivated by recent changes to the public health system following the “Reid Review” of the Department of Health (HRC 2004). The main changes effected were the transfer of almost all of the North Metropolitan public health unit (PHU) staff to Child and Adolescent Health Services (CAHS), and the separation of central health promotion and Aboriginal health from other central public health functions in the Department of Health. These changes have created perceptions that public health services are uncoordinated and patchy, and lack vision and clear accountability mechanisms.

The review, conducted during April/May 2007, involved consultation with key stakeholders in both metropolitan and centrally-located public health, and a review of the structure of public health in other states and the Northern Territory. In this review, we define the key functions of public health as: 1)

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Public health intelligence (e.g. surveillance); 2) Public health interventions (including priority setting and interventions); and 3) Public health infrastructure (such as identifying structural needs). More detailed core functions or public health units are listed in Appendix 4. The consultant time for discussions with key informants was necessarily brief and it is recognised that there are a number of relevant areas which have been only superficially covered. A consideration of Aboriginal and Torres Strait Islander health, an important component of any Australian public health strategy, is beyond the scope of this report. It is the view of the consultants that the recommendations, in any case, would enable the WA Health System to rebuild its public health infrastructure.

The main problems identified by the review were a lack of senior public health leadership and fragmentation of public health functions. The fragmentation of function has resulted in little formal communication between central components of public health, inconsistent public health service provision between Area Health Services (AHS), confused lines of accountability and lack of structure for communication/ accountability between Central and AHS staff and. In addition, public health staff reported low morale and reorganisation fatigue. There was also concern about the lack of direction and delivery of TB services and migrant health.

Summary of recommendations

1. That the State Health Executive Forum (SHEF) agrees on a vision and direction for public health for WA.
2. That the SHEF create a Public Health Network (PHN) subcommittee. The PHN should include the CHO; metro PHU directors; two Regional PHU directors; the director CDC and the director Environmental Health; the director of Health Promotion; the director Aboriginal Health; and the director Screening. We recommend that the PHN also be informed by an advisory group that includes a few selected public health academics, NGO leaders and representatives from consumer organisations such as the Health Consumers' Council of Western Australia.
3. That the SHEF agree, standardise and document metropolitan public health functions between the North Metropolitan AHS (NMAHS) and South Metropolitan AHS (SMAHS) and the Department of Health (non-metro public health is outside the scope of the review) and include key public health indicators in Chief Executive performance agreements. A proposed framework to form the basis of a WA Metropolitan Public Health functional matrix is presented in Appendix 1.
2. That the senior executive create a clear public health leadership, policy and planning unit under the Chief Health Officer (CHO)- the office of the CHO (OCHO) .
3. That the CHO link public health functions directly to the developing health networks with the role of incorporating prevention elements to all the clinical networks.
4. That the SHEF consolidate epidemiology and health promotion into the OCHO and leave small epidemiology and health promotion functions within PHUs to facilitate and link to local services.
5. That the SHEF agrees, standardises and documents clear roles, objectives and accountabilities for child and adolescent services

provided by CAHS and Area Health Services in a way that meshes with PHU functions. The SHEF should implement performance agreements for these services between the Director General, Area Chief Executives and the Chief Executive CAHS.

6. That the SHEF separate the roles of Director of Disaster Planning and Chief Health Officer. The Office of Disaster Planning could report to either the CHO or Executive Director Health Policy and Clinical Reform.
7. That the SHEF transfer the policy and planning for the TB clinic and migrant health unit to the Communicable Disease Control Unit in the OCHO with a service agreement between the NMPHU and the CDCD to reflect the state-wide public information, education, training and accreditation roles.
8. That the SHEF in conjunction with the PHN and with relevant stakeholders expand public health training urgently – particularly at the registrar level.

It is also important to quickly develop a shared vision of public health within WA and forge accountability lines that will improve the ability of the system to achieve its objectives.

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Problem statement

The current review of Metropolitan Perth public health services was initiated in response to problems identified following the restructure of the WA Department of Health (DoH) and motivated by the Reid review (See Box 1).

The problems identified by the WA Health Reform Implementation Taskforce to guide the current review were as follows:

- Lack of integration of public health with other Area Health Service functions
- A perception that there is substantial variation in practice across public health units in AHSs
- A perception that activity of PHUs is driven by historical and local management preferences rather than by data or Government priorities
- Duplication of epidemiology functions with those of the Department of Health
- Duplication of health promotion functions with those of the Government-funded NGO programs
- Research activities undertaken by PHUs that appear to be unrelated to WA Health or Area Health Service priorities
- Lack of agreement on best practice public health and core public health functions; and,
No role delineation and no consistency of service with after-hours/emergency defaulting to Department (Health Protection Group).

Box 1: Key recommendations from the Reid review (HRC 2004) relating to metropolitan population health function:

Recommendation 63: The service delivery components of population health, aged care, dental health, mental health and Aboriginal health programs, which are currently provided by the Royal Street office, should as far as possible be devolved to the Area Health Services. The associated budgets allocated to these programs should also be devolved.

Recommendation 69: The Area Health Service structure should be modified as soon as possible to include only three metropolitan Area Health Services: A North Metropolitan Area Health Service responsible for the health needs of the population north of the Swan River; a South Metropolitan Area Health Service responsible for the health needs of the population south of the Swan River; and a Women's and Children's Health Service.

Recommendation 70: The Women's and Children's Health Service should be responsible for co-ordinating and integrating a state-wide service for the health needs of the State's women and children. This will involve collaboration and consultation with a range of service providers in order to provide for the health needs of women and children from prevention and early intervention all the way through to tertiary care.

Methods

The review was undertaken through consultations with key stakeholders within WA Health, from April 10-13, 2007. These consultations were conducted individually, to facilitate open discussion about the current situation and recommendations regarding future directions. At the conclusion of the interviews, an open meeting was conducted (April 13) at which an initial assessment of the key issues was presented, with possible solutions. Further consultation was undertaken by email following the meetings in Perth, with a draft of the review findings presented to the Director- General for input.

Additional meetings were held on May 15-16 for further discussions on structure, function and accountabilities for public health, and to develop a vision for public health in WA.

The schedule of consultations and meetings is presented in Appendix 2.

Current situation

Structure of public health

The organisational structure of WA Health was comprehensively reviewed in 2004 (Reid) and as a result, significant restructuring of public health was effected.

- The Health Protection Group (HPG) was created, comprising some central public health functions (environmental health, communicable disease control, regulatory functions) and disaster management under the Chief Health Officer (CHO). The HPG was placed under the Executive Director of the Health System Support;
- Epidemiology functions were separated to 1) the Analysis and Performance Reporting group and 2) Information Collection and Management, both within the Health System Support division,
- The TB clinic and migrant health were transferred from the Department of Health to the North Metropolitan Area Health Service ,
- A central health promotion function (social marketing) was created under the Executive Director Health Policy and Clinical Reform
- The East Metro AHS was merged with the NMAHS and, to a lesser extent, SMAHS - to create 2 metro area health services, each with a PHU
- Child health functions were transferred from the (metro) Area Health Services to CAHS (located in metropolitan Perth). However, as the NMAHS PHU had a focus on child health, the entire unit was moved to the CAHS Community Health Division.

On Ministerial directive, much of the central health promotion function was contracted out to NGOs (primarily the 'social marketing' component).

Since the review, a “virtual public health executive” committee has existed, to enhance communication between the key components of public health – comprising:

- Chief Medical Officer (CMO) / Executive Director Health Policy & Clinical Reform
- Chief Health Officer / Executive Director Health Protection Group
- Director Health Reform Implementation Taskforce,
- Executive Director SMAHS PHU.

However, functions for each of the units, with clear lines of accountability between the central and Area PH functions, and between the Departmental divisions have not been agreed, let alone implemented.

Prior to the Reid review, in 2001 the Health Administrative Review Committee (HARC) report was endorsed by the Minister for Health. The key recommendations from this report have also informed the current review:

- “A single, unified health system working to a common vision, allowing for leadership, accountability and transparency,
- Simplified structures throughout the health system,
- A simplified central office structure,
- Structures for the metropolitan health service to provide stability, accountability and clear reporting lines, ...
- A focus on Population Health,
- Action to address some other key priorities.”

Public health status in WA

WA citizens enjoy a long life expectancy second only to residents of the ACT (Table 1) and almost equal to that experienced in Japan (Table 2). However, a relatively high proportion (3.5%) of WA’s population are indigenous, compared to other states (Table 3), and it is well documented that Indigenous Australians experience a substantially lower life expectancy. This suggests that

there may be health differentials within the WA population. Moreover, chronic preventable diseases are somewhat higher in WA than in some other states and the incidences of specific infectious diseases are increasing.

Table 1: Life expectancy at birth, 2004

Sex	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Aust	Indigenous (Aust, 1996- 2001)
Males	79.7	78.0	72.3	77.8	78.0	76.7	78.5	78.6	78.1	59
Females	83.5	83.3	78.0	82.9	83.1	81.8	83.3	83.3	83.0	65

Source: AIHW National Mortality Database (Australia's Health 2006)

Table 2: Life expectancy at birth, 2004, international comparison

Sex	Australia	New Zealand	France	Japan	Sweden
Males	78.1	77.0	76.7	78.6	78.4
Females	83.0	81.3	83.8	85.6	82.7

Source: OECD Health Data 2006

Table 3: Proportion of population which is indigenous, 2001

State	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Aust
Proportion Indigenous	1.2	2.0	28.8	3.5	1.7	3.7	0.6	3.5	2.4

Source: Australian Bureau of Statistics, 4705.0 Population Distribution, Aboriginal and Torres Strait Islander Australians

Notification of communicable disease in WA in 2006 for tuberculosis, meningococcal, mumps and pertussis was lower than the overall Australian rate (Table 4). For all other diseases shown, WA had a higher rate – particularly for Chlamydia and Hepatitis C. Recent reports, however, suggest that the TB rate is rising rapidly (personal communication from TB clinicians, 10 May 2007)

Table 4: Incidence of selected communicable diseases per 100,000 population, by State/Territory, 2006

Disease	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Aust
Hepatitis B (incident)	2.1	0.8	5.3	1.2	0.5	1.8	2.1	2.4	1.4
Hepatitis C (incident)	4.6	0.6	NN	NN	3.5	2	3.9	5.3	2.6
Meningococcal infection	1.5	1.6	2.9	1.8	1.3	1	1.7	1	1.6
Tuberculosis	4.3	6.9	16	3.7	4.9	1.6	7.2	5.6	6
Chlamydial infection	249.7	174	1,003.9	301.9	201.2	214.3	195.9	287.5	228.4
Measles	0.3	0.9	0	0	0.6	2.2	0.2	1.5	0.6
Mumps	0.3	2.3	3.4	1.1	1.4	0	0.3	0.8	1.3
Pertussis	78.5	71.8	46	53.7	140.1	8.4	21	12.9	53.3

Source: Commonwealth Department of Health and Ageing, National Notifiable Diseases Surveillance System (http://www9.health.gov.au/cda/Source/Rpt_2_sel.cfm)

Prevalence of chronic diseases in WA tend to be slightly higher than the overall Australian rates (Table 5). In particular, Western Australians reported high rates of diabetes and asthma. Conversely, Western Australians reported a lower prevalence of most risk factors, than those reported for Australia as a whole, with a markedly lower proportion consuming inadequate servings of vegetables and reporting sedentary behaviours.

Table 5: Prevalence (%) of selected chronic diseases, by State/Territory, persons aged 18 years and over, 2004-05

Long term condition	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Aust
Diabetes mellitus	3.2	3.8	n.a.	3.3	4.1	3.1	3.1	4.2	3.6
Ischaemic heart disease	1.1	1.7	n.a.	1.8	1.7	2.3	1.6	1.8	1.7
Asthma	10.2	9.2	n.a.	10.8	11.5	13.2	10.2	11.2	10.2
Hypertensive disease	10.2	10.5	n.a.	10.0	11.7	13.1	10.8	11.2	10.7
Cancer (total neoplasms)	1.9	1.7	n.a.	2.7	1.7	1.8	2.0	2.1	2.0

Source: Australian Bureau of Statistics, 2004-05 National Health Survey

Table 6: Prevalence (%) of selected risk factors, by State/Territory, persons aged 18 years and over, 2004-05

Risk factor	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Aust
Inadequate vegetable consumption	89.8	88.0	n.a.	84.7	87.9	79.4	84.6	80.2	85.7
Inadequate fruit consumption	46.5	46.0	n.a.	47.3	50.0	46.3	44.0	44.6	46.0
Current daily smoker	15.4	20.8	n.a.	22.7	20.4	24.1	21.0	19.9	21.3
High risk alcohol consumption	5.3	5.8	n.a.	5.6	6.8	4.4	4.4	6.8	5.6
Sedentary	22.8	35.1	n.a.	35.9	34.3	33.7	31.4	30.0	33.5
Obese	16.8	16.6	n.a.	17.6	17.6	17.1	15.6	15.9	16.6

Source: Australian Bureau of Statistics, 2004-05 National Health Survey

Key functions required for public health

Public health is the organised response by society to protect and promote health and to prevent illness and disability (National Public Health Partnership 1998). It has three main components of work:

1. **Public health intelligence:** gathering and analysing information about the determinants of health, the causes of ill-health, and the patterns and trends of health and ill-health in populations.
2. **Public health interventions:** Developing policy, setting priorities for action, implementing and coordinating services, strategies and interventions aimed at prevention, protection and promotion of the health of the community.
3. **Public health infrastructure:** identifying structural needs such as workforce, training and development, and information systems. This also includes ensuring appropriate legislative and regulatory frameworks are in place. (NPHP 1998)

More detailed core functions of public health are listed in Appendix 4.

The organisation of public health in other states and territories in Australia³

Victoria's public health system is centralised – most of the operational work occurs from the Central Office. Central office sections are: Communicable disease, Environmental health, Food safety and regulation, Chronic disease prevention and management, and Programs. There are also 3 metro and 5 rural DHS regional offices. Each has a Public Health Manager, Environmental Health Officer, Health Promotion Officer and a Drug & Alcohol Officer.

The Queensland public health system was recently decentralised. The Area Health Services (North, Central & Southern) are effectively autonomous. The Office of the Chief Health Officer is central base for public health, with epidemiology, health promotion, Aboriginal and Torres Strait Islander health, cancer screening, communicable disease, environmental health, planning and development functions. The structure of central office is replicated at the area level. The central office is responsible for policy & the Areas are responsible for operational functions, but both do strategy. The Public Health Board is forum for Central & Areas working together – meet every 2 months with executives (PH unit heads from areas) and 'discipline' heads (e.g. health promotion). There is also an Executive Management Team, with DG, CHO & Area General Managers.

Tasmania's public health system is primarily central, under the Department of Health and Human Services. There are eight main sections: Communicable disease, Environmental health, Cancer control, Epidemiology, Radiation control, Population health and priorities, Pharmacy services, Business support. In each of the three regions (North, North West & South [Central office in South, in Hobart]) there is an officer for Women's health and an officer for environmental health. In addition, each local council (29 LGAs) employs an environmental health officer to enforce regulations & investigate outbreaks, and they work with the DHHS staff.

³ See Appendix 3 for detail

New South Wales' public health system is based on Central responsibility for policy, data collection (e.g. CATI), and setting frameworks and criteria for projects (under the Chief Health Officer), with Area Public Health Units responsible for local planning and program delivery. There is one office in each Area, which may have different 'campuses' if it is a big geographical area. In the head office, there are five public health Centres: Health Protection, Chronic disease & health advancement, Epidemiology, Oral health, Aboriginal health. There are eight Area Health Services, which include Public Health Units, Health promotion and Aboriginal health.

South Australia's public health system is centrally structured, under the Office of Public Health (under CMO). The OPH has five branches: Communicable disease control, Applied Environmental health, Food policy and programs, Health promotion, Scientific services. Regional work is done under the Applied Environmental Health branch. All officers are located in Adelaide and travel out to regional areas. "Unincorporated areas" comprise 85% of the state (these have no local council). The AEH branch acts as local council in these areas, e.g. performing food inspections, Health Impact Assessments, working with indigenous communities. Other divisions in the health department with public health responsibility are: Aboriginal Health; Policy and Intergovernmental relations (incl. mental health); Operations (incl. state-wide co-ordination); State-wide service strategy (incl. chronic disease strategy).

The **Northern Territory's public health system** is both centrally & regionally co-ordinated. Central Public Health (under "Health Services" of Department of Health) sits mostly within the Centre for Disease Control, which includes epidemiology, environmental health, sexual health & medical entomology. Most policy and planning comes out of the Central Office (Darwin). There are two main, relatively autonomous, regions: the Top End and the Central Australian Region. The Centre for Disease Control has offices in every main population centre. Other divisions in the health department with public health responsibility include: family & children's services, aboriginal health policy,

mental health, strategy & quality division. These Sections/Divisions also have regional offices.

There are no published data familiar to the consultants which indicate which of these configurations are more effective in preventing and controlling disease. The NSW model is perhaps the most consistent with the Area Health Service model being promulgated in WA and has therefore guided the recommendations of the review.

Review findings

The main problems identified with the WA public health infrastructure in this review were as follows:

1. There is a lack of public health leadership at senior levels. There is no current public health strategic plan based on a comprehensive up-to-date report on health status and risk factors in WA. Roles, responsibilities and accountabilities for public health functions at the Department of Health and Area and Regional levels are not delineated and not clearly understood by all. There appears to be little corporate planning linking epidemiology, health promotion, health protection and clinical preventive practice. The developing health networks have weak links with public health policy and planning functions.
2. In addition to the weak links between public health and the developing health networks, there is no policy /planning group synthesising evidence and experience to underpin healthcare modernisation. Modern healthcare involves major service redesign, experimentation, and evaluation of clinical services and the development of new ways of deriving an appropriate workforce. The operations research providing an evidence base for such services is not visible in the current structure.
3. There is low morale, disenchantment and re-organisation fatigue. Staff are unhappy about recent developments and changes in the public health infrastructure (e.g. major reviews in 2001 (HARC), 2004 (Reid) and now 2007) and there is a perception that the service has declined over recent years.

Recommendations

- 1. That the State Health Executive Forum (SHEF) agree on a vision and direction for public health for WA.**

We suggest the following based on review consultations:

A WA population with the best health status and risk factor profile in Australia, with comprehensive data collection and reporting against other jurisdictions driving priorities for the health system.

- 2. That the SHEF standardise metropolitan public health function between the NMAHS & SMAHS, taking the following into account**

At the AHS level, we recommend that there be equality of public health service provision through some rationalisation of existing staff and replacing original PHU positions. Some of this has already happened under the leadership of the NMAHS, SMAHS and CAHS Chief Executives. Consideration of injection of funds into expansion of the public health sector is recommended. This may be assisted by a careful review of public health spending in WA in comparison to other States.

Formalisation and clarification needs to occur regarding AHS health promotion functions and community nurse functions within PHUs and CAHS, with collaboration on public health initiatives. The central role for these functions in policy and planning should be clearly stated in Departmental policy documents and/or public health legislation and regulations.

The Area Health Service PHUs should have clear responsibility for:

- local epidemiology: publication & dissemination of relevant & specific information
- local outbreak/incident investigation and action and contact tracing where appropriate
- local community health promotion action (with clearly demarcated roles for PHU and CAHS staff)
- Aboriginal public health services (coordination, monitoring, advocacy, health promotion)

And should assist the Central PH function with:

- surveillance functions as needed
- epidemiologic investigations and subsequent steps by negotiation with the OCHO where needed
- Inter-agency collaboration
- Public health workforce development
- Research and evaluation related to state-wide and AHS priorities, which in turn informs AHS priorities

3. That the SHEF create a clear public health leadership unit under the Chief Health Officer (CHO) – the office of the CHO (OCHO)

This is consistent with the Reid recommendations and will enable a coordinated approach to public health, through grouping central public health functions together and creating a focus for PH intelligence, policy and advocacy at the most senior level.

As surveillance and intelligence are central functions of public health, we recommend that the elements of epidemiology in the Health System Support Directorate be incorporated into the office of the CHO. As part of its whole of health focus and role, the function of the epidemiology unit should be to:

- Generate an annual CHO Report on WA Health to inform health system and public health directions and assess progress. The report should set the agenda for health and guide priority setting and resource allocation for health services.
- Assemble evidence to underpin and inform health promotion strategies and new health system designs
- Evaluate the effectiveness of health services

As the focus for public health advocacy and policy, the OCHO should:

- Recommend to SHEF strategic directions and policy for public health functions in WA.
- Via the Director General of Health (DG), delegate local public health action to the Area Executive Directors and recommend and monitor performance criteria for state-wide public health through performance agreements between the DG and Area/Regional Executive Directors.
- Develop and coordinate a training and development program for public health professionals.
- Develop and maintain inter-agency relationships (Governmental, academic, industry, NGOs)
- Provide leadership for state-wide public health advocacy efforts

The OCHO also has an important role in supporting and coordinating public health service provision. In particular, to:

- Coordinate public health investigations, programs and responses which extend beyond Area/Regional Health Service boundaries.
- Develop and coordinate state-wide public health strategies and programs according to the CHO report and government priorities
- Provide assistance to local public health units when requested/required.

To make the above feasible we recommend that:

1. The SHEF create a Public Health Network Subcommittee (WA PHN) of SHEF, with representation from DG, AHS & components of OCHO (see “Next steps” section for detail)
2. The SHEF brings together epidemiology functions (currently under two divisions within Health Systems Support) under the OCHO, with communicable disease and environmental health
3. The SHEF brings together health promotion staff (currently within Health Policy & Clinical Reform) into the OCHO. There should be an agreement for services between the OCHO and Health Policy and Clinical Reform
4. The Communicable Disease Control Directorate (CDCD) in central OCHO provide planning and policy for the state-wide public health services – tuberculosis control, immunisation, migrant health and Sexually Transmitted Infection (STI) control. These services should be provided by the North Metro Area PHU on behalf of the state. This service provision should be mediated by a performance agreement between the DG and AHS CEO, and a service agreement between NMPHU and CDCD specifying detail.
5. The SHEF move policy and planning for the cancer screening programs into the OCHO, with services to be delivered either centrally or again via an AHS with an agreement to provide state-wide service
6. CAHS have responsibility for policy, intelligence and metropolitan and state-wide strategies for children and adolescents
7. The SHEF oversee the development of performance agreements for achieving agreed objectives set between the DG and the CHO; the DG and the CAHS Chief Executive; and the DG and Metro (and Regional) AHS Chief Executives. The Chief Executives should have corresponding performance agreements with their PHU directors
8. The SHEF establish a public health workforce development program with direction and coordination from the OCHO

9. The SHEF separate the roles of CHO and director of disaster management unit. There should be an agreement between the director of disaster management and the CHO for public health functions in disaster preparedness. The DG could delegate policy, planning & coordination to ED Policy & Clinical Reform; and delegate PH functions to CHO

Options relating to location of the Office of the CHO

The OCHO could either:

1. Report directly to the DG.

Benefits:

- i. Strong advocate for PH at senior level
- ii. Clear responsibility for state-wide PH functions

Risks:

- iii. Increased number of direct reporters to the DG
- iv. Lack of direct connection to networks and clinical service.

If this option is pursued, there should be an agreement between the ED HPCR and the CHO re specific public health input into the clinical networks.

2. Report to the ED Health Policy and Clinical Reform

Benefits:

- i. Strong link to the clinical networks (important for improving prevention practice in the clinical sphere)
- ii. Easier to integrate the current health promotion functions within the Department of Health

Risks:

- iii. Lower profile of PH (subsumed by clinical services and perception that public health not as important as other health department functions)

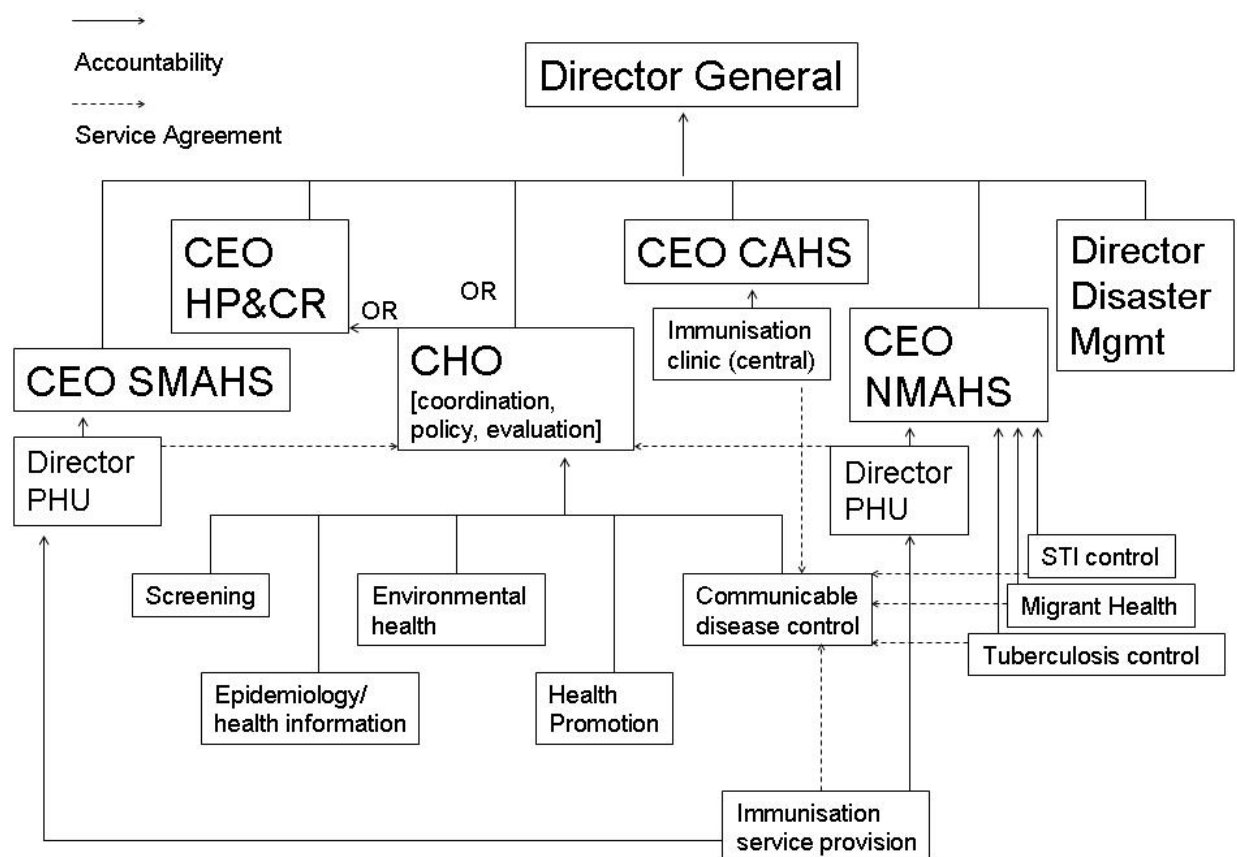
The future public health workforce

It is also recommended that public health training (prevocational and particularly registrar) be urgently developed and expanded, to facilitate training and recruitment of the future public health workforce.

Intersectoral collaboration

This review also recognises the importance of intersectoral collaboration, which continues to be a priority for WA public health practitioners. The above recommendations are designed to facilitate the Central public health function to improve and sustain intersectoral policy and planning at a high level, and to improve the capacity of local PHUs to engage colleagues in other sectors.

Proposed structure for WA public health⁴



⁴ Regional Public Health (WACHS) and Aboriginal Health have been excluded for simplification, as they are outside the scope of the review.

Next steps

1. Establish the Public Health Network (PHN) subcommittee of SHEF, with representation from:

- Chief Health Officer
- Metropolitan PHU Directors
- Director Epidemiology
- Director CDCD
- Director Environmental Health
- Director Health Promotion
- Director Aboriginal Health
- Director Screening
- 2 PHU Directors representing WA Country Health Services (WACHS)

The initial tasks for the PHN should be to establish a process for development of Key Performance Indicators (KPIs), and to ensure detailed role delineation and core KPIs for PHUs and the OCHO, with the most important KPIs reflected in AHS CEO and PHU Directors performance agreements.

The PHN subcommittee of SHEF should be informed by an advisory committee that includes:

- NGO participants
- Health Consumer organisation representation (such as the Health Consumers' Council of Western Australia)
- Public health academics

2. Develop necessary performance and service agreements for public health function and provision of services.

Performance agreements:

DG – CHO

DG – AHS CEOs (including key PH indicators)

DG – CAHS CEO

CHO - AHS CEOs

Service agreements:

CHO - AHS PHU Directors

OCHO CDC Director- TB control, STI control, migrant health

OCHO CDC Director - NMAHS PHU Director (TB control, immunisation,
STI control, migrant health)

OCHO CDC Director - SMAHS PHU Director (immunisation)

OCHO CDC Director - CAHS CEO (immunisation)

Abbreviations

AHS - Area Health Service

CAHS - Child and Adolescent Health Service

CHO - Chief Health Officer

DG - Director General

ED - Executive Director

HP&CR - Health Policy and Clinical Reform

HPG - Health Protection Group

HRIT - Health Reform Implementation Taskforce

HSS - Health Services and Support

KPIs - Key Performance Indicators

NMAHS - North Metro Area Health Service

NPHP - National Public Health Partnership

OCHO - Office of the Chief Health Officer

PHU - Public Health Unit

SMAHS - South Metro Area Health Service

References

- HARC (Health Administrative Review Committee) 2001. *Report of the Health Administrative Review Committee*. Western Australian Department of Health.
- HRC (Health Reform Committee, WA Department of Health) 2004. *A healthy future for Western Australians*. Viewed May 2007 at http://www.health.wa.gov.au/hrit/publications/docs/final_report.pdf
- NPHP (National Public Health Partnership) 1998. *Public Health Workforce Development* <http://www.nphp.gov.au/publications/wfpapers/wkforcebg.pdf>
- NPHP 2000. *Public health practice in Australia today: A statement of core functions*. Melbourne: National Public Health Partnership.
- Public Health Council of Western Australia 2004 (no date). *Investing in public health*.

Appendices

Appendix 1: Suggested outlines of performance agreements (public health)

1. DG – AREA CHIEF EXECUTIVES
 - a. Achieve targets recommended by the OCHO and PHN and the Directorate of Health Policy and Clinical Reform for
 - i. Communicable disease control including immunisation and food safety
 - ii. Environmental health
 - iii. Aboriginal and Torres Strait Islander health
 - iv. Behavioural risk factors
 - v. Statutory public health functions
 - vi. Cancer Screening
 - b. Achieve targets in child and adolescent health suggested by SHEF/CAHS
 - i. Targets to be set by CAHS/SHEF
 - ii. Note - CAHS and PHN should prepare a document detailing the exact roles of PHUs and CAHS staff for providing services to children and adolescents (We recommend that the CAHS services are essentially clinical one-on-one services to children and adolescents whereas the PHU functions are population interventions. There is, however, substantial overlap e.g. in school health programs and this leads to some confusion of roles and duplication of effort.
2. AREA CHIEF EXECUTIVES AND PHU DIRECTORS
 - a. Provide the services required to achieve the targets as above

- b. Prepare annual reports of the health of the Area population and monthly reports on communicable diseases and environmental hazards.
- c. Advise the Chief Executive of local threats to public health and well being
- d. Develop the Area public health workforce to a specified level

3. DG and CHO

- a. Prepare an annual report on the health of West Australians
- b. Provide real-time surveillance of communicable diseases and environmental health hazards with monthly reports
- c. Prepare a strategic plan for public health action in accordance with a) and revise this at least annually with realistic goals and targets for
 - i. communicable disease control,
 - ii. maintaining healthy environments,
 - iii. Aboriginal and Torres Strait Islander people (in collaboration with the Aboriginal Health Unit)
 - iv. healthy behaviours,
 - v. high and appropriate cancer screening rates
- d. Prepare an annual business plan specifying policies and programs to be implemented to achieve the agreed goals and targets as above and with elements to be incorporated in Area Chief Executive performance agreements
- e. Report on the public health workforce development program
- f. Provide advice to SHEF as requested on the evidence for health service modernisation
- g. Report on incorporation of prevention and public health elements into each of the health networks.

Appendix 2: WA Public health review schedule of meetings

TUES. 10 APRIL

Dr Robyn Lawrence - Executive Director, Child & Adolescent Health Service
Dr Charles Douglas - Public Health Physician, Kalgoorlie, WA Country Health Service
Dr Peter Flett - Chief Executive, South Metro Area Health Service
Dr Margaret Stevens - Chief Medical Advisor, Population Health
Dr Russell-Weisz - A/Chief Executive, North Metro Area Health Service
Dr Shirley Bowen - Executive Director, Outpatient Services
Mr Michael Pervan - Executive Director, Health Reform Implementation Taskforce

WEDS. 11 APRIL

Dr Mandy Seel – Director, Population Health, South Metro Area Health Service
Dr Simon Towler - Executive Director, Health Policy & Clinical Reform
Mr Colin Xanthis - A/Executive Director, Health System Support
Dr Andrew Robertson - Divisional Director, Health Protection Group, Health System Support
Mr Jim Dodds - Director, Environmental Health, Health Protection Group, Health System Support
Dr Bret Hart - Public Health Physician, North Metro Area Health Service

THUR. 12 APRIL

Dr Paul Van Buynder – Director, Communicable Diseases Control Directorate, Health Protection Group
Dr Donna Mak - A/Medical Epidemiologist, Communicable Diseases Control Directorate, Health Protection Group
Dr Lewis Marshall – Consultant, Infectious Diseases, South Metro Area Health Service
Dr Neale Fong - Director General, WA Health

Public Health Physicians, Australian Medical Association (WA)

FRI. 13 APRIL**Open meeting attendees (affiliation noted if not listed above):**

Bret Hart
Donna Mak
Karen – representing Andy Robertson
Robyn Lawrence
Peter Flett
David Russell-Weisz
June Doyle (SMAHS)
Michelle (SMAHS PHU)
Lewis Marshall
Simon Towler
Mandy Seel
Judy Stratton (CAHS)
Margaret Stevens
Paul van Buynder

TUES. 15 May**Open meeting attendees (affiliation noted if not listed above):**

Bret Hart
Jim Dodds
Peter Flett
Robyn Lawrence
David Russell-Weisz
Mandy Seel
Judy Stratton
Donna Mak
Andy Robertson
Paul van Buynder
Lisa Bastion (CDCD, HPG)

WED. 16 May**Open meeting attendees (affiliation noted if not listed above):**

Bret Hart
Jim Dodds
Mandy Seel
Judy Stratton
Andy Robertson
Lewis Marshall
Paul van Buynder
Tania Wallace (CDCD, HPG)
Richard Lugg (HPG)
Kate Gatti (Population Health, WA Country Health Service)
Melissa Vernon (Population Health, WA Country Health Service)

Appendix 3: Organisation of public health in other states and territories

S/T \$ & \$/person	Structure	Rationale	Limitations/changes
Vic \$321.9 M \$64.45	<ul style="list-style-type: none"> Operational work (project work, investigation, regulation etc) mostly occurs at the Central Office level because of focus of staff/resources here. 3 metro and 5 rural DHS regional offices. Each has a Public Health Manager, Environmental Health Officer, Health Promotion Officer and a Drug & Alcohol Officer. Structure of regional office decided by the Regional Office Director (usu within Community Health or Primary Care). Regional Office Staff regularly meet together, and also with Central Office Staff. Currently reviewing central/regional staff interactions. Sections are Communicable disease, Environmental health, Food safety and regulation, Chronic disease prevention and management, and Programs 	<ul style="list-style-type: none"> Focus on the Central Office due to the small physical size of the state –more efficient than splitting up into sub units, helps with employing specialist staff, reduces duplication. Employing public health staff in the regional offices is relatively recent – rationale is to improve ability to deal with local issues, & provide advice to local governments, who are required under the Health Act to do health planning etc. 	<ul style="list-style-type: none"> Need to consider geography and political climate – what works in one state may not work in another (e.g. if there are remote areas, centralization might not be so good)
Qld \$254.0 M \$64.69	<ul style="list-style-type: none"> Population health decentralised under Forster rev: divided up into the Area Health Services (North, Central & Southern), which are effectively autonomous Office of CHO is central base for PH: Health promotion, ATSI health, Cancer Screening, Communicable disease, Environmental health, Planning & development (includes epidemiology, mainly serves to link units together) [No longer have child and youth health but they have a seat on board] Structure of central office is replicated at the area level Qld Health is structured along a “continuum of care” model: PPP (promotion, protection & prevention), Primary health care, Ambulatory care, Acute care, Rehabilitation & extended care Total PH staff in Qld is ~700: Central office has 100 staff with balance in regions Central office responsible for policy & Areas responsible for operational functions, but both do strategy (Public Health Board is forum for this) Public health board is forum for Central & Areas working together – meet every 2 months with execs (PH unit heads from areas) and ‘discipline’ heads (e.g. health promotion) Also have Executive Management Team, with DG, CHO & Area General Managers 	<ul style="list-style-type: none"> Rationale for decentralisation of service provision is delivery of services at the local level Some state-wide services decentralised, including TB & health information (now with hospital base) 	<ul style="list-style-type: none"> Technical expertise varies btn areas, with PH integrated well in some areas but not in others, Issue is inequities in services provided, with danger of duplication and rivalry Issue is role of clinical services in preventive health, and also role of public health throughout the continuum... Investigating re-centralisation & mechanisms to improve formal accountability & lines of responsibility in order to improve provision of state-wide services and also improve equality of service provision between regions

S/T \$ & \$/person	Structure	Rationale	Limitations/changes
Tas \$39.4 M \$81.48	<ul style="list-style-type: none"> Tasmania's public health/population health group is under the Department of Health and Human Services, within the Community Health Services Group. Approximately 120 staff report to DPH. The DHHS budget is \$1.3 B – Pub health gets 1.7% of this (\$22.1 M). However, AIHW estimate for Tas pub health is \$26.3 M. 8 sections: Communicable disease, Environmental health, Cancer control, Epidemiology, Radiation control, Population health and priorities, Pharmacy services, Business support There are 3 regions (North, North West & South [Central office in South: Hobart]), officer in each for Womens health & environmental health. Each local council (29 LGAs) employs an environmental health officer to enforce regulations & investigate outbreaks, and they work with the DHHS staff. 	<ul style="list-style-type: none"> No regional public health offices, due to the small state population (approx 480,000) and the small physical size of the state (can easily drive from Hobart to regions). 17 months ago there was a big change with a new DHHS secretary – the “new fit program” Biggest change for pub health was an increase in management levels – used to be quite a flat structure, w/ all reporting to DPH. Now report to directors at several levels. 	<ul style="list-style-type: none"> This has created some difficulties with many “layers” to go through to get info to top (e.g. diabetes people now have 3 management layers to go through – none of which have ‘content knowledge’)
NSW \$450.7 M \$66.78	<ul style="list-style-type: none"> Public health in NSW sits within the Dept of Health, under the Chief Health Officer. It covers environmental health, NCDs, infectious disease & AIDS, bio-preparedness, and also pharmaceuticals & health care regulation. In the head office, there are five public health Centres: Health Protection, Chronic disease & health advancement, Epidemiology, Oral health, Aboriginal health. There are 8 Area Health Services, which include Public Health Units, Health promotion and Aboriginal health (couldn't give detail on staffing, but is happy to look this up if required). The head office is responsible for policy, data collection (e.g. CATI), and setting frameworks and criteria for projects etc. AHS are responsible for planning and program delivery. There is one office in each Area, which may have different ‘campuses’ if it is a big geographical area. 	<ul style="list-style-type: none"> Rationale for head office/regional division is that the AHSs are best placed to deliver local programs – based on a review that recommended the head office do only project design, not implementation. A recent review of the AHSs resulted in a reduction from 17 to 8. This was due to bigger geographical areas providing a better “framework” and being more efficient (not really about administrative efficiency though). 	<ul style="list-style-type: none"> New focus is improving accountability with funding: trying to move to an outcomes-based funding model, using behavioural measures from CATI surveys (e.g. f&v consumption, smoking) to try & tie funding to outcomes achieved. See this as a way to move priorities from head office to AHSs, through allowing regional offices to achieve common goals by implementing locally-appropriate programs.

S/T \$ & \$/person	Structure	Rationale	Limitations/changes
SA \$118.2 M \$76.89	<ul style="list-style-type: none"> Office of Public Health is a small directorate, with Director PH, 3 project officers & PA. Sits under CMO. Other relevant divisions in health dept are: Aboriginal Health; Policy & Intergovernmental relations (incl. mental health); Operations (incl. state-wide co-ordination); State-wide service strategy (incl. chronic disease strategy). There are 5 branches under the office of public health, with a total staffing of around 140-150: Communicable disease control, Applied Environmental health, Food policy and programs, Health promotion, Scientific services Regional work is done under the Applied Environmental Health branch All officers are located in Adelaide (approx 5) & travel out to regional areas. “Unincorporated areas” comprise 85% of the state (these have no local council). The AEH branch acts as local council in these areas, e.g. performing food inspections, HEAs, working with Indigenous communities. 	<ul style="list-style-type: none"> Used to have regional offices, but was centralised about 6 years ago. This may have been to simplify the logistics/ administrative reasons. 	<ul style="list-style-type: none">
NT \$62.7 M \$311.79	<ul style="list-style-type: none"> Public Health under “Health Services” of Department of Health – mostly within the Centre for Disease Control, which includes epidemiology, environmental health, sexual health & medical entomology. Two main, relatively autonomous, regions: the Top End and the Central Australian Region. Most policy and planning comes out of the Central Office (Darwin). The Centre for Disease Control has offices in every main population centre – e.g. around 6 people in small centres like Katherine and Tennant Ck, 25 people in Alice Springs and around 60 in Darwin. PH also spread throughout Section/Department (e.g. family & children’s services, aboriginal health policy, mental health, strategy & quality division), & these Sections/Divisions also have regional offices. 	<ul style="list-style-type: none"> There has been a recent move towards more centralization, with administration for the sub-regions of the Top End (Katherine, East Arnhem, Darwin) being combined. This was basically to improve efficiency. Additional change is that Katherine has community-controlled health services. Because of the sparseness of the population, there is quite a bit of regional autonomy – huge distances, esp from Darwin to Alice Springs. 	<ul style="list-style-type: none"> Four or five major restructures in past 20 years. Most recent was this move to administrative centralization about 4-5 years ago. Not aware of any plans to restructure. With this restructure, there was also a reduction in autonomy of Central Australian region. Small state pop’n means there is very little capacity to create policy at the regional level. Enough difficulty staffing for providing health and community care.

WA exp = 152.2 M; \$76.36 pp

* Expenditure is from AIHW: Total Govt expenditure, including funding from AG, on public health activities.

Appendix 4: NPHP defined core public health functions (NPHP 2000)

- Assess, analyse and communicate population health needs and community expectations.
- Prevent and control communicable and non-communicable disease and injuries through risk factor reduction, education, screening, immunisation and other interventions
- Promote and support healthy lifestyles and behaviours through action with individuals, families, communities and wider society.
- Promote, develop and support healthy public policy, including legislation, regulation and fiscal measures.
- Plan, fund, manage and evaluate health gain and capacity building programmes designed to achieve measurable improvements in health status, and to strengthen skills, competencies, systems and infrastructure.
- Strengthen communities and build social capital through consultation, participation and empowerment.
- Promote, develop, support and initiate actions which ensure safe and healthy environments.
- Promote, develop and support healthy growth and development throughout all life stages.

Promote, develop and support actions to improve the health status of Aboriginal and Torres Strait Islander people and other vulnerable groups.