



Public Health Association
AUSTRALIA

**Maximising Population Health:
An Innovative Model of Health Reform for Queensland
*'The Queensland Population Health Institute'***

LNP Health Policy Submission

from the

Public Health Association of Australia

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Overview

- The current health reform process has the potential to marginalise and constrain the capacity and effectiveness of the population health workforce in Queensland.
 - A devolved and fragmented population health service will mean poorer health outcomes for people in Queensland
 - Local Health and Hospitals Networks (LHHNs) and Medicare Locals (MLs) are not structured, funded or aligned to provide population based health protection, health promotion or disease prevention, either communicable or chronic.
- To protect and promote the health of the community, public health services have to work in open and collaborative partnership with a wide range of stakeholders including:
 - Primary, secondary and tertiary health care services and with many facets of government at the local, state and national levels (e.g. environment, primary industries, education, transport, land use planning, etc)
- The best outcomes for the health of Queenslanders will be to set up *The Queensland Population Health Institute* (the Institute) comprising the various streams of the public health workforce with the critical capability and capacity to cover the scope of work assigned to it
- The establishment of such an Institute can be achieved through regulation and can be cost neutral.

Background

The Public Health Association of Australia Incorporated (PHAA) is recognised as the principal non-government organisation for public health in Australia and works to promote the health and well-being of all Australians. The Association seeks better population health outcomes based on prevention, the social determinants of health and equity principles.

The PHAA is a national organisation comprising around 1800 individual members and representing over 40 professional groups concerned with the promotion of health at a population level. This includes, but goes beyond the treatment of individuals to encompass health promotion, prevention of disease and disability, recovery and rehabilitation, and disability support. This framework, together with attention to the social, economic and

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environmental determinants of health, provides particular relevance to, and expertly informs the Association's role.

Key roles of the organisation include capacity building, advocacy and the development of policy. Core to our work is an evidence base drawn from a wide range of members working in public health practice, research, administration and related fields who volunteer their time to inform policy, support advocacy and assist in capacity building within the sector. The PHAA has been a key proponent of a preventive approach for better population health outcomes championing such policies and providing strong support for the government and for the Preventative Health Taskforce and National Health and Medical Research Council (NHMRC) in their efforts to develop and strengthen research and actions in this area across Australia.

The PHAA has Branches in every State and Territory and a wide range of Special Interest Groups. The Branches work with the National Office in providing policy advice, in organising seminars and in mentoring public health professionals. This work is based on the agreed policies of the PHAA. Our Special Interest Groups provide specific expertise, peer review and professionalism in assisting the National Organisation to respond to issues and challenges as well as a close involvement in the development of policies. In addition to these groups the Australian New Zealand Journal of Public Health draws on individuals from within the PHAA who provide editorial advice, review and who edit the Journal.

In recent years the PHAA has further developed its role in advocacy to achieve the best possible health outcomes for the community, both through working with all aspects of government and promoting key policies and advocacy goals through the media and other means.

The PHAA is grateful for the opportunity to provide comment on the issues and possibilities around restructuring of the Population Health area of Queensland Health. This paper has been prepared by officers of the Public Health Association of Australia based in the collective experience of and analysis by public health experts with different organisational arrangements over many years, including from information and advice provided by prominent health academics, and managers of public health services at local and state levels. It describes how the disease protection and health promotion needs of the Queensland community will be best served if the core functions of Public Health are contained within a separate Institute for Population Health.

Note: Within the field of public health the terms "public health" and "population health" are used interchangeable, and this is the position that has been taken in this paper. However many people external to the profession think of hospitals when reference is made to the public health system, when the more accurate term is, the public sector health system.

Introduction

John Snow was a doctor in London during the 1840's. During a cholera outbreak as well as treating the sick he collected information about patients and victims. Patterns emerged in the data showing that most of those with the disease collected water from a particular public hand pump in Broad Street. By removing the handle from the pump Dr Snow was able to limit the spread of the disease and save thousands of lives. To this day John Snow is referred to as the "Father of Public Health"

Public health is integral to the protection from disease and the promotion of good health of the population. The importance of public health within a health system is frequently misunderstood due to the often perceived more pressing demands of treating the sick and injured. However, in these situations it is crucial not to sacrifice the "important" for the sake of the "urgent".

The current health reform process has the potential to marginalise and constrain the capacity and effectiveness of the public health workforce in Queensland. If the currently small number of practitioners is distributed among the LHHNs, their effectiveness and ability to respond to emerging issues will be destroyed. With the decentralisation of public hospital and clinical services into LHHNs, which will be independent statutory authorities, it will be important that public health services to the community are not perceived by the LHHNs and the MLs as being an arm of Queensland Health¹. This is because the main function of Queensland Health post health reform will be to act as system manager that purchases services, makes directives about service delivery and monitors service delivery quality and quantity.

To protect and promote the health of the community, public health services have to work in open and collaborative partnership with primary, secondary and tertiary health care services and with many facets of government at the local, state and national levels (e.g. environment, primary industries, education, transport, land use planning, etc). The best outcomes for the health of Queenslanders will be to set up an Institute comprising the various streams of the public health workforce with the critical capability and capacity to work effectively in true partnership with other government agencies, the LHHNs and MLs delivering expertise, services and programs where it is needed.

¹ 'Queensland Health' is used in this paper to refer to the entity (or entities) that will essentially undertake the roles of system manager and health system support, post the transition of Districts to Local Health and Hospital Networks.

The Nature of Public Health

Public health promotes health, prevents the spread of disease and protects against risks to health and wellbeing. Public health programs are focused at a population versus individual level, provide a unique role within a health system and sit alongside and complement individual focused clinical services.

Scope of Public Health functions

1. Surveillance, prevention and control of the spread of communicable diseases, including immunisation program coordination.
2. Monitoring and developing effective responses to environmental health hazards, including public health regulation particularly for food, water quality, drugs and poisons, radiation safety and other environmental health matters.
3. Coordination and implementation of responses to public health disasters in collaboration with the other response agencies (eg Safe Food Production Queensland, Department of Environment and Resource Management, Department of Employment, Economic Development and Innovation, Workplace Health and Safety Queensland).
4. Monitoring and publishing reports on public health indicators (vs. indicators of clinical service delivery)
5. Development and implementation of population wide health promotion strategies targeting behavioural, social and environmental determinants with an emphasis on the primary prevention of chronic disease and its underlying risk factors.
6. State wide planning and coordination of population based cost-effective cancer screening programs.

Public Health Strategies include:

1. Health assessment and disease surveillance – strategies critical for monitoring population health status, detecting and responding to outbreaks of disease or other health-related issues, and assessing the effectiveness of public health programs and services.
2. Health protection – strategies that protect people through legislation, regulation, inspection, and health risk assessment and specialist advice and, if necessary, enforcement and prosecution;
3. Preventive interventions – strategies that include immunisation, disease screening and early detection, and prophylactic or in some cases preventive treatments;

4. Health promotion – strategies that range from partnership building and coalition development, promotion of healthy social and physical environments, to social marketing and education that helps foster changes in community attitudes, change readiness and develop personal skills for health;
5. Emergency preparedness and response – maintaining and coordinating capacity and systems to respond to the public health risks posed by natural and human-caused disasters such as communicable disease outbreaks, cyclones, floods and criminal or terrorist acts such as intentional contamination of food.

Health Reform in Queensland

Recent reforms have attempted to clarify the roles of government in the health care system, and have led to the development of two new types of agency:

- Medicare Locals (MLs)
- Local Health and Hospitals Networks (LHHNs)

MLs will principally work to assure effective primary health care services, while the LHHNs will be principally focused on the provision of acute in-patient services. There may be some exceptions to this, especially in remote regions.

The main function of a Local Health and Hospitals Network is, as defined in Queensland law ‘... to deliver the hospital services, other health services, teaching, research and other services stated in the service agreement for [that] network’.

While the service agreements for LHHNs may be broad, experience in public sector health delivery shows that all performance indicators are not created equal. Networks will be principally oriented to the provision of acute services. The economic and political environment is such that the drivers of performance for LHHNs will be:

- Performance against budget
- Elective surgery waiting times
- Ambulance ramping and emergency department performance measures

The MLs’ strategic objectives have been defined by the Commonwealth. MLs will be responsible for functions which:

- Make it easier for patients to navigate the local health care system through provision of more integrated care

- Ensure more responsive local GP and primary health care services to meet the needs and priorities of patients and communities, and
- Make primary health care work effectively as part of the overall health system.

The Effect of Health Reform on the Structure and Delivery of Public Health

The LHHNs and the MLs are not structured, funded or aligned for the business of population based health protection, health promotion or disease prevention, either communicable or chronic. Networks will not be operating in an environment where altruism between networks will be encouraged, nor will investments held in stewardship by one LHHN for service delivery across a larger region be protected. This, in many ways, is as it should be. However, issues such as communicable diseases and the distribution of unsafe food and responses to it do not respect borders.

The need for chronic disease prevention will be highlighted following the transition to LHHNs. While there are significant opportunities to improve chronic disease morbidity through primary health care, a combination of ageing population and increasing risk factors for chronic disease mean that it will not be possible to manage all the expected chronic disease cases with the available primary health care workforce into the future.

Currently, there is a limited investment in the primary prevention of chronic disease in Queensland and it remains vulnerable. For example, this investment is currently being eroded as positions that were funded to sit within Districts to provide primary prevention under the Chronic Disease Strategy are realigned to clinical work in order to assist Districts meet acute demand pressures within their allocated budget.

LHHNs will be under immense short term pressures to squeeze as many weighted activity units (WAUs) as possible from the available funding. Recent movements by Districts to re-orient preventive positions to clinical work point the direction of the future. It has also been a common experience of the past in many similar health systems across the globe. With multiple, independent LHHNs across Queensland, there is no guarantee that any investments made in preventive health, placed within the LHHNs will endure.

Risks of Devolving Public Health Functions to LHHNs

Any model that breaks up the range of public health activity would only weaken its capacity. Public health has been split and joined several times in Queensland and there is much evidence of the negative impact a split model has on the stability, efficiency and effectiveness on service delivery.

The current public health workforce in Queensland is too small to be split and incorporated into 15 separate LHHNs. Efficiency would be lost because of the inevitable duplication that will follow the weakening of the public health network across the State. It would burden LHHNs with, small, poorly resourced, isolated and disconnected services, with a broad scope of responsibilities and high profile issues, that would create a significant burden of work unrelated to their core business of providing health care to individuals and managing the significant challenges for this sector alone, including the relationship with the new MLs in the significant challenges in ensuring efficient and effective access and continuity of care across the primary and acute health care system.

MLs and LHHNs are essentially clinically oriented organisations, and are focussed, as they should be, on allowing and supporting this to happen. However there also needs to be a robust and critical mass of capacity somewhere in the system to see the big picture with respect to the health of the population, and to prevent and respond quickly to threats to the health of Queenslanders in the short, medium and long term. A robust agency, which includes multidisciplinary public health staff located in public health units across the state, would provide the strength and capability to work effectively:

- a) As an equal partner together with both the LHHNs and MLs in their different but complementary roles, and with other key agencies at the local level in addressing the full spectrum of health functionality to the people of Queensland.
- b) With other state government departments and agencies at both state and local levels ensuring a whole of government approach to public health outcomes (eg. DERM, DEEDI, Safe Food Production Queensland, Education, Transport, Communities).
- c) With other jurisdictions where there is significant benefits in working collaboratively to achieve national consistency and effective nation-wide action where relevant, and reduce unnecessary duplication of effort

Queensland cannot afford public health (health protection, prevention and health promotion) to fail. Fragmenting a small workforce with specialist skills throughout the LHHNs, where the pressures will be to erode this capacity, will create unacceptable risks for the Queensland community, both now and into the future. The community has very high expectations that they

will be protected from risks to public health. Perceptions of failure to protect the public health pose significant political risk.

Organisation of Public Health

The Queensland Population Health Institute

Queensland's public health services are currently located together within the Division of the Chief Health Officer, along with a range of other services such as those that support clinical service delivery (eg. aeromedical retrieval services). Public health services have an excellent reputation nationally, and are the envy of many public health colleagues in other jurisdictions. Building on this, a single and clearly identifiable service delivery entity for public health is strongly recommended. The Queensland Population Health Institute would have the following features:

- Clearly identifiable within the organisational structure of Queensland Health but distinct from system manager and health care service (i.e. LHHN) support functions
 - However, LHHN and ML representation on an Institute advisory body would assist in retaining strong relationships
- Clear accountability and scope of responsibility based on specialist public health expertise/decision making and rapid response and flexible deployment capability to manage risks and protect health.
- Responsibility for the administration of public health legislation – i.e. that seeks to prevent harm to the community from environmental and disease risks and to promote health, including effective collaboration with regulatory partners (esp. other state government agencies and local government) at state and local levels.
- Seamless delivery of multi-strategy, intersectoral and multi level (state, regional, local) action, including coordinating state-wide initiatives, collaboration with other agencies, and management of investigations and responses, often within a national and international context.
- Responsibility for maintaining public health (health protection/promotion) system capacity, including public health information systems (eg. Notifiable Conditions System), communication and public education/social marketing, quality management, research, and workforce training and development necessary to deliver contemporary, evidence based public health strategies and implement core programs.

The Queensland Population Health Institute - Organisational Form

The above analysis indicates that public health functions would be most effectively and efficiently delivered through the creation of it as a separate statutory body under the *Health and Hospitals Network Act 2011* (another 'network') or similar.

In summary:

- It would provide clear recognition of public health as a specific and complementary service to health care of individuals as part of a contemporary health system and distinct from the system manager function and support function of a 'corporate office'.
- It would address what has been an ongoing problem where public health service delivery
 - is at continued risk of being classified as part of the 'health bureaucracy', or 'corporate office' (vs the department), and as an administrative overhead of health services rather than a valid unique health service in its own right
 - has ongoing difficulty in being recognised as part of health service delivery in funding models and thus securing funding to respond to growth in demand for public health services from increased population growth, additional responsibilities and environmental changes
- It would contribute to achieving a clear focus for the departmental entity/entities responsible for overall health system management and support. The presence of public health services in the residual Queensland Health (or equivalent) post the transition of Districts to LHHNs, blurs the roles of it as system manager and health care system support with that of a service provider. It would enable Department/equivalent to be streamlined in size, and ensure the public health programs, which are diverse and high profile, do not blur and distract it from its core roles.
- Administration of regulation can be delegated to this single entity which meets the requirements for consistency of administration, streamlined accountability to the Chief Executive and independence from LHHNs who are subject to public health regulation.
- Allows for funding to be on a program basis, rather than activity based. Activity based funding which will be the predominant funding model for LHHNs under the current health reform is generally not relevant to the public health program context.

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- Allows for accountability and independence of specialist public health, clinical and statutory decision making.
- Service would be viable as a network as it would be of equivalent size to small to medium sized LHHNs.
- As public health services are classified as health services under the Health and Hospitals Network Act 2011, there is no legal impediment to establishing, by regulation, public health services as a single Network and naming it the '*Queensland Population Health Institute*' or similar. No change to the Act is required.
- Delivering public health services from a separate statutory body would be cost neutral, as currently public health services are managed within one Division of Queensland Health, with adequate internal administrative and business support, services and the relevant program areas are already accommodated together, both in Brisbane and public health units across the state.

A diagrammatic representation of the proposed Institute can be found on pages 14 and 15.

The key public health program areas within the proposed institute are:

- Communicable disease prevention and control including coordination of immunisation programs;
- Health promotion;
- Environmental health – including food safety, drugs and poisons, water quality, health risk assessment, environmental toxicology, and radiation safety;
- Alcohol and tobacco prevention;
- Cancer screening program coordination; and
- Public health surveillance and evaluation.

Queensland Health staff who currently work in the six program areas within the proposed institute would transition to form the new Institute. A handful of positions would remain within Queensland Health with the Chief Health Officer to provide high level policy advice and support for implementation for Government, in line with its system manager function.

The PHAA realises that while the suggested model with separation of public health activity occurs in a number of other health systems internationally there has been limited progress in

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this direction in Australia, although Victoria set up a foundation (VicHealth) to undertake health promotion activity a number of years ago.

The PHAA would be happy to provide advice and assistance to the LNP in the development of population health policy in the lead up to the state election, especially in relation to the establishment of a Queensland Population Health Institute or similar organisation



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Diagram 1

Post reform relationship of the Institute with other health sectors

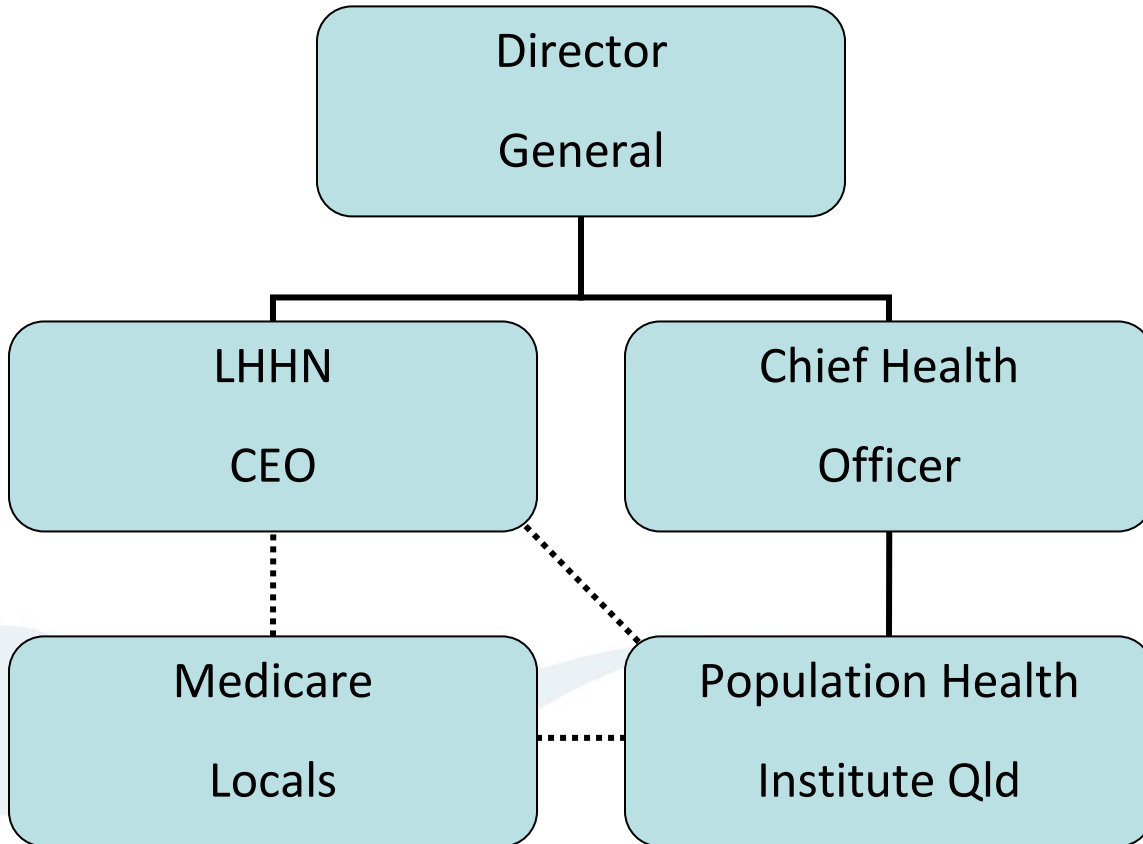


Figure 1. Relationship between The Population Health Institute Queensland and other sectors of the health system post reform

Diagram 2

Structure of the Institute and relationship with Queensland Health

