INDEPENDENT REVIEW
OF
THE PUBLIC HEALTH EDUCATION AND RESEARCH PROGRAM
IN
AUSTRALIA

Report to The Hon Brian Howe MP
Minister for Health Housing and Community Services
by
George C Salmond
External Reviewer

March 1992
The Hon Brian Howe MP  
Minister for Health, Housing and Community Services  
Parliament House  
CANBERRA ACT 2600

Dear Minister

I am pleased to present "The Independent Review of the Public Health Education and Research Program".

This has been a challenging, informative and enjoyable experience for me. The Public Health Education and Research Program is a landmark achievement in Australian public health. I hope that this report will help to further promote health for all Australians.

Yours sincerely

George C Salmond  
External Reviewer  
20 March 1992
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TERMS OF REFERENCE

The Federal Minister of Health, Housing and Community Services commissioned a national review of the Commonwealth-funded Public Health Education and Research Program.

The following terms of reference were set for the external reviewer:

1. To assess the performance of each of the nine Public Health Education and Research Programs which receive funding through the Department of Health, Housing and Community Services in relation to their contribution to public health education and training.

2. To examine the extent to which individual programs have responded to the changing needs of public health education and research in Australia and their ability to respond to changing workforce requirements.

3. To examine the needs for future public health research, education and training to facilitate the Government's social justice strategy and the achievement of national health goals and targets taking into account the range of public health programs in Australia — including those not funded by the current initiative.

4. To make recommendations about improved information, co-ordination and monitoring of public health developments across Australia.

5. To make recommendations about the future focus, operations and location of individual programs and to draft terms of reference for regular future evaluation of the programs.

6. To make recommendations about sources and mechanisms for future funding.
ACKNOWLEDGEMENTS

Many people have contributed to this review in various ways. Without their energy and sustained interest over a substantial period the review could not have been completed.

Recognition is due to those who presented submissions to the national review; to those who prepared and presented material to the individual site reviews; to those who served on the review panels and their support staff; and to those I interviewed in Canberra and elsewhere. To all of these people I offer my grateful thanks.

Special thanks are due to Valerie Hull and Margaret Dean who carried out the planning study in 1990 which shaped the review and provided a framework for the Individual Program Reviews. Margaret Dean went on to represent the Commonwealth at all of the site reviews. She not only provided me with information and on the spot insights but also was a sympathetic yet critical sounding board for my ideas and proposals.

Alan Bansemer, Liz Furler and the other members of my advisory committee also provided advice and encouragement and helped in various other ways.

The main task of managing the external part of the national review and of organising my work as the external reviewer fell to Loretta Thompson, Sue Mittermair and their colleagues in the Development Section of the Health Promotion and Development Branch of the Commonwealth Department of Health, Housing and Community Services. Without their understanding, patience, hard work and good will my task would have been more difficult and less enjoyable.

Notwithstanding the very broad terms of reference set for the external review the limitations and any errors of omission or commission in the report are my responsibility.

For me the review was a challenging, informative and thoroughly enjoyable experience. I hope that the outcome will be similarly positive for the future development of public health in Australia.

George C Salmond
Wellington
20 March 1992
EXECUTIVE SUMMARY

In 1985 Professor Kerr White MD was invited by the Commonwealth Government to undertake an independent review of Australia’s public health and tropical health research and teaching requirements. The outcome of his report and the associated deliberations was a "package" of measures promoted as Australia’s Bicentennial Health Initiative. One of these measures was the Public Health Education and Research Program (PHERP).

The PHERP was established as part of a concerted effort to strengthen public health education and training in tertiary institutions across Australia. Nine centres, in five States and the ACT, were individually contracted by the Commonwealth to provide education and research in keeping with specified objectives. Initial funding was provided for seven years - that is until December 1993 - with provision for a review after five years in 1991.

The 1991 review was carried out in three parts.

First, submissions were actively sought from a wide range of interested individuals and organisations. Over 50 submissions were received.

Second, an on site review was carried out at each institution. Each review panel included at least one external reviewer and a Commonwealth health representative. The panels reviewed and reported on program performance in relation to the contract requirements.

Third, an external reviewer was contracted by the Commonwealth to overview the relevant documentation - including the submissions and the Individual Program Reviews - to interview the key stakeholders at the various sites and to independently report on the program. A small advisory committee was established to assist and to provide a sounding board for the external reviewer.

The terms of reference for the external reviewer are given on page 4.

In consultation with the advisory committee it was agreed that the external reviewer would overview the whole program in the light of Australia’s evolving National Health Strategy and public health developments in Australia and internationally. Individual contract performance would be reviewed against this general background and possible lines of development and courses of action suggested and discussed. Firm, site-specific recommendations would not be made. Taken together the Individual Program Reviews and the report of the external reviewer would provide the information necessary for further decision making about the future of the PHERP at the Commonwealth, State and institutional levels.
Taken as a whole the "Kerr White" package has been very successful in helping to raise the profile of public health in Australia. Interest is rising in the population aspects of health development and the delivery of health services. Health promotion and disease prevention are increasingly being seen as everybody's business and not just the preserve of the regulatory health authorities. In this sense health is taking on the dimensions of a popular public movement with significance for society as a whole. This perspective is now being reflected in Australia's evolving National Health Strategy.

The review shows that Australia has the potential to develop effective public health infrastructure at the Commonwealth, State and area health management levels. In some places people with the required skills and experience are thin on the ground. But there is no shortage of enthusiastic young people eager to be part of the growing new public health movement.

The National Health Strategy papers to date suggest that the focal point for the reforms is likely to be the area health boards. Area health management is being promoted as the means to achieving a population-based health system in which interventions are effective, activities are planned and coordinated across the whole continuum, resources are used efficiently, community involvement is encouraged, and public accountability established. Viewed in these terms an effective public health capability is essential to the success of area health management.

What seems to be lacking at present is an effective public health infrastructure in which there is a systematic networking of resources. Such resources would include Commonwealth and State health departments, the universities, area health boards, territorial local authorities, industry, health promotion foundations, and other private and voluntary organisations. Ways should be found to enable these organisations to work together to provide a launching pad for the new public health agenda.

There are signs, particularly in NSW, that such networking is beginning to occur and that an infrastructure is evolving which will enable population-based health outcomes to be defined, priorities established and outputs specified in terms of activities and services. The effector elements of the network can then be contracted to deliver the prescribed outputs and to have their performance monitored. Public health professionals have important roles to play in facilitating these processes not only in relation to the delivery of traditional public health services but also to health sector activity as a whole. Other States, at this point, seem to be looking to NSW for leadership in the restructuring, strengthening, and focusing of their public health programs.
It is against this general background that the individual components of the PHERP have been reviewed. It has been suggested that the PHERP funding in each State eventually become part of a much larger resource available to properly constituted, state-wide public health networks. Within each network provision should be made to plan and develop the public health workforce. Resources, including the PHERP funds, should be available on a competitive basis to those institutions best able to meet specified program objectives. Funding presently protected to the existing PHERP funded institutions should be phased out as soon as the new arrangements are in place.

Once effective new public health infrastructures are up and operating, the continuing role of the Commonwealth, if any, in the promotion of public health education and research should become clearer. Also, once precise goals and targets are established for public health workforce development it should be possible to determine which of the various funding mechanisms available would best achieve the desired results. The objective should be to properly plan and efficiently fund workforce development at the State level.

The report gives special attention to the National Centre for Epidemiology and Population Health in Canberra, to the Tropical Health Program in Brisbane and to the Anton Breinl Centre for Tropical Health and Medicine in Townsville. The combination of research, development, and training activities at each of these sites is unique. Individually tailored arrangements are recommended for the ongoing administration and funding of each program.

Public health research is co-ordinated nationally by the Public Health Research and Development Committee of the National Health and Medical Research Council. A similar national mechanism does not exist for the co-ordinated development of the public health workforce. In the absence of such a focus the Public Health Association of Australia has shown considerable initiative in gathering and publishing information about the workforce and the public health training available in Australia. The review develops a case for the Commonwealth to contract with the Association to undertake information gathering, policy analysis, co-ordination, planning, quality control, and review functions for public health workforce development, nationwide.

The report includes short sections dealing with Aboriginal and Islander health and the administration and funding of international public health activities both within and outside of Australia.
1. Origins

1.1 The Commonwealth-funded Public Health Education and Research Program (PHERP) arose out of an independent review of research and education requirements for public health and tropical health in Australia. Carried out in late 1985 by Professor Kerr L White MD the review recommended that the Commonwealth invest in a wide ranging "package" of initiatives aimed at building a "healthier" future for all Australians.

1.2 Promoted as Australia’s Bicentennial Health Initiative the Kerr White Review raised the national level of health consciousness and has provided the stimulus needed for public health advancement.

1.3 Arising directly out of the review were three initiatives:

- rationalisation and decentralisation of public health teaching and research facilities with additional funding for public health programs throughout Australia - the PHERP.

- strengthening of the Australian Institute of Health (AIH); and

- creation of a Public Health Research and Development Committee (PHRDC) within the National Health and Medical Research Council (NH&MRC).

This review is primarily concerned with the first of these initiatives - the PHERP.

1.4 The program was established to provide assistance to tertiary institutions around the country to allow greater access to students. The target group and focus of individual programs vary at each location, with each contributing to the overall requirement for Australia. Funding is provided in accordance with contracts between the Commonwealth of Australia and the relevant institution. Accountability is usually in the form of six monthly expenditure reports and annual reports. Each institution has a board of studies for their individual program. The Department of Health, Housing and Community Services (DHHCS) is represented on these boards. The contract with each institution provides for a review after the fifth year of funding - that is in 1991.
1.5 The elements in the PHERP are:

- Closure of the School of Public Health and Tropical Medicine in Sydney and transfer of its major functions to the University of Queensland and the Queensland Institute of Medical Research.

- At the Australian National University – development of a National Centre for Epidemiology and Population Health (NCEPH).

- At the University of Sydney – development of a multidisciplinary Master of Public Health (MPH) program.

- At the University of Newcastle – extension of the postgraduate training and research activities of the Centre for Clinical Epidemiology and Biostatistics.

- At the University of Queensland and Queensland Institute of Medical Research – development of a tropical health teaching and research program.

- At the James Cook University – support for the Tropical Health Surveillance Unit at the Anton Breinl Centre.

- At Monash University – enhancement of the MPH program.

- At the University of Adelaide – expansion of the MPH program.

- At the University of Western Australia – establishment of a MPH program.

It was planned that these programs would receive funding for seven years, after which funds would be provided through the Commonwealth Tertiary Education Commission, since replaced by the Department of Employment, Education and Training (DEET).

1.6 The Commonwealth contract with each University and the Queensland Institute of Medical Research provides funding only until December 1993. Assuming that the objectives are met the contracts with the University of Sydney, the University of Queensland and Queensland Institute of Medical Research imply that the funding will be continued beyond December 1993. The funding levels for the individual PHERP funded institutions are shown in Appendix A.
2. The review process

2.1 The overall impact of the "Kerr White" initiatives has been to raise the public health profile in Australia. However, it is too early to make definitive judgements about the performance of a number of the individual PHERP funded programs. With the current funding ceasing in December 1993 the various institutions are looking to the review to give a lead as to future directions and funding. Without such a lead it is difficult to maintain the momentum of programs and the confidence of staff.

2.2 The general objective of this review is to examine the performance of individual programs in the light of the contract objectives and to assess the extent to which programs have responded to the changing needs of public health education and research and workforce requirements in Australia.

2.3 The review was in three parts.

First, submissions were invited from relevant organisations and from the public. Submissions were actively sought from certain groups such as students, the Public Health Association of Australia (PHAA), the Consumers' Health Forum and from non-PHERP funded public health programs. Over 50 submissions were received and reviewed. They are recorded in Appendix B.

Second, Individual Program Reviews (IPRs) were carried out at each site under the auspices of the host University and, in the case of the Tropical Health Program, Queensland University and the Queensland Institute of Medical Research. Terms of reference and membership of the review panels were agreed with the DHHCS. External reviewers and DHHCS representatives were included on all panels. The aim was to assess the extent to which individual programs had fulfilled the contract obligations with the Commonwealth and beyond that to evaluate performance against their own mission statement and declared objectives. Reviews were completed at all sites. The reports are listed as base documents in Appendix E.

Third, a national review was carried out by an external reviewer. Inputs to this review were:

- the relevant background documentation;
- the submissions;
- the IPRs;
- interviews with key officers at the DHHCS;
- PHERP site visit interviews and interviews with other interested parties in Canberra, Sydney, Newcastle, Melbourne, Brisbane, Adelaide and Perth; and
• inputs from the National Review Advisory Committee chaired by Alan Bansemer Deputy Secretary of the DHHS - the Committee provided guidance and a sounding board for the external reviewer.

The names of those interviewed are listed in Appendix C.

Membership of the National Review Advisory Committee is given in Appendix D.

3. Conceptual framework

3.1 Kerr White observed that:

"Australia needs not just more public health workers but more population based thinking throughout the health sciences and the health services."

"That is what Australia's Bicentennial Health Initiative should be all about" he said.  

3.2 The Committee of Inquiry into the Future Development of the Public Health in England (Acheson Committee) in 1988 defined the term "public health" as:

"the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society."

3.3 The Committee further pointed out that defined in these terms the public health functions of society would include:

"not only efforts to preserve health by minimising and where possible removing injurious environmental, social and behavioral influences, but also the provision of effective and efficient services to restore the sick to health, and where this is impracticable to reduce to a minimum suffering, disability and dependence. Such an all embracing concept, which could be deemed to include not only the provision of clinical and related services such as dentistry, pharmacy, etc., but also questions relating to the economic and social origins of health, would take us far beyond our collective capacity or the time available for our work."

3.4 Faced with similar limitations I have adopted the same approach as the Acheson Committee and have interpreted my remit as being concerned principally with efforts to:

• improve the surveillance of the health of the population centrally and locally;

• encourage policies which promote and maintain health; and
• ensure that the means are available to evaluate existing health services.

3.5 The developments which flowed out of the 1986 Kerr White Review over the last five years are now being reflected in Australia's evolving National Health Strategy. Rising interest in the population aspects of health development and the delivery of health services is part of what is becoming a popular health movement world wide - a movement in which Australia is close to the leading edge.

3.6 The World Health Organisation with its primary health care approach and associated health promotion strategies has led a world wide resurgence of interest in the public health - the so called "new public health". As pointed out by Halfdan Mahler in opening the Ottawa Conference on Health Promotion in 1986 the "new public health" is not "new" - rather, it is a renaissance. In some ways the distinction between the "old" and the "new" public health is artificial and not helpful. The basic, broadly based social approaches which were so successful in tackling the dominant public health problems of western societies in the nineteenth century - infectious disease, noxious environmental exposures, nutritional deficiencies and occupational injury - are equally appropriate to tackling the health problems of the post industrial society today.

3.7 The often narrow and rather mechanical approaches which have tended to characterise the practice of medicine are now being complemented by broadly based systems approaches which take more account of population perspectives and the need for greater community participation and social justice in the allocation and use of public health resources.

4. Evolving a national health strategy

4.1 The PHERP must be reviewed against the emerging National Health Strategy. Despite the fact that the strategic process is ongoing and has yet to deal directly with many of the public health issues, a sense of direction is emerging which should have an important bearing on the future organisation and funding of public health education and research activities.

4.2 In "Setting the Agenda for Change" Jenny Macklin indicated that the National Health Strategy would:

• work to reduce inequalities in terms of cost, access and health status;

• examine new models for the delivery of primary health care;
• seek incentives to encourage best practice care;

• review the balance between hospital and community care;

• study the public/private mix, the role of private health insurance and the required balance between market forces and regulation in the provision of services;

• seek better ways to promote good health by the use of public health standards and effective health promotion;

• frame options to ensure that the health needs of vulnerable groups are met;

• review the workforce implications of the proposed strategy; and

• review Federal/State funding arrangements.

4.3 For ease of understanding and operation she suggested that the delivery of health services should be promoted in a simple framework. Universal coverage and the equity of access provided under the Medicare arrangements meet this requirement, are widely accepted and are likely to remain.

4.4 Efforts will be made to improve the integration of health care delivery. This applies as much to the broad range of activities which bear on health promotion and community health development as it does to the more traditional treatment services. What will always be scarce resources must be rationed and choices made in balancing the mix between primary care, public health, and treatment services.

4.5 In the National Health Strategy papers produced to date the concept of area health management is emerging as a focal point for the reforms. It has been suggested that the objectives of area health management would be to:

• replace institutionally focused hospital boards with a management structure responsible for the health of a defined geographic population;

• improve networking and coordination between hospitals by promoting joint appointments of medical staff, inter-hospital service planning and clearer role delineation;

• improve the continuum of care across institutional based and ambulatory care;

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facilitate the separation of purchasers and providers and the development of output based funding, with the accompanying benefits related to efficiency, quality, and access; and

improve access to hospital care by facilitating better management of waiting lists across hospitals and better sharing of hospital work loads.

4.6 A variety of options for the funding of area health boards and for articulating their activities with those of other Commonwealth, State and private purchasers and providers of health and related social services have yet to be explored. The aim must be to simplify the pattern of funding, to reduce gaps and overlaps, to minimise the opportunities for cost shifting and improve accountability. Whatever the arrangements it is likely that moves may be made to separate the purchasing and the provision of services. This would see the progressive introduction of service models which use "budget holders" to purchase "packages of care" for designated groups.

4.7 Given such a framework, greater use can be expected of population based formulas in the allocation of Commonwealth and State resources to area health boards. Within boards, historical funding arrangements are likely to be replaced by contract funding based on defined outputs which specify quantity and quality and identify measures to monitor performance. In the case of hospitals this would be mainly case mix information. In the later 1990s it is likely that managing health services will evolve into managing the health of populations and that health care financing will be progressively linked to specified outputs and health outcomes. The emphasis will be on management for health rather than the administration of health services.

4.8 To simplify funding, improve efficiency and increase accountability it has been proposed that Commonwealth and State programs be realigned and consolidated into six program areas:

1 Public hospitals - inpatients, specialised outpatient services requiring a hospital setting, emergency departments, teaching and research.

2 Pharmaceuticals - non-inpatient both inside and outside hospital.

3 Non-inpatient medical specialist and diagnostic services - inside and outside public hospitals.

4 Primary health and community care

4a Primary health and community care services - GPs, community nursing, allied health, public health,
health promotion and education, home and personal care, respite care, public dental health, child and family health, aids and appliances, special needs groups.

4b High dependency living support - nursing homes, hostels, intensive community support, palliative care, rehabilitation, geriatric assessment, support for carers, non-acute patients in public hospitals.

5 Mental health services.

6 Small rural communities.

4.9 All six programs are of interest and importance to the public health community but the "primary health and community services" program is of prime concern. The various options as to how the elements of the program could be included in an area health management operation have yet to be explored by the Strategy. This program area is one in which there are likely to be major changes.

4.10 At area health board level it would be necessary, at least for operational purposes, to divide the program into its personal health care and population or public health components. The personal component would include general practice and other treatment and continuing care services in the community. In the past funding arrangements in this general area have not encouraged team work and the integration of personal and population health approaches. There are encouraging signs that traditional attitudes and practices may be changing in this important area as recorded in the reported proceedings of a recent "Think Tank on Financing General Practice". A key issue for the National Health Strategy will be to explore the options for integrating general practice and other community based services within the general framework of area health management.

4.11 There is a rising tide of interest and support in Australia for the "new public health". The population or public health perspective is likely to play a more central role in all aspects of health sector activity in the future than it has in the past. At one end of the spectrum is data gathering and analysis - the intelligence function essential for planning and management. At the other extreme public health practitioners and their associates have key roles to play in the practical business of health promotion and health development in community settings. If the current concepts of universality, equity of access, simplicity of structure and process, service integration with greater emphasis on population perspectives, and area health management go ahead the demand for people with knowledge, skills and experience covering the whole public
health spectrum will be enormous. New resources, or resources mobilised from other parts of the system, will be required to recruit, train and retain a new public health workforce. In this context a good start has been made with the PHERP. What is needed now is a plan and resources to build on the excellent foundation already laid.

5. Public health networks

5. For most of the last 50 years public health has been overshadowed by biomedical science, therapeutics, and technology. In recent years the statutory agencies which carry public health responsibilities have been repeatedly restructured. Lines of legal and managerial responsibility have been changed, often with confusing results. The links between clinical medicine and public health, and between the various government, university, industry, and community organisations interested and involved in the public health, have often been weak and sometimes non-existent. The net result has been a fragmented and generally ineffective public health infrastructure.

5.2 Today, the promotion of the health of the public requires more than the best efforts of the statutory agencies which carry public health responsibilities. This has been emphasised by the World Health Organisation in the development of its "Health for All" program which was the model for the "Health for All Australians" program in 1988. To quote the first chapter of the European "Targets for Health for All":

"One principle is true for all countries: the key to solving many health problems lies outside the health sector or is in the hands of the people themselves. High priority should therefore be given to stimulating the contributions that other sectors and the public at large can make to health development, particularly at the local level. It is essential in this respect to accept the basic principle that people’s involvement in health development cannot be merely passive. It is a basic tenet of the health for all philosophy that people must be given the knowledge and influence to ensure that health developments in communities are made not only for, but also with and by the people. Primary health care is the most important single element in the reorientation of the health system and will require very strong support. It is also important to ensure more economical, effective and humane use of existing health care resources".

5.3 Given the prospects for primary health care and for area health management it is likely that State departments of health and area health boards will be required to play
central roles in creating new infrastructures for implementing the new public health agenda. New networks of influence and action will be needed.

5.4 Good epidemiology and other population health skills, modern information technology and well developed abilities to communicate and manage will be needed, at all levels within the system, to build the new infrastructures. Effective networks must be built at the Federal, State, area health board and local levels. All of the organisations and agencies with significant involvement in, or power to influence, the public health should be involved. Such institutions would include elements of central and local government, the universities and other education authorities, industry, environmental organisations, community groups, and voluntary organisations as well as other parts of the health system. The aim should be to build, inform, enskill, empower, and focus networks which are able to effectively and efficiently oversee or undertake health surveillance for defined populations, plan and implement policies which promote and maintain health, and ensure the evaluation of existing health services.

5.5 The review has shown that most Australian States have the basic building blocks necessary to build an effective public health infrastructure. The challenge to the public health community and to the Federal and State governments is to bring these elements together in a concerted, co-operating and mutually supporting environment so that the networks can grow and flourish. The problem is not so much one of a shortage of resources or of people with ability, technical skills, and energy as it is of providing a convincing vision of what the public health future could be, and the infrastructure necessary to enable that vision to guide the evolving reality.

6. Aboriginal and Islander Health

6.1 It is convenient here to consider one of the highest priority public health issues in Australia – one which was raised many times in the course of the review – the issue of Aboriginal and Islander health.

6.2 Indigenous peoples the world over are with rising voice expressing their concern and dissatisfaction with their perceived place and role in society. Health, which is generally viewed in holistic terms, has become a central issue in these debates and an early target for change. For Australia, the National Aboriginal Health Strategy published in March 1989 makes this clear and deals with the issues at length.
6.3 As the prologue to the Strategy explains:

"'Health' to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity." •

There are striking parallels between this Aboriginal concept of health and the ideas and concepts promoted as part WHO's primary health care approach and the "new public health" movement.

6.4 Increased community control and participation are central components in most "new public health" agendas. They are also key elements in Aboriginal advocacy for health improvement, again as explained in the prologue to the National Aboriginal Health Strategy:

"In order to achieve the necessary improvement in Aboriginal health, Aboriginal people believe they must again be able to control their destiny and to accept responsibility for their own decision-making. In the area of health, this has seen the development of Aboriginal Health Services which function in accordance with the principles of community participation and control which operate alongside the mainstream services." •

6.5 Just as there can be no quick implementation of the "new public health" strategies there are no easy answers to the problems posed by the Aboriginal and Islander health movement. What should be recognised are the close parallels which exist between the two movements and the fact that they can and should be addressed together. The cultural settings may be different but the means to health improvement are the same.

6.6 Aboriginal and Islander health should be a significant element in the developing public health networks. State by State the issues, the priorities, and the resources are different. This should be reflected in different structures and processes across the networks. In some aspects of the work it may be appropriate to address Aboriginal health issues as part of the mainstream. In other areas parallel arrangements which respect cultural difference and enable more direct community participation and control may be best. The aim should always be to work with the people rather than impose upon them.

6.7 It is essential that the local indigenous people be involved directly in the setting up of any public health network. This will require much more than the odd indigenous person on advisory committees and boards of
governance. In systematically networking public health resources it is essential that the indigenous people be involved in a culturally appropriate fashion. This will take time and effort. Despite goodwill on both sides and the best of intentions there will be misunderstandings and mistakes, but the effort to build the mutual trust needed to work together must continue.

7. Workforce perspectives

7.1 One of the manifestations of the growing public health movement is the increasing demand for training. This is coming from people at all points in the public health workforce spectrum. The Report of the Public Health Workforce Study 1990, carried out by the PHAA, not only highlights the breadth and depth of the demand for training but also points out the uncertainties which exist in the minds of many people interested in pursuing careers in public health.

7.2 At present there is much uncertainty about the range and level of competencies which will be required in the future workforce. What roles will there be and how will these fit within the new infrastructures? What career structures will there be and what arrangements for the recruitment, training, and deployment of workers? These are some of the workforce issues which will need to be addressed by the National Health Strategy.

7.3 The report of the Public Health Workforce Study 1990 describes requirements at four levels.¹²

Public health specialists - with usually doctoral training whose function is to teach, guide, and support other workers in research, planning, and evaluation.

Public health practitioners - with generalist postgraduate qualifications in one or more public health related disciplines, who work across a wide range of public health activities in the public and private sectors.

General and associated health workers - by far the largest group in public and private sector employment who, in increasing variety and numbers, are seeking and benefitting from postgraduate training in public health disciplines. These range from medical specialists interested in clinical epidemiology or the attainment of management skills, to general practitioners, nurses, and other allied health professionals who feel that public health training (including training in primary health care) may enhance their effectiveness and perhaps their career prospects. In time this should lead to greater shared knowledge and understanding of the public health between all health workers.
Consumer and community organisations - have a pressing need for public health knowledge and skills. The provision of a well integrated, cost effective health service requires that consumer and voluntary organisations be encouraged to play fuller roles in the planning and management of services. Again a wide variety of involvement is possible ranging from priority setting and policy development through the various aspects of contracting for service provision to consumer activity concerned with individual patient services. This means that a wide range of public health education and training opportunities should be offered.

7.4 The complex and diffuse nature of the public health workforce makes information gathering difficult as the PHAA study shows. But, the demand for training is clearly increasing. This can be seen from the Directory of Public Health Training in Australia produced by the PHAA. The 1992/93 edition of the guide is twice the size of the 1989 edition. The number of institutions offering courses has increased by 80 percent and the range on offer has increased greatly.13

7.5 Most courses are over subscribed and most students part time. This suggests that the need for training is recognised by workers and employers alike. At least in prospect, those in training are able to apply their newly acquired knowledge and skills immediately.

7.6 It is important that the overall success of the PHERP be recognised before the Individual Program Reviews (IPR) are considered. Size, level of resourcing and other factors mean that some sites have achieved more than others. This is to be expected. Changing circumstances, not the least of which is the overall success of the PHERP, mean that some reorientation may now be necessary.

7.7 In terms of the workforce profile the emphasis of the PHERP has mainly been on public health specialists and practitioners - mainly medical graduates interested and involved in the more traditional disciplines. At all sites the resources have been vested in medical faculties. The requirements of non-medical graduates and those more concerned with the application of social science knowledge and skills to public health practice have not been as well catered for. Areas of relative neglect include the acquisition of communication, behaviour modification, and management skills in the context of health planning, primary health, and community care and broadly based health development. There is a growing demand for education and training in all of these areas and at all levels within the workforce.
7.8 The PHERP has funded mainly masters programs in public health. Only four of the ten MPH programs in Australia receive PHERP support. Very few of what is now an expanding number of masters programs related to public health receive support. New courses – including short as well as long courses – are being developed to meet the needs of people at all levels of the workforce. Questions are now being raised as to whether or not the currently favoured sites should continue to receive protected funding. There is a strong feeling that the available resources should be more generally available for competitive allocation to those sites best able to meet changing workforce requirements. For this to happen would require ongoing public health planning activity with tied resources for workforce development at both the Commonwealth and State levels.

7.9 Given that such a public health workforce development programs could be put in place a variety of methods are available for the channelling of funds to achieve the program objectives. Funding from a number of sources could be used to achieve different objectives. Funding could come from DEET, the DHHCS, from the States, and from special agencies such as the NH&MRC and the Australian International Development Assistance Board (AIDAB). The aim would be to achieve specified program objectives. Funding would be competitive on the basis of properly specified and time limited contracts. Once such programs were in place PHERP funding could be fitted or absorbed within the new framework. In the interim it is important that the achievements of the program to date not be judged prematurely and the existing gains jeopardised. It is from this perspective that the individual programs have been evaluated.

8 Individual program reviews
Almost without exception the IPRs report enthusiastically on the response to the PHERP by State health departments, the universities and the students alike. In the main, where problems have been highlighted these were operational rather than strategic concerns. At all sites student demand has stretched the available resources. In a number of places space limitation is a real problem. All of the reviews recommend that the existing funding be continued and most recommend that additional resources be deployed.

8.1 New South Wales
8.1.1 The last five years have seen a spectacular improvement in all aspects of public health activity in NSW. On the service side the Department of Health has led the way by establishing a network of public health units based on the area health boards. These have been supported by a strong public health core unit in the Department. As well as providing professional, technical, and administrative
support the Department runs an excellent public health officer training program. The service network has strong academic links to the University of Sydney.

8.1.2 The University of Sydney Faculty of Medicine Department of Public Health has, with PHERP funding, mounted a very successful MPH program which has a good reputation and is widely supported. The size of the program and the level of resource available to it means that it is financially more secure than some of the smaller programs.

8.1.3 The strength of the program is in epidemiology and biostatistics. Thought is currently being given as to how the course could be strengthened in areas such as health economics, health promotion and the various disciplines of management. A general dilemma is whether or not to seek to appoint "in-house" staff to develop these areas or whether to contract for the required inputs from elsewhere in the University of Sydney or further afield. There are also plans to strengthen the research and teaching in clinical epidemiology.

8.1.4 Part of the University of Sydney Faculty of Medicine is the Department of Community Medicine at Westmead Hospital. Collocated is the Centre for Health Economics, Research and Evaluation (CHERE). The University of Sydney Departments of Public Health and Community Medicine and CHERE are well integrated into the Department of Health- centred public health network being developed to include the area health boards. The evolving network is working well and is perceived to be the centre of public health action in the State. There is however a growing feeling that the resources of the network - particularly the PHERP resources - should be more widely shared.

8.1.5 The University of New South Wales has long been involved in graduate training in health related disciplines. Its masters courses in health administration are national benchmarks. Students come from all over Australia and internationally. The University also provides programs in education for health development which are of considerable international interest. The University has growing expertise and experience in distance learning. The courses are practical rather than academic in orientation. Faculty members are directly involved in consulting and in otherwise supporting the health services in the region.

8.1.6 Staff at the University of NSW feel that they have good resources which are not sufficiently recognised and could be better used in mainstream public health education and research in the State and nationwide.
8.1.7 The University of NSW receives no PHERP funding. Initially it was accepted that these funds would go to the University of Sydney as part of the restructuring of the School of Public Health. Now the feeling is that the funds should be more widely shared.

8.1.8 The University of Western Sydney Division of Public Health argues strongly for affirmative action to support its training programs. It claims that a health-deprived and rapidly growing population of more than 800,000 people must have the resources needed to train its own public health workers at all levels. If those resources are not provided local people will not be trained. Facilities provided in the centre of Sydney are not easily accessible to those in the west. Efforts to recruit trained people externally have been largely unsuccessful—hence the case for affirmative action. The Division competes successfully for research funds and feels that if there was an ongoing public health workforce development program with tied funds it could compete successfully for the resources it needs.

8.1.9 The University of Wollongong Faculty of Health and Behavioral Sciences has an expanding academic program in public health related disciplines. Of special interest is multidisciplinary research and training aimed at producing the information and developing the skills needed for health advancement in the context of ecologically sustainable development. As part of the program the Faculty seeks support to develop a national framework for health impact assessment as part of environmental impact assessment. The question of PHERP funding has been raised.

8.1.10 The University of Newcastle Faculty of Medicine has PHERP funding to enable the Centre for Clinical Epidemiology and Biostatistics (CCEB) to extend its externally funded graduate training programs to include Australian as well as overseas students. The Rockefeller funding used to establish the international program will be phased down and phased out over the next few years. If this very successful program is to continue within Australia and externally its operating arrangements and funding base will need to be reviewed within the next two years.

8.1.11 The core strength of the CCEB is in epidemiology and biostatistics. Even if the international work continues it will be necessary for the Centre to develop new products and to search out new markets in which it can use its accumulated resources of knowledge and skill.

8.1.12 The Centre has interests in occupational and environmental health. PHERP funds have been used to develop this area. Further expansion would receive strong support from the medical school, the university
and the town.

8.1.13 The Centre is expanding its distance learning capabilities. Combined with short home and away courses this could enable the Centre to take its expertise to students from a wider catchment area. Participation in rural training programs is a possibility.

8.1.14 To survive and to grow longer term the Centre must search out and develop new markets. It has already started to do this. If PHERP funding was to be discontinued abruptly an excellent prospect could be jeopardised. A phased redirection of the funding over three years from 1993 could be the answer.

8.1.15 The Newcastle Faculty of Medicine is internationally recognised for its innovation in undergraduate and postgraduate education. Its research and teaching are well integrated within the health services in the Hunter Region. Newcastle could well be leading the way nationwide towards the more public health focused, better integrated, and more efficient health service desired in the future. With this in mind care is needed to maintain and to build upon the excellent but small and vulnerable foundation laid in Newcastle.

8.1.16 NSW has public health resources in both breadth and depth. Until recently the resources have not been systematically networked. This is now beginning to happen around a core made up of the Department of Health, public health units in the area health boards and elements of the University of Sydney. The other universities in the State would like to be more significant partners in the evolving network. Important to the success of the network will be high quality information systems, good communications and well designed processes to define priority outcomes and the outputs required to achieve those outcomes, state-wide. Individual components of the network could be contracted to deliver these outputs to defined specifications and their performance in doing so assessed. For the network to be effective and efficient it is essential that disagreements be negotiated to find a consensus, and opportunities, problems and resources shared.

8.1.17 It is not possible to know how the public health infrastructure in NSW will develop. What is clear is that at some point the PHERP funding should be integrated with the local arrangements. A convincing case cannot be argued for continuation of the protected funding. What is needed in NSW, as elsewhere, is a shared vision and plan for the public health which includes a plan and resources for workforce development.
8.2 Victoria

8.2.1 Monash University has PHERP support for its MPH program. Run by the Department of Preventive and Social Medicine the program has strength in epidemiology, toxicology and occupational health.

8.2.2 Despite the capable and enthusiastic efforts of the course supervisor the program is fragmented and weak in some components. Victoria clearly has the resources to mount a first class MPH. There are resources which could be used at the University of Melbourne (epidemiology, biostatistics, drug and alcohol and health services evaluation) and at La Trobe (social sciences, education, nursing, primary health care, and community health development). The National Centre for Health Program Evaluation (NCHPE) and the Victorian Health Promotion Foundation (VicHealth) could contribute along with the Victorian Department of Health.

8.2.3 In the area of health development Victoria has extensive experience which is possibly unique in Australia.14 Involvement of local government in Victoria in health development is longstanding and can be traced back to the Whitlam Government's Community Health Program in 1973. The women's health movement, the Aboriginal health movement and more recently the Commonwealth Better Health Program have all had influence. In 1988 the Victorian Government passed legislation which requires local government to take an active planning and co-ordinating role in the public health area. In keeping with this requirement the Municipal Association of Victoria (MAV) takes a leading part in encouraging health planning and all aspects of health development.15

8.2.4 Another potential participant in the public health network is VicHealth. Established in November 1987 as a bipartisan initiative of the Victorian Parliament the Foundation seeks to promote health and prevent disease in the community. Funded by a levy on the wholesale sales of tobacco products the Foundation distributes about $30m a year. Funding goes for sponsorships in sports and the arts and for health research, development and related education.16 VicHealth has the interest and the funding capacity to play an active, even a leading role, in public health workforce development in Victoria. Some States have already followed the Victorian lead and set up their own health promotion foundations funded by levies on the sale of tobacco products and others may follow. At least
potentially these foundations could play important roles in state public health networks and in facilitating associated workforce development. For this reason, if for no other, the developments in Victoria are of national interest.

8.2.5 There is in Victoria general acceptance of the need for a state-wide and concerted effort to reshape, network, and energise public health activities. The tradition and the resources are there but structure and process are lacking. What is needed is a network similar to that developing in NSW. The general strategy could be the same but the implementation could well be different. For a start to be made leadership must come from the Department of Health. A start may have already been made as a result of a recent review of infectious disease treatment services in the State. This could be the beginnings of a new public health infrastructure.

8.2.6 There has been talk of a consortium of key interests to work with the Department of Health to broaden and strengthen public health training and workforce development. The universities, VicHealth and the MAV could be lead players. The task of defining the requirements, setting objectives, identifying and mobilising resources and negotiating contracts with the various interests would not be easy. But, given the commitment, Victoria has the capacity to solve the problem without Commonwealth intervention. The PHERP resources vested at Monash are modest and should at an appropriate time be phased out or transferred to the State network.

8.3 South Australia

8.3.1 The University of Adelaide Faculty of Medicine Department of Community Medicine runs a PHERP supported MPH program. The postgraduate teaching activities are well integrated with an undergraduate public health program which features excellent multidisciplinary teaching of students from a wide range of disciplines. The program specialises in health policy and occupational health but is also strong in epidemiology.

8.3.2 The IPR raised questions about the management of what is now a very large program of activities in the Department of Community Medicine. As well as undergraduate medical and multidisciplinary teaching the portfolio includes general practice teaching and research together with postgraduate occupational and environmental health and general public health programs. The problems are further compounded by serious space limitations.
8.3.3 Until recently the South Australian Health Commission (SAHC) has provided funding support for the multidisciplinary teaching program. With Worksafe the Commission has also supported the occupational health program. All of this funding is now to be phased out over the next three to five years. The Department is seeking funding support from the Commonwealth to enable it to subsume the occupational and environmental health teaching into its general public health program.

8.3.4 Flinders University has a postgraduate diploma and a masters program in primary health care within the Faculty of Medicine. Over subscribed, this broadly based and popular modular program – much of which can be taken by distance learning – has wide appeal to health workers and health development people both within and inter-state. The program does not have and would like PHERP funding.

8.3.5 South Australia has a long tradition of leadership in public health and community health development. This is not so evident at present. Leadership changes, organisational restructuring and budget cuts have created an environment of great uncertainty in the health services. There is little to suggest that a new public health infrastructure may be emerging. Communications between the potential participants in such an enterprise seem poor. If they exist the policies for public health workforce development are not widely known or understood. It seems that the SAHC may be reducing rather than increasing its investment in public health education. In the light of these findings it is recommended that PHERP funding after 1993 should be conditional upon an across-the-board review of public health education and training in the State.

8.4 WESTERN AUSTRALIA

8.4.1 The University of Western Australia (UWA) Division of Medicine and Dentistry, Department of Public Health has a PHERP funded MPH program. This was built on the strong foundation provided by the NH&MRC funded Cancer Epidemiology Unit and its long established links with the Western Australia Department of Health.

8.4.2 Academically the program has done well. Research wise it is very productive, perhaps the most productive unit within the Division of Medicine and Dentistry. The teaching has been well received despite serious space limitations.

8.4.3 Support from the UWA and its Division of Medicine and Dentistry has been slow in coming but the Public Health Department now has independent standing within the Division and the establishment of a full chair has been
given highest priority by the University. An acceptable solution has been found to the space problem. Thus prospects for the new department and its MPH program are bright.

8.4.4 Curtin University has provided almost all of the training in WA for nurses and allied health workers since the late 1960s. Curtin was disappointed but did not oppose establishment of the PHERP funded MPH at UWA. Curtin's strengths are in nutrition, occupational, and environmental health. It is widely involved internationally in health related activities and runs its own MPH program.

8.4.5 Plans are being made to strengthen the UWA MPH in the management area, in health economics and in the social sciences as applied to public health. Such strengthening could come from within UWA, from Curtin or from other universities in the State. Arising out of these discussions has come the possibility of creating a consortium of public health interests which could evolve into a Western Australian Institute of Public Health. This is being actively explored.

8.4.6 The UWA Department of General Practice has a postgraduate diploma and a masters in primary health care. Externally funded at the outset the program has a preponderance of overseas students. There is the potential for closer integration between this and the MPH program to the advantage of both.

8.4.7 Western Australia has a strong public health tradition and the resources to provide excellent opportunities for education and research in public health. Control of the MPH should remain with the UWA but within the context of a collaborating network of agencies concerned with all aspects of the public health.

8.4.8 After a somewhat hesitant start the MPH at WA is thriving and the prospects are good. The health services in WA are in the midst of restructuring. The changes could well see greater emphasis given to area health management. The WA Department of Health has a strong public health tradition. The proposals to establish a WA Institute of Public Health is evidence that the need to strengthen the public health infrastructure is recognised. Also of significance is the recent establishment of the WA Health Promotion Foundation. Already there are signs that the Foundation will soon make its public health presence felt.

8.4.9 It now seems that WA will meet its PHERP obligations. The IPR recommends that funding be at least maintained if not increased. It seems likely that a strong public health network could soon develop in WA. Included should be a plan and resources for public health
workforce development. If and when this occurs the
PHERP funding should be transferred to the network.
Until then the present arrangements should continue.

8.5 Australian Capital Territory

8.5.1 The Australian National University Centre for
Epidemiology and Population Health (NCEPH) is the
principal manifestation of the PHERP in Canberra. The
Centre's prime concern is research with some teaching
in the Master in Applied Epidemiology.

8.5.2 Fully operational for less than three years the Centre
has initiated a wide range of research and development
activity. Already it has demonstrated an ability to
convene and to inform debates on key issues and thus
has achieved a position of national leadership in
health service development. It will require a more
focused effort and will take longer to establish a
reputation for excellence in research.

8.5.3 The challenge for NCEPH is to achieve the right blend
of activities in its program. On the one hand it is
important that the Centre address policy relevant
issues. At the same time it must pursue excellence in
research. To achieve this balance it is essential that
the Centre be guided and supported by the DHHCS,
particularly on relevant policy issues, and by the
NH&MRC on excellence in research. In this context the
NCEPH Advisory Committee has an important role to play.

8.5.4 Working with the Director the Advisory Committee should
each year draw up strategic and business plans which
define the program of work for the year and indicate
how performance will be measured. The planning process
should be closely specified and followed. A full
operating budget should be prepared and signed off by
the Advisory Committee. Only in this way will
unreasonable expectations and misunderstandings be
avoided and the Director given the clear mandate he
needs to get on with the work and provide a framework
within which he can reasonably be held accountable.

8.5.5 On the policy side the DHHCS should agree a set of
policy objectives with the Centre. These may be health
system development rather than research objectives. On
the research side the NH&MRC should work with the
Director to put in place a review process. The end
result of the review would be an independent assessment
of the scientific quality of the Centre's research.

8.5.6 It is important that details of the planning process
and related agreements be widely known and understood.
Only in this way will the Centre be able to establish
itself at what is a difficult interface between research and policy development. The process proposed should help the Centre to attract and retain the skilled staff it requires and to advocate and account for resources used.

8.5.7 It is too early to make any firm judgements about the performance of NCEPH. It is however important that a planning process along the lines suggested be put in place immediately. An independent and full review should be carried out after the Centre has been fully operational for five years — that is 1994/95. Pending that review the DHHCS should continue to fund the Centre.

If for any reason this is not either appropriate or possible managerial oversight and funding could be provided by way of the NH&MRC.

8.6 Queensland

8.6.1 The Tropical Health Program (THP), jointly operated by the University of Queensland (UQ) and the Queensland Institute of Medical Research (QIMR), is the largest of two PHERP supported initiatives in Queensland. The Brisbane based program has an impressive record of research and training achievements and is held in high repute internationally. The IPR records that the program has met and in some cases surpassed the objectives it was contracted to deliver and recommends that its funding be increased.

8.6.2 The problem, if there is a problem, is that the THP is mainly focused off shore. It contributes relatively little to the advancement of public health in Queensland. Program staff spend up to 30 percent of their time overseas supporting students or consulting. Much attention is given to practical instruction and on site institutional strengthening. A strong case is made for expansion of the Program. The question now is what arrangements should be made to provide the THP with ongoing administrative oversight and funding.

8.6.3 The on site review made a series of recommendations aimed at having the Program recognised as a national unit and funded on a five year program basis subject to satisfactory external review. If a change was to be made to the existing administrative and funding arrangements the on site review recommends the NH&MRC as the appropriate body.

8.6.4 Given the off shore focus it is important that the activities of the Program be seen in the wider context of Australia's foreign policy objectives. A case could be argued for there to be a major foreign affairs funding contribution presumably made by way of the AIDAB. At present the training of overseas students is not provided on a full cost recovery basis. The course
fees paid by the students are insufficient to cover costs which are of the order of $40,000 per student per year. If the THP was DEET funded it would probably lose about two thirds of its funding and not be viable.

8.6.5 The external focus of the THP is a cause for both pride and concern to Queensland Health and the University of Queensland. Queensland Health would like to see the resources of the Program made more available to strengthen public health education and research activities in the State. The Dean would like to see the Program more directly involved in the public health teaching in the medical school. In Queensland the Program is seen as a national rather than a State resource. This raises further important questions about the ongoing administration and funding of the Program.

8.6.6 The solution could be similar to that suggested for the administrative oversight and continued funding of NCEPH. An Advisory/Management Committee representative of the key interests - Queensland Health, UQ, QIMR, DHHCS, AIDAB and the NH&MRC - could be established to work with the Director to produce annual strategic and business plans and an operating budget. Once approved and signed off by the interested parties this would give stability to the Program and provide the required basis for accountability. The NH&MRC would be responsible for independently reviewing and reporting on the scientific quality of the research.

8.6.7 Regardless of what happens to the THP, Queensland requires a plan and resources to meet the full range of public health workforce requirements. A consortium of the Queensland universities has been set up to run a MPH program. The participants are the University of Queensland, Griffith University and the Queensland University of Technology. A co-ordinator with a small staff runs the program. No PHERF funds are involved. In its second year the course has had some difficulties and its future, as a consortium, may be in some doubt. The Queensland experience to date suggests that one university should be charged with the responsibility of running such a program. A director should be appointed and given full responsibility to manage the enterprise. All inputs should be contracted and tailored to fit a properly specified course design. In this context the Queensland experience is of interest nationwide.

8.6.8 Queensland Health has the central role to play in public health in the State. The Department is presently passing through a period of major organisational change. A regional structure has been established which would lend itself well to area health management. There are plans to create a centrally co-ordinated network of public health units somewhat similar to those in NSW
but shaped to meet the unique requirements of the State. Lack of a suitably qualified and experienced public health workforce is a major limitation.

8.6.9 The most valuable public health education and research resource in the State is the THP. The knowledge and experience of the staff, gained mainly overseas, is directly relevant to the practice of public health in Queensland. The THP should certainly be centrally involved in the systematic development of a new public health infrastructure in Queensland. There are signs that moves in this direction may now be underway.

8.6.10 The Anton Breinl Centre for Tropical Health and Medicine at the James Cook University of North Queensland is the second PHERP supported activity in Queensland. The on-site review records that from the outset the Centre has had staffing problems and as a result has been unable to achieve its contracted objectives. Despite improved prospects recently the general tenor of the IPR recommendations suggests that the administration of the Centre and its program of work should be much more closely integrated with Queensland Health and the THP.

8.6.11 To succeed the Centre needs to be part of a larger network involving the University of Queensland Faculty of Medicine, the THP, Queensland Health, and the James Cook University. Queensland Health plans to establish a public health unit and the University of Queensland a clinical school of medicine at Townsville. The Centre should certainly be part of the Queensland public health network but there may be advantage in including it under the administrative and funding umbrella suggested to cover the THP. A charter linking the Anton Breinl Centre with the THP was proposed in the IPR and should be explored further. Ongoing PHERP funding after 1993 should be dependent upon such a restructuring.

8.6.12 Aboriginal and Islander health is a high priority issue in Queensland. The IPR Committee reporting on the THP recommended support for the establishment of an Aboriginal Health Unit as part of, or in association with, the THP. More general support for Aboriginal and Islander health initiatives was recommended by the Anton Breinl Centre Committee.

8.6.13 As part of the evolving infrastructure in Queensland there may be a case for establishing an Aboriginal Health Unit in association with the THP as recommended by the IPR. In part this will depend upon what role it is decided the THP and the Anton Breinl Centre should play in the advancement of the public health generally in Queensland. What is important is that the nature and location of such a unit be agreed with the indigenous people and that it be well integrated into the public
health scene in the State. It should not be, or be seen to be, something imposed from outside.

9. Workforce development

9.1 The health sector reforms of recent years are likely to be ongoing. Many organisational structures and processes which worked well in the past will not be wanted in the new environment. New knowledge and skills will be required to realign area health and public health management processes to take account of changing social and economic conditions, changing attitudes and expectations, and changing technology. In particular information technology has the potential to require a total restructuring of the way the health business is done. In short, the present organisational turbulence will continue.

9.2 Experience shows that these changes are not likely to be made in a predictable or orderly fashion. At least at the outset change is likely to come in fits and starts which provide exciting opportunities for some and disappointment and disillusionment for others. As information systems and strategic planning capability improve the way ahead for organisational development may become clearer.

9.3 In these turbulent times workforce requirements are difficult to specify in anything other than general terms. Much of the workforce planning activity promoted in the 1970s and early 1980s has little credibility today. The orderly cycle of information collection and analysis, model building, policy development, implementation, monitoring, and review has been overtaken by the pace of the changes. Human resource management now must be a less mechanical, more flexible, and more dynamic process than it was even only a few years ago.

9.4 Workforce development in the new environment requires well informed and ongoing dialogue between the principal stake holders. The process must be information-rich, timely, dynamic, and flexible rather than ill informed, episodic, mechanical, and stiff. New directions must be sensed and responded to quickly. Those involved must include the employers, the educators, the professional bodies and other employee organisations, and the research and development community - specifically the Commonwealth, the State departments of health, the Universities, the NH&MRC, and organisations like the Faculty of Public Health Medicine and the PHAA.

9.5 A workforce dialogue in these terms is not as well developed in the public health area as it could and

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should be. In some places the required networks are being built, information is flowing and co-operation, collaboration, and competition are occurring. In other places the traditional structures are breaking down before the new infrastructures have been developed leaving an hiatus in which there is confusion and uncertainty.

9.6 Rapid expansion in the number and variety of education and training opportunities available has raised questions about the appropriateness and the standards of programs. For instance, are there now too many MPH programs in Australia? Should courses be more precisely tailored to the needs of different sections of the workforce? Are doctoral programs being offered without adequate academic support and supervision? Answers are required to these and many other questions.

9.7 Workforce development is not a prominent feature of the developing public health networks in most States. Hopefully, in time, this will change. Given the size and complexity of the task and the need for workforce development to be closely aligned with changing patterns of public health activity the process should be firmly grounded at State level. There is however, particularly in the early stages, a good case to be made for a national focal point to facilitate information gathering, enable the sharing of experience, encourage debate and research on the key issues, and to generally inspire and energise the workforce planning and development process nationally. Such a centre could provide information, guidance, and planning support for the States which in turn share their experience and their ideas and aspirations with the centre.

9.8 There could be a role here for an organisation like the Public Health Association of Australia (PHAA). Potentially at least the PHAA has in its membership people interested and involved at all points in the public health spectrum. Researchers, teachers, employers, public health practitioners, clinicians, consumer advocates - all are involved in the PHAA. Of the various possibilities the PHAA is probably best placed to play the neutral role of an honest broker.

9.9 The PHAA is already deeply involved in workforce development. It has been commissioned by the DHHCS to review postgraduate public health training and by the NH&MRC/PHRDC to review the public health workforce.

9.10 In its submission the PHAA highlighted what it saw as the key issues for public health workforce development.
There are:

- General training vs specialisation
- Need for short courses
- Advanced training
- Distance learning
- Cooperation and transferability
- Credentialing of non-medical public health professionals
- Deficiencies in relevant disciplines
- Lack of health policy input
- Dissemination of information about courses
- Lack of brief pre-entry bridging courses.

In general terms, the national review confirms this list of key issues.

9.11 Given support for the idea of a national centre, the suggestion is that the DHGCs and the PHAA together draw up terms of reference and negotiate a contract for the creation of a National Centre for Public Health Workforce Development (NCPHWD). The NH&MRC/PHC/FHRDC and State representatives could also be involved. The contract, which should run for at least three and possibly five years, should set out clear goals and targets, identify performance criteria, and specify reporting, monitoring, and review procedures.

9.12 The objective would be to create a national centre to promote and coordinate development of the public health workforce. The contract could provide for the following.

- A regular nationwide survey of the public health workforce.
- A regular nationwide survey of undergraduate and postgraduate education.
- Creation of a nationwide workforce data base easily accessible to all.
- Creation of a directory and clearing house for information on all aspects of public health education.
- A study of the division of labour in the public health. What range of competencies are required from the specialist end to the generalist end of the workforce spectrum? In terms of numbers:
(requirements) what does the spectrum look like? What education (qualifications) are required at different points in the spectrum? This would need to be a multi-dimensional project staged over some years.

- Review of the provisions made for, and the performance and experiences of, overseas students - including follow up.

- Explore possibilities for the accreditation of courses and the credentialing of training.

- Run workshops or seminars on topics such as:
  - course content
  - cross crediting of units
  - "expert" units
  - distance learning
  - short courses
  - pre-entry bridging courses

9.13 It is too early to estimate what funding such a centre may require. To be effective it would be significant. The contract should probably provide for a suitably representative board of management with say five to seven members. Of paramount importance would be the appointment of an appropriately qualified, experienced, and credible director with perhaps two support staff. A small office in association with the PHAA secretariat may be a possibility. Most of the work could be done on contract. A total resource of the order of $500,000 per year may be needed.

10 Public Health Research and Development

10.1 The main thrust of the PHERP is on education. Research is the principal activity at NCEPH and an important consideration at the Queensland THP. Specific issues concerning the ongoing administration and funding of these programs have already been dealt with. More general issues concerned with the organisation and funding of public health research are addressed here.

10.2 During the review many questions were raised about the organisation and funding of public health research. Funding is at least potentially available from a number of sources. These include:

- Commonwealth funding from DEET and DHHCs.

- DHHCs funding includes Research and Development
Grants, special funding for research on AIDS, drug abuse, primary care, and rural health as well as the PHERP. A number of the Department's programs also have funds available for contract research.

- NH&MRC funding is part of the Council's Health and Medical Research Program and is administered mainly through the PHRDC.

- Most State governments provide some funds for health research but the pattern of investment is highly variable.

- Other agencies such as the health promotion foundations, heart foundations, and anti-cancer organisations are becoming increasingly important funders of research particularly at State level.

10.3 What is required is greater clarity and transparency as to who funds what and how. What organisation funds what type of research? What are the terms and conditions of the funding? How can applications be made? How are they assessed and how is performance measured?

10.4 The Minister of HMHC has initiated moves aimed at giving the NH&MRC greater statutory independence. At the same time he had expressed a wish to see the Council go faster with developing a program "which is both excellent and relevant to Australia's emerging needs." He has also requested the Department to review and report on the administration and funding of all of its research activities.

10.5 The DHHCS is primarily concerned with policy relevant applied research. Research priorities are advertised and tenders invited for specific projects. For the Department the problem often is to find someone who is willing and able to do the work in the required time and to the required specifications. Assessing the quality of the work is sometimes difficult. For the NH&MRC the problem is more one of encouraging and promoting research in identified priority areas. As was pointed out recently Aboriginal research has been a priority for as long as anybody can remember.

10.6 Problems and misunderstandings may arise where policy relevance and high scientific standards and credibility are required at the same time. Of course this is possible but it is often difficult to achieve in a tight time frame. These issues were addressed in relation to the ongoing administrative and funding arrangements for NCEPH. The Queensland TMR presented the added problem of trying to combine in a single entity education and research activity mainly focused
Multiple funding sources and a variety of administrative arrangements are not necessarily a problem as long as priority research can be advanced and scientific standards maintained. What must be clear and widely known is who funds what and how, and how the various agencies work in together. In the first instance these are issues for the DHHC and the PHRDC.
specific recommendations given the breadth and complexity of the issues and the relative brevity of the review. This approach has been adopted throughout the report.

12.2 The review shows that the PHERP has successfully met its general objectives. It may now be time to remodel the program in the light of changes in the practice of the public health already occurring or foreshadowed by the Government’s evolving health strategy.

12.3 It is generally accepted, reluctantly by some, that the PHERP should not continue much longer in its present form. Most agree that the resources now vested in the program should continue to be used to target high priority developments in public health education and research. This objective would not be met if the funds were simply main streamed into single line block allocations made by the DEET or the DHCS or added to the general funds available to the NH&MRC. A more targeted approach is required.

12.4 It may be time to rearrange at least some of the funding. At least until the time of its first major review it has been recommended that NCEPH funding remain with the PHERP. Pending some funding rearrangements involving AIDAB and possibly Queensland Health and the NH&MRC, the suggestion is that the funding of Queensland’s THP and the Anton Breinl Centre stay with the PHERP.

12.5 It has been suggested that the education funds mainly vested in MPH programs be eventually transferred to targeted workforce development use within state-wide public health networks. Along with other funds these would be used to competitively fund the high priority initiatives specified in public health workforce development plans. The first task would be to specify the objectives and targets clearly, the second to identify the resources, and the third to decide upon the most appropriate funding mechanisms.

12.6 A strong case is made to increase Commonwealth funding for public health research and development. In 1986 Kerr White recommended that $70 million per year be appropriated for a health research endowment fund. It is generally agreed that the bulk of such funds should be available on the basis of competitive funding through the NH&MRC/PHRDC. In its use of these funds the Council must seek to strike a right balance between an open awards system based largely on assessed scientific merit, and a targeted awards system based largely on established priorities for development. The system for open awards is already well established. An effective and efficient system for setting, marketing and meeting developmental targets is beginning to emerge and should
be actively encouraged.

12.7 A targeted and expanded public health research program will require strengthening the workforce infrastructure. One way would be to expand, diversify, and promote the workforce awards program operated by the PHRDC. The ready availability of competitive but flexible funding for postgraduate students for course work and for help in meeting the costs of a dissertation could help to recruit good students to public health research. Modest investment along these lines could pay handsomely.

12.8 At the national level the NH&MRC/PHRDC has an overarching responsibility to assist in the planning and development of the research workforce. There is at present no such body to similarly oversee other aspects of public health workforce development. A proposal has been made to establish a National Centre for Public Health Workforce Development to inform and coordinate the planning nationally and to generally facilitate workforce planning and development activities in the States. It has been suggested that the task of operating the Centre be offered as a contract to the PHAA and funded by the DHHCS. The Centre could be the best way to tease out and debate the issues, to establish priorities, to set objectives and targets and to competitively fund education and training for the public health.
REFERENCES


5. Ibid p5.


11. Ibid p. xiii.


APPENDIX A

PUBLIC HEALTH EDUCATION AND RESEARCH PROGRAM FUNDING

<table>
<thead>
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<th>Institution</th>
<th>Base Allocation $</th>
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<td>Australian National University</td>
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<td>Queensland Institute of Medical Research</td>
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<td>James Cook University</td>
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<td>University of Adelaide</td>
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</tr>
<tr>
<td>Monash University</td>
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</tr>
<tr>
<td>University of Western Australia</td>
<td>200,000</td>
<td>243,922</td>
</tr>
</tbody>
</table>
APPENDIX B

SUBMISSIONS RECEIVED

Aliprandi S
Anderson B, Rawson G
Barclay L
Batten H, Walker R
Beck E
Binns C
Bouvier R
Brennan P
Burns R
Calvert G
Conley M, Hall J
Crofts N et al
Cumming A
Cunningham F
Douglas R
Duckett S
Esterman A, Dobson A
Ewan C
Finocchiaro C et al
Gale F
Gifford S
Hamilton J
Harper A
Harvey K
Heller R
Heywood P
Jamrozik K
Lawson J
Leggat P
Liveris M
Marjoribanks K
Matrice D
McInerney K
McMichael A
Morey S
Phoon W
Narrabundah
University of Western
Sydney, Macarthur
Flinders University
Lincoln School of Health
Sciences, La Trobe
Personal submission
Curtin University, WA
Personal submission
Department of Health, WA
Personal submission
University of Wollongong
Public Health Association
of Australia
Macfarlane Burnet Centre
for Medical Research
Faculty of Public Health
Medicine, WA
Personal submission
Personal submission
Department of Health,
Victoria
Health Statistics Special
Interest Group, PHAA
University of Wollongong
Department of Health,
Victoria
University of WA
Personal submission
University of Newcastle
Occupational Health
Services, WA
Lincoln School of Health
Sciences, La Trobe
University of Newcastle
University of Queensland
University of WA
University of NSW
Personal submission
Curtin University, WA
University of Adelaide
Consumers Health Forum
Royal College of Nursing
University of Adelaide
Faculty of Public Health
Medicine
Worksafe Australia

A few people made more than one submission.
Radford A, Barclay L
Riley I
Rubin G
Sansom-Fisher R
Siggins E
Speare R
Stanley P
Tonuma M
Underwood P
Wilkins P
Wilson B

Flinders University
Tropical Health Program, Queensland
Department of Health, NSW
University of Newcastle
Australasian College of Occupational Medicine
Anton Breinl Centre, James Cook University, Townsville
Queensland Health
Monash Master of Public Health Society
University of WA
Australian Medical Association
University of Queensland
APPENDIX C

INDIVIDUALS INTERVIEWED BY THE EXTERNAL REVIEWER

AUSTRALIAN CAPITAL TERRITORY

Department of Health Housing and Community Services

Adams A
Ariotti D
Bansemir A
Batman G
Boatwright R
Dean M
Evans B
Furler E
Gray P
Leslie A
Lilley A
Loy J
Mead C
Welch R
Wells R
Wingett I

Department of Education Employment and Training

Parr J

Australian Institute of Health

Donovan J
Smith L

National Centre for Epidemiology and Population Health

Douglas R

Public Health Association of Australia

Conley M

NEW SOUTH WALES

Department of Health

Morey S
Rubin G
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Arbon V
Berry G
Cumming R
Dorsch S
Irwig L
Kerr C
Lancaster P
Leeder S
Mulhall B
Nutbeam D
Taylor R
Young J

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Lawson J
Rotem A

University of Western Sydney

Rawson G

University of Newcastle

Carter M
Christie D
Dobson A
Donald K
Gillespie W
Hamilton J
Heller R
Higginbotham N
Kemp R
Lau E
O'Connell D
Pekarsky B
Sansom-Fisher R
Sprogis A
Smith B
Stephenson J

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Horvath D

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Hall J

Healthy Cities Australia

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Department of Health
Duckett S

Monash University
Abramson M
Gifford S
Goddard D
Lowther D
McNeil J
Oliver G

Lincoln School of Health Sciences
Evans O
Harvey K
Walker R

Victorian Health Promotion Foundation
Galbally R

National Centre for Health Program Evaluation
Selby-Smith C

Monash Master of Public Health Society
Tonuma M

SOUTH AUSTRALIA

Health Commission
Blakey D
Kirke K
Maynard E

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Clark S
Frewin D
Gunn R
Hicks N
Hiller J
Marley J
Moorhead R
Murrell T
Pisaniello D
Raftery J
Reynolds C
Woodward A
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   Baum F
   Barclay L
   Radford A

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   Kearney B

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   Brennan P
   Holman D
   Lugg R
   Penman A

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   English D
   Gale F
   German A
   Hobbs M
   Jamrozik K
   Lambert L
   Stratton J
   Underwood P
   Wood R

Curtin University

   Liveris M
   Howat P
   Pickett R
   Spickett J

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   Southgate P

Princess Margaret Hospital

   Daube M

Research Institute for Child Health

   Stanley F
QUEENSLAND

Minister of Health

McElligott K MLA

Department of Health

Lange D
Murphy G
Ring I

University of Queensland

Doherty R
Geffen L
Harvey P
Livingstone F
Manderson L
Riley I
Wilson B

Queensland University of Technology

Reid J

Griffith University

Simpson R

Queensland Institute of Medical Research

McManus D
Powell L
APPENDIX D

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Department of Finance

Pettingell J
Sheedy C

National Health and Medical Research Council

Donald K
Holman D

Public Health Association of Australia

Conley M

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Salmond G

Support

Fitzpatrick R
Mittermair S
Thompson L
APPENDIX E

BASE DOCUMENTS

Independent Review of Research and Education Requirements for Public Health and Tropical Health in Australia. Report to The Hon Neal Blewett MP, Minister of Health by Professor Kerr White MD, 1986.


The University of Newcastle, Individual Program Review of the Kerr White Program, April 1991.


The University of Adelaide. Review of the Department of Community Medicine, September 1991.


