

Public health and health reform in Australia

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A question that has been troubling me since the Australia 2020 Summit and the government's rhetoric on preventive health has been: where does public health fit into national health reform? Despite huge national investment in attempting to avert the crisis in human resources for health, including the establishment of Health Workforce Australia, the need for a public health workforce has been ignored. The National Health and Medical Research Council (NHMRC) commissioned the Nutbeam report in 2008¹ to improve the effectiveness of research funding for public health, despite its recommendations, no concrete changes have resulted. In fact, since that report, the excellent NHMRC Capacity Building Grants in Population Health² have been ceased and rolled up into a new scheme, the Centres of Research Excellence scheme, which appears to me to provide a smaller total pool of funding for which public health researchers now have to compete with clinical and other researchers.

There has been recognition by the Australian Government of the overwhelming proportion of health expenditure on acute health services compared with prevention, and this imbalance in health spending is what has driven the national health reform agenda. Having read the various documents on national health reform, such as *Building a 21st century primary health care system: Australia's first national primary health care strategy*,³ the government's response to the National Preventative Health Taskforce,⁴ and *A national health and hospitals network for Australia's future*,⁵ I am left wondering why public health is such a notable omission.

The focus on primary health care and individual disease prevention is important and long overdue, and is a welcome recognition of the importance of this area. However, I get the sense that the powers that be believe that "public health" and "primary care" are one and the same thing. I have come across this confusion among other stakeholders who work in areas removed from either primary health care or public health. Perhaps it is as simple as politicians and the public thinking that "public health" means provision of acute health care in public hospitals and through Medicare, but I believe there is confusion even among relatively well informed stakeholders. Therefore, it may be worth clearly stating what the differences are between primary health care and public health.

In my understanding, the main focus of primary health care is the care of individuals and communities outside of the hospital system, for example, in general practice. This includes an emphasis on preventive strategies for patients in primary health care. A definition based on the Alma-Ata declaration of 1978 and endorsed by the Australian Health Ministers' Advisory Council in 1988 defines primary health care as follows:

Primary health care seeks to extend the first level of the health system from sick care to the development of health. It seeks to protect and promote the health of defined communities and to address individual problems and populates health at an early stage. Primary health care services involve continuity of care, health promotion and education, integration of prevention with sick care, a concern for population as well as individual health, community involvement and the use of appropriate technology.⁶

On page 12 of *Building a 21st century primary health care system*³ is a diagram that summarises a vision for a reformed health care

ABSTRACT

- The national health reform agenda appears to have omitted public health.
- In this article, I outline how public health is different from primary care, and why a holistic approach to reform should include public health.
- The current reform agenda is very much focused on addressing the problems in acute care and the hospital system, with the focus on primary care being a means to this end.
- Until the health system is addressed as a whole, with all its essential components integrated and interlinked, truly successful reform of the health system, with genuine long-term vision and sustainability, will not be possible.

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system, titled "Towards a 21st century primary health care system — a snapshot". Prevention activity is mentioned as follows:

Increasing the focus on prevention. Strengthened, integrated and more systematic approaches to preventive care with regular risk assessments are supported by data and best use of workforce. People know how to manage their own health and self-care.

Prevention activity is well integrated, coordinated and available with regular, risk assessment, support and follow up.

This is explicitly an approach to prevention on an individual level, which is crucially important for better health care, and an excellent step. However, nowhere in any of the documents I have read is public health included as part of the vision for a healthier country. The 1996 Australian Health Ministers' memorandum of understanding to establish a National Public Health Partnership for Australia defines public health as "the organised response by society to protect and promote health, and to prevent illness, injury and disability".⁷ Public health comprises three essential components:

- Health protection — this includes the use of legislation and regulation for better population health, such as the banning of smoking in workplaces and restaurants, seatbelt legislation to reduce road trauma, and the legislation around labelling of consumer food products.
- Health promotion — according to the World Health Organization Ottawa Charter of 1986, this is "the process of enabling people to increase control over, and to improve, their health".⁸ The concept of health promotion goes beyond the health sector and includes lifestyle, societal and personal resources.
- Disease prevention and early detection — this includes surveillance, screening, and prevention programs. The massive public health impact of the Pap smear is a classic example of the impact of public health. Before screening with Pap testing, cervical cancer was a leading cause of death from cancer among Australian women.⁹ It is now a rare cause of death from cancer in Australia, but remains the third leading cause of cancer in women in many

developing countries that do not have such screening.¹⁰ Our vaccination programs are another example of disease prevention; they have led to infectious diseases becoming rare when they were once the leading cause of infant mortality in Australia.¹¹

Granted, there have been some key health protection actions introduced by the government, such as the initiative on packaging of cigarettes. In addition, health promotion is a key feature of the proposed new National Prevention Agency,⁴ but the focus of this agency is very much on three selected areas — alcohol, tobacco and obesity — as these contribute much of the burden on the acute health services. However, public health as a recognised and integrated component is glaringly absent in the new vision for a reformed health care system. The three components of public health described above require specialised skills, training and a workforce, and the third component is underpinned by special legislation such as the jurisdictional public health acts, which grant states and territories special powers in circumstances where the public good overrides individual rights. For example, responses to public health emergencies such as pandemic influenza, a bioterrorist attack, or natural disasters require investment in public health capacity, training and infrastructure. Although these investments exist at state and territory level, and to some extent at the federal level in the forms of the National Incident Room¹² and the Office of Health Protection,¹³ their role and how they fit within national health reform has been ignored.

This is important because there is still uncertainty surrounding proposed models for health systems governance. Current government organisations that fulfil core public health functions, such as public health units in decentralised states like New South Wales and Queensland, or health departments in more centralised models such as in Victoria, are left out of the equation completely in discussions about hospital networks. How will current public health entities fit within hospital and primary care networks? This is a key aspect of the debate which has been ignored.

Further, the huge investment in addressing the workforce crisis is entirely focused on acute and primary health care workforce. There is no recognition of the fact that a skilled public health workforce is required for basic business continuity in a healthy society. Countries like the United Kingdom and the United States have this explicit recognition of public health through their commitment to national agencies, whereas in Australia this recognition is absent. The Health Protection Agency in the UK and Centers for Disease Control and Prevention (CDC) in the US have explicit responsibility for core public health functions as outlined above, with a focus that is far broader than that of the National Prevention Agency proposed for Australia. Within the Australian Government Department of Health and Ageing, public health functions are spread across several different divisions that do not necessarily have close working links, and the career promotion system within the department results in frequent movement of personnel between divisions, with a resultant loss of corporate knowledge. This is in contrast to jurisdictional health departments, which typically have longstanding corporate memory, expertise and critical mass in public health.

The US, the UK and Australia are part of the global network of countries using the Field Epidemiology Training Program (FETP), which is a specialised, integrated, international workforce program that arose from the groundbreaking Epidemic Intelligence Service (EIS) training program of the US CDC.¹⁴ The US EIS began in 1951 in response to the Korean War and the threat of biological

warfare, and developed into a renowned and exceptional training program which led to the establishment of the global network of FETPs in 1980.¹⁴ In Australia, we have had the Master of Applied Epidemiology (MAE) at the Australian National University since 1991, which is part of the global network of FETPs. This masters program has made a critical contribution to building a skilled public health workforce in Australia, and has contributed to international and regional disease control efforts, yet the Australian Government, in its wisdom, has relinquished the MAE program by cutting its funding. Historically, the MAE program was funded separately from the Public Health Education and Research Program (PHERP), which provided funding for public health training, predominantly Master of Public Health programs, across Australia for over a decade.¹⁵ PHERP funding ceased mid 2010, thereby cutting investment in public health training further, but, by some accident, the MAE was a casualty of the axing of PHERP funding. So now, Australia may be left with only two state-based initiatives, the NSW and Victorian Public Health Officer Training Programs, as the last bastion of field-based public health training in the country. In public health, we know there is a critical shortage of epidemiologists and biostatisticians to fill the need for our most basic functions, yet this is another glaring omission in the national health workforce agenda.

Organisations like the Public Health Association Australia and the Australasian Faculty of Public Health Medicine, as well as state and territory governments, have been key in trying to highlight these gaps in the national health reform juggernaut, but public health is still the invisible man in a reform agenda that is very much focused on addressing the problems in acute care and the hospital system. Perhaps the success of public health in Australia over more than a century explains why it is now invisible. Until the health system in Australia is addressed as a whole, with all its essential components integrated and interlinked, truly successful reform, with genuine long-term vision and sustainability, will not be possible.

Competing interests

I am a graduate of the Australian National University's Master of Applied Epidemiology program.

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