31 January 2006

Mr Stephen Lodge
Manager
Legislation Review
Public Health
Department of Human Services
GPO Box 1670 N
MELBOURNE VIC 3001

Dear Mr Lodge

Following our attendance at the December consultation forum on the draft policy paper for the Review of the Health Act, we would like to provide comments on a few aspects of the paper that are most relevant to divisions of general practice.

Public health; social model of health; reducing health inequalities

GPDV welcomes the shift in emphasis to a broader concept of public health, in particular, the recognition of the need to address inequalities in the health and wellbeing of disadvantaged communities (recommendation 4) and the definition of health and wellbeing as a positive condition, not merely the absence of disease (recommendation 6). We support the inclusion of reducing health inequalities as one of the objects of the Act, but we are unsure how the provisions of the Act are likely to achieve this.

One avenue is through the implementation of municipal health plans, but the recommendations are not very specific about what should be included in the plans, so there is no requirement that, for example, the plan must address health inequalities in the local area. Clearer specification of what the plans should include might be desirable to ensure that health inequalities are addressed across the state.

Immunisation
Recommendation 19

GPDV strongly supports the recommendation that the legislation recognise the municipal role in providing as well as coordinating immunisation. There have been a number of contributing factors to the improvement of immunisation rates in Victoria over recent years, including the increased involvement of GPs and divisions of general practice, the crucial role of local government as a major provider and collaboration between local government and general practice on immunisation (including through the Regional Data Quality Officer Program). It is important that the municipal role will be recognised and reinforced in the new Act.

Pre- and post- test information and counselling
Recommendation 185

We have some concerns about removing the requirements for pre- and post- test counselling for HIV testing. The advice we have received from health providers who are

members of GPDV's reference group on our Hepatitis C GP education project (funded by DHS) is that the reasons proposed in the first discussion paper for retaining the provisions remain sound. As the draft policy paper summarises the earlier argument:

> Given that no cure nor vaccine for HIV exists and that the best prevention strategy remains education of those whose activities place them at risk, regulatory means appear warranted to ensure that information and support are provided to assist in changing behaviour, managing the disease, reducing anxiety and avoiding discrimination. (p.100)

We note the argument that it would be more appropriate to have guidelines than a legislative requirement (p.94), but administrative guidelines to support the provisions do not send the same message to health practitioners about the importance of pre- and post-test counselling and information. Additionally, we are unsure whether recommendation 170 means that DHS would be *required* to develop the guidelines, and we are concerned that in any case there would be no obligation to implement them.

The paper goes on to say that a legislative requirement for information and informed consent could be a barrier to antenatal screening (p.100). This argument is disturbing, because its implication is that screening does not require adequate information to allow *informed* consent, as well as effective follow-up. A good screening program should include both.

It is important that either the current provisions are maintained or, failing that, that guidelines such as those quoted from the US Model Act (p.94) are developed and implemented.

Information systems/data collection
Recommendation 15

We support the recommendation related to the comprehensive information system to be established and maintained by the Secretary (recommendation 15d). We note that public health legislation in some other states and territories is more prescriptive than is suggested here, but we believe it is important to ensure that the National Health Performance Framework is used as the basis for defining the information to be collected. The draft policy paper says that the framework *could* inform the type of information that should be collected by the Secretary under the Act, but we believe it would be useful to have a clearer requirement that the dimensions of the framework be used, because the framework is clear and workable, and has been adopted by AHMAC as a national framework for assessing the health system.

Medical Officer of Health
Recommendation 23

Our original submission acknowledged that current use of the MOH is variable across the state and we suggested that the requirement to access medical expertise should be included in legislation but that the mechanism is not important. We also stated that we would strongly support clearer definition of the functions that are required to be resourced by the council.

We do not support the recommendation to abolish the MOH requirement with no alternative mechanism in place to provide councils with local medical expertise. None of the alternative mechanisms for accessing medical expertise mentioned in the draft policy

paper (p.17) – which include links with divisions of general practice – are followed up in the recommendations. The paper suggests there would be a loss of local knowledge of the community if medical expertise comes from outside the area; that it may be difficult for Departmental officers to quickly assume the role of the 70 current MoHs in the event of something like pandemic flu; and that councils would still require medical practitioners to provide advice to nurse practitioners performing immunisations, but the paper's recommendations do not address any of these issues.

Nor does it make clear the functions regarding medical advice and expertise expected of councils. We believe the current components of the MOH role should be spelt out, especially the role in immunisation, the role in infection control and the role in response to medical emergency. The councils should be required to specify through the municipal health plans how they would access medical advice. If the council wished to access medical expertise by continuing to appoint an MOH, then they could do so, but it is likely many would find it more useful to access expertise through their local divisions of general practice, where the division could nominate a different person for the type of advice, depending on the particular issue raised. Establishing the relationship with an organisation (and the members of it) rather than an individual could lead to more consistent quality of the medical advice provided to councils. We note that some of the councils' own submissions suggested that DHS should consider linking councils to local divisions of general practice, to access the necessary medical expertise.

We also note one of the submissions DHS received in its consultation round following the release of the discussion paper in 2005 on the MOH role, which provides some detail on the scope and potential of the role, where it is performed well. We would urge you to reconsider that submission (excerpt attached) before implementing the recommendation to discard the MOH requirement.

Yours sincerely

Bill Newton
CEO

Excerpt from submission re Review of the Health Act 1958 – Role of MOH

In 1987, a Working Party established by the Victorian Health Department consisting of Departmental Officers and experienced Public Health Officers from outside of the Department, published their review of the MOH Code of Duties. The Working Party recommended that the Medical Officer of Health should continue to be responsible for immunisation, but should re-establish interests in environmental hazards, and be utilised by council as a valuable resource for advice on local epidemiology, health education and the health of minority and disadvantaged groups.

The MOH fulfils many roles for local government, which go beyond the provision of "medical public health expertise". The MOH role is one of advising, liaising, educating, monitoring, and reporting; these functions cannot be performed in a comprehensive and integrative way if the MOH is confined to being an intermittent source of information rather than an integral member of the Council health team.

With the expansion of public health beyond drains, sewers and vaccinations into the social model of health, the MOH is a crucial link between different departments within council, and between council and government and community agencies.

Some of the tasks that the MOH is called upon to undertake require specialised public health knowledge. Most MOHs have a substantial background in local public health issues, and invest significant time and effort in improving their public health knowledge, through the DHS conference, immunisation conferences and self-directed learning. It is difficult to envisage that this level of expertise would be maintained by a local doctor who was consulted in an ad hoc fashion by local government staff.

Annual conferences provided to MOHs by DHS not only enhance the public health knowledge and skills of MOHs, they provide an avenue for MOHs to meet with DHS personnel and become familiar with their individual roles and responsibilities. If local governments chose not to appoint an MOH, this valuable opportunity to both enhance the skills of the council's medical adviser, and to strengthen links between DHS and local government will be lost.

Many MOHs currently adopt a monitoring and/or 'watchdog' role with regard to public health within the LGA, and to the health implications of Council policies, strategies and services. It is unlikely that the proposed (non-legislated) relationship between council and the MOH would encourage or even support this role.

Some of the crucial roles of the MOH are unlikely to be adequately served if non-legislative mechanisms are relied upon. These include:

- Regular and ongoing liaison regarding health issues, between local government and:
  - Victorian Department of Health and Community Services
  - Divisions of General Practice
  - General Practitioners
  - Other service providers
  - The community
  - Other municipalities
- Liaison with all council directorates and units, other municipalities and other organisations, to achieve an intersectoral multidisciplinary approach to public health.
- Participation in the development, implementation and review of the Municipal Health Plan

- As a member of the Council team, an ongoing and overarching role as expert advisor to Council and all City Directorates on all medical issues
- Provision of expert advice on policy, strategic, best practice and clinical issues to council and council departments including environmental health, aged care services, children's services, risk management, waste and sharps disposal
- Expert advice on the standards of practice for the conduct of public immunisation, and in some cases, administration of vaccinations
- Monitoring and analysis of infectious disease notifications within the local government area, and appropriate response
- Reporting regularly, and urgently if necessary, on public and community health matters affecting the population with recommendations for council response
- Participation in the development and in some cases coordination of Municipal Emergency Management Plans
- Spokesperson for the City on public health issues, providing media interviews, community information sessions and presentations if required

To ensure the maintenance of a high focus on public health at the municipal level, it is crucial that the legislative requirement to appoint a Medical Officer of Health is retained in the Health Act.

Dr Joanne Molloy