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Public Health Association AUSTRALIA

5 February 2024

Dear Mark,

**RE: Unleashing the Potential of our Health Workforce (Scope of Practice Review)**

Thank you for presenting at the PHAA Public Health Workforce Cluster Conversation meeting late last year. PHAA members and staff welcomed the opportunity to engage with you and your team, and to receive a briefing and learn of progress, regarding this important review. We now write to follow up on that recent conversation and provide an outline of our position on issues pertaining to the terms of reference of this review.

The Public Health Association of Australia (PHAA) is Australia's peak body on public health. We advocate for the health and well-being of all individuals in Australia. We believe that health is a human right, a vital resource for everyday life, and a key factor in sustainability. The health status of all people is impacted by the social, commercial, cultural, political, environmental, and economic determinants of health. Specific focus on these determinants is necessary to reduce the root causes of poor health and disease. These determinants underpin the strategic direction of PHAA. Our focus is not just on Australian residents and citizens but extends to our regional neighbours. We see our well-being as connected to the global community, including those people fleeing violence and poverty, and seeking refuge and asylum in Australia.

**Public Health Workforce (PHW)**

PHAA is keen to drive conversations around the need to professionalise the PHW that, with some exceptions, is currently unregulated in Australia. The PHW consists of a broad range of professions, the core of which focus on delivering the essential public health functions (EPHF) as defined by the WHO. As the Global Charter for the Publics' Health sets out, the key services provided by the public health profession include health promotion, health protection, and disease prevention whilst the enabling functions include governance, advocacy, capacity and information.

There are also three components of the PHW, as categorised in the WHO Public Health and Emergency Workforce Roadmap (henceforth the WHO Roadmap): namely the core public health personnel (e.g. public health physicians and nurses, epidemiologists, environmental health officers, public health policy and program managers); the health and care workforce (e.g. medical, nursing and dental practitioners, allied health professionals, Aboriginal health practitioners and workers, biomedical laboratory technicians); and all other non-health professions that don't see themselves as part of the public health profession but nevertheless contribute to the EPHF (e.g. architects, lawyers, water and sanitation engineers, food supply chain workers).

Consequently, the health workforce that is part of your review largely fits into the second category of the PHW, whereby they provide primary health and care services to individuals but might also provide public health services or functions as part of their scope of practice (e.g. health promotion advice, immunisations). In contrast, the core public health personnel provide services and programs that affect whole of population groups, either locally, nationally or even globally (e.g. disease surveillance, emergency response). Notably, public health physicians and nurses could be classified within scope of this review, as they are still registered as health care practitioners, but are specialists in public health service and program planning and provision.

It is the intersect in practice between these two categories of the PHW that is of relevance to this review and of particular interest to the PHAA, particularly in terms of funding allocations and mechanisms, as well as education and training.

**Public Health Funding**

There is a significant evidence-base that indicates prevention and reduction of the burden of disease has a much higher economic value than treating illness. Indeed, it has been shown that public health interventions effectively save costs for the healthcare system in high-income countries, with a median return on investment of 14.3 to 1.[i] Yet public health programs and preventive measures in healthcare services are chronically underfunded, as disease treatment and management remain prioritised. Funding allocations and payment mechanisms both therefore need to change.

Payment mechanisms change is needed to address the funding gap of preventive healthcare services to improve the quality of life and promote better health outcomes for individuals. Currently, payment mechanisms for health and care providers centre on treatment rather than prevention of disease, and are modelled around hospital or physician-led care, instead of value-based and team-based payment models that would better support preventive services.[ii] Other barriers contributing to the low implementation of preventive services in healthcare include time constraints and workload, competing priorities, resistance to change, limited awareness and knowledge of appropriate preventive measures, and the prevention paradox whereby population-level interventions yield fewer benefits when applied to individuals.[iii, iv]

Thus, investment in population-level programs, which address the broader determinants of health and target underlying risk factors, is also essential to alleviate the burden of disease. The National Preventive Health Strategy 2021-30 recommended a target for all Australian governments of directing a minimum of 5% of health expenditure to preventive health programs by 2030, but to date we have seen limited activity to work towards achieving this target - across all jurisdictions. More than a decade ago, the Assessing Cost Effectiveness (ACE) in Prevention Study provided a comprehensive analysis of the comparative cost-effectiveness of preventive intervention options addressing the non-communicable disease burden in Australia. The study evaluated the cost-effectiveness of 150 preventive health interventions, addressing areas such as mental health, diabetes, tobacco use, alcohol use, nutrition, body weight, physical activity, blood pressure, blood cholesterol and bone mineral density. The study remains a policy roadmap for Australian Government budgetary investments in preventive health.

**Education and Training**

PHAA argues that the establishment of temporary pandemic registers for a surge workforce was required to respond to the COVID-19 pandemic, because practitioners of most public health disciplines are either unregulated or not specifically regulated for public health practice in Australia, so it is impossible to identify those workers trained and qualified in public health. You will be aware that recruiting from the general health and care workforce and drawing on departmental staffing or defence force personnel among others, was therefore necessary – a major flaw in our national response to the pandemic.

Australia therefore urgently needs to professionalise and enumerate its public health workforce through accreditation of core public health education programs, including bachelor's and master's degrees, enabling graduates to become registered as public health practitioners under a yet to be determined registration scheme. In turn, the requirement to maintain continuing professional development can be enforced through an associated credentialing program for regular re-registration. Only then will we be able to draw on those with appropriate training and qualifications for emergency preparedness and response via a permanent register of public health practitioners.

Furthermore, we recommend development and implementation of standardised public health training, which incorporates basic public health, disease prevention and emergency response training, that all health

students undertake as part of their degrees. First, this will rapidly lead to an additional pandemic-ready workforce, who can be surged at short notice addressing capacity issues. Second, in the longer term, it will lead to upskilling of clinicians working across the health system to deliver appropriate preventive services as outlined above.

Of the professions within the public health workforce, the public health physicians (PHP) are currently regulated under the Australian Health Practitioner Regulation Agency. The Australasian Faculty of Public Health Medicine (AFPHM) recently undertook a labour market analysis of this workforce in Australia. It based its recommendations on an established practitioner to population ratio of 2.5 PHPs per 100,000 population, which did not account for those PHP employed in teaching and research.[v] This is compared to recommendations from the UK Faculty for Public Health, which recommend 3.0 full-time equivalent public health specialists per 100,000 population as being a 'feasible, desirable and affordable' benchmark for a world class public health system, and which does include both service and academic specialists [vi]. Notably, the UK offers an integrated public health training program which includes both medical and nonmedical graduates. Similarly, NSW has long had a world class Public Health Officer Training Program (PHOTP), which trains both medical and non-medical individuals. We have repeatedly recommended the establishment of an Australian Public Health Officer Training Program, built upon the NSW model, including medical and non-medical health professionals, under the banner of the newly established Australian Centre for Disease Control.

However, across Australia, non-medical public health specialists are unaccredited and not regulated, therefore estimates of this workforce are difficult to ascertain and are not included in the AFPHM workforce analysis. Irrespective, the number of PHP is well below the recommendations of 2.5-3.0 full time specialists per 100,000 of the population, even without inclusion of the non-medical graduates. It is unlikely that this will account for the entire public health specialist workforce gap, and there is a need to increase the capacity of the PHOTP to meet future demand. The need to regulate and thus enable enumeration of the non-medical public health workforce is also clear.

The PHAA Board were informed in late December that you kindly presented at our meeting, and in due course we will make your presentation available on our members-only section of the PHAA website.

As we indicated, the PHAA greatly appreciates the opportunity to participate in ongoing consultations and conversations during your review. We note the recent release of the Issues Paper 1 and will look to provide you with a submission. Hon Assoc Prof Leanne Coombe, our Policy and Advocacy Manager, will also be attending one of the roundtable meetings in Brisbane scheduled for this week.

If it is not too late, the PHAA would also welcome the opportunity to provide representation on your expert advisory committee.

Please do not hesitate to contact us should you require additional information or have any queries in relation to this correspondence.

Yours Sincerely,

Terry Slevin
Chief Executive Officer
Public Health Association of Australia

Leanne Coombe
Policy and Advocacy Manager
Public Health Association of Australia

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