

**Discussion Paper on the National Public Health
Partnership**

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Introduction

For some time now, there has been concern expressed over the need for a national approach to public health. Preliminary discussions in late 1995 and early 1996 between Australia's Chief Health Officers and other stakeholder groups saw the response take the shape of a National Public Health Partnership. It would be a coordination and collaboration mechanism with clearly articulated roles and responsibilities, which adds value to the work of each jurisdiction rather than inhibit decision-making or the setting and pursuit of local priorities.

The Federal Minister for Health and Community Services placed the proposal to develop such a Partnership on the agenda of the Australian Health Minister's Council in July 1996, for consideration and endorsement by his State colleagues. In the meantime, the Council of Australian Government (COAG) agreed on 14 June 1996 that:

Long-term arrangements for system-wide reform are to be explored and developed ... a significant realignment of roles and responsibilities could flow from this approach, involving both levels of government in jointly setting objectives, priorities and performance standards, and funding the system; with the Commonwealth taking a leadership role in relation to public health standards and health research; and the States primarily responsible for managing and coordinating the provision of services and for maintaining direct relationships to most providers.

Furthermore, COAG agreed that interim steps would be taken in several areas including public health, whereby existing Special Purpose Payments (SPPs) would be considered for broadbanding in the form of new bilateral Public Health Agreements between the Commonwealth and States/Territories. The concept would be explored in 1996/97 with a view to such agreements operating from 1997/98 onwards.

It was in this context that the July Australian Health Ministers Council endorsed the concept of a National Public Health Partnership and agreed the proposal should be further developed under the guidance of the Chief Executive Officers Working Group (G9) established to progress the health and community services reforms. This decision in effect recognises that the Partnership provides a multilateral public health policy framework within which the specific COAG proposal for bilateral public health funding agreements should be negotiated.

The G9 met on 12 August and agreed that the details for a National Public Health Partnership should be developed quickly through a process of consultation between the Commonwealth and States/Territories (in consultation with a limited number of national stakeholder groups, e.g. National Health Medical Research Council, Australian Local Government Association, Public Health Association, Australian Community Health Association). The intention is to put a proposal before Australian Health Ministers in early October for consideration, approval, and referral to COAG for their endorsement on 14 November 1996. This would then set the context for consultation and development of the bilateral Public Health Agreements between the Commonwealth and States/Territories.

This brief discussion paper has been developed to underpin the consultation over a National Public Health Partnership, to cover jurisdictional and non-government interests.

Why Public Health?

George Rosen, the eminent historian of public health, has summed up the concept of public health as the recognition, throughout human history, that the major problems of health faced by society have been concerned with community life and therefore the importance of community action in the promotion of health and the prevention of disease. While the emphases of public health activities change, the objectives of protection, prevention and promotion have remained constant, underpinned by epidemiological analyses and informed by multidisciplinary research.

Government involvement in public health has generally arisen from two perspectives. One being the importance of a healthy population as a contributor to sustained social development and creation of social capital. The second being the investment in human capital as critical for economic development. Indeed, public health is often identified as a public good where government involvement is justified on grounds of public interest and market failure. (World Bank, 1993)

The success of early public health interventions (e.g. sewerage, waste management, water supply, housing, and nutrition) has contributed significantly to altering patterns of mortality and morbidity. New patterns of mortality and morbidity require new approaches to risk factors present in the physical, social and economic environment and to changing individual and community attitudes and behaviours. In addition to chronic and degenerative diseases, Australia is experiencing new and emerging infections, socio-behavioural pathologies, and new environmental threats. While these require attention and strategic responses from public health services, there remains a need for continued vigilance about "traditional" hazards. Indeed, the basic environmental health issues remain central concerns in parts of Australia.

In the context of globalization of the economy and developments in telecommunications, public health problems and solutions have transcended borders more than ever. Furthermore, the advances in biomedical and social sciences also dictate that public health strategies are continually updated. Public health interventions thus employ multiple techniques and technologies to leverage change from the molecular to the contextual levels.

While many public health interventions are society-wide, there is also a close interdependence between public health goals and activities and individualized personal care. Individual actions to improve the health of Australians are constantly taking place throughout the health care system. Providers of personal care services, be they general practitioners (GPs), community health centres, maternal and child health services (MCH), or others, are critical avenues at the local level for identifying public health issues and meeting health improvement objectives. Indeed, the achievement of population health gain depends on well articulated approaches to improvement of health literacy, reduction and avoidance of risk, early detection and treatment, reduction of complication, and appropriate rehabilitation and maintenance to minimise the consequences of illness and disability. The skill base of public health (eg. epidemiological analysis, risk management, risk communication, consumer empowerment, etc.) is also increasingly used to inform and improve health services delivery.

The simultaneous presence of multiple factors which influence health and the wide range of contributors to health improvement across settings and sectors suggest a coordinated and collaborative approach - a partnership approach -

across constitutional and territorial boundaries is the most efficient and effective approach for governments to discharge their responsibilities in public health.

Coordination is required due to the need for complementary action at different levels at the same time.

Current Roles and Responsibilities

Government has been the major provider of public health services. Consistent with constitutional principles, most core functions of public health have traditionally been the responsibility of states/territories.

While the organization of public health activities differs across states and territories, in the main state health authorities have responsibilities for:

- carrying out statewide epidemiological surveillance to identify public health issues, ensure timely interventions, and monitor health outcomes;
- developing policy and implementing statutory responsibilities related to communicable diseases, environmental health, immunization, food, radiation safety, workplace risk, water quality, drugs and poisons, and emergency management;
- organizing preventive and early detection programs, such as cancer screening, maternal and child health, school health and dental screening, immunization, etc;
- supporting enhancement of health literacy and health promoting behaviour in population groups, including developing strategic responses to enhance the effectiveness of health services for population groups;
- supporting health care providers at the local level in the provision of information and education and in the control of diseases;
- developing strategies to meet challenges of new/emerging health problems;
- examining the effectiveness of health services and programs in achieving health gain;
- collaborating with local government public health services;
- working with other relevant authorities, non-government organizations, and the public on shared public health concerns, such as environmental pollution, occupational health and safety, injury, alcohol and drug abuse, non-communicable disease prevention (e.g. cancer, heart disease, diabetes, etc.);
- coordinating with relevant authorities and providers to ensure the availability of an appropriately skilled public health workforce.

These activities are carried out through multi-disciplinary teams, often with highly specialised expertise, using the range of powers available to the state.

The state/territory responsibilities may be delivered through a range of organizations. For instance, in several states, health promotion foundations play a vital role and complement the activities of the state department. Local government is the main vehicle in most states for food inspections and environmental health services related to habitat. Immunisation services may be delivered through GPs, community health centres, local government, or maternal and child health services. States may also use university-based expertise for public health functions as well as non-government organisations and private sector services. Furthermore, the cooperation of other government agencies, such as those responsible for environmental protection, road safety, consumer affairs,

food and agriculture, education, etc, may be vital to the achievement of public health objectives.

At the Commonwealth level, there are a range of entities playing important roles. The responsibilities for quarantine and immigration are examples of long-standing Commonwealth contributions to public health. Additional contributions in specific areas are made by the Australian New Zealand Food Authority, Australian Radiation Laboratory, Nuclear Safety Bureau, and agencies in other portfolios, such as the Commonwealth Department of Primary Industry and Energy, Department of Veterans' Affairs, Worksafe Australia and Commonwealth Environmental Protection Authority.

Within the Commonwealth Department of Health and Family Services:

- there has been a series of large and small vertical programs through the 1980's and early 1990's as well as national strategies targeted at particular diseases, risk factors, population groups and settings. Notable among them are the programs and strategies for HIV/AIDS, illicit drugs, and women's cancer screening programs.
- Financial support of post-graduate public health education through the Public Health Education and Research Program (PHERP) has significantly expanded the workforce available.
- The coordinated development, implementation and review of strategies in national health priority areas (cancer, cardiovascular disease, mental health, injury, and diabetes) is currently being consolidated by the Department on behalf of AHMAC. The development of priority indicators for reporting will provide a focus for ongoing assessment of progress.
- The national medicinal policy, implemented through the Therapeutic Goods Administration (TGA) and the Pharmaceutical Benefits Branch, are critical in ensuring timely availability of therapeutic products while maintaining adequate assurances of product safety and efficacy and appropriate use.
- The creation and funding of GP Divisions established the foundation for a more coordinated primary care system, in concert with the states and territories, strengthening the local vehicles for public health activities. The introduction of outcome-based block grants offer a further opportunity for closer integration of population health and personal care roles.
- The signing of the Framework Agreement between the Commonwealth and States/Territories on Aboriginal and Torres Straits Islander (ATSI) health also provides a strategic opportunity for the public health dimensions to be addressed alongside the improvement of health services for ATSI communities.

Other key Commonwealth agencies contributing to the broad spectrum of public health objectives are the NHMRC (National Health and Medical Research Council) and AIHW (Australian Institute of Health and Welfare), the former through its role in public health research and development and the provision of expert advice and the latter through the development of national and consistent systems for public health information and its role in supporting the National Health Information Agreement. Examples of recent NHMRC reports shaping the public health agenda include: prostate cancer screening, re-use of single use therapeutic devices, infection control guidelines. Some directly relevant activities of the AIHW include: injury surveillance, health outcomes clearinghouse, perinatal statistics, and death index.

Non-government organizations also play vital part in setting and supporting the public health agenda, as well as contributing to health improvement. These

include professional, community, and consumer organizations and research and educational institutions.

Why a Partnership?

While there have been significant achievements by all jurisdictions in the various areas of public health, there are also some significant weaknesses in the current arrangements, from the viewpoint of a national effort in public health.

- The vertical programs have introduced rigidities and boundaries between the Commonwealth and the States/Territories and between programs, while the highly successful national strategies to date (such as HIV/AIDS and characterized by planning, adequate resourcing, cooperation and continuity) could be applied more broadly across public health activities;
- There are areas of activity (such as health promotion) where the potential exists for unnecessary duplication and inefficiencies due to lack of clear roles and responsibilities;
- The complexity and national significance of many public health issues (e.g. HIV/AIDS, food-borne diseases, ATSI health, etc.) require the capacity to identify and respond in a collaborative and complementary manner be strengthened;
- as the focus of the health system moves to health outcomes and allocative efficiency issues, there is need for better articulation of the contribution of public health knowledge and skills to health system development.

The NHMRC's Health Australia Review, conducted in 1996, identified the key ingredients of successful public health interventions as: (1) technical capacity - knowledge, skills, and information necessary to identify and implement change; (2) policy and strategic direction - commitment and mechanisms to bring about agreement on goals, priorities, plans and delivery of interventions; (3) supportive structures - the organizational, financial and other resources necessary to encourage all relevant parties to cooperate to bring about health improvement.

A National Public Health Partnership provides the broad multilateral, intergovernmental framework to build a cooperative approach to ensure these pre-conditions for success can be met and the health of Australians is protected and improved. It is a move away from Commonwealth/State arrangements for management of selected programs towards a more systematic and strategic approach for addressing public health priorities. It will also provide a vehicle through which major initiatives, new directions, and best practice can be assessed and implemented.

The Partnership approach thus portrays:

- the integration of currently fragmented activities in public health and a movement to a "whole of system" approach;
- a shift in emphasis towards evidence-based policy and practice in public health and focus on outcomes;
- the clarification of Commonwealth and State/Territory roles and responsibilities, with each jurisdiction focussed on its core business, supplying appropriate skills and infrastructure accordingly.

Broad Aims of the Partnership

The main aim of a national effort in public health is the improvement in the health status of Australian, in particular population groups most at risk. The Partnership is a mechanism and a process to ensure that government responsibilities in public health are consistent (where needed), coordinated (where complementary activities are required) and collaborative (where pooling of expertise and resources is beneficial).

The broad objectives of the Partnership are proposed to be:

- improved collaboration in the national public health effort
- better coordination and sustainability of public health strategies
- strengthening of public health infrastructure and capacity

As such, there should be better capacity to manage existing issues (such as immunization and food safety) as well as more efficient and strategic responses to emerging issues (such as hepatitis C). Additionally, improved consistency in public health information and regulatory framework and more strategic investment in research and workforce development should result in more effective use of resources.

The Partnership arrangement should enhance the capacity of States and Territories to respond to public health issues of particular relevance and add value to the work of each jurisdiction, rather than inhibit decision-making or the setting and pursuit of local priorities. It is not concerned with a uniform approach except where appropriate, nor with dictating the way each jurisdiction arranges and carries out its public health responsibilities. It recognizes that there different approaches will be adopted in different localities even for the same priority issue. At the same time, it enhances the capacity to account for outcomes and benchmark activities across the nation.

Case studies of how the Partnership could contribute to current public health efforts are attached.

What is the Scope?

Population level action in the health and related community services system comprises activities and processes which:

- protect and promote health and well-being and prevent illness and disability at a population level;
- use population-based methods to monitor health and well-being of communities and apply population-based knowledge to guide and improve health outcomes;
- empower communities through improved health literacy.

The Partnership provides a focal point for coordinated, collaborative and complementary national action. It is therefore not a rolling up of programs as it is a process and a mechanism for planning and coordination around those activities aimed at population health maintenance and improvement, whether delivered through individuals (e.g. immunization and screening), specific population groups or society as a whole (e.g. regulation).

How Would the National Public Health Partnership Work?

The National Public Health Partnership would be framed by:

- a multilateral memorandum of understanding (MOU), initially for a 5-year period, setting out key principles and processes, roles and responsibilities;
- a coordination mechanism consisting of senior representatives, known as the National Public Health Partnership Group, operating as a subcommittee of AHMAC;
- a rolling 3-year work program, approved by Health Ministers, setting out key result areas, including joint priorities and how they would be progressed and monitored.

The MOU would set out aims and objectives, principles for public health, roles and responsibilities of all jurisdictions, operational arrangements and processes, key result areas, date of commencement and period of review.

The signatories to the MOU would be the "Principal Partners" - the Commonwealth Department of Health and Family Services and the health authorities of the States/Territories. The MOU, together with the Work Program, would form the basis for more specific bilateral agreements between the Commonwealth and the States/Territories about rolling up existing SPPs in new intergovernmental financing and reporting arrangements for public health (as proposed to COAG in June 1996).

The Partnership Group would consist of senior representation (of decision-makers) from each of the jurisdictions participating in the MOU. In addition, because of their critical involvement in key aspects of public health, senior representation from NHMRC and AIHW would join the Partnership Group as full members. The Partnership Group would be the point for planning and coordination, and provide the leadership, for matters of national significance. It would also ensure that communication channels exist for specific areas of public health program delivery and monitor implementation of agreed priorities. The Partnership Group would be chaired by the Commonwealth Chief Medical Advisor and secretariat services would be performed by the Commonwealth Department of Health and Family Services.

While the Public Health Partnership is an intergovernmental arrangement, the Partners are fully cognizant of the critical contribution to public health made outside of health authorities. Other providers of public health, such as local government, public health research and education programs, and relevant agencies from the States/Territories and the Commonwealth, would be involved in specific activities on the "rolling" Work Program related to their public health functions.

Additional consultative mechanisms would be instituted by the Partnership Group to ensure two-way exchange with key professional, community, consumer, educational, and industry interests occurs on the development of national public health priorities and strategies. The strengthening of working relations with non-government interests would require further consideration as the Partnership Group arrangements are consolidated.

The Work Program, to be approved by Health Ministers, would be initiated and maintained by the Partnership Group, ensuring integration of the various elements of the national effort. It could constitute both a register of significant projects being undertaken by each jurisdiction which have national implications as

well as developmental projects either on joint priorities or which can add value to current activities. For example, innovative work in health outcomes, ATSI health, immunization, etc. in particular states/territories could be listed so that other jurisdictions may consider participating or adapting. Similarly, all jurisdictions may agree to benchmark current public health activities as a work program priority which adds value.

The Work Program could also include, for cross-referencing, the work undertaken by other bodies which have immediate relevance for public health. For instance, the development of priority indicators for the national health priorities, the refinement of the national health information framework by the National Health Information Management Group (NHIMG), the assessment of public health technologies by the Australian Health Technology Advisory Committee (AHTAC) should be linked to and not be duplicated by other work to be directly commissioned by the Partnership Group.

As new public health issues emerge, the Partnership Group, using the mechanism of the Work Program, can commission work from relevant parties, including NHMRC, AIHW, and others.

The Work Program is the basis for reporting back to AHMAC and Health Ministers on progress against key result areas.

Proposed Broad Roles and Responsibilities Under the Partnership

Commonwealth

Department of Health and Family Services

- Facilitate the development of national public health policy in collaboration with government, non-government, professional, and community organisations.
- Advocate at the national level for public health and build and strengthen a population health constituency with key players and with the public.
- Facilitate ongoing negotiation and agreement between Governments on national policy, planning, monitoring, reporting, programs, research, training and evaluation.
- Facilitate the development of national consistency in areas where there is agreement that this is needed (e.g. policy standards, legislation and regulation, workforce competencies, environmental protection, disease prevention and outbreak control methods).
- Initiate and initially finance innovation in population health programs, in conjunction with states/territories.
- Conduct national programs, in coordinated fashion with States and Territories, where the need is agreed.
- Monitor, evaluate and report on the performance of national public health strategies and programs, in collaboration with states/territories.
- Conduct, in consultation with other partners, Australia=s international responsibilities and obligations in public health.

Australian Institute of Health and Welfare

In accordance with the functions specified in the Australian Institute of Health and Welfare Act 1987, the mission of the Institute is to inform community discussion and to support public policy making on health and welfare issues by:

- coordinating, developing, analysing and disseminating national information on health status, health and welfare services, and housing assistance in Australia; and
- undertaking and supporting related research and analysis.

To this end the Institute will work closely with other partners to collect public health data, set standards for data quality, produce public health statistics and undertake research and analysis to inform and improve public health policy and practice.

National Health and Medical Research Council

The National Health and Medical Research Council Act 1992 requires the NHMRC to pursue activities designed to:

- raise the standard of individual and public health throughout Australia; and
- foster the development of consistent health standards between the various States and Territories; and
- foster medical research and training and public health research and training throughout Australia; and
- foster consideration of ethical issues relating to health.

The NHMRC will work closely with the partners to provide timely expert advice, assess best practice in public health interventions, and stimulate strategic research in public health.

State and Territory Health Authorities

- Collaborate in national policy development, determine state/territory priorities, and develop strategies for implementation within the jurisdiction.
- Facilitate development and implementation of state policy and regulatory framework for public health.
- Design, plan and deliver services and programs at State and regional levels to protect and promote health of the population.
- Apply public health knowledge and skills to health system development.
- Undertake State/Territory specific intersectoral collaboration, particularly in facilitating whole of government approaches and in working with local Government, State-based non-government organisations, and education and research institutions.
- Participate in collaborative efforts at the national level and with other states/territories, including leading particular projects, and conduct those elements of the National Public Health Partnership which the particular State/Territory might agree to undertake.
- Monitor and respond to public health workforce issues within national framework for workforce development.
- Monitor health issues and outcomes and report on performance of public health functions.

Possible Work Program Priorities

The Work Program would be finalized upon the establishment of the Partnership Group and then submitted to AHMAC and Health Ministers. In principle, the projects should be progressed through streamlined structures and processes, delivering results within agreed time frame. While the final form cannot be determined and there is still the need to examine which items would be covered under bilateral arrangements instead, discussions to date suggest the following as potential priority areas for joint development.

Public Health Practice Improvement

There are a number of potential avenues to improve public health practice across jurisdictions. These include:

- benchmarking of public health services
- developing best practice guidelines for public health interventions
- formalizing arrangements for cross-border deployment of expertise and resources especially for highly specialised areas (e.g. toxicology, chemical safety)
- instituting electronic bulletin board for rapid communication at early stages of investigations of outbreaks
- assessing the uses of information and telecommunications technology for public health activities and health gain
- assessing innovations in service delivery models to priority population groups
- assessing governmental strategies for public health (e.g. municipal public health plans in Victoria, health impact assessment in Tasmania)
- assessing systems of standards (such as CHASP) for their capacity to improve public health practice

Local governments may be interested in participating in some of the above projects, such as benchmarking.

Public Health Information Development

Australia's health information system is well-developed to monitor mortality and hospital morbidity. Progress is being made under the National Health Information Agreement on non-institutional services data, but much of the information required for designing and monitoring public health interventions is not collected and analysed in a systematic fashion. For example, effective efforts to improve health depends on having good information on community knowledge, attitudes and behaviours but no consistent surveillance system exists nationally. Program funds have been made available for specific surveys on specific topics of interest. Some states/territories have a more developed capacity to repeat data collection on some issues. The development of a Behavioural Risk Factor Surveillance System, modelled on the system developed by the Centers for Disease Control and Prevention (CDC) in the US, could be a more efficient and effective way to re-orient current resources. The AIHW and South Australia, which has a surveillance system of this type, could take the lead.

The development of appropriate surveillance system to monitor environmental hazards and exposures, and to link them to health status, could be another area for systematic development.

In addition, the translation of systematically collected data into meaningful indicators will require consideration across whole of government. The Tasmanian Health and Well-being Indicators Project could serve as the basis for national development.

As a first step, however, the national health information framework should be refined so to guide the development of public health information systems, ensure the inclusion of information on priority population groups, and help set priorities.

National Public Health Regulation and Legislation

There is fragmentation of responsibility between the Commonwealth and States/Territories in many regulatory domains. Regulatory standards need to be harmonized to support a consistent approach to public health and contribute to microeconomic reform within a health framework. In doing so, new models of regulation may be developed as well. The first task is to "map" current and anticipated review of public health - related legislation so that common issues can be jointly examined and consistent approaches developed where needed. While some of this work has already begun, issues which could be prioritised by the Partnership Group and pursued through working groups on behalf of AHMAC include:

- food safety
- uniform therapeutic goods regulation (including use of radiopharmaceuticals)
- drugs and poisons scheduling, licensing and inspection
- handling of blood and blood products
- standards and procedures for handling of radioactive materials
- notifiable diseases
- tobacco and alcohol control

Responsibilities for legislation with important public health implications may reside outside of the health portfolio. Consideration about these (such as Coronial Acts and legislation pertaining to environmental protection and road safety) will require whole-of-government approach.

The Partnership Group will also consider Trans-Tasman Mutual Recognition and involve New Zealand in discussion of regulatory harmonization.

National Public Health Strategies Coordination

The Partnership Group could facilitate and provide high level coordination across current and new national strategies, including developing a systematic approach to identifying priorities. The proposed third National HIV/AIDS Strategy, a National Environmental Health Strategy, and the National Communicable Diseases Surveillance Strategy are some of the current efforts underway. Hepatitis C is another one identified for attention. The Partnership Group could also be a high level coordination point for major campaigns, such as on quality use of medicine. Other strategies may be developed at the request of AHMAC and Health Ministers.

The development of each strategy will require clarity about roles and coordination mechanism, including the definition of the specific policy and structural reform agenda at the national level and coordination mechanisms for national campaigns, if required. Specific intersectoral collaboration efforts will need to be articulated and supported, building on experiences in various jurisdictions (e.g.

food and nutrition policy in Victoria and Tasmania). The involvement of key non-government organizations may be vital for successful attitude change and public policy development.

The Group would need to ensure appropriate input is provided to the Commonwealth in relation to the public health dimensions of the national health priority areas. Taking an integrated approach, the Group would also ensure that the needs of priority population groups, such as Aboriginal and Torres Straits Islanders and people of non-English Speaking background, are adequately addressed in all public health strategies.

Public Health Research and Development

At present, public health research has tended to be investigator-driven. A relatively small amount has been commissioned by various health authorities to address specific policy requirements. While there will continue to be research tied directly to specific policy requirements or be driven by investigator interests, a public health research and development strategy could be developed by the Partnership Group to indicate the research and advice work needed and which could be undertaken by the NHMRC as a contribution to the national public health effort. Such a plan would balance, rather than replace, the research activities informed by intellectual curiosity.

The public health R&D strategy would also underpin a more coordinated investment of funds from different programs, thus systematically generating information required for an evidence-based approach to public health policy and practice. Some or all jurisdictions may identify common problems and commission joint research, involving relevant Cochrane-style systematic reviews of evidence, university consortia funded by PHERP, and other approaches.

States/Territories could further benefit from strengthening capacity for research and evaluation in public health program delivery units, including primary health care services. Practice-based research opportunities could be created (such as the South Australian Community Health Research Unit) where research and action become mutually informing and reinforcing.

The Centres for Public Health designated under PHERP could also be linked into a national public health Research and Development network. They could also be joined by NHMRC and state-funded centres (such as the National Research Centre in Environmental Toxicology). In linking with the Partnership effort, these centres would play a truly national role in relation to strengthening the practice of public health.

Public Health Workforce Development

PHERP has made a significant contribution to workforce development although there remains the need for both more advanced researchers and for practitioners who have well-developed public health knowledge and skills. Recent reviews have pointed to the need for reorienting public health workforce development from a focus on postgraduate education to broader, practice-based learning. The creation of a wider base of practitioners with public health expertise has been identified as an essential ingredient in strengthening public health infrastructure. NSW and Victoria have already developed multidisciplinary public health traineeship schemes and additional resourcing to make these schemes accessible to smaller states who wish to participate may be a cost-effective approach to workforce development.

Continuing education for primary health care providers and local government health officers is, however, unevenly developed across the country. At the same time, public health content and skills are lacking in the basic training for doctors, nurses, dentists, allied health professionals, etc. Both areas may benefit from joint consideration.

The Partnership Group would establish mechanism for working with relevant government agencies, educational institutions, and professional organizations to ascertain employer and workforce needs, assess quality of public health training and education, promote models for workforce development, and develop consistent frameworks for training particular categories of workers (such as Aboriginal health workers). State-level deliberations, such as through the NSW Public Health Workforce Development Committee, may have applications nationally. Linkage with the Australian Health Management Network may be productive in progressing common interests.

At the same time, there is a need to continually improve public health knowledge through research. How to strengthen postgraduate public health education to produce doctoral level researchers could be considered jointly by the health authorities, NHMRC, and tertiary education interests. Research deficits in the longer term may need to be addressed through appropriate workforce development. That research workforce also need to have the capacity to make meaningful the findings of research for public health practice.

Public Health and Resource Allocation

Output-based funding has been identified as an appropriate direction for the health and related community services system. Casemix and its variants are now accepted and used as basis for funding or purchasing hospital-based personal health services. The most appropriate approaches for funding or purchasing population health programs and some primary health care services, however, is not yet clear. As some jurisdictions are considering how to develop appropriate incentives and accountability arrangements in funding or purchasing for public health, shared developmental work, including analysis of international experiences, is likely to be invaluable. One starting point may be the NSW project on classification of public health products.

Increasingly state health authorities are interested in purchasing for health gain, which requires the strengthening of the evaluation capacity and the application of public health knowledge and skills to health system development. There is a range of developmental work being undertaken in this complex area. The NSW Health Outcomes Project has focussed on clinical interventions while the Victorian efforts have been concerned with community information and education. The ACT Care Continuum and Health Outcomes Project is a population-based evaluation of the impact of interventions on quality of life. A collaborative approach will accelerate the pace of development in this area and make significant contributions to debates about allocative efficiency.

Implications for the Commonwealth and States/Territories

The National Public Health Partnership will promote clarity of roles and responsibilities and a collaborative and complementary approach to work in public health for the Commonwealth and States/Territories. It will be accompanied by a rationalization of funding arrangements, thus allowing for a shift to an integrated 'whole of system' approach to public health. The Partnership should maximise

coherence and simplify complexity without losing the necessary machinery, including communication mechanisms, to progress individual issues.

Rationalization of funding and program arrangements will support the move to a focus on accounting for outcomes, provide greater flexibility for States/Territories to allocate resources to meet local population needs, and reduce Commonwealth involvement in service provision. The Commonwealth will be more focussed on national policy and planning, including an agenda of structural reform to underpin state level activities, and will require a strengthening of substantive expertise within the Department of Health and Family Services. The nature of links with Australian Institute of Health and Welfare and National Health Medical Research Council will be clarified and the working relationships strengthened.

It is anticipated that a national collaborative approach will facilitate infrastructure development, harmonization of regulatory frameworks, and joint investment in developmental projects. As such, the arrangement should result in a more effective national outcome.

Next Steps

The National Public Health Partnership is an aspect of the reform of health and related community services system. As such, it is concerned with microeconomic reform of intergovernmental arrangements. Because of the intersectoral nature of public health, involvement of other stakeholders will be important for the implementation and ongoing refinement of the partnership arrangements and the broad public health agenda.

Public consultation on the Public Health Partnership, following the Health Ministers' meeting on 4 October and in the lead up to the COAG meeting on 14 November will ensure that key stakeholders:

- are informed about government intentions;
- have opportunity to provide advice and feedback to add value to inter-governmental discussion;
- can contribute and feed into detailed planning on the operations and work program of the Public Health Partnership.

Following COAG endorsement, the Commonwealth and the States/Territories can commence discussions on the draft MOU, with the intention for the arrangements to be in place during the first half of 1997.