

Belated comments re: proposed changes to Health Act 1958

I am MOH for Greater Shepparton, a past councillor and an advocate of public health. The following comments are personal, but are based on my experience and productive interaction with local government for several decades.

### **1. Municipal Public Health Plans (part 4.4)**

A great supporter of the concept, I was involved with the first batch of plans drawn up about 14 years ago and have been instrumental in making our local plan (Greater Shepparton) more than just a fixture on the shelf. Our plan has become a focus for the local community, and considerable strides have been made on local problem areas such as drug and alcohol abuse, and issues surrounding the safety of our children. It has become such a public entity that the plan has been cited in a range of issues - from the commercial development of a public park to the appropriateness of a Club X megastore in the district ! The community has really become involved.

I therefore support all the suggestions as outlined on p.20 of the Review, with the exception of fixed term reporting to the Secretary. This might satisfy bureaucratic measures of activity but, as has been the case with many MPHPs in the past, will achieve nothing of practical benefit.

I suggest the following:

(a) **Reporting to the Secretary** should occur with the completion of each project, as that occurs. Some projects take several years to complete, others a few months. Of course, maximum times might be set, but results are the issue not warm and fuzzy do nothings.

(b) **Performance indicators** should be determined in advance and be acceptable to the Council itself and not be invented by staff.

## **2. Medical Officer of Health (part 4.5)**

The role of the medical officer of health has changed over the past 20 years. It is no longer necessary or practical to have a medical qualified person in every municipality.

However, there exists a need for a medically qualified person to provide services in emerging roles and probably to a number of different municipalities.

The needs of each municipality differ and the needs in the metropolitan areas of Melbourne are less than those of rural municipalities. Rural areas have different needs but, commonly, fewer resources to employ their own MOH.

The role of that person assumes a new, clearly specified role.

1. It is in the interest of both HSV and local government to have a medically trained person in close contact with the Council.
2. That person should have interests or demonstrated expertise in matters of public health, immunisations, etc, but I think should also be familiar with the local environment.

I recommend the following:

1. **Removal of the requirement** for Councils to employ MOsH.
2. Implementation of a requirement for **Councils to maintain access to a MOH** who might, for instance, be shared by neighbouring councils.
3. Incorporation of the **MOH position into the MPHP** as a fixture, rather than as a public-minded volunteer. The staffs of Councils (not just in Shepparton) need some professional advice on MPHPs.

4. **More responsibility** should be placed on MOsH. They should be better trained and should be obliged to report annually to their Councils, as used to happen in the past. They should be the first point of call for DHS in the event of disease outbreak and should be included in DHS communications to Councils.

### 3. Control of infectious diseases (part 8)

I have had the experience of sustaining a **needle-stick injury** after injecting an intellectually-disabled ward of the state, whose guardian was uncontactable interstate. I was unable to determine the immune status of the child affected and received no help from our local Council or from Officers of DHS, both believing that the privacy of the child was more important than my health. DHS could offer me nothing but counselling. Clearly this situation should never occur again.

I feel very strongly that the current Act does not protect people such as myself, working as a public vaccinator. It should be modified with great haste, leaving no room for ambiguity.

I support recommendation **Recommendation 84** in the Review.

### 4. Immunisation (part 8.8)

As a GP involved with travel health, the constant problem we face is the **uncertainty of the immune status of adults**. Anything which provides for better record keeping, especially for secondary school leavers, would be very helpful for our adult population, especially when they seek certain occupations.

I believe the Act should require the provision of evidence of immunisation at the completion of the school vaccination program, ie at Year 10. The information is now collected by Councils and should, without a lot of cost, be readily available to students in that year of secondary schooling.

## **Offenses**

It appears to me that the requirements to provide an ISC are widely ignored and no penalties are applied. In comparison, the linkage of Commonwealth child care and maternity payments to childhood immunisation, has had an acceptable impact on immunisation uptake.

Why put non-productive pressure on schools, when they have a vested interest in not upholding the ISC requirement? This should be the job of the vaccine providers.

I support the **provision of a certificate of vaccination** at the completion of the school program.

1. This certificate should list the **antigens provided**, not the brand names of the vaccines, and should be provided via a laminated card, which might last more than one year in the home.
2. The **responsibility for this certificate must lie with Councils**, not with the school principals.

Where vaccines are provided by GPs, they should be obliged to notify the local Council accordingly or, alternatively, provide the same quality certificate of vaccination themselves.

I support the concept of consistency with NHMRC recommendations. Is there any alternative ?

Thank you for the opportunity to lodge this late comment.

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Submission of John Mackeller to the review of the Health Act 1958