

# Submission regarding “Review of the Health Act 1958”

Issue for comment:

17. Should the new Act remove the requirement that every council appoint a MOH, and instead rely on non-legislative mechanisms for ensuring municipal councils have access to medical expertise?

The Medical Officers of Health Association (MOHA) present this submission in response to Issue 17 of the discussion paper regarding a new legislative framework for public health in Victoria.

The Medical officers of Health Association represents the 70 MOHs currently employed by municipal councils as required under the provisions of the current Health Act.

The number of MOHs was reduced by two-thirds following the amalgamations of local councils in the mid 1990s. Their duties and responsibilities have also decreased in recent years, as public health expertise has become increasingly formalized and centralized, and more recently, following the introduction of nurse immunizers. However the MOHA believe that the role continues to be useful to councils and the community and suggest that it should be retained as a requirement under the revised Health Act.

The MOHA has canvassed the opinions of members of the Association, and almost without exception they believe that the role should be enhanced rather than abandoned. Their supporting arguments are outlined below.

## 1. Providing advice and assistance on health matters to the council

The medical knowledge of Environmental Health officers is very circumscribed, and they often need more information about topical or difficult issues. The public health expertise of MOHs is less than the specialist public health physicians employed by DHS, however most have experience and interest in the field and some have formal qualifications in this or related areas. What they all have, without exception, is a high level of expertise with regard to individual health problems (as GPs). Many health related local issues have both community and individual aspects and the MOH is in a strong position to provide appropriate advice. Are the public health experts employed by DHS prepared to undertake this role, in addition to their current duties?

The advice MOHs provide is not wholly, or even primarily, related to “big issues” of council policy. On a day-to-day basis, they act as a useful resource for council staff (particularly child care staff and Maternal and Child Health nurses), other GPs and clients of council services, providing advice, information and reassurance about a myriad of health issues.

## 2. Local knowledge

Most MOHs are local GPs with an intimate knowledge of their particular community and environment. They are aware of geographic and demographic peculiarities of their area, and this is particularly valuable in country and remote locales. MOHs also have valuable knowledge of, and contacts with, other service providers such as other GPs, Divisions of General Practice, hospitals, nursing homes etc. Access to this knowledge and network is valuable both for councils and, potentially, for DHS, if they care to utilize it.

## 3. Professional independence

MOHs are employed by their council, but only as part-time employees or on contracts. No MOH is dependent on their council for their livelihood, which gives them more professional independence than other council employees. This means that where conflicts of interest arise they can provide disinterested medical advice, or on occasion direct instructions to council which might otherwise be disregarded. An example of the value of this was the imposition of an order to boil drinking water on Philip Island

following the detection of E. Coli in the local supply, a move insisted upon by the MOH, but strongly resisted by the council as the problem arose during a peak holiday and tourist period. Another example was the production and distribution of a pamphlet describing M.Ulcerans, which the MOH insisted be delivered to potentially at-risk households in another tourist area, even though, again, the council believed it would be “bad for business”.

MOHs are main stream medical practitioners, with an evidence-based scientific approach to their work. They are thus in a position to intervene if other attitudes become prevalent within the council milieu, be these clashing business or environmental interests such as those described, or others such as “alternative” medical philosophies which are becoming more prevalent in other professional groups. As an example of the occasional but important necessity to intervene, one MOH described his concerns about the strong anti-fluoridation views expounded by the chief environmental health officer of his rural council.

#### 4. Cost

If the position of MOH is abolished and councils are given the option of retaining or dispensing with the services of a medical officer, many will see an opportunity to save themselves some money, especially if they believe that they can obtain any necessary advice from DHS at no cost to their ratepayers. As the Health Act stands at the moment, appointing and paying for a MOH is one of the mechanisms for ensuring local government contributes to the cost of public health services. Abolishing the position is a work force readjustment which will shift costs to centralized services, which may or may not be able to provide an equally effective service.

Overall, the MOHA would argue that the position has served the state well in the past and can continue to do so in the future, particularly if councils are encouraged to make optimal use of this in-house medical resource. No MOH is dependent on their council work for essential income. The majority, especially in country areas, belong to general practices which are crying out for more of their professional time for direct patient care, yet MOHs continue in the role because they believe it is important to local community health. As can be seen by attendance at the annual MOH conference, they make real efforts to maintain their expertise in public health matters. It would be a pity if this group of professionals is to be disbanded and discarded.

*This submission was written by Dr. J. Keys-Brown (MOH City of Stonnington) with input from Drs. P.Kelly, M. Verso, I. Wilson, A. Richards, A. Gault, J. Philpot and G. Rowles.*