

# Queensland Centre for Public Health



## ANNUAL REPORT 2004



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# Director's Foreword

Welcome to the Annual Report of the Queensland Centre for Public Health (the Centre) for 2004.

In order to deliver effective population health education and research programs, the Centre facilitates collaboration with partners in the tertiary education, health industry and community sectors. The Centre seeks to identify and assist with education, research and training needs to improve and maintain population health and well being across Queensland. The Commonwealth Department of Health and Ageing Public Health and Education Research Program (PHERP) and Queensland Health provide funding support for the Centre.

In 2004 the Centre continued to foster strong links with health industry representatives through the Queensland Public Health Forum and various other committees. The key focus areas for the year included enhancing education quality, linking student research to industry needs, initiatives focusing on the needs of Indigenous Australians and industry focused workforce development.

Throughout the year alternative models for continuing education were presented to industry representatives. The Professional Development Model is a new vision for post-graduate education in public health that looks beyond traditional formal awards (eg the Master of Public Health, Graduate Diploma in Public Health, and Graduate Certificate in Public Health). It recognizes the complexity of the public health workforce and its educational and training requirements and allows greater flexibility in the design of non-award, non-assessable professional development. The model incorporates the use of new education short courses to accompany existing academic modules.

To ensure a benchmark for the quality of the program, the three universities assessed their MPH Program against a set of core learning objectives identified by the National Public Health Education Framework. These are graduate qualities considered to be independent of the curriculum at each university and therefore do not restrict course content, teaching methods or student learning experiences. This process was complemented by a qualitative survey. The findings identified several gaps, however it was noted that these are addressed by the core functions of the dissertation and research preparatory subjects. In effect, all learning outcomes are addressed through our MPH program.

There has been substantial improvement in our ability to link MPH students to the public health research priority areas identified by our industry and academic partners. The new research topic proforma provides a consistent format for industry groups and academics to submit their priority research areas to the Centre. These are presented to students at their Dissertation/Project Workshop and on the Centre website. Many students have chosen to pursue nominated topics.

A major centre activity in 2004 was organising and hosting a Satellite Program for "Health 2004, International Union of Health Promotion and Health Education (IUHPE) Conference" in Brisbane as a gateway conference. Our two-day program, "Settings for Health Promotion" on 4-5 May, 2004 (following the Melbourne Conference), was an overwhelming success. The Centre cooperated with Queensland Health to organize the event. We are grateful for the additional financial support provided by Queensland Health, Queensland Department of Families, and Queensland University of Technology.

## Director's Foreword

The Gateway Conference displayed leading health promotion developments in South-East Queensland and included field trips to schools, childcare centres and Indigenous settings. This event was by far our most effective professional development activity to date. The event attracted a large number of international, interstate and local participants.

In addition to a significant component of the Settings for Health Promotions satellite program, our Indigenous initiatives in 2004 also included an ACHSE Satellite Broadcast on Indigenous Sexual Health chaired by Professor Cindy Shannon. We collaborated with OATSIH on a project that investigated the feasibility of a professional association for Aboriginal and Torres Strait Islander Health Workers. The Centre Manager was seconded to OATSIH on an 8 week part-time basis to develop a background paper for the Queensland Aboriginal and Torres Strait Islander Reference Group. This group reports to the State Partnership Group which oversees the Aboriginal and Torres Strait Islander Health Workforce Strategic Framework Implementation Plan. This project played a major role in developing Strategy 20 from the Framework. It also provided an opportunity to improve relationships between Indigenous groups, the Centre and the Queensland Public Health Forum.

In continued involvement with the Queensland Public Forum Workforce Development Group, the Centre Manager drafted their Workforce Development Strategic Statement (see Appendix 1). This document details the background and context for the Forum's priorities on workforce development and will guide their work in 2005. The policy document was conditionally endorsed by the Forum in December 2004.

PHERP Phase III, was reviewed in the second half of 2004. The aim of the review was to report to the Commonwealth on the outcomes of Phase III and compare them against national Program objectives. The review is intended to guide the future strategic direction of the program. The Centre's submission for review is included in Appendix 2.

We look forward to a busy and challenging year in 2005. It will be the last year that the Directorate is based at QUT. The PHERP Review Report is expected to be released in the second half of 2005 and will provide further indication of future directions for the Centre.



A/Professor Don Stewart  
Director, Queensland Centre for Public Health

# Acknowledgements

2004 was a very busy and productive year for the Queensland Centre for Public Health (the Centre). We would like to acknowledge the support received from organisations and individuals which enables the Centre to operate and exist.

The Centre receives valuable funding and in-kind contributions from various public health sectors.

We wish to acknowledge all those who have contributed to the success of the program this year. Academic staff from the three universities have, in addition to their considerable teaching, research and supervision loads, made a significant commitment and contribution to various committees coordinated by the centre, as well as a number of important intersectoral committees. Their contribution to the Centre and public health is gratefully acknowledged.

We also wish to acknowledge our administrative staff. Usually, these staff have many commitments to other academic programs, academic staff and students. Programs run by the Centre frequently require additional and often complex coordination of information with submission dates during busy academic periods. Their diligence and commitment to their work, students and colleagues is to be commended.

Through the Public Health Education and Research Program (PHERP) Phase Three contract, the Department of Health and Ageing continues to support the range of the Centre's activities. Particular thanks to Angela McKinnon, Jane Bell, Annie Dullow, Kate Brown and Brendan Gibson.

The continuing support from Queensland Health is acknowledged. In 2004, Queensland Health funded the Centre Manager's salary. Particular thanks are extended to Dr John Scott, Andrea Casasola, Jackie Steele, Dr Amanda Bell, David Strain, Alison Thompson and Robyn Clark for their contribution to various collaborative activities.

Martin Webb, Project Officer for the Queensland Public Health Forum (the Forum) was a valuable resource to the Centre. Thanks must also be extended to a number of Forum members who gave freely of their time for numerous planning meetings. Mike Knowles from the Australian College of Health Service Executives is acknowledged for his contribution to combined Seminars with the Centre.

Finally, thanks is extended to all those who participated in collaborative meetings, forums, seminars, guest lectures and workshops. Your valuable participation has assisted the Centre in addressing the continuing and emerging needs for public health research, education and training.

# Introduction

The Queensland Centre for Public Health is a joint initiative of Griffith University, Queensland University of Technology and the University of Queensland.

In 1991, this consortium became the first to establish a Master of Public Health program (MPH) in Queensland. It has been delivering post-graduate public health programs since that time. The Queensland Centre for Public Health (the Centre) was formalised as a sustainable and fully developed agency in 1995.

The Centre directorate has been held and based at the School of Public Health, Queensland University of Technology, Kelvin Grove Campus since December 2002. Management of the consortium rotates every three years so that each institution has an opportunity to host the public health programs. The next rotation will take place in December 2005, at which time the directorate will move to Griffith University.

The Centre is one of nine State/National level centres that are funded by the Public Health Education and Research Program (PHERP) budget of the Department of Health and Aged Care. In Queensland, the Australian Centre for International and Tropical Health and Nutrition at the University of Queensland and The Anton Breinl Centre at James Cook University of North Queensland are also PHERP funded.

PHERP National Objectives have been identified. These are to:

- build on existing public health education and research infrastructure;

- provide leverage for more extensive public health work;

- strengthen the basis for high level and consistent quality education and research programs;

- foster innovation to ensure emerging population health education, research and workforce development needs are addressed;

- support initiatives in population health workforce development and education that focus on the needs of Indigenous Australians;

- foster co-operation and collaboration across education and research sectors for population health, particularly via links with the government and public health workforce;

- foster multi-disciplinary approaches to population health education and research.

These objectives are met through successful collaboration and partnerships with academic, government and non-government organisations.

This Annual Report highlights the achievements and activities of the Centre in addressing Queensland's public health education, training and research needs to date.

# QCPH Strategic Plan 2001 - 2005

## Mission

The mission of the Centre is to promote and deliver high quality population health education and research programs to health care professionals from a broad range of backgrounds, with knowledge and skills from a variety of disciplines in order to define, critically assess, and resolve public health problems.

## Vision

The vision of the Centre is that facilitating collaboration between partners in tertiary education, industry, and the community will identify education and training needs in population health across Queensland. Where appropriate, it will facilitate responses to identified needs both within the consortium, with other groups across Queensland, and nationally. It will also foster collaboration in population health research and be guided in its responses by research where relevant.

## Strategic Aims and Objectives

- Strengthen the capacity and expertise for population health education, research and training programs across Queensland in partnership with government, industry and the public health workforce;
- Identify the needs of student, industry, and community groups across Queensland in guiding content and delivery approaches of existing consortium population health programs;
- Develop mechanisms to facilitate inclusion and participation by all relevant stakeholders in education, training, and research programs run by the Centre;
- Foster co-operation and collaboration across the tertiary education sector to develop new opportunities in population health education, training, and research where needs are identified;
- Collaborate with the Queensland Public Health Forum, Queensland Health, and other industry groups to assess the specific education and skills required for specific population health specialties to inform training programs and employees.

# Management and Governance

The management and governance structure of the Centre is in accordance with conditions outlined in the PHERP contract and Queensland Health Service Agreement. The governance committees (see Figure 1) are structured to allow key stakeholders to participate in the strategic planning, policy development and operation of the Centre. Consortium members also agree to participate in, and to have regard to, the deliberations of the Queensland Public Health Forum.

## 2004 Directorate

The Directorate coordinates the administrative and academic activities of the Centre.

Director: Assoc Prof Don Stewart  
Deputy Director: Dr Elizabeth Parker  
Centre Manager: Kathleen Lilley  
Administration: James Athanasoff, Kate Lilley

## Board of Management

The Board of Management is comprised of the Director, the coordinators from each university and the Centre Manager. It manages the formal award programs, curriculum, teaching and student matters. It also acts as the Board of Examiners to the Centre while a separate committee reviews Dissertations.

Chair: Assoc Prof Don Stewart  
Members: Assoc Prof Cordia Chu  
Dr Elizabeth Parker  
Assoc Prof Philip Schluter  
Kathleen Lilley

## Consultative Committee

The role of the Consultative Committee is to provide policy advice, support and direction to the Board of Management in relation to national and regional population health education, research and workforce needs.

Chair: Assoc Prof Don Stewart  
Members: Vicki Murphy (Dept of Health and Ageing)  
Dr John Scott (Queensland Health)  
Dr Peter Anderson (Public Health Assoc, Qld)  
Bryce Hines (Local Government Assoc, Qld)  
Dr Peter Abernethy (Qld Public Health Forum)  
Prof Stephanie Short (Head of School, GU)  
Dr MaryLou Fleming, (Head of School, QUT)  
Venkat Reddy (UQ student representative)  
Chris Setter (QUT student representative)  
Assoc Prof Cordia Chu  
Assoc Prof Philip Schluter  
Dr Elizabeth Parker  
Kathleen Lilley

## Planning and Review Committee

The Planning and Review Committee develops industry/academic links. With the Centre Manager, its members represent Queensland Health, Commonwealth Department of Health and Ageing, Queensland Public Health Forum, consortium academics, and the consortium universities.

# Management and Governance

Queensland Public Health Forum  
Research and Workforce Development Group

The Research and Workforce Development Group examines competencies in Public Health and aims to determine the need for investment by industry to meet current and emerging needs of the public health workforce.

Public health research was prioritised by the Queensland Public Health Forum in 1999. This working group was consequently established. Its terms of reference are to:

- recommend current and emerging public health priorities to Health Promotion Queensland, for major health promotion grants;
- promote partnerships between Forum members and other affiliated bodies to develop these priorities and implement public health research and workforce development initiatives;
- encourage research and workforce development initiatives that ensure sustainable public health outcomes;
- advocate research and workforce development initiatives that build capacity in the public health workforce.

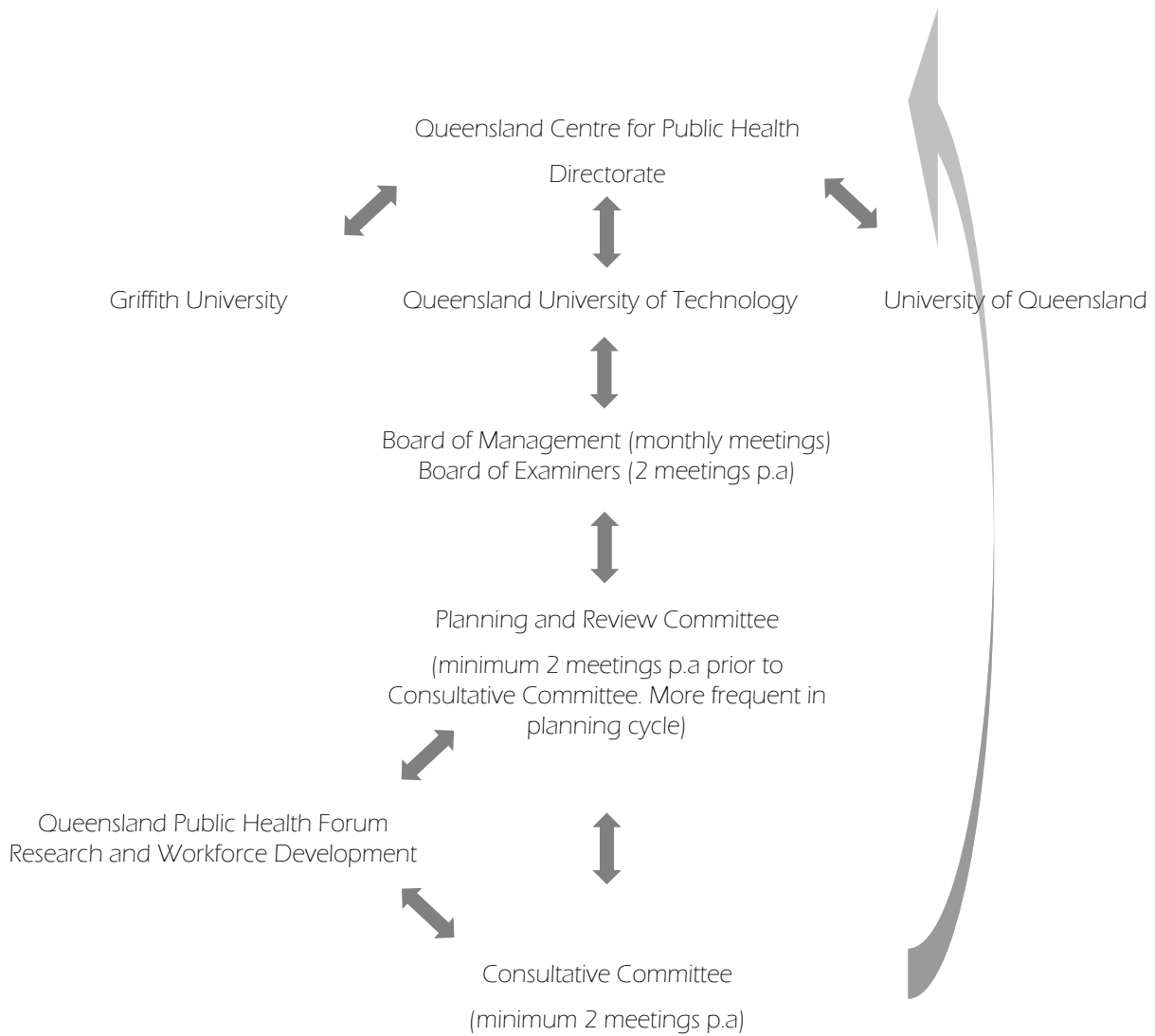
In 2004, a sub-committee for this group was formed to develop a Strategic Statement for Workforce Development.

Chair: Kathy Brown (Department of Health and Ageing)

Sub-committee members:           Martin Webb (QPHF)  
  Andrea Casasola (QH)  
  Alison Thompson  
  Kathleen Lilley

# Management and Governance

Figure 1



# Resources

The Public Health and Education Research Program (PHERP) of the Department of Health and Ageing is the primary source for the Centre funding. Queensland Health has continued to sponsor the Centre Manager position. In total the financial assistance for the Centre in 2004 was \$549,549.

The current contract was negotiated with the Department of Health and Ageing in 2001. It provides funding for the Centre until December 2005. The provision of PHERP funds allows the Centre to operate from a stable base, build on its strengths, and meet industry objectives while fostering innovation to meet the emerging health education, research, and workforce development needs. The PHERP financial support for the Centre in 2004 was \$469,549.

Queensland Health sponsors the position of Centre Manager. The primary purpose of the position is to facilitate effective links between the Centre, Queensland Health, Queensland Public Health Forum, and other universities in Queensland, to ensure that public health programs and research are linked to industry needs. The grant from Public Health Services Division of Queensland Health for 2004 was \$80,000.

In addition, each of the three universities contributed to the operation of the Centre through provision of services in-kind, namely academic time, services, and facilities. These in-kind contributions have been valued at \$529,779.

The Centre will endeavour to secure additional funding and other assistance from current and new sources to support and expand its education, research and collaborative activities. Refer to page 35 for the Centre's 2004 Consolidated Financial Statement.

# Staffing

## Directorate

Director	Assoc Prof Don Stewart
Deputy Director	Dr Elizabeth Parker
Centre Manger	Kathleen Lilley
Administration	James Athanasoff, Kate Lilley
MPH Coordinators	Assoc Prof Cordia Chu (GU), Dr Elizabeth Parker (QUT), Assoc Prof Philip Schluter (UQ)

## Other PHERP Funded Personnel

### Academic

#### GU

Dr John Grootjans  
Assoc Prof Peter Howard  
Karen McPhail-Bell  
Dr Claire Brown

#### QUT

Grant Warren  
Sue Gargett  
Simon Kitto  
Kate Lemerle  
Kay Mills  
Helen Higgins

Kenneth Josey  
Dr Nicholas Graves  
Paul Yardon  
Sue Wilson  
Louisa Collins  
Dr Dominique Bird

#### UQ

Assoc Prof Rod McClure  
Dr Christine Nagle

### Administration

Trish Gould  
Alison Butler  
Catherine Foster  
Kate Lilley

Christine O'Donnell  
Amanda Chape  
James Athanasoff

Diana Glynn-Connolly  
Mary Roset

## Program Academic Staff Funding from other University Sources and Other Personnel Associated with Curriculum Development & Delivery

### Academic

#### GU

Prof Stephanie Short  
Assoc Prof Cordia Chu  
Peter Davey  
Jennene Greenhill  
Neil Harris  
Zoe Murray  
Bernadette Sebar

#### QUT

Assoc Prof Don Stewart  
Assoc Prof Brian Oldenburg  
Peter Anderson  
Dr Josie Di Donato  
Gary Day  
Desley Vine  
Dr Elizabeth Parker  
Dr Diana Battistutta  
Dr Shilu Tong  
Dr Thomas Tenkate  
Dr Tertius De Kluyver

#### UQ

Prof Alan Lopez  
Prof Andrew Wilson  
Assoc Prof Peter O'Rourke  
Assoc Prof Philip Schluter  
Dr Chris Bain

### Administration

Paul Cunningham  
Lyn Guy  
Debby Findlay

# Student Data

## Public Health Program Student Data

As at 31 December 2004, 48 students graduated with either a Master of Public Health (34), a Graduate Diploma in Public Health (13), or a Graduate Certificate in Public Health from the Centre (1). 16 Students completed their dissertation.

443 students have completed the requirements for graduation from the Master of Public Health or Graduate Diploma in Public Health since 1991.

## 2004 Enrolment Statistics

University	Female	Male	Total	O/Seas	% Part Time
<b>New Students</b>					
GU	5	3	8	1	88
QUT	16	5	21	5	29
UQ	42	12	54	11	83
<b>Total New</b>	<b>63</b>	<b>20</b>	<b>83</b>	<b>17</b>	<b>70</b>
<b>Continuing Students</b>					
GU	17	6	23	17	0
QUT	27	12	39	0	23
UQ	50	15	65	1	80
<b>Total Continuing</b>	<b>94</b>	<b>33</b>	<b>127</b>	<b>18</b>	<b>48</b>
<b>Total Students</b>					
GU	22	9	31	18	23
QUT	43	17	60	5	25
UQ	92	27	119	12	82
<b>Total Students</b>	<b>157</b>	<b>53</b>	<b>210</b>	<b>35</b>	<b>57</b>

## 2004 Lunchtime Seminar Series

The Centre holds a seminar series on topics of public health interest to a wider public health community. The following seminars were convened in 2004.

- Date: 11 March 2004  
Speaker: Panel discussion and interactive forum  
Topic: **Health promoting schools: Evidence for effectiveness**
- Date: 4<sup>th</sup> & 5<sup>th</sup> May 2004  
Speakers: Various  
Topic: **IUHPE Brisbane Satellite Program, Settings for Health Promotion (See Pg 27)**
- Date: 13 May 2004  
Speaker: Mr Peter Davey & Assoc Prof. Don Stewart  
Topic: **Community public health planning and implementation review summary**
- Date: 10 June 2004  
Speaker: Professor Robyn Mc Dermott  
Topic: **Indigenous health and chronic disease; recent advances in North Queensland**
- Date: 8 July 2004  
Speaker: Dr Nick Graves  
Topic: **Would universal antenatal screening for HIV infection be cost-effective in Australia?**
- Date: 9 September 2004  
Speaker: Kathryn Wenham, Alexis Stockwell & Kylie Smith  
Topic: **MPH dissertation seminar: PHA prize dissertation nominees**
- Date: 14 October 2004  
Speaker: Professor Cindy Shannon  
Topic: **Indigenous workforce development**
- Date: 11 November 2004  
Speaker: Professor Annette Dobson  
Topic: **Australian longitudinal study on women's health; current directions and recent findings**

# Queensland Public Health Forum

The Queensland Public Health Forum (QPHF) is a strategic leadership alliance of 18 organisations that is committed to improving public health outcomes in Queensland. The QPHF partnering approach capitalises on each organisation's expertise and areas of influence to develop the most appropriate course of action for intervention in key public health issues. The benefits of this collaborative approach are integrated public health initiatives, minimised duplication of effort, and a clearly defined strategic position to advocate.

The Centre is one of the 18 member organisations on the Forum. As part of the Commonwealth contract the consortium members agree to participate in, and have regard to the deliberations of the Queensland Public Health Forum.

Associate Professor Don Stewart is a Forum member representing the universities in Queensland. Kathleen Lilley is a member of the Research & Workforce Development Group. Other university representatives include Peter Davey (Australian Environmental Institute of Queensland), Dr Peter Anderson (Public Health Association), and Dr Peter Howard (Australasian Faculty of Public Health Medicine).

The QPHF was the major outcome of the Public Health Partnerships in Queensland Symposium, held in July 1998. Over 240 representatives from government, non-government, private and tertiary education sectors attended the Symposium. There was a significant level of agreement among participants that there were opportunities to strengthen cooperation between organisations involved in public health, both in terms of strategic alignments and networking to implement strategies.

The Forum agreed to effect these outcomes through:

- collaboration between members of the QPHF;
- external advocacy;
- promoting capacity development (primarily in terms of the public health workforce and research); and
- over-seeing groups charged with implementation of interventions.

## Achievements

In 2004 the QPHF focused on specific key priorities and the health implications for all Queensland communities including Indigenous communities. QPHF also responded to public health developments and emerging issues. Strategic Statements have now been developed for the following issues:

**Food and Nutrition** — extending actions developed under the Eat Well Queensland strategy;

**Active Living** — encompassing state and national strategies;

**Tobacco Control** — encompassing state and national strategies;

**Research and Workforce Development.**

The Strategic Statements have been developed by implementation working groups comprised of relevant QPHF Members and the Executive Officer. These groups meet on a regular basis and report to the QPHF Executive Meeting. The Executive meets at least once per month and provides support for the bi-monthly QPHF Meeting.

# Queensland Public Health Forum

The QPHF addressed a number of topical and emerging issues throughout the year.

## Immunisation Value Added Project

Queensland Health has identified significant funds which could be invested in research through the QPHF. A sub-committee has been convened to develop a process for allocating funding to selected areas of immunisation research. The sub-committee includes representatives from Queensland Health, Queensland Divisions of General Practice, Local Government Association, and the QPHF, as well as Professor Peter McIntyre, Acting Director National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases.

## Eat Well Queensland

This is the first public health food and nutrition strategy to be developed for Queensland through active partnership between government, non-government, and professional associations. Through Eat Well Queensland, the QPHF has provided a framework for action to address the extremely high prevalence of diet-related disease including cardiovascular disease, diabetes and some forms of cancer in Queensland. Eat Well Queensland identifies priorities with the potential to achieve health gain including maternal and infant nutrition, vegetable and fruit intake, and overweight and obesity issues. Concerns such as increasing food security and access to healthy food throughout Queensland are also addressed. The results of the last Healthy Food Access Basket (HFAB) Survey have been a particular focus this year.

## National Health Impact Assessment Workshop

The National Public Health Partnership, through the enHealth Council, has awarded the development and conduct of a national HIA to QPHF. This important workshop will form a foundation for the advancement of HIA as an effective tool for identifying the benefits and opportunities for public health interventions. The National Health Impact Assessment Workshop will draw together a broad group of stakeholders from government and non-government organisations, community groups, and industry representatives with a vested interest in 'built environment' programs and projects. The workshop will focus on the national status of HIA, shared experiences through case studies, development of collaborative links, and future practices. The outcomes of the workshop will be collated and edited and will be available for presentation at the 36<sup>th</sup> Asia-Pacific Academic Consortium for the Public Health Conference in December 2004.

# Public Health Program

The Public Health Program aims to prepare health professionals to define, critically assess, and resolve public health problems.

The programs are designed for health professionals from a broad range of backgrounds, with knowledge and skills from a variety of disciplines who are interested in moving into the public health area, mid-career health professionals seeking advancement in their area of work, and for clinicians wishing to broaden their range of expertise and /or move into management.

The Centre provides students with access to staff, expertise and facilities of three metropolitan universities. Students are exposed to a range of public health perspectives through contact with other students from Australia and overseas. The programs allow the flexibility to choose full-time or part-time attendance mode, and to alter mode mid-course. Where attendance at classes is difficult or geographically impossible, students are able to study through external or flexible delivery. All students have access to a mentor system whereby they can receive individual academic guidance throughout the program.

The four core subjects of the program include Epidemiology, Health Care Delivery Systems, Social and Behavioural Determinants of Health, and Statistics. Each consortium member convenes a core subject and has their own statistics requirement.

Students identify their area of interest within public health to select electives and may later develop their interests in this area through a dissertation. They then develop a long-term study plan to suit their professional commitments and the availability of relevant subjects. Students may discuss their plans with the academic staff at any or all of the universities before selecting their “home university”.

# Coursework Masters

In 2003 the Centre introduced the Coursework Masters Degree. The program was introduced as part of a strategic planning process based on industry needs. The consortium agreed that the introduction of a Coursework Masters in Public Health would:

- provide increased flexibility and choice for students;
- appeal to a different population in the postgraduate market;
- increase program completions;
- be an option favoured by students with English as a secondary language;
- provide additional opportunities for the Centre to liaise with industry, in order to develop more innovative options for the delivery of public health education in the workplace.

The Coursework Masters allows students the flexibility to choose from a full coursework option, coursework with a guided study component, small research project or guided vocational experience.

The full coursework stream requires that a student complete the MPH with 100% of the program dedicated to coursework subjects. A student is required to complete the core subjects and an approved Research Methods subject. The normal rules governing the choice of a major apply. A student is required to choose a major by the end of Semester 1 (FT student) in order to select Semester 2 subjects. No introductory subjects will be permitted by Semester 3.

The option for coursework with a guided study component or a minor research project is a variation on the full coursework stream. While the rules for core subjects, research subject, advanced level subjects, and a major apply, this option will allow someone to take 20 credit points (GU), 24 credit points (QUT) or 4 units (UQ) in the final period as a guided study component or a minor research project. A mentor is appointed to assist the student in developing a study/research plan.

The coursework with a program of guided vocational experience option is similarly structured. The rules for core subjects, research subject, advanced level subjects, and a major still apply and the option student takes a 20 credit point (GU), 24 credit point (QUT), or 4 unit (UQ) option in their final period as a work place practicum experience. The workplace mentor and academic supervisor will assist the student to plan the practicum and the student is assessed on their preparation of a report or portfolio that documents their work place experience and the development of high-level skills.

# The Student Dissertation

The promotion of research is a priority for the Centre. As part of the requirements for the Master of Public Health Program, students undertake a research dissertation which is intended as a practicum to offer experience in investigating and/or solving a public health problem. This is usually undertaken on an individual basis.

The level or standard of an MPH dissertation is set between that of an honours thesis and that of a research masters thesis. It is expected that the dissertation will form the basis for a paper publishable in a major public health journal (eg. Australian and New Zealand Journal of Public Health).

## Topic and Supervision

Academic staff of the Centre guide students in regard to the appropriateness and development of their Dissertation topic. There are many projects in the community and within Queensland Health which may be suitable for a dissertation. The Centre acts as an agency to external service providers seeking assistance with research.

Work-place mentors with appropriate qualifications may co-supervise a dissertation. The Centre provides associate supervisor training and academic support for this process.

## Dissertation Format

Dissertations may take various forms:

- analysis and interpretation of a pre-existing data set of known good quality;
- individual solutions to small-scale practical public health problems identified by the organisation as a key priority area;
- development of a detailed research proposal which could include a literature review, critical appraisal, and piloting of proposal methodology; or
- critical review of an issue of major public health importance.

## Collaboration with Industry

The Centre has established a Dissertation Framework which guides the development of industry based research. The framework includes a set of protocols for joint industry-university approval and supervision of research dissertations. This was done in consultation with both Queensland Health and non-government organizations.

## 2004 Dissertation Summaries

**Diagnostic accuracy of rapid immunochromatographic assays for the detection of dengue virus IgM antibodies during the acute phase of infection: A systematic review and meta-analysis**

**Candidate: Stuart Blacksell**

A systematic literature review was performed using computer-based search engines to locate studies that used rapid methods for the detection of dengue IgM antibodies. Standardised quality assessment of selected studies using the QUADAS tool was performed to identify high quality studies for the final meta-analysis. A meta-analysis was performed on common outcome measures to determine the overall diagnostic accuracy of immunochromatographic tests (ICT). Heterogeneity between studies, and its sources, were investigated. From a total of 302 potentially suitable studies, 36 were included in the quality review from which 11 studies were selected for the final meta-analysis.

Significant between study heterogeneity invalidated pooling of diagnostic indices and therefore subgroup analysis was performed. When compared to the Panbio Duo ELISA, the dengue ICT demonstrated high levels of diagnostic accuracy. Furthermore, diagnostic accuracy was improved when samples were collected later in the infection. It is recommended that a high quality study be performed using the standardised diagnostic assay assessment methodologies described by the Cochrane Collaboration to confirm the results of this study.

**Surgical site infections within the vascular surgical patient: Identification of an appropriate index for risk stratification**

**Candidate: Merrilyn Curtis**

The aims of this study were to identify specific risk factors for vascular surgery patients that are predictive of the development of a surgical site infection (SSI) within the in-hospital and post-discharge settings. A case control study was conducted. Cases consisted of all patients who had developed a post-operative SSI after undergoing one of three similar vascular surgical procedures at a major tertiary hospital. A same-size sample of control cases was randomly selected from the remainder of patients who underwent the same procedure.

The study identified risk factors predictive for the development of an SSI following vascular surgery involving revascularisation of the lower extremities. Factors identified differed between those SSIs occurring within the in-patient setting compared to those occurring following discharge from hospital. For the purpose of prediction and preventative intervention, obesity is the only significant risk factor which can be identified pre-operatively. There is scope to modify this risk since there are commonly delays between the development of symptoms and the procedure.

## 2004 Dissertation Summaries

**Antenatal predictors of delivery outside a tertiary perinatal centre in mothers delivering extremely low birthweight infants in Queensland, 1998-2000**

**Candidate: Tim Donovan**

Despite advances in obstetric and neonatal care, the delivery of an infant of extremely low birthweight 500-999 grams (ELBW) outside a tertiary perinatal hospital continues to be associated with higher mortality and morbidity. The primary objective of this study was to establish quantitative risk measures among antenatal characteristics of mothers delivering an ELBW infant of gestation  $\geq 24$  weeks for birth outside a tertiary hospital. The Queensland Perinatal Data Collection was used.

Significant differential neonatal mortality remains between ELBW infants delivered outside the highest-level perinatal centres when compared with those delivered in the three tertiary hospitals. Antenatal factors associated with place of delivery suggest that appropriate in-utero transfer occurs following the presence of prelabour rupture of membranes, when pregnancy induced hypertension is detected, and in pregnancies with a congenital anomaly. However, mothers aged less than 25 years remain at higher risk of non-tertiary ELBW birth. Assessment of the admission – delivery time interval data suggests that at least 31% of mothers delivering an ELBW infant outside an appropriate perinatal centre had an opportunity for in-utero transport. The proportion of ELBW infants delivered outside a tertiary perinatal hospital should be used as one of the clinical indicators of a region's efficacy in perinatal care over time.

**Are there gender differences in the associations of physical activity and waist circumference with risk of undiagnosed abnormal glucose tolerance in Australian adults?**

**Candidate: Genevieve Healy**

There is clear evidence that type 2 diabetes and its precursor, impaired glucose tolerance, have a substantial impact on the Australian community. Physical activity and waist circumference are established independent risk factors for these conditions of abnormal glucose tolerance (AGT). However, the extent to which physical activity attenuates the risk of AGT in overweight and obese men and women is not clear. The aim of this dissertation was to explore the associations between waist circumference, physical activity, and undiagnosed AGT in men and women using a study sample of 7,356 adults (3,210 men; 4,146 women) from the cross-sectional 1999-2000 AusDiab study.

Logistic regression analysis revealed that sufficient physical activity was significantly associated with a reduced risk of AGT in men and women with a normal waist circumference. When waist circumference and physical activity status were considered simultaneously, men and women who were overweight or obese had a greater risk of AGT compared to men and women with a normal waist circumference, regardless of physical activity level. No gender differences were observed in any of the associations. The findings from this study suggest that both physical activity level and waist circumference should be used to identify men and women at risk of undiagnosed AGT.

## 2004 Dissertation Summaries

### **Workplace wellness and its measurement: A systematic review of randomised controlled studies**

**Candidate:** Beverly Oliver Leger

A systematic review of randomised controlled trials was undertaken to assess recent study designs and the outcomes of workplace health promotion activities. A range of databases were searched for relevant studies published in English, during the period 1996-2003. Two independent reviewers concurred on the inclusion of randomised controlled studies that measured outcomes in terms of worker, worker-organisation interface, or were structured to meet four core reporting quality criteria: employ a control or comparison group, provide pre-intervention and post-intervention data, and report on all the outcomes that the study set out to examine.

Fifteen studies were eligible for inclusion in the systematic review. None of these studies provided comparable outcome data that enabled meta-analysis of results. The outcome results of several original reviewed studies suggest increased benefits of workplace health promotion interventions. Despite these reports, all but two of 10 outcome categories provided insufficient data to establish important patterns of change. Outcome categories of fruit and vegetable consumption and cancer screening provided mixed and positive trends respectively for effectiveness in mass and high-risk prevention strategies. Due to selection and publication bias and problems with methodology and reporting quality, drawing a conclusion from this review regarding the effectiveness of workplace health promotion interventions is implausible.

### **Regional variation of end stage renal disease in Indigenous Australians**

**Candidate:** Anne Preston-Thomas

End stage renal disease (ESRD) is a significant health issue for Indigenous Australians in that it has an enormous impact on quality of life and contributes to high mortality and morbidity rates. It also has marked regional variation. This study aimed to determine the extent of regional variation in treated ESRD during the study period 1993-2001. The indirectly standardised incidence ratio of treated ESRD relative to the incidence in the total Australian population was calculated in order to compare rates between states and territories, between Aboriginal and Torres Strait Island Commission regions and to compare rates in regions with differing proportions of Indigenous population.

There has been a small but steady increase in incidence rates of treated ESRD in Indigenous Australians throughout Australia from 1993 to 2001. This increase is seen in most areas, from urban to remote. However, the previously documented exponential increase in incidence rates in certain remote areas was not confirmed by this study. Regions with a greater proportion of Indigenous population demonstrate high treated ESRD incidence in indigenous Australians. A high proportion of these patients have to relocate in order to access renal replacement therapy. There still exists a paucity of renal services in a number of areas of high need.

# 2004 Dissertation Summaries

## **Defining the boundaries of Autistic Spectrum Disorder diagnoses**

**Candidate:** Catherine Skellern

This study examines difficulties faced by paediatricians and child psychiatrists in confirming or denying a diagnosis of Autistic Spectrum Disorder (ASD). In addition to the inherent uncertainties involved in using behaviourally defined criteria, this study examined the practice of deliberate misrepresentation of ASD diagnosis as a potential contributing factor to the high prevalence rates of ASD in Queensland. A survey that examined the frequency of this type of consultation for newly referred patients, self-perceptions of accuracy of diagnoses and adequacy of training preparation, use of deliberate misrepresentation of diagnosis, and attitudes relating to this practice was sent to paediatricians and child psychiatrists in Queensland. Responses were received from 85% of paediatricians and 58% of child psychiatrists.

A significant number of children receiving ASD diagnoses relate in part to the practice of deliberate misrepresentation of ASD diagnoses in response to external pressures. Many paediatricians are struggling with the diagnostic challenges presented by this “new morbidity” and feel they are inadequately prepared by their training.

## **Risk factors for Barrett’s Oesophagus**

**Candidate:** Kylie Smith

Over the past 30 years there has been a rapid increase in the incidence of oesophageal adenocarcinoma. As a result, there has been recent interest in the disease which often precedes it, Barrett’s oesophagus. This study aimed to measure the risk of incident or dysplastic Barrett’s oesophagus associated with environmental and phenotypic exposures in a population-based case-control study as well as comparing the pattern and magnitude of associations found for incident and prevalent Barrett’s oesophagus. Preliminary data from a large population based case control study of Barrett’s oesophagus being conducted by the Queensland Institute of Medical Research was used. Eligible cases were classified as incident (newly diagnosed  $n = 143$ ) prevalent (previously diagnosed,  $n = 183$ ), or positive dysplasia ( $n = 53$ ) Barrett’s oesophagus cases. Two hundred and fifty-three controls, who were Queensland residents, were randomly selected from the electoral role.

There was a large difference between the risk estimates obtained for incident compared with prevalent Barrett’s oesophagus for the variables strenuous physical activity, acid reflux, heartburn, cigarette smoking, female BMI and history of hiatus hernia. Therefore investigators planning studies of Barrett’s oesophagus should determine whether cases are newly diagnosed, or existing as this is likely to influence their results. While a causal association cannot be inferred from one observational study it would appear from a public health point of view that both cigarette smoking and increased BMI are potentially avoidable risk factors for Barrett’s oesophagus.

## 2004 Dissertation Summaries

**Universal or selective directly observed treatment? A clinical audit of directly observed treatment and tuberculosis in north-east London (United Kingdom) cohort**

**Candidate: Kerri Viney**

Tuberculosis (TB) persists as a global public health challenge in the 21st century. Treatment completion remains a major objective and is an indication of program success. Universal directly observed treatment (DOT) is advocated by the World Health Organisation (WHO) as a recommended TB control strategy and is a means of addressing the challenge of completing a course of TB medication. Patients in countries offering selective DOT, are considered to be more at risk of non-adherence to treatment.

This study represents a retrospective clinical audit for the period 1997-2001. It compares actual practice against the standard in a selective DOT program in East London, UK. The study found that a program of selective DOT is appropriate in this setting. It appears that it is when approximately 30% of patients were on DOT treatment completion rates were optimised. Selective DOT may be appropriate in this setting, provided that treatment completion rates are maintained above 90% and that treatment outcome is documented for every patient with regular cohort analysis.

**A study of the offence histories of 200 speed offenders.**

**Candidate: Jane Manderson**

A demographic picture of speed offenders in terms of age groups, sex distribution and criminal histories is supplied. The recidivism rate and mean time for re-offence is calculated. An association was found between speed offences in the twelve months prior to the index offence and the presence of a high speed offence. Antisocial driving tendencies were more strongly associated with the presence of high speed offences in female speed offenders than male speed offenders. The presence of a crash history was associated with the presence of high speed offences and this effect was modified by age and the presence of a criminal history.

**What works? A select review of Indigenous mental health promotion interventions**

**Candidate: Nikki Clelland**

The need for action to promote mental health awareness and prevent mental health problems and disorders for Indigenous populations is undisputed. The purpose of this study was to identify effective Indigenous mental health promotion interventions to inform future policy, practice, and research. Twenty-three reports of Indigenous mental health promotion interventions were identified and analysed using a systematic review technique.

The results suggest that currently, the available evidence on effective Indigenous mental health promotion is limited. Future developments should ensure meaningful Indigenous participation and focus on the implementation and evaluation of comprehensive health promotion interventions together with appropriate research dissemination.

## 2004 Dissertation Summaries

### **Reorientation of child and family health Services: Sunshine Coast Health Service District**

**Candidate: Marilyn Chew**

The research that underpins this thesis focused on analysing specific elements of the change management processes that were employed to effect reorientation of child and family health services in the Sunshine Coast Health Service District. In particular, the research aimed to understand the impact of implementing the Family CARE Home Visiting Program on child and family health staff and the services that they provide. This necessitated changes in program and service structures, changes in practice for individual staff, and changes in working relationships.

Examination of these aspects of change required gaining an understanding from staff regarding their experience of the change processes and the impact of the changes on their practice, their behaviour and attitudes, as well as their working relationships. Qualitative methods, including focus groups and interviews, were used to conduct this research. The data were systematically analysed and collated into themes that emerged from the focus groups and interviews. These themes were further analysed by reflecting on the literature and developing a concept diagram which illustrated the key research findings.

The results of this research indicate that the Sunshine Coast Health Service District has made significant changes to the services it provides to families with infants and young children. The process of change has been supported by policy and a strong evidence base for providing services differently. In addition, there is a culture of continuous improvement and learning, with strong leadership and opportunities for staff to participate at all levels of service development.

### **Needle and syringe availability and support programs for HIV/AIDS prevention: An examination of community perceptions in Ganjiakou, Beijing, China**

**Candidate: Jia Li**

China has been experiencing a serious HIV/AIDS epidemic and the primary cause is the sharing of injection equipment among intravenous drug users (IDUs). In this regard, Needle and Syringe Availability and Support Programs (NSASPs) have proven effective in reducing the risk behaviour in this population. HIV/AIDS spread associated with IDU is an emerging issue in Ganjiakou, Beijing, China, and there is an urgent need to introduce a NSASP to help prevent or reduce the incidence of HIV/AIDS among IDUs in this community. In practice, community acceptance, support, and involvement are essential to the success of NSASPs, highlighting the importance of understanding community views and concerns about NSASPs. This study addresses this need by examining community perceptions of NSASPs.

The study was interpretive and explanatory in nature utilising qualitative methods to develop an in-depth understanding of community perceptions of NSASPs in Ganjiakou. The primary data collection method was semi-structured in-depth interviews. A thematic analysis of the data informed by grounded theory methodology was undertaken.

The study identified three categories of community perceptions of NSASPs: situation of community, circumstances of individuals, and nature of NSASPs. Each of the categories encompasses a number of factors clustered under themes.

## 2004 Dissertation Summaries

An explanatory framework was built to present the interrelations and interactions between the categories, themes, and factors. The study findings enhance our understanding of community views and concerns about NSASPs and provide useful information for the planning and implementation of NSASPs in China.

### **An investigation of the role of local government in obesity prevention**

**Candidate: Libby Baillie**

This study investigated the actual and potential role of local government jurisdictions in obesity prevention. Data were collected using three methodologies for providing public health intelligence relating to this issue, including a review of literature, analysis of existing obesity prevention strategy frameworks, and key stakeholder interviews. The analysis of these three intelligence sources focused on investigating potential areas where local governments can contribute to the actions, settings and targets of obesity prevention interventions, as outlined in existing national obesity strategy frameworks. In Australia, responsibility for obesity prevention has tended to rest with State and Federal government jurisdictions. There is limited scientific literature outlining the potential role of local governments available. This study demonstrates that stakeholders at the local government level believe they are in a unique position to contribute to the prevention of obesity at a population level, as they have the capacity to link local communities and neighbourhoods with state and federal governments. This potential is also supported by analysis of the types of interventions required, in particular those relating to reducing the impact of obesogenic environments.

### **Exploring theory, policy, and practice of sexuality education on the Gold Coast**

**Candidate: Elizabeth A. Barber**

This dissertation identifies key themes in the current literature and policy of sexuality education and applies these findings to the context of the Gold Coast, Queensland to gain insight into how health and education policies and research literature relate locally. Overall, current policies and guidelines reflect social justice and contemporary public health principles. However, the literature highlights several aspects of how sexuality education is commonly practiced contrary to these principles. Major criticisms emphasise a lack of clear definitions and values, inadequate teacher training, support and resources, fear of community response, and social environments that reward sexist and homophobic behaviours and promote conformity in children.

The Gold Coast was considered unique in terms of its celebration of glamour and partying in events such as “Indy” and “Schoolies”. Complements and disparities between government policies and the practice of sexuality education on the Gold Coast were found. Focus groups and an in-depth interview involving six school staff, two parents and four sexual health educators investigated how these stakeholders perceive sexuality education. The participants of the qualitative component agreed that involvement of parents and local community is the most significant missing link in comprehensive sexuality education. This dissertation concludes that much of society is not yet prepared to accept children’s need and right to learn about, experience, and express their sexuality. Community engagement in the development, implementation, and evaluation of sexuality education will likely improve its acceptability.

## 2004 Dissertation Summaries

### **Cambodian Mental Health Plan: A case study of the mental health policy process in a post conflict developing country**

**Candidate: Alexis Stockwell**

Cambodia, a post colonial developing country whose physical, social, human and economic capital was violently restructured over 20 years by the Khmer Rouge regime, recently undertook a policy process to reform their mental health sector by developing a DRAFT Cambodian Mental Health Plan 2003-2022. This qualitative research explores the development of this Plan within a post conflict developing country context using personal interviews with key informants involved in the policy development process. In particular the research explores the influences on the policy process, including stakeholders and context, using theories predominantly drawn from radical policy analysis perspectives but also from literature on colonisation, globalisation, international organisations, violence/conflict, mental health, health, and mental health policy perspectives.

The policy process research approach was taken because analysis of the mental health policy process is a young and underdeveloped discipline particularly for post conflict developing countries like Cambodia. Consequently this research was formative in nature. It gives insight to the dynamics of policy formulation and the significance of structural, professional, and interpersonal issues, to provide opportunities for the generation of hypotheses rather than final findings. The policy analysis theories and the interview tool developed to collect data for the research have been critiqued and a number of recommendations have been made for the use of this interview tool in similar research in the future.

### **Patterns of sun exposure and their relationship to melanoma of the trunk, of the head and neck, and of lentigo maligna melanoma in southeast Queensland.**

**Candidate: Mark Stickle**

This study, utilising a case-case design sought to determine whether each of several different measures of self-reported sun exposure, relating to childhood, adolescence or adulthood had a differential effect on the development of three different subtypes of melanoma – specifically superficial spreading melanoma or nodular melanoma of the trunk, superficial spreading melanoma or nodular melanoma of the head and neck, and lentigo maligna melanoma.

In this series, participants with truncal melanoma were younger than those with either head and neck melanoma or LMM. There were few significant associations between child and adolescent sun exposure and type of melanoma. Workday sun exposure tended to be associated with either head and neck melanoma or LMM, while weekend and holiday exposure tended to be associated with truncal melanoma, although few of these measures reached statistical significance. This data lends some support to theory that melanoma arises from more than one pathway.

## Academic/Industry Collaboration

The Centre aims to facilitate communication between academic and industry professionals in the Health domain. The collaboration across sectors in 2004 provided the Centre with strategic direction and enhanced the consortium's ability to respond to industry research and training needs.

A major part of this role in 2004 arose in response to the XVIIIth World Conference on Health Promotion and Health Education held in Melbourne from 26-30 April by the International Union of Health Promotion and Health Education (IUHPE).

The Centre developed and hosted a two day satellite program; Settings for Health Promotion from 4-5 May in Brisbane to draw guests from the conference and to encourage further consideration of conference themes. The satellite program showcased health promotion projects in Queensland. These included Health Promoting Schools, health promoting early childhood environments (child care centres), and Indigenous settings.

Day 1 of the program introduced visitors to conference themes through a series of keynote speeches. Speeches were delivered by members of IUHPE, Queensland Health, Department of Communities, Education Queensland and QUT. In the afternoon, participants attended breakout sessions in order to discuss conference focuses in greater depth. Topics discussed were; Aboriginal and Torres Strait Islander issues in health promotion, evaluation of health promotion in a settings framework, becoming a Health Promoting School, promoting health in early childhood environments, and community capacity building and planning.

On day 2, participants were invited to attend field trips to schools participating in the Western Gateway Health Promoting Schools Grant Scheme (Durack State School and Bremer State High School), the Resilient Children and Communities project funded by Health Promotion Queensland, and childcare centres participating in the Promoting Health in Early Childhood Environments program run by Queensland Health. There were also site visits to Ngutana-Lui (Aboriginal and Torres Strait Islander Cultural Centre in Inala) and the Aboriginal and Islander Community Health Service.

The program was an overwhelming success. There were over 120 registrants including overseas guests from Canada, Finland, Ireland, New Zealand, Samoa, Indonesia Singapore, South Africa, Taiwan, and the United Kingdom.

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# Consolidated Income & Expenditure Statement

Consolidated Income and Expenditure Statement  
for 1 January 2004 to 31 December 2004

	GU	QUT	UQ	QCPH Non PHERP	QCPH Total
	\$	\$	\$	\$	\$
<b>INCOME</b>					
Bought forward 1 January 2004	-11,054.24	52,243.41	-59,939.28	-474.47	-19,224.58
Amend b/fwd balance following audit	53,000.00				
PHERP Funding	90,450.07	166,571.41	212,528.00	-	469,549.48
Queensland Health	-	-	-	80,000.00	80,000.00
University In-kind contributions	106,000.00	180,185.98	243,593.00	-	529,778.98
Interest	0.00	1,900.70	0.00	891.76	2,792.46
<b>Total Income</b>	<b>238,395.83</b>	<b>400,901.50</b>	<b>396,181.72</b>	<b>80,417.29</b>	<b>1,115,896.34</b>
<b>EXPENDITURE</b>					
<b>Salary Expenses</b>					
Academic	125,230.00	58,806.31	116,319.36	-	300,355.67
Administrative	0.00	50,111.98	38,840.44	84,459.24	173,411.66
<b>Sub Total</b>	<b>125,230.00</b>	<b>108,918.29</b>	<b>155,159.80</b>	<b>84,459.24</b>	<b>473,767.33</b>
<b>Administration Expenses</b>					
Centre - Non PHERP Expenses	-	-	-		0.00
Communications	0.00	2,009.59	610.49	234.23	2,854.31
Consumables	0.00	13,911.73	818.43	62.27	14,792.43
Travel	0.00	3,121.20	0.00	2,330.64	5,451.84
Assets/Hire Services	6,022.00	0.00	0.00	-	6,022.00
<b>Sub Total</b>	<b>6,022.00</b>	<b>19,042.52</b>	<b>1,428.92</b>	<b>2,627.14</b>	<b>29,120.58</b>
<b>Total Expenditure</b>	<b>131,252.00</b>	<b>127,960.81</b>	<b>156,588.72</b>	<b>87,086.38</b>	<b>502,887.91</b>
<b>Net Surplus/(Deficit)</b>	<b>107,143.83</b>	<b>272,940.69</b>	<b>239,593.00</b>	<b>-6,669.09</b>	<b>613,008.43</b>

# Appendix 1 – QPHF Strategic Statement

## Queensland Public Health Forum Purpose Statement

The Queensland Public Health Forum facilitates collaboration between organisations with the aim of maximizing outcomes.

## Key Message of the Forum

To improve the health status of the individuals and communities of Queensland

## Strategic Statement – Workforce Development

### Background

Public health workforce development as a single issue is highly complex. It includes a diverse workforce, multiple delivery options, and involves numerous international, national, and state organisations and employers. To address the global burden of communicable and non-communicable diseases and emerging issues, the public health workforce must include the indirect workforce; professionals, disciplines, and workers influencing health and not previously considered in the public health domain.

Internationally, the World Health Organisation (WHO)<sup>1</sup> and the International Union for Health Promotion and Education (IUHPE)<sup>2</sup> are considering workforce capacity with respect to the global health crisis, issues of preparedness, and future directions.

Nationally, the workforce development agenda involves many key organisations; including the National Public Health Partnership (NPHP), Australian Network of Public Health Institutions (ANAPI), Public Health Education Research Program (PHERP), the Australian National Training Authority (ANTA), as well as employers, educational institutions, and training providers.

Models of workforce development include continuing professional development (short courses, seminars, and workshops), formal award programs (undergraduate, postgraduate, corporate awards, and higher degree options), and vocational training (certificate, diploma, and advanced diploma).

The Queensland Public Health Forum has identified workforce development as a key priority.

### Guiding principles

1. An appropriately skilled, sustainable, and distributed public health workforce is essential for maximising health outcomes.
2. Public health issues are complex in nature and influenced by a range of factors, many of which are outside the scope of health agencies. A multi-strategy, inter-sectoral approach which recognises that the achievement of good health is the shared responsibility of multiple sectors, is essential to produce real gains at the population level. Workforce development is guided by strong and sustainable approaches across the whole of Government.

### Burden of disease

1. Chronic diseases and conditions have been estimated to contribute to 70% of the total burden of disease, when measured by disability-adjusted life-years in developed countries<sup>3</sup> and contributes to 75% of the Australian national health priority areas.
2. The majority of the chronic disease burden is due to relatively few risk factors (high blood pressure, obesity, lack of exercise, smoking and alcohol). However, behavioural change can reduce this burden considerably<sup>4</sup>.

# Appendix 1 – QPHF Strategic Statement

3. The health of Queenslanders by some parameters is not as good as some other state populations, particularly that of Aboriginal and Torres Strait Islanders<sup>6</sup>.

4. An epidemiological and economic analysis of five public health programs - programs to reduce tobacco consumption, coronary heart disease, HIV/AIDS, measles and Hib-related diseases, and road trauma found the combined net value to be estimated at \$9.423 billion<sup>7</sup>.

## Health policy and services

1. Health policy is increasingly influenced by use of the best available evidence in an explicit, rigorous, and accountable way<sup>8</sup>.

2. Social and economic circumstances strongly affect health throughout life, so health policy must be linked to the social and economic determinants of health<sup>9</sup>.

3. Prevention also includes investing in outside the health care arena, including investments in education, housing, families and communities, sport, and recreation<sup>6</sup>.

4. Current organisational structures for health care delivery are discipline and funding based which interfere with the ability to deliver effective services which also impact positively on public health priorities now and in the future<sup>10</sup>.

5. Consumer involvement, community engagement, health promotion, integration, and multi-disciplinary approaches to primary health care will significantly alter the provision of health services and the education and training for health professionals<sup>6</sup>.

## Australian health workforce development agenda

1. The vision, principles, and strategies of the National Health Workforce Strategic Framework which identify key action areas including, supply, distribution, workplace environments, skills, workforce adaptability, evidence based policy, and planning are linked to the broader health system and key stakeholder collaboration<sup>11</sup>.

2. The National Public Health Partnership workforce planning agenda requires an organisational commitment to predict demand for public health knowledge, skills, and practice: to ensure demand is met and to set standards which ensure the quality of supply across the nation<sup>12</sup>.

3. Future workforce policy and planning must address multiple challenges which include: shortages and maldistribution, increasing flexibility in response to need, new technologies, health workforce reform, a shift in professional barriers, and the need to collaborate with universities, training authorities, health providers, and the community<sup>6</sup>.

4. The aim of the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework is “to transform and consolidate the workforce in Aboriginal and Torres Strait Islander health to achieve a competent workforce with clinical, management, community development, and cultural skills to address the health needs of Aboriginal and Torres Strait Islander peoples supported by appropriate training, supply, recruitment, and retention strategies”<sup>13</sup>.

5. The future challenges for public health require multi-faceted public health actions using a well-educated interdisciplinary team of professionals with an understanding of population health and the influence of multiple determinants<sup>14</sup>.

# Appendix 1 – QPHF Strategic Statement

## The Queensland Public Health Forum notes:

1. The increased national and state effort in developing frameworks relevant to the prevention of chronic disease and workforce development (see Table 1).

2. The recent trend to move away from workforce planning at a macro level to focus on the workforces of organisations<sup>14</sup>.

3. Public health education and training must be aimed at multiple levels of the workforce including those who will have senior level (leadership) responsibility, at masters and doctoral levels for many public health professionals, and educating the broader public health workforce through curriculum setting, distance learning, cross training, and continuing education and other methods<sup>14</sup>.

4. A number of international and national bodies are investigating strategies that address leadership development and systematic incentives for workforce development<sup>14</sup>.

## Consequences of not focusing on Public Health Workforce development:

- Inadequate workforce planning and development will not address workforce shortages, recruitment, and retention.

- A poorly skilled, unsustainable, and unequally distributed public health workforce will not have the capacity to effect public health outcomes.

Table 1

National Chronic Disease Strategic Framework	Queensland Chronic Disease Initiative
National Health Workforce Strategic Framework	Queensland Health proposed strategic plan for health workforce needs and risks (10 years and longer)
National Service Improvement Framework	
National Health Workforce Strategic Framework	
Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework National Aboriginal and Torres Strait Islander Health Worker qualifications and units for competency for health workforce	Queensland Aboriginal and Torres Strait Islander Health Workforce Implementation Plan
The PHERP investment in advancing public health workforce capacity	Queensland Centre for Public Health, James Cook University, and Australian Centre for Tropical Diseases and Nutrition linkages
ANAPHI collaboration among public health institutions	
NPHP workforce planning agenda	
	Queensland Public Health Forum Workforce Development Implementation Group
	Queensland Health Public Health Workforce in Local Government Project
	Director General's Allied Health Recruitment and Retention Taskforce Report 2001

# Appendix 1 – QPHF Strategic Statement

## Reference List

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## Appendix 2 – Submission for PHERP Review

### Summary

Over the last 15 years, the Griffith University, Queensland University of Technology, and the University of Queensland consortium, acting as the Queensland Centre for Public Health (the Centre) has made a substantial contribution to the development of both the Queensland and national health workforce to address our nation's public health challenges. It has provided a steady supply of emerging leaders and mid-level professionals with skills and experience in both core disciplines and specialist areas that are relevant to public health practice. The support of PHERP has been vital to these developments and it is unlikely that either the quantum or quality of graduates and coursework would have been achieved without such support. PHERP support has provided opportunities for key organisational gains, such as leverage with Queensland Health and across sectors, and motivation within the university environment for partnership, collaboration, and building on strengths.

However, although the Centre has made a very important contribution since its establishment in 1994, the current directorate is well aware that we must now respond to changing circumstances and develop a new vision for the future. Such a vision includes support for existing initiatives, together with a new focus on such issues as Indigenous health and health workers, a recognition of the distinctive demographic and environmental circumstances prevailing in the State including disparities in wealth, the importance of partnership with key industry providers and other academic institutions to focus on national and state public health priorities, and the importance of extending PHERP support beyond current formal educational awards to research and broader health workforce training. The establishment of a Queensland Institute for Public Health may provide an integrating structure to achieve such goals.

Evaluation of the Centre against national Program objectives

#### **Workforce development principles:**

The guiding principles of the Centre are aligned with the Queensland Public Health Forum (QPHF):

- i. Workforce development is guided by strong and sustainable relationships between health and education sectors and is informed by evidence, policy, and planning relating to the broader health system.
- ii. An appropriately skilled, sustainable, and distributed workforce is essential for maximizing public health outcomes.

#### **a) Value for money.**

##### **As a proportion of income and as leverage for additional income**

The PHERP grant has allowed for developments and support which has improved the teaching program in particular, such as through both dedicated contract positions and short-term visiting/casual lecturing. In addition, it has allowed for leveraging against QH and other funding opportunities. Although the contribution from PHERP to the public health teaching program of the Centre has been relatively minor it has been an important factor affecting the program. Over the life of the PHERP contracts the Consortium contribution has consistently been matched, usually by a factor of greater than 2:1, by DEST funding.

QH has provided about \$80,000pa to the Centre to fund a Centre Manager since 1995.

## Appendix 2 – Submission for PHERP Review

Also, *ad hoc* grants have been made available for various tasks, projects and positions, building on the Centre/PHERP/QH partnership, such as funding for:

- a community health planning research project,
- the Queensland Public Health Forum project officer,
- summer Schools and Indigenous student scholarships.

### Promotion of dialogue at State level

The Centre Manager has been an important focus for planning and facilitating links and partnership between the three universities and Queensland Health. The position is directly linked to PHERP funding and PHERP objectives. The current Business Plan for the centre, developed in collaboration with QH, requires the alignment of PHERP, QH, and the Centre's objectives.

In 2002 the Centre commissioned an external Review to investigate future directions. As a result, a decision was made to modify the Manager's position to promote dialogue and facilitate academic/industry linkages. Thus, over recent years the role and function of this position has increasingly been modified from direct Centre support, to promoting QCPH/industry links. The current Service Agreement requires 60 per cent of the Centre Manager's efforts to focus on promoting industry-consortium links.

The Centre Manager position has allowed for:

- improved dialogue with QH Public Health Services regarding mutual requirements and objectives (via the Centre's Planning and Review Committee);
- improved understanding of State needs, such as linking QH research priorities to student research projects (via the Centre's web page);
- more efficient linkage between industry employment requirements and graduate opportunities (via industry surveys and postings on the Centre's web page);

- improved understanding of the breadth of the public health industry employment requirements (via the Centre's web page);
- improved contribution to Indigenous Health Worker support and organisation (via 2 days per week secondment of Centre Manager to OATSIH to work on the development of the Aboriginal Health Worker Association);
- agreement with QH regarding the Centre's development of a flexible and responsive industry professional development model;
- developmental work with QPHF on the Research Work Force Development Group;
- the drafting and tabling to industry (at the QPHF) of multiple desktop papers (eg, Queensland Rural and Remote Public Health Workforce Development; Rural workforce workshop summary; Shared Teaching Model; Professional Doctorate & Workplace Training Issues Paper; Professional Development Model Discussion Paper; the Centre and QPHF Research Agenda; Recruitment opportunities; Future of Public Health Training in Queensland; Population Health Training Package; QPHF Workforce Strategic Statement (draft); Public Health Professional Competency Standards on Queensland (draft)).

### Staff positions and improved teaching capacity

Each university has used the PHERP funding to build up academic staffing (eg, in epidemiology/biostatistics, health economics and health service management, environmental and community health). These staff, in turn, have typically been involved in applying for grants, conducting consultancies, writing and publishing, as well as teaching various public health programs in a range of undergraduate and postgraduate courses. Evidence of this direct PHERP contribution has been noted in the Centre's Annual Reports.

## Appendix 2 – Submission for PHERP Review

### b) Quality, impact and relevance of Program outputs

#### Workforce Training

The Centre has made a substantial impact on the public health human resource infrastructure in Queensland, with almost 400 MPH/GDPH completions. As indicated in data provided in the Centre's Annual Reports to DoHA, there is continuing steady demand for places on the MPH program and our graduate employment is strong. There is also a solid demand from international students. We consider that we have developed a platform for mid-career public health professionals such that they are able to respond to new and/or emergency issues with 'surge capacity' if required. Discussions regarding the feasibility of a public health officer scheme have been initiated and remain on the Centre's agenda.

#### Research

PHERP funding, through the appointment of academic staff, has provided an important opportunity to increase public health research. In terms of the coursework programs supported by PHERP, approximately 250 industry based dissertations have built skills, professional expectations, and a research or evidence-based culture within the health industry sector employing our graduates. QH (Public Health Services) and the Centre, through the Planning and Review Committee, have developed a mechanism to link QH public health research priorities to student interests. However, a more systematic, resourced framework for public health research, that builds sustainable links between industry research requirements and the Centre's strengths is still a challenge.

#### Innovation projects

Members of the Consortium have been successful in accessing PHERP Innovations funding and these projects have provided a key focus on research and have been leading public health research in many ways. To gain the maximum benefit from these and the other 40 or so PHERP Innovation projects currently funded, it is necessary to review their sustainability as well as the optimal pathway to ensure that important new learning is 'mainstreamed' into the Centre's teaching and coursework. It is recognised that ANAPHI and DoHA are working to promote this important linkage/pathway.

#### Summary

The PHERP investment in the consortium has had a multiplier effect on the Return on Investment for DoHA. In terms of professional public health practitioners and researchers there is good evidence to indicate that the Centre has made a substantial contribution and that demand is sustained for the Centre's courses.

i) PHERP funding has facilitated leveraging and the development of partnerships, such as with QH, eg, the Centre Manager role, and the Queensland Public Health Forum. Substantial benefits have accrued which would have been unlikely without PHERP support.

ii) PHERP has stimulated research across members of the Consortium directly, via student dissertations, and indirectly, via the Innovations program (e.g. Environment Health education; Social Inequalities and Health; Health across the life cycle). At the same time, there is room for greater collaboration and partnership with the health industry, for example the development of a systematic funding mechanism linking QH research priorities to research strengths within the Consortium.

## Appendix 2 – Submission for PHERP Review

Future strategic directions for the Program

### **a) Alignment with current and emerging national public health priorities**

#### **Indigenous health (student support, coursework, extension teaching)**

Queensland has a number of unique circumstances, such as population distribution, climatic zone/ecology and Indigenous populations which need to be recognised. The Centre accepts the health workforce education and training challenge encapsulated in the QH view that: “The complex challenges required to improve the health of Indigenous Queenslanders include, local governance arrangements, access to culturally appropriate primary care services, adequately skilled workforce in remote areas, especially the Indigenous health workforce.” (*Health 2020 p. 33*). The centre considers that to prevent increasing levels of inequity it is necessary to build on existing strengths to support Indigenous students and relevant curriculum initiatives that recognise the specific needs of this group.

#### **Burden of disease**

The Centre recognises the significance of chronic diseases and conditions that have been estimated to contribute to 70-75% of the total burden of disease, when measured in disability-adjusted life-years in developed countries such as Australia (*The world health report 2003 - shaping the future; Preventing Chronic Disease: A Strategic Framework, Background Paper, NPHP Oct 2001*). Research into the changing burden of disease as well as the mechanisms through which this information flows to a wide range of public health workers is required and this research must be reflected in relevant coursework for the health workforce.

#### **Demographic issues (Statewide, outer metropolitan, urban, rural, remote) and population movements**

The Centre recognises that social and economic circumstances have a major effect on health throughout life and that health policy must be linked to the social and economic determinants of health. The Centre concurs with QH in its statement that: “Prevention [also] includes investing in outside the healthcare arena, including investments in education, housing, families and communities, sport and recreation.” (*Health 2020*). The impact of rural/remote environments as well as outer metropolitan and urban living on health outcomes is required. Migration within Queensland and from southern states, as well as international migration, poses issues relating to housing, employment and transport, as well as access to health services. As an international and national focus for travel and tourism, Queensland is frequently a gateway and thus issues relating to mobility and rapid transmission of potentially dangerous diseases must be recognised.

### **b) The delivery of high quality, sustainable, and value for money Program outputs**

The Centre considers that there is potential for greater linkage of both national and state public health priorities to coursework and research. This will require a substantial review of current teaching and learning processes such that academic requirements and learning objectives are achieved through more targeted coursework. Possible options include a more ‘problem-based’ learning perspective. Resources will be required to support this approach across the consortium.

## Appendix 2 – Submission for PHERP Review

It is also likely that additional or alternative partners will have expertise in specific public health priority areas. This may therefore require a looser consortium arrangement and opportunities to include additional partners for specific functions or purposes.

It is conceivable that a more widely oriented structure formed as a 'Queensland Institute for Public Health' may be more appropriate. Such a structure could be modelled on the NSW Institute of Health Research, or the Victorian Public Health Research Centre, and could provide a focus for activities currently provided through Health Promotion Queensland, the QPHF, the Centre Manager, and other public health bodies. It would require substantial support from Queensland Health to ensure State priorities were addressed.

### c) Role of workforce and research capacity building

The Centre accepts that a broad definition of 'health workforce' is required when considering the public health field. To date, most effort has been directed to mid-career professional awards (MPH, Grad Dip PH, Grad Cert PH). At the same time, each member of the Consortium offers individual award and non-award pre-service (eg, BHLthSc) and in-service (eg, CPE and Professional Development) health workforce support.

However, bearing in mind developments in the USA: "Public health education includes a senior level responsibility, masters, and doctoral level as well as educating the broader public health workforce through curriculum setting, distance learning, cross training, and continuing education and other methods" (*Who will keep the public healthy? Educating Public Health Professionals for the 21st Century. The National Academy of Science, 2003, p 110*).

With respect to a vision for the future that may see a declining workforce, the Centre is eager to engage and partner industry across jurisdictions to prepare for a future in which: "The competition for a declining workforce will require health workforce reform, a shift in professional barriers, consultation with universities, training authorities, health providers, and the community, and consideration of new professions in order to meet future workforce needs" (*Health 2020*).

### d) Future design of the Program

The challenge for PHERP is to provide incentives for multi-faceted workforce development that not only builds on the established disciplines of public health, but also recognises the importance of developing problem solving skills, and reinforces the importance of an interdisciplinary and ecological focus. In the light of these comments, the Centre will work collaboratively with the government and non-government sectors and in consultation with national interest groups to develop an action plan to address Queensland workforce developments. Possibly through QPHF, as an inter-sectoral, multidisciplinary group, new and innovative approaches to workforce development which encourage workplace training, mentoring, joint or adjunct appointments, secondments and implementation strategies involving all stakeholders can be considered.

### Summary

iv) The issues relating to Indigenous health, Indigenous health worker, and appropriate health service models must be addressed in a more systematic and comprehensive manner. This will require increased support for Indigenous students and appropriate learning environments.

## Appendix 2 – Submission for PHERP Review

v) The unique demographic and environmental circumstances prevailing in Queensland and the impact of rural, remote, outer metropolitan, and urban living on morbidity and mortality must be recognised. Research regarding the burden of disease and policies/services related to emerging trends must be integrated into health workforce education. Core studies in demography should be integrated into the public health workforce curriculum.

vi) Disparities in wealth and the socio-economic determinants of health should provide a focus for workforce education and research development.

vii) In partnership with other academic and industry partners in Queensland, the Centre should:

- improve linkage of both national and state public health priorities to the coursework and research programs that we offer;
- align these priorities and pedagogical options; and
- critically evaluate new/alternative partners within the current Consortium arrangement.

viii) Consider the establishment of a Queensland Institute for Public Health as a means of coordinating, advocating, supporting, and enhancing public health education, research, and workforce development in the State of Queensland.

ix) Department of Health and Ageing (DoHA) and QH should enter a dialogue with the Centre regarding support, such as internships, scholarships, and professional development leave in order to encourage public health study at the doctoral level as well as opportunities for educating the broader public health workforce.