

Public Health Workforce in Local Government

Functions, Skills, Recruitment and Retention

PROJECT REPORT

July 2004



Queensland Government
Queensland Health

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FOREWORD

Local governments, including Aboriginal Community Councils and Torres Strait Island Community Councils, have the primary role of maintaining public health standards in their community. In Queensland many of these functions are also reflected in legislation where local governments are devolved the responsibility to administer and enforce certain public health requirements. To achieve its desired public health outcomes, local government requires a workforce with relevant and appropriate public health expertise and experience.

In 2000 Queensland Health's Public Health Services, the Local Government Association of Queensland (LGAQ) and Local Governments of Queensland developed a Public Health Partnership Protocol in relation to the provision of public health services to the population of Queensland. The protocol provides commitment to protecting health; preventing disease, illness and injury; promoting health and well being; and supports the capacity to positively influence decision making in a sustainable manner that improves the health status of Queenslanders.

This report will also inform the environmental health workforce of discussions at the national level. EnHealth, who provides national leadership on environmental health issues through the National Public Health Partnership, is considering issues regarding the practice of environmental health at the local government level.

A number of other reports and events have reinforced issues relating to the capacity of local governments to administer and enforce public health legislation. Recent legal determinations, such as the Wallis Lake Oyster incident, have emphasised that agencies that devolve legislative responsibilities to other agencies retain a degree of accountability for outcomes relating to those devolved issues.

This Project Report is a comprehensive identification of issues faced by Queensland Local Government, including Aboriginal Community Councils and Torres Strait Island Community Councils, surrounding the enforcement of public health legislation. I encourage regulatory agencies, including local government, to utilise the information in this report to assist in the development of strategies to address issues and plan for the future delivery of public health outcomes.

Dr Steve Buckland
Director-General
Queensland Department of Health

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Acknowledgement

Our appreciation is conveyed to all who participated in this Review.

All personal submissions have been treated as confidential. Illustrative quotes have been edited as necessary to preserve anonymity.

Thank you for your support.

The opinions expressed in this report, and recommendations on strategies and actions are those of the consultant. They are not an adopted policy position of Queensland Health or other stakeholders.

*Alan Morton & Lorell Edwards,
Morton Consulting Services Pty. Ltd. July 2004*

EXECUTIVE SUMMARY

1.0 Project Background and Scope

Queensland Health, commissioned this project in March 2004. A project Steering Committee comprising representatives from Queensland Health, the Department of Local Government and Planning (DLGP), the Department of Aboriginal and Torres Strait Islander Policy (DATSIP), the Local Government Association of Queensland (LGAQ) and the Australian Institute of Environmental Health (AIEH) was established.

The focus of this project is on the functions and skills of the workforce responsible for public and environmental health at the local government level, along with issues related to recruitment and retention of a suitably skilled workforce across the range of local government situations in Queensland.

This study is of particular relevance to rural, remote and indigenous communities where the problem of attracting a suitably skilled workforce is greatest.

In undertaking the project, a strong emphasis was placed on consultation with all relevant stakeholders.

2.0 What is Public Health from a Local Government Perspective?

The National Environmental Health Strategy (NEHS) notes that environmental health practice covers the assessment, correction, control and prevention of environmental factors that can adversely affect health, as well as the enhancement of those aspects of the environment that can improve human health.

At the local government level, a wide range of functions relate directly to public health including:-

<ul style="list-style-type: none"> ▪ Provision of a safe potable water supply; ▪ Removal, treatment and management of solid and liquid waste; ▪ Ensuring healthy housing and accommodation; ▪ Mosquito control; ▪ Control of vermin; ▪ Control of nuisances including animals, dust, noise, overgrown lots, smoke and fumes; ▪ Safety of noxious and hazardous goods; ▪ Prevention of infectious diseases; ▪ Ensuring food safety; 	<ul style="list-style-type: none"> ▪ Regulation of personal appearance services (hair dressing, skin penetration); ▪ Management of sharps; ▪ Management of recreational water including public pools/spas; ▪ Street cleaning; ▪ Immunisation; ▪ Control of mass events; ▪ Public health planning and promotion; ▪ Environmental pollution response and cleanup; ▪ Protecting health in disasters and emergencies.
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There are many other activities that support maintenance of public or environmental health in a community such as housing standards, traffic control, street lighting, provision of shade, landscaping, sport and recreation facilities, control of noxious and pest plants and environmental regulation. In essence, it is possible to link almost every activity of local government with public health outcomes.

It is also important to note that any failures in relation to implementation of other legislation (eg EPA/IPA - poor planning decisions on separation of incompatible uses) may lead to public health issues requiring action under the Health Act.

There is a range of professional and technical skills involved in functions that have a direct impact on the public health of a community. When each of the streams of potential public health risk (eg housing, food, water, waste, vectors, vermin, pollution, etc) are considered as a whole, it is the skill to develop, integrate, coordinate and manage risks, strategies and responses that minimise poor health outcomes in the community that are key competencies required at the local government level.

3.0 Legislative Background

At the time the *Health Act 1937* was enacted, the primary role of local government was seen as providing basic infrastructure and property related services.

As a result of the approach by the state to local government in the early part of the 20th century, the *Health Act 1937* contains many provisions that allow the state to direct local government (eg s. 22(4) appointment of medical officer of health, analyst, inspector; s.9 and s.16 default of local government; s.170 step in powers).

Prior to the LG Act 1993, the appointment of an authorised officer under the Health Act required approval of the chief executive of Health. Today such an appointment is the responsibility of the CEO of the local government.

It is appropriate to note that, in an historical context, many functions that were covered by the *Health Act 1937* have, over time, resulted in separate pieces of legislation. This includes the Food Act, some functions under the Environment Protection Act (EPA) and Water Act and now the new Public Health (Infection Control for Personal Appearance Services) Act 2003. A new Public Health Act draft Bill is expected to be presented by mid 2005. A revised Food Act should also be enacted in 2005.

There has been a substantial shift in the approach of the state government to its control and regulation of local government since 1937. At that time, local government was seen as a creature of the state, and powers devolved to local government were strictly controlled and monitored.

Considerable change is taking place in legislation covering the role of local government in public health. Central to the changes is the concept of a risk-based framework. It is apparent from discussion papers on the proposed food and public health Acts that the new legislation will be far less directive and controlling, respecting the modern approach to the division of powers between two spheres of government.

Based on information currently available, a key impact for local government will be that authorised officers can be appointed for a specific activity (eg food auditing, personal appearances, etc.). What this means in practice could be that persons with specialised (but narrow) skill sets may be available to undertake components of the public health role rather than such inspections being done by an AIEH accredited EHO with broad competencies covering a wide field of public health matters. If this trend towards specific authorisation provides greater choice and flexibility to local government, and acts to reduce costs, then these changes are likely to be supported by local government.

On the other hand, some elements within the environmental health profession may see this as an erosion of the skills and competencies required to superintend devolved legislation, and as an adverse impact on the functions of the environmental and public health profession as it is currently known.

4.0 The Broader Challenge for Professional Recruitment and Retention

The issues related to recruitment and retention of the public health workforce required by local government need to be seen in the wider context of social and demographic trends within Australian society. These broader demographic, economic and social factors have challenged the viability and vitality of rural communities for over three decades and continue to foster the 'urban drift' – or to use the current phrase 'sea change'.

Frequent comment was made on the issue of lifestyle when EHOs consider rural positions. Matters such as family stage (eg partner career, children at school) impact on people differently. A capacity to integrate with the community coupled with employment opportunities for a partner, were seen as vital elements for successful career development in rural and remote locations.

Other studies of recruitment and retention of professional staff confirm points made in consultation on this project. Family factors in both recruitment and retention are of particular relevance.

Profile of Queensland EHOs and Local Government

- An estimated 320 (FTE) EHOs service Queensland local government. This represents 0.86 per 10,000 population;
- Some 172 (54%) EHOs are employed in SEQ, with 75% of the population. This represents 0.68 per 10,000 population;
- Some 148 EHOs serve the rest of Queensland local government or 1.26 per 10,000 population;
- 28% of mainstream councils are served through arrangements with other councils or service providers;
- Only 27 councils in Queensland have a population greater than 20,000 people;
- There are 39 mainstream and 34 indigenous councils with less than 3,000 population;
- 20 mainstream councils (16%) represent 80% of the state's population;
- Only 25% of councils in the state have more than one qualified EHO position available.

NEHS notes that the role of environmental health practitioners is changing and there needs to be:

- effective under-graduate and post-graduate education, research and continuing professional development;
- increased concentration by EHOs on areas of speciality, such as food safety or waste management;
- more rigorous continuing professional development.

Consultation undertaken for this project confirms that these elements remain as critical issues.

5.0 Awareness and Understanding of Public Health Role in Local Government

With such a broad range of functions and disciplines involved at a local government level, it may not be surprising that EHOs responsible for public health functions devolved under the *Health Act 1937* and *Food Act 1981* (and associated regulations) often feel that their role is not well understood or properly valued by councilors, senior officers or the community. Such feelings are an issue within the environmental health profession and impact on job satisfaction and career paths within local government.

There are also significant differences in the way in which individual councils perceive environmental factors as causing a risk to public health. Frequent comment from EHOs in smaller provincial and rural locations focused on the low priority afforded environmental health functions by councils in budgets and administrative resource allocation. The problem manifests itself through a reluctance of some councils to require rectification of defaults and, in some cases, to proceed to a prosecution.

A review of the LGAQ elected member training course content indicates that there is virtually no mention of the delegated public health functions of local government. While functions such as

mosquito control and health inspections and licensing are noted as activities of a council, there is no coverage of the delegated powers under the Health Act or Food Act, and in particular the potential risks to public health as a consequence of not adequately addressing this function. In contrast, the EPA, IPA and the Water Act are covered in some detail.

Given the legal liability issues associated with public health responsibilities, some increased emphasis on public health functions in elected member training might assist in getting the message across.

While enhanced training programs will raise awareness and understanding, it is essential that councils develop policy positions on public health roles as an element of their corporate planning. By actively considering public health and determining strategies, actions and performance indicators, the profile of this function would be raised and the council would be required to translate this into initiatives within the operational plan.

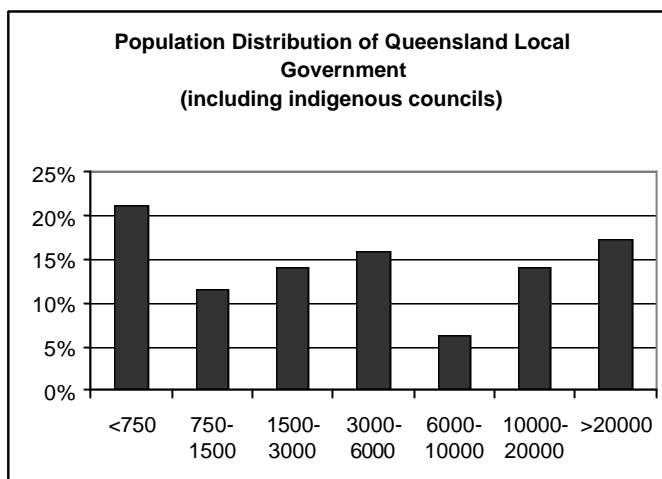
Concerns exist in relation to the lack of reporting by councils on public health outcomes within their communities. Given the legislative emphasis in the LG Act on the autonomy of local government, there are those who feel it is potentially not appropriate for QHealth to require specific reporting when the function has been delegated to local government. From this perspective, it should in reality be an element of "good practice" for the local government to provide effective reporting to the community (and other stakeholders) on their performance. The council Annual Report could effectively become a mechanism for a "state of the environment" report by local government.

The current Health Act provides little guidance to councils in relation to the public health responsibilities of local government. The ability to better communicate the role and function of local government in public health would be enhanced by a more definitive statement in the proposed Public Health Act.

6.0 Servicing Smaller Rural and Regional Councils

This review has identified a significant problem for small councils in cost effectively retaining the required resources and expertise to undertake public health functions. With around one-third of councils in the state containing less than 3000 people, the public health function for these councils requires less than one-quarter of a full-time equivalent EHO. In these situations, there is clearly a need for shared arrangements or other mechanisms if public health roles are to be effectively addressed.

A number of EHOs commented on the high loss rate from the profession. One reason given for this turnover was the lack of opportunities to progress within smaller councils.



While shared arrangements with a larger council or use of consultants will continue to assist smaller councils, some additional options need to be explored, and may be appropriate in some regional situations. These options include Regional Organisations of Councils (or similar regional bodies) becoming service providers for a number of councils in the region sufficient to allow employment of two or more EHOs, or some other forms of group employer type arrangement.

A more “arm’s length” employer being involved in inspection and regulatory functions in small communities may also assist in overcoming some of the inappropriate local “pressures” on EHOs, as identified in this report.

It is noted that LGAQ is also considering whether it could operate as a group employer for some professions to better facilitate provision of required skills to rural and remote councils and to enable more effective career path development and mentoring. This labour market need is currently not being met by any other sector.

The rural EHO is required to be multi-skilled if the council is to have an EHO on staff full time. In many rural councils, environmental health duties may represent less than 20% of professional activities. As one EHO in a rural council observed “... *public health is almost an insignificant part of our role.*”

While there are a number of current rural EHOs with professional qualifications in addition to those required for public health functions (eg building, plumbing), these are the exception rather than the rule.

7.0 Skills, Knowledge and Capacity

Significant comment was made on the need for tertiary institutions to develop more “work-ready” graduates. A number of submissions pointed to the merits of the optional one-year work experience element of the Swinbourne University degree course, and to positive experiences with graduates entering the profession from this background.

Comment was made that there is a need for tertiary courses to provide better understanding of delegations and roles under the range of Acts likely to be administered by a local government EHO. An increased emphasis on communication and conflict resolution in courses would assist in preparing new EHOs for the realities of life working in a local government, small community, environment.

Another option presented was for a graduate diploma course to be available within Queensland to allow those with other professional qualifications, possibly already employed by a council, to gain the required public health competencies. Both Griffith University and Queensland University of Technology are considering post graduate options.

Increased flexibility in terms of entry to the profession whether as a graduate or through post-graduate studies should be encouraged by all stakeholders. Obviously, flexible entry opportunities must be balanced with ensuring required competencies are achieved.

An additional point made in relation to greater flexibility in obtaining required competencies, particularly for those already employed in rural and regional areas, was the need for availability of distance education courses from a Queensland tertiary institution. Capacity to undertake accredited courses off campus is particularly important in developing locally based EHO skills.

This may depend to some extent on the market demand, but should be considered further. It is understood that Griffith University in conjunction with Curtin University is currently developing an environmental health post graduate program in a flexible learning mode (non campus based), which should commence in 2005.

Many EHOs complained about the lack of opportunity to update skills and specialised knowledge. It was particularly noted that there is a lack of accessible training and professional development for those in rural and regional areas. Specialist training courses are necessary to allow practicing EHOs to update their skills and capacity as well as to allow skills to be developed for specific streams of public health regulation under individual legislation (eg Personal Appearance Services Act).

8.0 Mandated Qualifications

As might be expected there are differing views on whether qualifications for an EHO should be mandated by legislation. This is the case in Victoria, and there is strong AIEH support for a similar approach in Queensland. AIEH submitted that a Registration Board (as exists in some professions) should be established.

Given the way in which recent legislation is written, it appears unlikely that a more regulated approach to the profession will occur. The emphasis is likely to be on the CEO of a local government appointing competent officers. There may however be a need for guidelines or regulations on how such competency is to be determined.

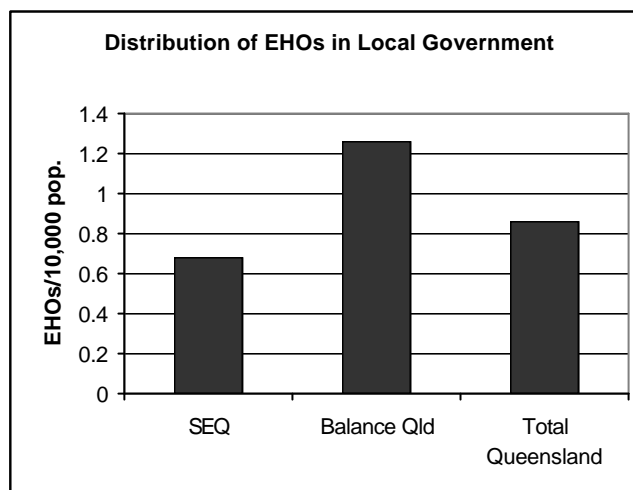
In some professions, the representative professional body takes a lead role in accreditation of members, with differing grades of membership, and in continuing professional development to maintain the accredited status.

An industry self-regulation approach often raises the status of the organisation, and professionals recognise that membership is important in enhancing their career prospects. This would be an option for AIEH to consider.

9.0 Career Paths

There was frequent reference to the merit of traineeships or cadetships or supported study arrangements. The opportunity to pursue tertiary education whilst working in a Council is considered to offer a chance of career development for local people who would have otherwise typically left the community.

A number of studies of recruitment and retention of professionals for rural and regional locations support this position that people whose careers develop from within the region are more likely to stay within the area. A number of councils already offer cadetships in an attempt to encourage school leavers to consider local government as a career. Cadetships at a local level would also be facilitated by enhanced external study arrangements.



An AIEH northern branch survey reveals strong support from councils for a shared cadetship program, particularly if some external funding support was available. This may present an opportunity for QHealth to encourage EHO cadetships in rural and regional areas.

An optional one-year Industry Based Learning placement could also assist rural and regional councils to promote their region to those entering the profession.

Councils across the state need to support undergraduates looking for workplace placements, particularly if graduates are to be attracted to rural and regional areas. It may be possible for LGAQ to act as a clearing house for undergraduate placements, providing a link between tertiary institutions and individual councils, thus developing a more coordinated approach.

It is also likely that EHOs would give greater consideration to working in rural and regional locations if mechanisms were available for them to return to coastal/provincial locations after a two or three year term. This labour market issue will be better addressed if an external group employer, operating at either a regional or state-wide level, seeks to meet the service gap.

10.0 Mentoring and Support

A lack of peer support and mentoring is a critical issue in terms of developing and maintaining a suitably qualified public health workforce in local government. It is certainly an impediment for the initial placement of graduates.

It is however important to recognise that individual EHOs currently play an active but informal role in supporting and

The need for recent graduates to desirably have support of a more senior EHO as a mentor and in supporting their professional development further amplifies the difficulties associated with an effective servicing of smaller rural and regional locations.

It is very difficult for recent graduates to receive appropriate mentoring and support in a council where that person is the only qualified EHO.

While regional arrangements may assist in this respect, there will remain a need for more formalised mentoring and support arrangements.

mentoring new EHOs in councils within their region.

Given the regional environmental health network operated by QHealth, and the overall responsibility for effective public health services across the state, it would seem reasonable to expect QHealth to take a lead role in developing support and mentoring services.

It may also be possible for LGAQ to increase its support role to the profession. This may only occur if additional funding resources were available.

A number of larger councils have hosted a rural EHO for a few weeks to allow upskilling on particular elements of the role eg food, dangerous goods, environmentally relevant activities. Opportunities for secondments and exchanges are being considered by individual councils, and could be actively promoted by LGAQ.

11.0 Developing Partnerships

There is a need for QHealth to take a more active role in supporting councils, particularly smaller rural and regional councils, in performance of their public health role. While regional public health units in QHealth do provide support to EHOs, the process is informal, and formal communication protocols are not in place.

This leads to different approaches in the way matters are handled by QHealth EHOs (eg in response to failed water sample results or in supporting local difficulties in relation to food premises), and inconsistent responses across local government areas.

While a Public Health Partnership Protocol was put in place between QHealth and LGAQ in August 2000, it does not appear to have been a driver of initiatives at the regional level. Both parties would benefit from developing formal liaison, consultation and communication processes and from fostering shared working arrangements to minimise duplication, overlap and service gaps as articulated in the protocol.

The Protocol is currently being reviewed, and it would be appropriate to consider development of regional specific working relationships that emphasise the intended partnership approach.

12.0 Resources and Procedures

EHOs, particularly in rural and regional areas, identified difficulties in staying abreast of changes in legislation and standards. Ability to readily access current policies, procedures and legislation was regarded as essential. Projects such as "Toolbox" developed by Brisbane and Gold Coast City Councils were seen as providing the type of resources that would be applicable to both large and small councils.

It would be desirable for LGAQ to make this (or other resource material) available through "Local Government On-Line". Funding support from QHealth may facilitate such on-line resource provision, especially for the benefit of rural and remote practitioners.

13.0 Support to Indigenous Communities

In discrete indigenous communities, environmental health conditions are typically substantially worse than experienced in mainstream communities. This is often a function of the poor standard of housing, significant overcrowding, poor water supplies, poor solid and liquid waste disposal systems.

These infrastructure problems are compounded by other environmental problems such as poor control of food premises, poor animal health, mosquito breeding in the wet, and dusty conditions in the dry. Poor operation and maintenance of infrastructure can also result in breakdowns resulting in loss of water supply or treatment and overflows of sewage.

A number of issues identified in relation to indigenous community councils were similar to those identified in mainstream councils. In particular, the need to raise awareness of the public health role with elected

Previous research on indigenous environmental health has identified that successful management of problems must include:-

- Community involvement in and control of environmental health systems;
- Provision of effective environmental health programs and services together with a workforce skilled to deliver them;
- An infrastructure supportive of environmental health programs;
- Adequate relevant information on and for indigenous communities;
- Enhancement of environmental health knowledge in the communities;
- Reducing cultural barriers which have the potential to affect behaviour and communication;
- Adoption of a holistic approach to health which includes education and economic development.

representatives and senior management was identified along with the need to devote appropriate resources to infrastructure and services of relevance to public and environmental health.

With DOGIT councils to come under the LG Act (a four year transition), it may be appropriate for LGAQ to develop some specific training programs of relevance to indigenous councils. Alternatively, this could be considered as an element of capacity building initiatives to be undertaken by DLGP as part of the transition to the LG Act.

With a more substantial range of community services, needs and issues being the focus of the role of indigenous councils in comparison with mainstream councils, it is often difficult for councils to allocate appropriate funding for the provision and maintenance of services and infrastructure for the health of their community.

While State Government Financial Assistance (SGFA) funding is intended to support all local government functions, it is often very difficult for councils to prioritise such funding to environmental health and essential service functions when it is received as an untied grant. It may be appropriate to consider converting a portion of this untied funding to specific purpose funding of key environmental health services and infrastructure.

Specific purpose funding available under the Cape York Partnerships arrangement for employment of dedicated EHWs in indigenous communities has played an important role in supporting the environmental health role, and enhanced the status of EHWs within the council workforce. Maintaining this specific purpose funding, and expanding it to other indigenous councils and communities is vital to a continued focus on environmental health.

There are significant indigenous populations in a number of mainstream local government areas in Queensland, and in some cases the indigenous population represents the majority of people in a small town. In these situations, there sometimes appears to be a lack of priority given by the mainstream council to environmental health problems in these communities. However, solutions to environmental health problems in these small towns (eg Coen Sewerage, Dajarra water supply) are often beyond the resources of the local council and require significant state government funding support.

It is important in these predominantly indigenous communities that QHealth plays a strong and active role in supporting the local council to address environmental health issues, as is the case for the DOGIT councils.

14.0 Action Plan

A series of recommendations has been made in relation to the key issues covered by this review. The appropriate lead agency and supporting stakeholders for each recommendation are also identified in the Action Plan.

15.0 Detailed Report

The detailed report of the project contains a full discussion of issues identified by research and consultation. The support of all stakeholders who participated in the review is gratefully acknowledged.

Action Plan - Recommendations		Lead	Support
1	Public Health/Environmental Health functions and legislation to be included in elected member training courses, with particular emphasis on risk management approaches and legal responsibilities.	LGAQ	QHealth DLGP
2	The LG Finance Standard 1994 (s.16(1)) should be amended to require corporate plans to include information on the role of the local government in Public Health.	DLGP	QHealth, LGAQ
3	The LG Act 1993 (Part 8) and/or the LG Finance Standard 1994 (s.44(1)) should be amended to require enhanced performance reporting on key functions, including public health responsibilities.	DLGP	QHealth, LGAQ
4	The proposed Public Health Act should include a more definitive statement of the role and function of local government in public health.	QHealth	LGAQ
5	Regional Organisations of Councils (or similar bodies) to be encouraged to consider acting as a host employer for EHOs to service a number of councils in their region.	LGAQ	ROCs

6	LGAQ, as part of its current review of mechanisms to support councils experiencing difficulties in recruitment of key staff, to consider opportunities to act as a group employer providing contracted personnel to councils.	LGAQ	
7	LGAQ to consider acting as a clearing house/coordinator for workplace placements for EH undergraduates, particularly for rural and regional councils, to foster a greater spread of opportunities for undergraduates to gain on-the-job experience.	LGAQ	AIEH, Tertiary Bodies
8	Tertiary institutions to be encouraged to consider a range of measures that can provide more flexible entry or multiple pathways to the profession, particularly for those in rural and regional locations. Measures to be considered include post-graduate courses, distance education options as well as an optional one-year Industry Based Learning placement as a component of an undergraduate degree.	AIEH	QHealth Tertiary Bodies
9	A bridging course should be developed to allow qualified EHOs from inter-state and overseas to obtain those skills and competencies of relevance to professional practice in the Queensland legislative context.	QHealth	Tertiary Bodies AIEH
10	Registered Training Organisations to develop/deliver courses which provide an accredited qualification for specialised public and environmental health tasks.	QHealth	LGAQ AIEH
11	AIEH to consider introducing an enhanced accreditation scheme that will define career path opportunities in local government. AIEH to consider a more active role in continuing professional development as part of such an accreditation scheme.	AIEH	QHealth LGAQ
12	Encourage councils to consider scholarships and cadetships, including shared arrangements at a regional level. QHealth to consider funding support for cadetship/scholarship programs involving smaller rural and regional councils.	QHealth	LGAQ, AIEH
13	More formalised mentoring and support arrangements should be developed by key stakeholders, with QHealth taking a leadership role. Such support arrangements should be detailed in the revision of the Protocol with LGAQ.	QHealth	AIEH, LGAQ
14	In the review of the Public Health Partnership Protocol, develop more formalised liaison and communication arrangements, with emphasis on region specific requirements, including working arrangements that offer more active technical support by QHealth. Particular attention should be given to rural and remote councils.	QHealth	LGAQ
15	Development and dissemination of on-line resources to support EHOs, particularly in rural and regional locations, should be facilitated jointly by LGAQ and QHealth.	LGAQ QHealth	AIEH
16	Model policies and procedures for common public and environmental health tasks should be developed to assist councils in more effectively addressing their roles under delegated public health legislation. Templates would also assist councils in the transition phases during legislation changes.	LGAQ	QHealth DLGP
17	In developing training programs and capacity building for indigenous councils, DLGP/LGAQ consider programs of specific relevance to these communities, including emphasis on the public and environmental health elements of their role and function.	DLGP	LGAQ
18	As part of the revision of arrangements for governance of indigenous communities, consideration should be given to converting a portion of untied funding to specific purpose funding for key environmental health services and infrastructure.	DLGP	QHealth
19	Specific purpose funding for EHWs in indigenous communities should be maintained, with expansion of the program to service other indigenous councils and communities.	DLGP	QHealth

1 Introduction

1.1 Background

Queensland Health, commissioned this project in March 2004. A project Steering Committee comprising representatives from Queensland Health, the Department of Local Government and Planning (DLGP), the Department of Aboriginal and Torres Strait Islander Policy (DATSIP), the Local Government Association of Queensland (LGAQ) and the Australian Institute of Environmental Health (AIEH) was established.

The focus of the project is on the functions and skills of the workforce responsible for public and environmental health at the local government level, along with issues related to recruitment and retention of a suitably skilled workforce across the range of local government situations in Queensland.

Local government has a key role in maintaining public health standards in the community. In Queensland, many of these functions are also reflected in legislation. Local governments are devolved the responsibility to administer and enforce certain public health legislation.

To achieve its desired public health outcomes, local government requires a workforce with the relevant/appropriate public health expertise or experience.

1.2 Terms of Reference

The objective of the project, as outlined in the Terms of Reference, was to:-

- Map public health functions undertaken by local government;
- Identify those functions that because of public health risk require particular public health competencies to address. Those competencies include both the capacity to provide public health advice to local government, and administer relevant public health legislation;
- Assess the current skill base available within local government;
- Identify the workforce issues that either enhance or inhibit the ability of local government to achieve its public health responsibilities. Particular consideration has been given to the requirements of rural, remote and indigenous communities;
- Develop a report that identifies the issues that impact on local government undertaking public health functions, along with recommendations on policy and program options to encourage and support the maintenance of a skilled public health workforce within local government.

For the purposes of this project, local government includes indigenous community councils established under the *Community Services (Aborigines) Act 1984* and the *Community Services (Torres Strait) Act 1984*.

The project intent was to identify initiatives to support local government in meeting its public health responsibilities, including those public health legislative responsibilities that Queensland Health has devolved to local government, particularly the *Health Act 1937* and *Food Act 1981* and any regulations made under these Acts.

1.3 Research Approach

In undertaking the project, a strong emphasis was placed on consultation with all relevant stakeholders. The consultation processes included:-

1. Call for submissions from Local Government, Australian Institute of Environmental Health members, Queensland Health Public Health Unit Officers and from other stakeholders including academic institutions;
2. Workshops and discussions at regional or district level with AIEH members, elected members and CEOs of local government, indigenous Environmental Health Workers, and with public health unit staff;
3. Meetings with individual EHOs, representatives of tertiary institutions and other public health officers;
4. Phone discussions with a cross-section of stakeholders.

Details of the consultation components of the project are contained in **Attachment B**. It should be noted that all submissions from individuals are confidential. While matters raised in submissions have been used to identify issues of relevance to the project, any details that could identify individuals or locations have been excluded.

In addition to the consultation components, the project was informed by a review of reports and papers of relevance to the role of local government in public health regulation. A list of references is included at **Attachment A**.

2 Background Context

2.1 Changing Functions, Control and Accountability

When the *Health Act 1937* was enacted, the primary role of local government was seen as providing basic infrastructure and property related services. In fact, many councils were so limited in their operation in the early part of the twentieth century that they were simply called Roads Boards.

As many reviews of local government functions have noted, there has been a significant shift in the balance of property services versus human services provided by local government, particularly since the 1970s. This point is illustrated in a number of LGAQ Submissions.¹

There has also been a substantial shift in the approach of the state government to its control and regulation of local government since 1937. At that time, local government was seen as a creature of the state, and powers devolved to local government were strictly controlled and monitored.

As Tucker notes² “...the extension of the responsibilities and powers of local governments was associated with some form of control or supervision. This was particularly marked in the case of public health. The adulteration of food and drugs was the first aspect of public health brought directly under the control of local governments...local governments were largely entrusted with the care of public health in their areas, but the Central Board of Health had a general oversight and possessed wide powers to make regulations to supervise the work of local governing bodies.”

Functional Change in LG
An LGAQ submission to the Cost Shifting Inquiry notes “... the last fifteen years has seen an expanding service role for Queensland Local Government in Human Services (Education, Health, Welfare, Recreation, Culture). Whereas in 1982/83 only 13.7% of total outlays were for these Human Services purposes, by 1997/98 these functions accounted for 20.7% of total outlays ... in real terms per capita, outlays for the Human Services categories increased from \$91 in 1982/83 to \$158 in 1997/98, an increase of 74% over the fifteen year period.”

This past prescriptive approach is also identified in a study of public health laws. The report³ notes “... in the 19th century, public health laws were a “top down” process, imposed by sanitary reformers on those in want of sanitary reform. Public health law was prescriptive. Thus it required parents to vaccinate their children, it contained powers to detain for long periods of time without any recourse to appeal, people suspected of being infected.”

As a result of the approach to local government in the early part of the 20th century, the *Health Act 1937* contains many provisions that allow the state to direct local government (eg s. 22(4) appointment of medical officer of health, analyst, inspector; s.9 and s.16 default of local government; s.170 step in powers). Under s.20 local governments are required to provide an annual report on public health to the chief executive, and under s.24 local government analysts are required to report on a three monthly basis.

These reporting provisions have fallen into disuse. Based on information provided by Public Health Unit officers, no council in the state currently provides regular reports to Queensland Health on its role and activities in public health.

¹ LGAQ, July 2002, Initial Submission to Cost Shifting Inquiry

² Local Government in Queensland, Volume 1, J.D. Tucker, July 1981, p.80

³ Public Health Law in Australia, Its Current State and Future Directions, Ian Bidmeade and Chris Reynolds, June 1997, p.5

However, since the late 1980s there has been greater recognition of partnership arrangements between state and local governments. In 1989, amendments were made to the Queensland Constitution Act to recognise local government as a sphere of government.

Since that time a number of MOUs and protocols have been signed by the Queensland Government and local government. This includes a Public Health Partnership Protocol⁴ signed in August 2000.

It is apparent from discussion papers on proposed new public health legislation that any new legislation will be far less directive and controlling, respecting the modern approach to the division of powers between two spheres of government.

The QHealth Draft Policy Paper⁵ comments that this modern approach is characterised by “... *the ability of the State Government to intervene in the exercise of a local government’s powers is generally limited to circumstances where some action or omission by a local government is likely to compromise State Government interests or public safety. The approach is less directive and more performance-based ... the State Government does not direct local governments as to how to fulfil their responsibilities, but rather allows local governments to determine their own priorities and the approach they intend to take to carry out their functions.*”

A number of Public Health Unit staff made comments on the fact that a number of councils have ‘unqualified’ officers performing Health Act and Food Act responsibilities. However, as qualifications are not mandated by legislation, this does not necessarily mean that such officers do not have appropriate skills, but rather that they may not have an AIEH recognised qualification. This is an issue discussed later in this report.

One EHO commented on the dated nature and inadequacy of the Health Act “... *most local authorities have good local laws to use rather than referring to the Health Act. The Health Act is not being used as it is dated and anything but easy to use, and sufficient evidence is difficult to obtain and prove... Nuisance provisions aren’t being used unless there is no other choice.*”

It is appropriate to note that, in a historical context, many functions that were covered by the *Health Act 1937* have, over time, resulted in separate pieces of legislation. This includes the Food Act, some functions under the EPA and Water Act and now the new Public Health (Infection Control for Personal Appearance Services) Act 2003.

Public Health Partnership Protocol Provides for:-

- Establishment of mechanisms and processes to enhance collaborative and/or complementary actions;
- Articulation of respective public health roles and responsibilities;
- Identification of mutual priorities, and development and implementation of joint Action Plans.

Action Plans were proposed for:-

- Public Health Planning;
- Communication and Consultation;
- Marketing;
- Mosquito Control;
- Fluoridation;
- Sharps Disposal.

Whereas some 15 years ago, the appointment of an authorised officer under the Health Act required approval of the chief executive of Health, today appointment of an authorised officer is the responsibility of the CEO of that local government.

Under s.27B, the chief executive of Health may make rules with respect to qualifications of authorised officers appointed by local government, although this section has not been used.

It is left to the council CEO to determine whether an officer has the skills and competencies necessary to perform tasks they are authorised to undertake.

⁴ a Public Health Partnership Protocol between Public Health Services (QHealth), Local Governments of Qld and LGAQ, Aug. 2000

⁵ Review of the Health Act 1937 (Public Health), Draft Policy Paper, February 1998, p13

2.2 National Context

The National Environmental Health Strategy (NEHS) released in 1999 was intended to provide a national framework to achieve better health outcomes through better management, increased capacity to address new and emerging issues and more effective use of valuable resources.

In relation to the Environmental Health Workforce NEHS notes⁶ that increasing the capacity of the workforce, both by increasing the numbers of practitioners and improving their training is critical. It is also noted that the role of environmental health practitioners is changing and needs to be supported through effective under-graduate and post-graduate education, research and continuing professional development.

NEHS suggests that there is an increasing need for EHOs to concentrate on areas of speciality, such as food safety or waste management. As is discussed later in this report, the opportunity to be a specialist simply cannot exist for EHOs in small rural councils, and challenges the concepts put forward by NEHS.

A need for more rigorous continuing professional development to enhance skills, performance and career opportunities was also noted by NEHS. Consultation undertaken in this project confirms that this remains as a critical issue.

A national review of the role of local government in health regulation⁷ identifies a number of common issues requiring further investigation. These include:-

- Analysis of the effectiveness of current legislative provisions for assessing local government compliance with statutory public health roles;
- Examination of local government's role in relation to environmental protection and planning legislation and the interface with public health functions;
- Identification of any potential benefits in promoting model approaches in regard to some issues (for example public health plans);
- Analysis of the adequacy of current legislative approaches in permitting a rapid and flexible response by local government to emerging public health risks.

It is apparent that many of the issues identified in this current project are common concerns across local government in Australia, as illustrated in the above extract.

The national report on health regulation notes a variety of challenges including:-

1. resourcing implications,
2. balancing of competing priorities,
3. ensuring contracting out of services does not adversely impact on public health,
4. difficulties in attracting and maintaining appropriately skilled workforces.

The report comments "...almost all submissions received during consultation identified the same issue – a lack of resources both financial and staffing to perform the tasks required of local government, including regulatory functions. In other words, it is one thing for local government to have regulatory responsibilities, the capacity to carry them out effectively is another."

2.3 Other Relevant Background Research

As the Terms of Reference note, this study is of particular relevance to rural, remote and indigenous communities where the problem of attracting a suitably skilled workforce is greatest.

⁶ National Environmental Health Strategy, EnHealth, 1999, p.29

⁷ The Role of Local Government in Public Health Regulation, National Public Health Partnership, March 2002, p.69 & p.5

The issues related to recruitment and retention of the public health workforce required by local government need to be seen in the wider context of social and demographic trends within Australian society. These broader demographic, economic and social factors have challenged the viability and vitality of rural communities for over three decades and continue to foster the 'urban drift' – or to use the current phrase 'sea change'.

There is no single action that is going to reverse this national pattern of population movement from the country toward the coast. There is no definitive group of attributes that will encourage numerous people, with or without a family, to make a life long career in rural and remote local government.

The focus needs to be on better utilisation of resources that are available within a community, and on attracting people to relevant areas as a part of their professional and family life experience.

There has been significant attention focused on recruitment and retention of health professionals for rural areas in recent years. While most of these studies focus on medical practitioners, many of the issues identified in these studies are relevant to recruitment of environmental health officers to rural and smaller councils in general, particularly to locations away from the rapidly growing coastal regions.

A Victorian study⁸ (see text box) findings in relation to the importance of family factors in both recruitment and retention are of particular relevance to this study. Also the finding that a rural background and/or rural training are likely to be predictors of rural recruitment suggests that initiatives such as cadetships and scholarships at the local or regional level are valuable.

One Queensland region has undertaken relevant background research on issues related to recruitment and retention of primary health professionals in the Kingaroy and South Burnett Medical Workforce Project.

This project⁹ was stimulated by a perceived lack of general practitioners and specialist medical workforce in the South Burnett. Kingaroy Shire Council was a key stakeholder in the project, and in strategy implementation. The report notes that rural students choosing to enter university medical courses more frequently choose careers in rural practice.

This suggests that strategies aimed at marketing career opportunities to high school students in the region may increase the numbers eventually choosing to practice in the region.

The study of recruitment and retention of health professionals in rural Victoria suggests factors influencing recruitment and retention are not necessarily the same. Key findings include:-

- **Predictors of recruitment**
 - Rural background, rural training
- **Attractors to rural practice**
 - Sense of community, rural lifestyle, scope/variety of work, comprehensiveness/continuity of care, happiness of spouse/family
- **GP retention**
 - Professional considerations (on call arrangements, professional support, variety of practice) most important

Recruitment and Retention Factors were seen to include:-

- Locum cover
- Career path
- Professional support and mentorship
- Access to professional development
- Management support
- Rural background
- Rural lifestyle

Key recruitment factors were:

- Personal / family
- Job opportunities

Whereas **key retention factors** were:

- Career / job satisfaction
- Family needs

⁸ Victorian Universities Rural Health Consortium, 2003, Victorian Rural Allied Health Recruitment and Retention Study

⁹ Kingaroy and South Burnett Medical Workforce Project, January 2001

The report also discusses the approach to John Flynn medical scholarships as part of an initiative to attract more GPs to rural practice. Scholarship holders spend two weeks a year over four years in the same rural setting.

The document also notes the need for a recruitment and marketing strategy for the region, including promotion of the attractiveness of lifestyle and amenities.

The need for ongoing support and mentoring is also discussed.

A fundamental issue discussed later in this study is encapsulated in the following statement from the South Burnett project “... *the key to retention of a rural practitioner is frequently the preferences of a partner and family members. If a mutual enjoyment of and fulfillment in a rural lifestyle cannot be achieved for doctor and partner/family, length of stay in rural practice inevitably shortens.*”

The problems confronted in attracting health professionals to rural areas are much the same as for recruitment and retention of professionals to undertake public health functions for local government.

A labour market study undertaken in 1990¹⁰ provides some interesting background on issues of relevance to this project (see text box).

Other states are also experiencing problems with recruitment of EHOs.

In South Australia, the LGA's Workforce Planning Study¹¹ identified that there was a shortage of Environmental Health Officers in SA Local Government. A working party with representatives from the LGA, Department of Human Services, Flinders University and the Australian Institute of Environmental Health has been formed to research, analyse, develop and implement/recommend strategies to address:-

- current and anticipated shortages of suitably qualified and experienced Environmental Health Officers available to Local Government in SA for both permanent and temporary positions
- difficulties in attracting and retaining Environmental Health Officers in regional areas of SA
- choices, accessibility and suitability of training, education and qualifications available to Environmental Health Officers in SA

The results of the above project are not available at this time.

The 1990 labour market study noted that the number of EHOs employed by local government fell between 1981 and 1986 and supported the view that councils had difficulties recruiting and retaining EHOs.

The study estimated a 10% per annum turnover of EHOs and noted that the majority of EHOs are not satisfied with their duties, career paths or promotion prospects.

Some specific recommendations of relevance to this project include:-

- present barriers of entry into the profession must be lifted so that the base of labour, from which EHOs are recruited into local government, can be expanded;
- there needs to be an improved distance education infrastructure, so that individuals in the rural areas have the same opportunity as their urban counterparts.

These recommendations remain relevant to current EHO workforce professional development. It would appear that little has been done in the last ten years to lift the barriers referred to above.

¹⁰ National Local Government Training Council, December 1990, Environmental Health Officer, Labour Market Study

¹¹ South Australia Local Government Association, Workforce Planning Study, 2001

The South Australian LGA had previously undertaken a project looking at skill shortages in the planning profession. The Planning Skills Retention Project¹² resulted in the development of a series of pathways to enable persons currently employed by councils, or seeking employment in councils, to assess training relevant to the support requirements of Planners in councils. In essence the reference group has developed a succession plan comprising a traineeship and relevant staff training for a planning para professional.

This concept of support skills to assist with some of the public health responsibilities of councils is discussed later in this report.

¹² Planning Skills Retention Project, Local Government Association of South Australia, Circular 32.11, 2003

3 Public Health Functions in Local Government

3.1 Scope of Public Health Activities

As noted earlier, the focus of the project is on those functions undertaken at a local government level which promote, protect and enhance public health. For local government, these are typically referred to as environmental health functions.

Public health can be defined as “... *the organised response by society to protect and promote health and to prevent illness, injury and disability.*”¹³

The National Environmental Health Strategy (NEHS)¹⁴ defines **health** as “... *a state of complete physical, mental and social well being and not merely the absence of disease or infirmity*”, **public health** as “... *the science and art of preventing disease, prolonging life and promoting health.*” and **environmental health** as “... *those aspects of human health determined by physical, chemical, biological and social factors in the environment.*”

NEHS goes on to note that environmental health practice covers the assessment, correction, control and prevention of environmental factors that can adversely affect health, as well as the enhancement of those aspects of the environment that can improve human health.

At the local government level, a wide range of functions relate directly to public health including, but not limited to:-

- Provision of a safe potable water supply;
- Removal, treatment and management of solid and liquid waste;
- Ensuring healthy housing and accommodation;
- Mosquito control;
- Control of vermin;
- Control of nuisances including animals, dust, noise, overgrown lots, smoke and fumes;
- Safety of noxious and hazardous goods;
- Prevention of infectious diseases;
- Ensuring food safety;
- Regulation of personal services (hair dressing, skin penetration);
- Management of sharps;
- Management of recreational water including public pools/spas;
- Street cleaning;
- Immunisation;
- Control of mass events;
- Public health planning and promotion;
- Environmental pollution response and cleanup;
- Protecting health in disasters and emergencies.

There are many other activities that support maintenance of public or environmental health in a community such as housing standards, traffic control, street lighting, provision of shade, landscaping,

¹³ National Public Health Partnership MOU

¹⁴ National Environmental Health Strategy, EnHealth, 1999, p.3

sport and recreation facilities, control of noxious and pest plants and environmental regulation. In essence, it is possible to link almost every activity of local government, particularly in an urban environment, with public health outcomes.

It is also important to note that any failures in relation to implementation of other legislation (eg poor planning decisions on separation of incompatible uses) may lead to public health issues requiring action under the Health Act.

For indigenous communities, there are many additional environmental issues which impact on health standards, many of which are no longer significant issues for mainstream communities. For example, while dog control in mainstream communities is predominantly about nuisance control, in an indigenous community the poor health of animals may impact directly on the health of community residents. Poor housing standards and chronic overcrowding are significant factors impacting on indigenous health as are issues related to water quality, sanitation and solid waste disposal.

While many indigenous councils have environmental health workers who play a key role in enhancing public health in these communities, they rely on Queensland Health for professional EHO support in many legislatively devolved activities.

The functions which promote, protect and enhance public health are often assigned to a range of disciplines within a local government including:-

- Environmental health officers;
- Engineers;
- Building and Plumbing Inspectors/Certifiers;
- Water and sewerage plant operators;
- Town planners;
- Environmental scientists;
- Vector control officers;
- Local laws officers.

While EHOs in larger councils are more likely to focus on the core environmental health tasks, in rural councils an EHO may be responsible for many additional functions beyond those delegated under the Health Act or Food Act. Typical additional roles include EPA delegations, local laws, stock routes, noxious weeds, building control and workplace health and safety. In some cases, functions which are now covered under other legislation (eg EPA, Water Act) were previously components of the Health Act.

The rural EHO is required to be multi-skilled if the council is to have an EHO on staff. In many rural councils, environmental health duties may represent less than 20% of professional activities. As one EHO in a rural council observed “... *public health is almost an insignificant part of our role.*”

The multi-function nature of the EHO position in a rural council is underlined by the extracts from a typical rural council Environmental Health position description as shown in the following text box.

With such a broad range of functions and disciplines involved at a local government level, it may not be surprising that those responsible for public health functions devolved under the *Health Act 1937* and *Food Act 1981* (and associated regulations) often feel that their role is not well understood or properly valued by councillors and senior officers.

However, as later sections of this report reveal, such feelings are an issue within the environmental health profession and impact on job satisfaction and career paths within local government.

Duties and Responsibilities – Rural EHO (Extract from a Rural Council’s Position Description)

To provide assistance and support to senior managers in the assessment, monitoring and implementation of activities under the jurisdiction of Council’s Environmental Management and Public Health functions.

Shall include but not be limited to:

- (1) The control, compliance and enforcement of relevant legislation including but not limited to;
 - (a) Council Local Laws and Local Law Policies.
 - (b) The Health Act 1937-1988 and Amendments.
 - (c) The Food Act 1981.
 - (d) The Local Government Act 1993.
 - (e) Environmental Protection Act 1994.
 - (f) The Food Safety Standards.
 - (g) Health Regulations 1996.
 - (i) Environmental Protection (Waste Management) Regulations 2000.
 - (j) Environmental Protection Regulations 1998.
 - (k) Dangerous Goods Safety Management Act 2001
 - (l) Dangerous Goods Safety Management Regulations 2001
 - (m) All Environmental Protection Policies
 - (n) Land Protection (Pest and Stock Route Management) Act 2002.
- (2) The investigation and resolution of complaints lodged by the public using appropriate levels of tact and discretion.
- (3) The performance of routine administrative duties including but not limited to;
 - (a) Assessment of applications for Licenses, Permits and Registration as required by Statute.
 - (b) Service of Notices under the aforementioned legislation, and
 - (c) Assessment of the Environmental Management and Public Health aspects of development applications.
- (4) To liaise with other Council Officers, representatives of other levels of Government, Council Contractors, property owners and licensees in regard to Environmental Management and Public Health matters.
- (5) To draft and issue Statutory Notices, obtain sound legal evidence and institute legal proceedings in accordance with the above mentioned duties and responsibilities.
- (6) To draft agenda items to Council Committees relating to Environmental Management/Health matters requiring the approval or acknowledgment of Council.
- (7) To implement, co-ordinate and oversee Environmental Management/Health Programs as they apply to special events and/or projects.
- (8) To undertake as directed special measures designed to reduce or prevent public environmental/health risk in disaster or emergency situations.
- (9) To actively and consistently engage in environmental / public health promotion and community education in Environmental and Public Health and Safety issues.
- (10) To provide on the job instruction and training to less experienced colleagues and Technical assistants as required.
- (11) To perform any other reasonable Environmental Management and Public Health Duties as required by the Senior Managers.

3.2 Public Health Functions and Competencies

The project Terms of Reference pose this question. *What are those functions of local government that, because of public health risk, require particular public health competencies to address?* There is no simple answer to this question. As the discussion in the previous section identifies, there is a range of professional and technical skills involved in functions that have a direct impact on the public health of a community.

If the definitions from NEHS are considered, then it is effectively the higher order skills of assessment, risk management and strategy based on a knowledge of public health science which are likely to be effective in *“preventing disease, prolonging life and promoting health”* and lead to the *“correction, control and prevention of environmental factors that can adversely affect health, as well as the enhancement of those aspects of the environment that can improve human health”*.

In reality, there is a continuum between the strategic public health competencies and the practical application of technical skills which control and prevent public health risk. For example, the management of risk associated with food borne illness is a key public health function of local government.

However, a number of technical competencies may assist in preventing food borne illness including food handling trainers, food safety program auditors and building designers and certifiers. In this example, it is the skill to oversight all of these risk components, manage interventions and respond appropriately in the case of identified risks or outbreaks that define the required public health competencies.

When each of the streams of potential public health risk (eg housing, food, water, waste, vectors, vermin, pollution, etc) are considered as a whole, it is the skill to develop, integrate, coordinate and manage risks, strategies and responses that minimise poor health outcomes in the community that are key competencies, not the operational tasks themselves, even though these are necessary to achieve the desired result.

A study of public health law¹⁵ identifies this continuum in public health response (see text box).

In a sense the question posed in the Terms of Reference underlines the complexity of the issues involved in ensuring that local government has a workforce with the expertise and experience to effectively manage public health risks.

From a legal perspective, statements in the Health Regulation 1996 and Food Hygiene Regulation 1989 that each local government *“shall superintend and see to the execution of this regulation within its area and shall do and provide all such acts, matters and things as may be necessary for superintending or aiding in the execution thereof.”* suggest that councils have little discretion in their responses to public health matters.

The study of public health law identifies an inner core and outer group of legislation of relevance to public health. The report identifies the core as *“...public health acts and the laws relating to food, drugs, poisons, therapeutics, tobacco and radiation. This central or “inner” group of laws are invariably regarded as public health laws.”*

The report goes on to identify an “outer” group of laws that have significant impacts on public health outcomes including legislation relating to product safety, liquor licensing controls, environmental protection, town planning and occupational health and safety.

¹⁵ Bidmeade I & Reynolds C, Public Health Law in Australia, June 1997, p.3

Where there is a likelihood of adverse impacts on personal health, a council that does not take action faces a real risk of legal action from those who suffer injury. Queensland Health also faces a risk of legal action in such circumstances.

The legal implications for councils which flow from the delegation of powers under State legislation, coupled with the cost implications to effectively superintend the functions, has resulted in a number of councils questioning why they should be responsible for what is a state role.

Again there is no definitive answer to such a question. It is common practice in Australia for public health functions associated with the local environment to be delegated to local government. However, in practice there is no reason why a state could not choose to take complete control of, for example, a function such as food safety using a state-wide body.

However, because responsibility for the local environment is generally seen as best being handled by the sphere of government closest to the people, it is unlikely that there will be any significant change in the current sharing of roles and responsibilities in relation to matters impacting on community health as a result of the way in which the local environment is managed.

As a review of the role of local government in public health regulation notes¹⁶ “... it is acknowledged that responsibility for public health in Australia is somewhat fragmented across three levels of government and a wide range of stakeholders, making coordinated management of issues difficult. However, it is also recognised that the pervasive nature of public health means there will always be legitimate overlap and interplay between public health legislation and that of other sectors.” A fragmentation, duplication and overlap of roles between spheres of government is however not unique to responsibility for public health in Australia. It has been observed in functions such as environmental and natural resource management, and in the community services sector.

3.3 Variations in Response to Risk Management

There are differences in the way in which individual councils perceive environmental factors as a risk to public health.

For example, one council in Queensland currently licences and inspects all rental accommodation including strata title units and detached dwellings as part of their environmental health functions.

Only 30 (25%) of the councils in the state provide immunisation services (see Table 3.1), and these councils cover major urban centres to remote rural localities, with significantly different rates of involvement in overall immunisation of their community.

At least one council in the state has not employed (in-house or on contract) the services of a qualified environmental health officer for some ten years, relying instead on Queensland Health to undertake the devolved responsibilities under the Health Act and Food Act.

Some councils undertake house to house surveys to identify potential mosquito breeding areas while others in the same geographic area rely on individuals to manage potential breeding areas on their private land.

A number of councils offer food handling courses as an element of risk management whereas others see this as the responsibility of each operator. As the discussion in section 3.4.2 reveals, there is a large variation in the procedures used by councils for licensing and registration of food businesses and premises.

¹⁶ The Role of Local Government in Public Health Regulation, National Public Health Partnership, March 2002, p28

Table 3.1: Role of Councils in Immunisation, 2003/04

COUNCIL	No. IMMUNISED 2003/04 AGED <8	Population 2002	% pop. Immunised 2003/04
Barcaldine Shire Council	230	1732	13.3%
Beaudesert Shire Council	29	55612	0.1%
Brisbane City Council	9967	917216	1.1%
Bundaberg City Council	194	45043	0.4%
Caboolture Shire Council	388	116992	0.3%
Esk Shire Council	75	14869	0.5%
Fitzroy Shire Council	127	10010	1.3%
Gladstone City Council	157	27099	0.6%
Gold Coast City Council	1233	438473	0.3%
Hervey Bay City Council	1199	44402	2.7%
Ipswich City Council	1823	128986	1.4%
Jondaryan Shire Council	14	13229	0.1%
Kilkivan Shire Council	10	3227	0.3%
Kingaroy Shire Council	100	11990	0.8%
Kolan Shire Council	14	4672	0.3%
Logan City Council	200	169433	0.1%
Longreach Shire Council	279	4033	6.9%
Mackay City Council	305	77157	0.4%
Maryborough City Council	865	25260	3.4%
Miriam Vale Shire Council	8	4620	0.2%
Mount Isa City Council	2507	20785	12.1%
Murweh Shire Council	280	5030	5.6%
Nanango Shire Council	40	8540	0.5%
Pine Rivers Shire Council	1657	127439	1.3%
Redland Shire Council	475	120371	0.4%
Rockhampton City Council	1076	59410	1.8%
Sarina Shire Council	55	9862	0.6%
Toowoomba City Council	1157	91187	1.3%
Warwick City Council	136	21387	0.6%
Winton Shire Council	257	1611	16.0%
	24857	2579677	1.0%

Source: LGAQ Records

3.4 Legislative Context

3.4.1 Health Act and Regulations

The *Health Act 1937* provides no prescriptive definition of the responsibilities of Local Government in public health. Section 19 states “ ... *the local government ... shall if required by the chief executive superintend and see to the execution thereof, and shall do and provide all such acts, matters, and things as may be necessary for superintending or aiding in the execution of such regulations or orders as the case requires.*”

The QHealth Draft Policy Paper¹⁷ defines the responsibilities of local government under the Act as:-

1. to ensure that vermin or insects do not present unacceptable health risks to people in the local government area;
2. to prevent the outbreak of notifiable diseases;
3. to ensure that sewers, stormwater drains and sanitary conveniences do not become a health risk;
4. to periodically inspect the local government area to ascertain the whereabouts of nuisances, to respond to complaints about and to abate nuisances.

Section 22 provides local government with the power to appoint officers for the execution of the provisions of the Act and regulations. No qualifications are mandated for these roles, it being left to the council CEO to be satisfied that authorised officers are capable of undertaking the delegated functions.

The *Health Regulation 1996* provided for the superintendence by local government of regulations relating to:

1. hairdressers
2. mosquito prevention and destruction;
3. skin penetration;
4. vermin control

Regulations relating to hairdressers and skin penetration will be repealed and covered under the Public Health (Infection Control for Personal Appearance Services) Act which comes into effect on 1 July 2004. This new Act is based on a risk management approach with only those activities classified as high risk (typically skin penetration resulting in blood or body fluid release) requiring licences. Authorised officers can be appointed under this Act to carry out the duties devolved to local government.

As noted previously, under s.20 of the Health Act “ ... *every local government shall make an annual report to the chief executive in the form directed by the chief executive in relation to public health of its area and its inhabitants.*” In practice however, there is no evidence of such direct annual reporting to Queensland Health by councils within Queensland. Nevertheless some Council Corporate Plans include components on public health and some annual reports provide performance reporting on public health matters.

The following text box provides an example of public health objectives in one council Corporate Plan. This shows the wide-range of council activities that contribute to community health outcomes. Because the Operational Plan must be linked to this Corporate Plan, it is an important tool in developing council understanding of, and commitment to, a public health role.

¹⁷ Review of the Health Act 1937 (Public Health), Draft Policy Paper, Queensland Health, February 1998, p14

EXTRACT FROM GOLD COAST CITY COUNCIL CORPORATE PLAN 2003-07**STRATEGIC PRIORITY 6 -COMMUNITY HEALTH AND INDIVIDUAL WELLBEING****The Outcomes we want to achieve for ‘Community Health & Individual Wellbeing’ are...**

- ❖ An active community
- ❖ A healthy community
- ❖ Affordable and accessible housing
- ❖ Clean and safe drinking water

The Performance Measures we shall monitor for ‘Community Health & Individual Well-being’ are...

- 1 Level of active and passive recreational pursuits in the community
- 2 Extent to which community services are available
- 3 Incidence of food-borne illnesses
- 4 Incidence of diseases preventable by immunisation
- 5 Incidence of arbo virus (mosquito-borne illness)
- 6 Level of housing need
- 7 Compliance with the National Health & Medical Research Council guidelines for drinking water quality

What we shall focus on to achieve our ‘Community Health & Individual Wellbeing’ outcomes...

- 1 Implement the Recreation, Sport and Open Space Strategy through working with land developers to identify and ensure that there is appropriate provision of sports fields and parklands in the city
- 2 Consider and implement appropriate recommendations from the Community Health Plan Review so as to move towards a more collaborative approach with respect to social and health issues
- 3 Develop and implement a Social Plan aimed at supporting all residents, including young people, older persons, people with a disability, people from multicultural backgrounds and Indigenous people, through community development activities
- 4 Work with community organisations to support people who are disadvantaged through location or social isolation
- 5 Provide improved access to Council facilities for people with a disability through the implementation of the recommendations of the Disability Access Audit
- 6 Consider options for implementing the recommendations of a review of the needs of Indigenous people on the Gold Coast such as developing consultation protocols, cross-cultural training and encouraging alliances
- 7 Continue to implement the National Food Safety reforms with a focus on the incorporation of a risk-based framework for such things as the categorisation of food establishments, premise audits and the education of food handlers
- 8 Develop and implement the Mosquito Management Strategy through such initiatives as the prioritisation of mosquito breeding areas and the integration of control agents to minimize resistance
- 9 Review the Immunisation Program and implement appropriate recommendations, in particular, in the areas of clinic location and times, methodology for the delivery of services and resource levels
- 10 Develop and implement a Housing Strategy with a focus on the range, quality, affordability and availability of housing options as a major step towards achieving equitable housing outcomes for residents
- 11 Maintain third party certification to ensure the quality and safety of drinking water

In comparison, public health legislation in some other states is far more prescriptive. In Tasmania, for example, councils must include a public health component in their operational plans and annual reports, and a requirement to report annually on drinking and recreational water quality.

In Victoria the *Health Act 1958* has been assessed as assuming a considerable role for municipal councils.¹⁸ Section 29A provides for councils to “*seek to prevent diseases, prolong life and promote public health through organised programs including the prevention and control of:*

- a) *Environmental health dangers; and*
- b) *Diseases; and*
- c) *Health problems of particularly vulnerable population groups – by*
- d) *Isolating the special factors affecting the health of people within the municipal district; and*
- e) *Developing and enforcing up-to-date public health standards and intervening if the health of people within the municipal district is affected; and*
- f) *Monitoring the activities of and assisting other agencies whose work has an impact on public health and, if necessary, advocating on behalf of the people within the municipal district for adoption and enforcement by those agencies of appropriate standards; and*
- g) *Co-ordinating the immunization of children living or being educated within the municipal district; and*
- h) *Ensuring that the municipal district is maintained in a clean and sanitary condition.”*

In Victoria, there is also a requirement for councils to prepare public health plans (s.29B). In addition, qualifications necessary for the appointment of Environmental Health Officers are mandated under the Act (s.30A).

3.4.2 Food Act

The *Food Act 1981* identifies (s.26) the following responsibilities for local government:-

- a) Ensuring that food businesses sell and handle food in accordance with the provisions of the Food Safety Standards 3.1.1, 3.2.2 and 3.2.3;
- b) Exercising powers to enforce hygiene requirements in relation to food stores, food vehicles and equipment; and
- c) Undertaking registration and licensing of food businesses under the Food Hygiene Regulation.

Local Government also has the role of investigating single cases of food-borne illness that are suspected of being linked to a food business in their local government area, while Queensland Health is responsible for outbreaks involving more than one case.

Because the Act does not bind the Crown, inspection of food premises in public hospitals and other institutions is undertaken by Queensland Health. However local government is responsible for food premises in private hospitals, private nursing homes and other private institutions.

There is no power for local government to appoint authorised persons under the *Food Act 1981*. However, if a local government has appointed an “inspector” under the *Health Act 1937* (s.22), then that person is automatically appointed as an authorised officer under the Food Act.

A Discussion Paper on the review of the Food Act¹⁹ proposes inserting provisions which would provide capacity for local government to appoint authorised persons under the Food Act, recognising that Food Act responsibilities require expertise and experience which differs to that of persons authorised under the Health Act. Persons appointed would need to satisfy the CEO of a local government that the person has the necessary expertise or experience.

¹⁸ The Role of Local Government in Public Health Regulation, National Public Health Partnership, March 2002, p60

¹⁹ Review of the Food Act 1981, Discussion Paper, Queensland Health, August 2002, p44.

The Discussion Paper also promotes a risk based framework for food regulation similar to that taken in the Public Health (Infection Control for Personal Appearance Services) Act. Low risk businesses may become exempt from the requirement to be licensed, although the business would still need to meet the Food Safety Standards.

A national risk validation project²⁰ has been undertaken to assist in classifying risks from food businesses and to identify costs and benefits (see text box). It is likely that the results of this national project will guide the approach taken in the revised Food Act for Queensland.

Food Safety programs could become mandatory in high risk businesses (eg those providing food to vulnerable populations such as in hospitals and nursing homes, catering operations, producers of manufactured and fermented meats). Such programs would require auditing, but this could be done by a second party auditor (eg local government) or by a third party auditor (eg private contractors).

The national risk validation project shows that for each of the high risk food industries, other than eating establishments, (i.e. those providing food to vulnerable populations such as in hospitals and nursing homes, catering operations, producers of manufactured and fermented meats), the costs of food safety programs are outweighed by the benefits associated with avoiding class 1 outbreaks.

Other than for eating establishments (benefit cost ratio of 0.8), the benefit cost ratios for the other high risk industries were all in excess of 6.5.

Consideration will need to be given to competencies and licensing of food auditors (eg auditors for premises covered by Food Safe Queensland require membership of Quality Society of Australia). The registration/certification of auditors remains under consideration by Queensland Health as part of the Food Act review.

As part of the review of the Food Act some background research has been undertaken on performance of local government responsibilities in relation to food premises.

The main findings of the study²¹ were:

- ❖ A large variation exists in the procedures used by local governments for licensing and registration of food businesses and premises in Queensland;
- ❖ Generally, local governments would like to see the current system of licensing and registration maintained with provision for a few changes;
- ❖ Generally larger local governments are more likely to:
 - license and register, and offer a fee reduction to charitable organisations;
 - use risk, floor area, or inspection length to determine fees;
 - have a larger the fee, and the longer the inspection time;
- ❖ Generally, smaller local governments have a fixed fee based on what is fair and reasonable;
- ❖ For some local governments (mainly regional), revenue does not cover the cost of inspection; funds from general revenue are needed to subsidise the remaining costs. This is resulting from increased inspection cost due to: long travel times, low compliance, and charging the minimum due to the financial situation of the business owner;
- ❖ 33% of local governments license and register food business and premises according to the classes in the *Food Hygiene Regulation* schedule;
- ❖ 29% combined the licensing and registration fee;
- ❖ 39% have created local laws to authorise the issue of permits for temporary food stalls;

²⁰ Food Science Australia and Minter Ellison Consulting, July 2002, National Risk Validation Process

²¹ A Survey of Licensing and Regulation of Food Businesses and Premises, Q Health, Environmental Health Services, April 2001

From the data received in the Queensland Health surveys, it was projected that:

- ❖ 30,000 food premises are registered in Queensland annually;
- ❖ 147 full time equivalent Environmental Health Officers work on food safety in Queensland;
- ❖ Between 5 and 8 million dollars is raised from licensing and registration fees in Queensland annually.

Diversity in the licensing and registration of food businesses and premises was attributed in part to different interpretations due to the wording of the Food Hygiene Regulation, which appears to provide local governments with discretion to license and register or not (in reality, LG does not have such discretion), and creates confusion on who should be licensed and registered, how often inspections should occur, and what rights the local governments have to create their own licensing and registration system.

The report recommended that additional support is needed for local governments to help with the licensing and registration process by such methods as developing standards or a user guide on licensing and regulations. This was seen as creating:

1. equity to business owners;
2. statewide consistency;
3. inter-local government collaboration for addressing common rural and regional problems;
4. clarification of the regulations including provisions for regulation of itinerant or temporary style food shops; and
5. consistent national reporting systems.

Other research suggests that there is no major threat to public health in the way food premises currently operate or the way in which individual councils undertake their regulatory responsibilities. A benchmarking survey²² on food handling found that “... *Queensland has reason to be confident in the level of food handling and knowledge of food safety compared to the national averages. More than 96% of food businesses achieved compliance for 26.4% of the 53 compliance questions on the Queensland Survey, compared to only 7.5% on the National Survey.*”

3.4.3 Impacts on Local Government Workforce

The above discussion reveals that considerable change is taking place in legislation covering the role of local government in public health. Central to the changes is the concept of a risk based framework.

Some of the changes have been driven by National Competition Policy requirements for states to review and reform legislation that restricts competition, except where a Public Benefit Test shows that benefits of restriction outweigh costs involved or the legislative objectives can only be achieved by such restrictions.

The modern style in drafting legislation also reflects a performance based approach rather than being prescriptive. In addition, separate pieces of legislation are required for each specific topic rather than being covered under regulations of an umbrella Act, as was the case with the *Health Act 1937*.

Based on available information about the Health Act review, a key impact for local government will be that authorised officers can be appointed for a specific activity (eg food auditing, personal appearances, etc.). What this means in practice could be that persons with specialised (but narrow) skill sets may be available to undertake components of the public health role on a task basis rather than such inspections being done by a professional EHO with broad competencies covering a wide field of public health matters.

²² Queensland Food Handling Benchmark Survey, Queensland Health, 2002, p.2

If this provides greater choice and flexibility to local government, and acts to reduce costs, then these changes are likely to be supported by local government. On the other hand, some elements within the environmental health profession may see this as an erosion of the skills and competencies required to superintend devolved legislation, and as an adverse impact on the functions of the Environmental and Public Health profession as it is currently known.

Clearly, the removal of some of the more basic procedural and local law enforcement tasks from the day to day duties of an EHO would allow their professional skills to be better focused on proactive public and environmental health strategies.

However, in smaller rural councils resources are unlikely to be available to remove some of the more basic tasks from the EHO role. It is also possible that the availability of specialised personnel, capable of focusing on say one single piece of legislation but without the broader competencies of an EHO, may further erode the perceived need for a qualified EHO in smaller councils.

4 The Local Government Public Health Workforce

4.1 Distribution of EHOs in Local Government

There is no available database showing the number of full-time equivalent Environmental Health Officers (EHOs) employed (directly or indirectly) by councils in Queensland. AIEH membership records indicate that there are around 405 members resident in Queensland, although only 310 of these are full members (the list includes student and retired members). However, it is also known that there are a number of council EHOs who are not members of AIEH.

In addition to the EHO workforce employed by local government, an estimated 70 are employed by Queensland Health, with the majority of these EHOs dispersed throughout the state in public health units. EHOs are also employed by other government agencies, the military and private enterprise.

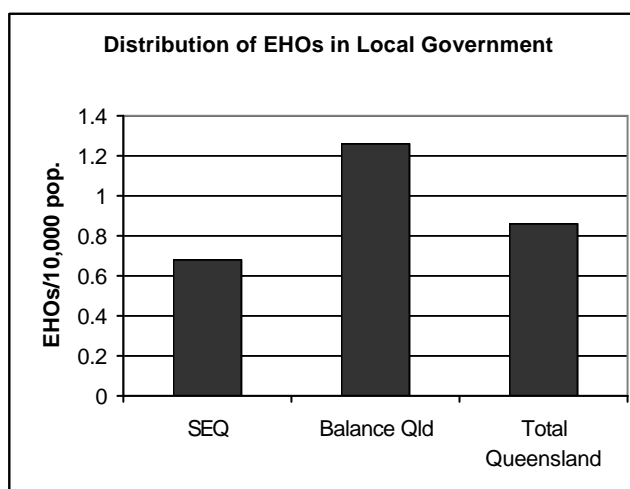
As part of the consultation process, details of the current number of EHOs servicing councils across the State were sought. It should be noted that this list is not restricted to formally qualified EHOs, as some persons performing public health functions may not have qualifications from courses accredited by AIEH. Nevertheless, the details are considered sufficiently accurate to provide an overview of the number and distribution of the Local Government public health workforce. Full details of the workforce distribution are included in **Attachment C**.

It should be noted that this table records the distribution of EHO resources, not the resources devoted to public health activities. As noted earlier, **EHOs perform a wide range of local government functions and in typical rural situations only 20% to 30% of their total time may be devoted to functions devolved under the Health Act or Food Act**.

Even in large councils, the EHO workforce available will not be predominantly engaged in matters related to public health as covered by the Health and Food Acts and associated regulations. In one outer-metropolitan council for example where the health and environmental functions are split into separate sections, less than 40% of the available EHOs are in the health section. Larger urban councils also reported that a number of technical officers/local laws officers supported the EHOs in compliance, regulation and other operational activities associated with public health functions.

Based on this research, there are around 320 full time equivalent EHOs employed directly or indirectly by councils in Queensland. This represents an average of 0.86 EHOs per ten thousand population. Just over half of these (54%) are employed within councils in South East Queensland. In population terms, SEQ councils represent some 74% of the population of the state. This lower per capita rate of employment in SEQ (0.68 per ten thousand) is an indicator of the capacity of larger councils to more effectively utilise such professional resources.

This figure of 320 local government EHOs compares with some 398 estimated in 1990 as part of a labour market study²³. While this may indicate a decline in numbers in the profession serving local



²³ Environmental Health Officer, Labour Market Study, National Local Government Training Council, December 1990, p.7

government, the estimates made in 1990 are not regarded as sufficiently definitive to support such a conclusion as the assessment methodology was hampered by changes in ABS definitions.

Approximately 35 (28%) of the 125 councils under the Local Government Act are served on the basis of a shared arrangement with another council in the region or employ a contractor or consultant EHO on a part time basis. Smaller councils may, for example, obtain EHO services on a one-day per fortnight basis (at least one council is reported as having a one day visit every three months).

Rural Councils tend to have the highest number of full time equivalent EHOs per ten thousand population. This is a reflection of the fact that the only way in which a small council feels it can resource an EHO is to have that person responsible for a wide range of regulatory functions, other environmental tasks as well as public health matters.

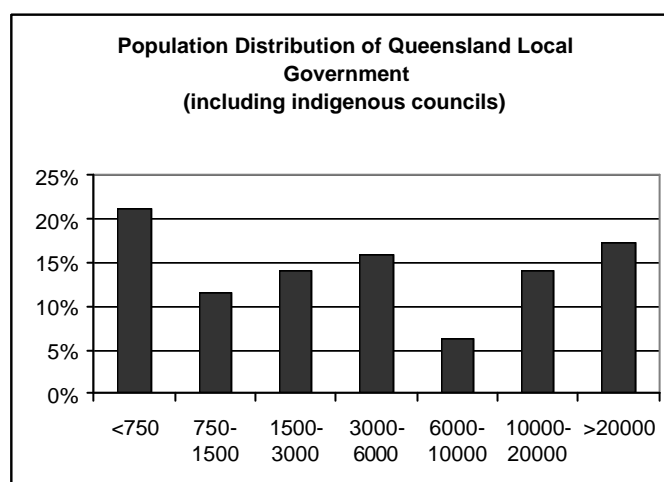
As noted previously, it is not uncommon for a rural EHO to be responsible for devolved public/environmental health functions but to also have assigned responsibility for environmentally relevant activities (ERAs) under the Environment Protection Act (EPA), local laws, workplace health and safety, stock routes and rural lands protection, and in some cases building and planning matters.

Frequent comment from EHOs in smaller provincial and rural locations focused on the low priority afforded environmental health functions by councils in budgets and administrative resource allocation. Additionally, some EHOs are required to collect outstanding fees from business operators when this should be an administrative role.

In contrast, larger urban councils can use the EHO resources to focus on key EHO roles and employ other specialists (eg environmental scientists, building certifiers) for other functions.

4.2 Size of Local Government

The previous analysis of the local government environmental health workforce highlights the difficulty for smaller councils in cost effectively undertaking their public health role. If, on average, less than one EHO is required to service a population of 10,000, then **it is very difficult for a council with less than 3,000 people to consider employing a qualified EHO unless the majority of their duties are not directly related to public and environmental health matters.**



The above figure provides some perspective on this problem while Table 4.1 profiles the details of the population distribution of local government in Queensland. Aurukun and Mornington councils have been included with the indigenous councils as the legislative framework is not relevant to the analysis.

As the table reveals, there are only 27 mainstream councils in Queensland with more than 20,000 people. At the other end of the spectrum, there are 39 mainstream councils with a population less than 3,000. In this context, the atypical situation represented by Brisbane City (917,000) and Gold Coast City (438,000) is apparent.

When the indigenous councils are added to the picture, there are 73 councils in Queensland with under 3,000 population.

Table 4.1: Size Distribution of Queensland Local Government

Population Range	Mainstream Councils	Indigenous Councils	Total Local Government
<750	11	22	33
750-1500	8	10	18
1500-3000	20	2	22
3000-6000	25		25
6000-10000	10		10
10000-20000	22		22
>20000	27		27
Total	123	34	157

To further complicate matters, there is a diversity of situations covered by local government. For example, a rural council with less than 3,000 people may not have a significant urban center whereas other councils in the size range may support a town of 1,500 people. The Australian Classification of Local Governments uses 22 separate categories to deal with this diversity of situations.

From a public health risk perspective, it is effectively the distribution of the population rather than the distribution of councils that is the key factor. In this context, some 20 councils (16%) represent 80% of the population of Queensland.

What this analysis suggests is that **there may be a need for Queensland Health to differentiate the way in which it supports councils in performance of their public health roles, with recognition of population distribution, geographic size and location in determining strategies.**

At present Queensland Health provides a high level of support to indigenous councils across the state, in recognition of the significant health problems facing indigenous people, and the lack of skills and resources to undertake public health functions devolved to local government. In some cases, significant support is also extended to smaller mainstream councils.

4.3 Indigenous Environmental Health Workers

Indigenous Environmental Health Workers (EHWs) are a valuable community-based resource providing health promotion, organising health services such as refuse collection and disposal, pest and dog control as well as monitoring essential services such as water and waste water systems. The concept is one of skilled indigenous people working and living in their communities, enhancing community control through local decision-making and community involvement.

Appropriate training programs are essential if individuals are to take environmental health skills and knowledge back to their communities. The first EHW course in Queensland commenced in 1996, providing Diploma level graduates from 1998 onwards.

The Deed of Grant in Trust (DOGIT) communities²⁴ in Queensland do not at present employ EHOs. Qualified EHO support is provided from the Queensland Health Regional Public Health Units.

However, some 13 mainland communities are eligible for DATSIP funding of EHWs under the Cape York partnerships agreement. Of these, 11 signed up to the EHW program. The non-Cape York

²⁴ These are councils under the Community Services Acts. It is intended that the legislation for Aboriginal Councils is repealed and that they become Shire Councils under the LG Act 1993. These changes will be phased in over four years. Changes for Island Councils will be addressed at a later date.

communities with the exception of Doomadgee, Mornington Is. and Woorabinda currently have EHWs employed by their DOGIT Council. There are approximately 14 EHWs working for mainland DOGIT councils.

In the Torres Strait communities there are approximately 24 EHWs employed (not necessarily full time positions). Of these around 12 have completed the Diploma level training.

At present there are around 25 EHWs studying towards their Diploma.

Many of these are undertaking their Diploma through Cairns TAFE, while others are enrolled through Batchelor College in the Northern Territory. Queensland Health also provides a number of indigenous co-ordinators to support EHWs in communities.

Since 1998, some 40 EHWs have graduated at the Diploma/Advanced Diploma level. As these figures suggest, there has been a significant turnover of qualified EHWs since the program began.

Issues confronting these and other indigenous communities are discussed later in this report.

4.4 Regional Arrangements

As noted previously, some 35 (28%) of councils in the state are supported by other council EHOs or use private contract arrangements through an external service provider to meet primary public health responsibilities. These arrangements are most often found in western and far north Queensland.

There were mixed responses in relation to the success of such arrangements. Some small councils see these arrangements as very cost effective, noting that they could never afford the services of a full-time EHO. In a number of these cases, the frequency of visits by an EHO to the community is quite low (1 day per month to 1 day per three months). The scope of activities assigned to the visiting EHO is minimal, and covers only mandated public health activities, particularly food licensing/inspection. In addition, the EHO is also contracted to undertake ERA activities.

One EHO noted "...because lack of money is such a huge issue, I was required to contract my services to other Shire Councils ... while away you are still expected to do all your own work ... and by the way you don't get overtime ... The Council/s you are contracted to want all of the work done in a week because they don't have any money either."

This issue of lack of funding for small councils to undertake their public health functions must be seen in context. While the rate base of many small councils is very low, the Local Government Grants Commission takes factors such as scale, dispersion and location into account when determining their share of financial assistance grants (FAG), which include functions such as environmental health. In many cases, the FAG grant for small councils is substantially greater than the rate revenue. However, because these grants are untied, there is only limited recognition that the funding covers all standard functions of local government across the state.

This matter of local priorities versus overall needs is however an element of any democratic system, particularly in a local government setting where the emphasis is on local autonomy and accountability.

One Council CEO commented that the primary concern with shared arrangements is with the host council simply giving them the "dregs" of the EHO resources. The primary interest for the host council is in first meeting their own local needs.

A number of EHOs confirmed that they often felt pressured by such shared arrangements, particularly where they were “loaded up” with many other functions, not just those related to environmental health.

Furthermore, the ‘fee for service’/ shared arrangements were described as being sometimes ill-defined. As one EHO commented “... *what is really meant by ‘on an as-needs basis’? Unfortunately my professional view isn’t usually part of the decision.*” Clearly defined share arrangements would assist in mitigating the ‘left over’ sentiment.

A suggestion from one local government forum was that small councils would be better served if the EHOs for the region were employed through a regional organisation of councils (ROC)²⁵ or similar body, with a formal task schedule for each locality. The feeling was that the EHO would then have a professional commitment to all councils rather than a competition between a primary employer and between other ill-defined contracts.

Profile of Queensland EHOs and Local Government

- An estimated 320 (FTE) EHOs service Queensland local government. This represents 0.86 per 10,000 population;
- Some 172 (54%) EHOs are employed in SEQ, with 75% of the population. This represents 0.68 per 10,000 population;
- Some 148 EHOs serve the rest of Queensland local government or 1.26 per 10,000 population;
- 28% of mainstream councils are served through arrangements with other councils or service providers;
- Only 27 councils in Queensland have a population greater than 20,000 people;
- There are 39 mainstream and 34 indigenous councils with less than 3,000 population;
- 20 mainstream councils (16%) represent 80% of the state’s population;
- Only 25% of mainstream councils in the state have more than one qualified EHO position available.

²⁵ Most regions in Queensland have some form of voluntary arrangement bringing together councils in the region. These may be separately incorporated bodies or the regional body may simply be hosted by one council in the region. In some cases such regional organisations may employ staff to address matters of regional significance eg economic development.

5 Training and Skill Development

5.1 Accredited Courses in Environmental Health

From 2004, the only Queensland based course offering accredited entry into the EHO profession is at Griffith University through its Bachelor of Science (Environmental Health) degree. The Queensland University of Technology (QUT) Bachelor of Applied Science (Environmental Health) is now only available for continuing students in second year and beyond.

It is understood that both Griffith and QUT are considering offering an EHO course at Post-Graduate level. The formal process of accreditation and content detail are in the early phase of deliberation.

A number of northern and western councils commented that capacity to undertake accredited courses off campus is important in developing locally based EHO skills. It was felt that it was more likely that a person working for the council while undertaking studies was more likely to remain in the “bush”. While some Universities (eg University of Western Sydney) offer distance education degrees, there was a feeling that a Queensland based course would be more appropriate.

It is also understood that Griffith University in conjunction with Curtin University is currently developing an environmental health post-graduate program in a flexible learning mode (this would include distance education options), which should commence in 2005.

A number of comments and submissions questioned the appropriateness of current tertiary qualifications in providing graduates with skills and competencies necessary for employment in a rural EHO position. One EHO noted “... *I believe a simple one year course would be adequate for rural areas. I did four years and learned more in the first two weeks on the job.*”

This need for greater practical training in university courses was raised by both experienced EHOs and recent graduates as well as by CEOs. The issue of practical experience is addressed in part in the Griffith University course where students are required to undertake some 60 days of placement within the industry during the duration of their course. Nevertheless, some councils feel that such short term placements results in a substantial burden on them in trying to make the placement rewarding for both student and council.

Swinburne University of Technology has a one year option of a salaried Industry Based Learning as the third year of a four year Bachelor of Health Science (Public and Environmental Health) degree. Comment from those familiar with graduates from this course indicated that they were more “work-ready” than other graduates.

One submission commented that “... *there is a trend emerging for tertiary institutions to graduate “Public Health Officers” (ie generalists) rather than EHOs (officers specialised in Environmental Health). University courses must have an environmental health focus. Changes need to be made to the tertiary courses to ensure graduates are fully qualified to undertake the role of an EHO in Local Government i.e,they must hit the ground running. Food Auditor training needs to be included, as well as dangerous goods safety management, enforcement, budgeting, human resource management and management in general.*”

The question of appropriate competencies for the environmental health profession was considered by a project in the USA²⁶. The project identified some 14 core competencies for an environmental health program grouped into three primary functional areas defined as Assessment, Management and Communication. The Communication stream includes competencies in conflict resolution as well as marketing the importance of environmental health programs within a community.

²⁶ Environmental Health Competency Project, American Public Health Association, May 2001

An increased emphasis on communication and conflict resolution in courses would assist in preparing new EHOs for the realities of life working in a local government, small community, environment. Comment was also made that there is a need for tertiary courses to provide better understanding of delegations and roles under the range of Acts likely to be administered by a local government EHO. It is important that tertiary institutions work with stakeholders to ensure these needs are appropriately met.

Training for Indigenous Environmental Health Workers (EHWs) was also raised in consultations. EHWs currently undertaking studies expressed some concerns in relation to changes in the Cairns TAFE Diploma course, particularly where classes had been combined with other courses.

A number of indigenous EHWs have enrolled in the Batchelor College (NT) Diploma course as they feel that this is more culturally appropriate and also offers an opportunity to continue on to an EHO degree qualification.

5.2 Graduate Employment

Only 25% of councils in the state have more than one qualified EHO position available. This lack of peer support and mentoring is therefore a critical issue in terms of developing and maintaining a suitably qualified public health workforce in local government, especially in rural areas. It is certainly an impediment for the initial placement of graduates.

A number of rural councils that had recently advertised for an EHO noted that they are reluctant to appoint a recent graduate to the EHO position because of their lack of practical experience. As one council CEO noted “...sometimes they are fresh out of university without life experience and have difficulty ... there is not much peer support.”

This issue of life experience was noted by one EHO in rural Queensland who observed “... most of all EHOs need people skills.” The view was that it was simply not possible for a recent graduate (other than a mature age graduate) to have sufficient people skills to handle the requirements of a rural EHO position where there is no other senior person to provide support. One young graduate with their first career experience in a small rural council commented “... I was scared witless a few times.”

This situation in terms of the need for peer support for recent graduates is of course common to all professions and is not a reflection on those graduating in environmental health. The difference is that the major employer of EHOs is local government, with a highly regulatory role. Further, 75% of such potential employment destinations are as a sole practitioner, which are really not suitable placements for a young graduate. When the employee and employer experience consequent difficulties, there are negative impacts on both parties.

Clearly, young EHOs deserve professional support in handling personally threatening situations. Instances of threats and abuse were described in submissions. Specialist training as provided to police officers was suggested as one option to develop conflict management skills.

EHOs in rural Queensland repeatedly noted that they establish contact as a network and provide support to recent appointees in other councils. Whether it is feasible for such informal networks spread over significant distances to provide adequate support and mentoring required and deserved by recent graduates is debatable. When trying to arrange consultations in one region as part of this project, the fact that the incumbent EHOs had not all met in person was strong testimony to the issue of professional isolation in rural areas.

With the best of intentions, often the only support is a phone call to a neighbouring (200-300 plus kilometres distant!) EHO, days after an 'event'. *"Management offers little support ... as their job would be on the line too then ... people don't realise that something like an FBI (food borne illness) can go really wrong .. don't know how long I'll last"*. This is not a positive view of potential career satisfaction for a young EHO who was reflecting on job stresses.

5.3 Cadetships

Workshop comments and written input frequently referred to the merit of traineeships or cadetships or supported study arrangements. The opportunity to pursue tertiary education whilst working in a Council is considered to offer a chance of career development for local people who would have otherwise typically left the community. Expectations of Councils vary as to the term of retention of the candidate and whether or not cadetships are seen as a way to develop the profession as opposed to a more narrow local job focus.

A number of councils are already active in provision of scholarships, cadetships and bursaries as illustrated by the following examples.

An example of a bursary scheme operated by Richmond Shire is provided in the following text box. This includes a bursary for an EHO position.

Richmond Shire – Profile of Bursary Scheme

Council has offered a bursary of \$5000 a year for Accounting and Engineering now for the past four years. One student has taken it up, an Accounting student in his first year.

They receive the money in advance however the next payment is determined via subject passes. Semester 1: \$2500, semester 2: \$2500, which equates to \$1250 per subject for a 24 unit degree.

Recipients are loosely bonded back to the Council, they also get 6 weeks work experience at \$500 per week.

This year was the first year a bursary was offered for an EHO. Council is now talking about a Bursary for sporting and cultural pursuits.

If every Academic Bursary was taken up that was offered it would cost council \$72,000 a year. The Sporting and cultural one varies up to maximum of \$5000 a year.

The bursaries are only offered to Richmond Shire residents, they are given on application after acceptance into the appropriate course. Bursaries are only offered in areas that Council can support with existing professional staff.

The reason behind inception of the bursaries was to encourage locals to pursue university with the hope that one day they would return home and provide professional services to this community, either as private enterprise, in council, school or other areas.

Calliope Shire also provides cadetships across a number of disciplines as shown in the following text box. At present, no cadetship is available for an EHO.

Townsville City Council currently offers an EHO cadetship program at an annual cost of approximately \$16,000. The cadetship includes some 20 weeks of employment within council per annum during semester breaks. The cadetship is on the basis of providing three years full time employment on graduation, with a contract entered into by the cadet.

Dalby Town Council is understood to be considering scholarships for key council positions with students to be offered \$500 p.a. plus vacation employment, followed by two years of bonded employment on graduation.

A survey undertaken by Bowen Shire Council²⁷ found that the concept of a shared cadetship was supported by 47% of councils in North Queensland, and that this support would increase to 60% if funding was available from external sources for a scholarship. The survey results note that 63% of the 30 councils in the region indicated they had experienced difficulties in recruiting an EHO.

The AIEH Northern Division has also sought to encourage current students to seek rural employment, particularly in North Queensland by sponsoring two students to attend the May and November 2004 division meetings.

Calliope Shire - Profile of Cadetships

1. *Bachelor of Business Degree (accounting) – Finance Dept - 5 years*
2. *Business Double Degree (human resources)– Training Officer - 3 years*
3. *Information Technology – 3 years*
4. *Building Surveying – one person – 3 years*
5. *Bachelor of Business Degree (accounting) – Building Administration – 1 year*
6. *Town Planning – 3 months project work*

The cadets have moved within Council to gain broader experience in accordance with their professional interests and expertise. All personnel are reported to have achieved very good academic results.

“Breaking the Unemployment Cycle” grant (\$16,000) has been received for some of the personnel. The availability of such assistance obviously depends on the specific guidelines of Commonwealth or State programs.

The outlays paid by Council include student union fees, membership of professional bodies and conference attendance where applicable, and HECS which is subject to FBT, are described as really minimal costs to Council.

The cadets are paid in accordance with Council’s EB and as they are appointed to actual positions, they are being paid above the rate for their age.

“None of our trainees has left the nest yet. There is probably a degree of loyalty on their part although we have talked to them about the fact that moving on will not be frowned upon and could be good for their long term development.”

5.4 Support and Mentoring

Individual EHOs currently play an active, but informal role, in supporting and mentoring new EHOs in councils within their region. A number of experienced EHOs noted that they valued the support when they first entered the profession, and feel that making sure a new EHO knows that “... *they are welcome to call at any time – no question is too small*” is important.

Comment was made that AIEH should play a more active role in mentoring within regions. One submission noted “... *whilst it has been talked about, a mentoring system for new graduates in rural and regional Queensland needs to be formalised and promoted to assist new EHOs who are employed in a single EHO council to get through the first year or two*”, and also that there is a “... *need to consider promoting sub regional groups as a means of support for regional and rural EHOs.*”

Another submission noted that there is “...*little or no support for young graduates who may take up rural or remote positions. Consideration should be given to facilitating a formal mentoring program which provides oversight, assistance, resources, guidance and includes a diagnostic tool such as an audit process to help identify suitable areas for focused coaching.*”

²⁷ Results of Needs Analysis Survey, Environmental Health Officers in North Queensland, Jon Gibbons, Bowen Shire Council, 2003

The Northern Group of AIEH has suggested that a database should be set up by AIEH to match graduates with enthusiastic EHOs.

Support from larger councils in training of EHOs from rural and regional locations was also identified as an option. It is understood there are a number of larger councils who have hosted a rural EHO for a few weeks to allow upskilling on particular elements of their role eg food, dangerous goods, environmentally relevant activities. Exchange opportunities are also under consideration by some councils (eg Gold Coast and other provincial cities). This not only ensures the rural center is not without an EHO, but facilitates diversification of experience for the participants.

5.5 Resources

A number of short courses are available to council personnel to enhance particular skills and competencies. These courses are available through a number of registered training organisations.

LGAQ have provided a number of courses of relevance to EHOs and other officers involved in regulatory roles. The programs are specifically prepared for local government and are delivered about ten times each year throughout the state. These courses include:-

- ❖ **Investigation Skills Course.** This three-day course deals with the LG Act in relation to monitoring, compliance, enforcement, policy, regulations, delegations, licences, complaint handling, investigations and court procedures. The program is offered to plumbing and building inspectors, local laws officers, development control officers and EHOs. The course complies with national competency standards.
- ❖ **Authorised Persons Workshop.** This one-day workshop (non-accredited course) is delivered for local laws and animal management officers as well as EHOs. Elected members are also encouraged to attend.
- ❖ **Animal Management Course.** This course was targeted at local laws officers and EHOs. However, the course has been suspended because the trainer is not currently available.

Other agencies have also provided courses to enhance skills and competencies. Examples include:

- **AIEH - Disaster Management Course;**
- **QHealth - Mosquito Identification Course;**
- **ChemUnit - Dangerous Goods Course.**

A number of councils, either individually or in regional groups, have developed resources that can assist local government across the state in refining processes and procedures.

The “*Toolbox*” project being undertaken through SEQROC (by Brisbane City and Gold Coast City) was identified by a number of EHOs as an invaluable support tool that provides a range of standard resources and information relevant to day-to-day EHO activities. Reportedly, a number of councils have agreed in principle to subscribe to this resource. Based on feedback from those EHOs that have seen the project demonstrated, it appears likely that a significant number of councils will also join, assuming that pricing and maintenance arrangements are satisfactory.

A regional course has been developed by Bundaberg City and Burnett Shire aimed at providing free training for food handlers within the four councils in the region. Maroochy and Noosa Shires also provide food-handling courses for operators on the Sunshine Coast.

In the central region, a group comprising Livingstone, Rockhampton, Gladstone, Calliope, Burnett and Bundaberg councils has produced a resource kit for the development and assessment of environmentally relevant activities. It was reported that this has been a successful venture with the CD from the kit making its way around Queensland.

Comment was made that Queensland Health could provide better support to councils, particularly in relation to changes in legislation and implications for operational policy.

The need for interpretive information to upskill EHOs was seen as necessary to minimise the need for every officer in each council to analyse legislative changes and implement revised procedures. The Personal Appearance Services Act was cited as the most recent example, with strong criticism by LG of QHealth for the timing of information releases relative to the start date of the legislation. On the other hand, support from the Food Reform Implementation Team (FRIT) was often raised as a good practice example.

6 Career Paths

6.1 Recruitment and Retention

As noted previously, many small councils with a position for only one qualified EHO are reluctant to recruit a recent graduate. A number of councils indicated that it was difficult to attract quality applicants when positions were advertised. One CEO noted “... *we had real problems with a previous employee and when he left we did not advertise. The CEO contacted and offered the position to the current employee.*” This statement shows the difficulties encountered by young graduates in trying to meet the expectations of rural councils and further underlines the inappropriate nature of a recent graduate being appointed to an EHO position in a council where that person is the only EHO resource in the area.

This is not a criticism of technical competencies, but a reflection of the community and political pressure exerted on a young person, who has a regulatory role without the benefits of formal institutional support.

Another CEO whose council does not have a EHO position at present indicated that the only way they could have such a resource on staff was to combine a number of duties in the position description such as EHO, Building, Planning, Rural Services and Natural Resource Management. The council is currently scoping such a position although the comment was made that elected representatives see EHOs as “... *greenies, bureaucrats and anti-development.*” This CEO expressed an awareness of the public health liability concerns and was trying to develop a better appreciation of issues by councillors.

The difficulties in recruitment and retention of EHOs for rural councils with the above attitude of elected members is reinforced by a comment from one EHO on ‘going by the book versus the pressure to ‘turn a blind eye’. “... *Common sense is necessary but technically that will not stand up if a serious issue arises. The whole game is a balancing act. I would be out of the game in an instant if the opportunity arose.*”

Some EHOs pointed to a lack of financial incentives to attract them to rural or remote employment opportunities. Under the award, smaller councils have a lower salary scale than larger ones for senior officers including department heads. This inevitably transfers to staff such as EHOs, with the potential result that it may be difficult for EHOs in rural councils classified in Categories 1 to 4 for award purposes to progress beyond Levels 5 or 6 of the award, acting as a disincentive. However, some other EHOs saw this as something to negotiate, noting that a contract arrangement rather than the award can often be beneficial to both parties.

As discussed earlier, an EHO team employed by a ROC may be an option in overcoming some of the problems identified in relation to recruitment and retention.

A number of EHOs commented on the high loss rate of EHOs from the profession. One commented that of five EHOs known, probably four would leave the profession in the next year. One reason given for this turnover was the lack of opportunities to progress within a council.

Further, another EHO in a rural council stated that the problem is that the salary doesn’t increase much from what is offered to a graduate, as “... *councils simply see the person as doing the same job*”.

A number of EHOs felt that their opportunity to progress into senior management was blocked because of the way in which council corporate structures were put in place with emphasis on engineering or planning and development, and with health as a small section within a larger department. The lack of priority afforded to health policy has been raised earlier.

While no figures were available on the turnover rate within the profession, anecdotal evidence suggested that around 20 EHOs could be leaving the profession each year in Queensland. It is assumed that this figure is a result of the conclusions of the 1990 labour market study previously noted. The basis of this estimate is not considered sufficiently rigorous to be confident that turnover (in terms of loss to the profession) is this high. Nevertheless, concern was expressed by a number of people that the numbers graduating each year were not sufficient to meet the turnover within local government in Queensland. Graduate numbers may also decrease in the immediate future as a result of the QUT decision to cease its intake of new students. It is noted that a number of recently employed EHOs in Queensland have come from other states.

Because each council is an individual employer, it can be difficult to develop incentive packages aimed at attracting EHOs to smaller communities for a short term contract (viz 2 or 3 years).

The opportunity to return to a location of choice exists in the State Public Service to a far greater extent than in Local Government. This issue is addressed in the LGAQ IR *“Roadmap for Change”, Reforming Industrial Relations* – in the context that there are 125 individual Council employers in the State as compared with one State Public Service. If, for example, LGAQ became an employer rather than individual councils, there could be opportunities to provide incentive packages for term appointments in one geographic area.

The difficulties in recruiting and retaining EHOs, particularly for rural and regional localities is not simply a Queensland problem. Interstate councils report similar problems.

In western Victoria, five councils have joined together to develop a recruitment and retention strategy because of difficulties faced in attracting a skilled EHO workforce to the region²⁸. The councils (Glenelg, Corangamite, Moyne, Southern Grampians and Warrnambool) have implemented a program to attract graduates to the region.

The program includes development of a coordinated professional development training package along with a peer support network. The report on the trial program suggests that it was beneficial to students, providing them with an opportunity to consider their career choice. While one student gained full time employment in the region another decided not to continue within the environmental health profession. The collaborative approach was seen as particularly important in providing the opportunity for professional development.

Councils in the UK also report difficulties in attracting EHOs to rural and regional locations. Breckland²⁹, a council serving a rural population of 120,000 people in five market towns has experienced difficulties in attracting suitably qualified graduate EHOs. The graduate EHO market in the UK is considered highly competitive due to a lack of trainees coming through university courses. A further concern noted, is that graduates are often too general in their approach to the subject

A number of state government agencies are able to offer incentives for rural placements.

For example, Queensland Transport - Main Roads has a management scheme that provides improved benefits in rural and remote areas, defined as the Districts of Cloncurry, Barcaldine, Roma and Emerald for the purpose of the agreement.

This Rural and Remote Area Incentives Scheme includes elements such as specific term appointments, housing subsidies, provisions for guaranteed transfer to a provincial or coastal centre, including Brisbane after three (3) years service in a rural and remote center, professional development entitlements up to \$10,000, relief opportunities outside the district, pre-start familiarisation and job search assistance for a partner, real estate commission refunds, specialist dental/medical and travel entitlements.

²⁸ Putting the “C” back into Capacity, presentation by Glenelg, Corangamite, Moyne, Southern Grampians and Warrnambool Councils, undated

²⁹ Environmental Health Department, Breckland District Council

whereas the environmental health work in local government is seen as requiring more specialised knowledge. The council is now trialing specialist technical officers to cover particular functions such as food. Consideration is also being given to part time and shared positions.

A similar problem of attracting graduate EHOs was reported by Guildford³⁰, a council in the south east of the UK with a population of 130,000 people. The council has introduced an initiative to market the profession to secondary school students. This is achieved through a one week work placement in the health department. The council also supports trainees by paying a full salary while undertaking university studies.

While Western Victoria and rural UK may not be considered rural and remote by Queensland comparisons, the fact is that in terms of relativities, that is the circumstance.

The point is that these labour market issues are not unique to the environmental health profession in Queensland local government³¹.

6.2 Mandated Qualifications

As might be expected there are differing views on whether qualifications for an EHO should be mandated by legislation. This is the case in Victoria, and there is strong AIEH support for a similar approach in Queensland.

AIEH has submitted that a State Registration Board should be established to ensure that all agencies appoint appropriately qualified and professionally competent EHOs to undertake statutory, existing and emerging environmental health functions. AIEH sees the Board as State based, similar to those for nurses, dental therapists and pharmacists.

A suitably qualified and competent person is regarded as a graduate of an AIEH accredited undergraduate or post graduate course. For EHWs, registration is also recommended by AIEH, with an accredited AIEH diploma being regarded as an appropriate qualification.

Temporary registration for a period of two years is also proposed where a current EHO does not have an AIEH accredited qualification, allowing completion of a suitable qualification by external studies (external study courses would need to be developed).

AIEH believes it is unacceptable that a number of councils in the state employ persons whom AIEH regard as not competent (because of the lack of an AIEH accredited EH degree) to undertake public and environmental health functions in local government. The AIEH considers this results in the dilution and subsequent undervaluing of the profession. However, there are also the recruitment issues of applicants' credentials and employer's requirements versus AIEH accreditation

In recognising the differences relating to academic qualifications and core competencies, the Draft Policy Paper³² suggests that for a person to be appointed as an authorised officer there is a need to demonstrate appropriate competencies. Currently, there is no test of core skills to assess competency. The paper suggests that **this could be done by including a list of competencies in a Regulation accompanying the Act.**

Given the nature of recent legislation, including the lack of definition of appropriate competencies, it does not appear likely at this time that a Registration Board or equivalent will be established. There

³⁰ Chief Environmental Health Officer, Guildford Borough Council

³¹ see also the Review of CEO Recruitment and Retention in Rural and Remote Local Government in Qld., LGAQ/LGMA, Feb. 2004

³² Review of the Health Act 1937 (Public Health), Draft Policy Paper, Queensland Health, February 1998, p.59

may however be other **mechanisms to ensure that council CEOs have some guidance on what qualifications are deemed as appropriate when making appointments, including initiatives from AIEH in its role as professional representative body as well as guidelines developed by QHealth.**

6.3 Council Support

There was considerable comment by EHOs on the lack of support from elected members for the EHO role. One EHO noted “... *we study for three years and come out to be a dog catcher. I get sick of dealing with nuisance complaints.*”

Another noted that councillors “... *have a very poor understanding and commitment to EHOs. Planners and engineers are seen as positive as they approve and build things. We stop, licence and fine people.*”

Another EHO commented on the reluctance of elected representatives to prosecute business operations noting that “... *in rural areas councils don't want food businesses closed. If I tried to close a business I would be sacked. I just have to work slowly at the problem and try to overcome the issue. Councils feel that promoting business and keeping them going is paramount.*”

Another summarised the expectations and priorities of councils in rural areas as “...*(1) don't rock the boat and (2) solve the problem without ruffling ratepayers.*”

One EHO who closed down a food business in a rural town noted that there was tremendous outcry in the community “... *no one seemed to realise the disastrous consequences for a tourist bus full of older folk with food poisoning*”. EHOs also identified situations where they were abused by residents as a result of their regulatory role in enforcing legislation or local laws and found it very difficult to continue to reside in that town.

Some rural EHOs referred to different approaches in the city versus the bush “... *EHOs in the city must go by the book more than rural EHOs. I use a lot of common sense. Basically, if the shop is clean and food is stored correctly then they should not be a problem*”. This could of course mean that current approaches to food premise licensing and inspection are not based on a risk management framework as is likely in the revised Food Act, leading to an over-regulation of some premises. On the other hand, it could also demonstrate an inadequate approach to meeting Food Act objectives.

These views on elected member interference are reflected less in comments from EHOs in larger councils. However, some similar situations were recorded in submissions. One city EHO noted “... *councillors ...make comments to proprietors at premises which council's health officers are investigating ... the result of these councillors interfering with the investigation caused a great deal of stress upon me and additional costing of council resources ... a certain councillor was given a separate standard of compliance to that of ... fellow competitors.*”

Other strong concerns expressed by EHOs in submissions/discussions related to the need for community alerts about potable water standards on several occasions, in different council areas. Elected members were described as “... *refusing to allow alert releases because of fear of ratepayer backlash*”. **Queensland Health protocols require clearer definition of roles and responsibilities in these circumstances. It would also seem desirable that Queensland Health receives formal advice on all failed water tests.**

The Northern Division of AIEH has identified the level of understanding of councils of the EHO profession as a significant issue. Their report³³ on issues notes that the group identified as a serious

³³ Report on Northern Group Issues in letter to AIEH Executive Officer, December 2002

concern “...*the limited knowledge displayed by some Local Governments with respect to our degree level of qualifications and the fact that we are often thought of as nuisance and animal inspectors.*”

It is no wonder that EHOs are reluctant to work in some council environments.

The suggestion noted earlier in relation to the benefit of using a ROC as the EHO employer for a number of councils could also have merit in reducing the reported level of elected member ‘interference’ in operational matters.

The question of effective corporate governance, including the separation of policy and operational elements between the elected council and the CEO has been a concern identified by LGAQ. LGAQ’s elected member training has a strong focus on this topic³⁴. Despite the fact that the *Local Government Act 1993*, with a clear statement on the policy role of councillors, has been in place for over a decade, there remain too many elected members, both new and long term, who persist in what would be regarded as inappropriate behaviour under the Act.

Given the legal liability issues associated with public health responsibilities, **some increased emphasis on public health responsibilities in elected member training might assist in getting the message across.** The LGAQ elected member training does not at present specifically refer to the public health functions of local government and their statutory basis (other than noting various activities such as health inspection/licensing, mosquito control in a list of services provided).

It is also important that councils focus on development of policies and procedures which then allow effective delegation of operational matters to appropriately qualified and authorised staff. With clear policies and procedures, fair and consistent decision-making is possible, eliminating the need for many matters to be referred to the elected Council. It may be appropriate for both LGAQ and QHealth to support councils by developing model policies and procedures for common public and environmental health matters.

6.4 Lifestyle

As the LGAQ/LGMA Review of CEO Recruitment and Retention³⁵ notes *...The real or perceived influences or impediments to people moving west for lifestyle change or career development depend to a significant extent on the structure of the family and stage of life cycle. Relevant issues include availability of, or access to, suitable employment for a partner, education options, range of government, community, sport/recreational and entertainment services and shopping facilities.*” The review recommended *“Councils to provide for attendance of partner to visit and assess town when interviews arranged. Facilitate meeting community members, visit schools, etc. to encourage the decision to relocate.”*

The recommendation is relevant to this review of public health workforce recruitment issues.

There is evidence from international experience that the “sea change” concept has moved beyond simply coastal locations, and that well serviced rural locations are attractive to those seeking to break away from the pace of city life. An article in the Australian Financial Review³⁶ notes *“... the next great migration is already underway: whether they’re chasing life on the coast, in small rural communities or new regional hubs, people are everywhere forsaking the city in unprecedented numbers, reversing the last great migration. Could it be that our love affair with cities is over?”*

³⁴ Returned-Councillor and Newly-Elected Councillor Training Manual, LGAQ, 2004, Sections 1 & 2

³⁵ Review of CEO Recruitment and Retention Issues for Rural and Remote Councils, LGAQ/LGMA, February 2004, p.17

³⁶ City Flight, Australian Financial Review Magazine, December 2003

In particular, professional reaching the mature family stage are often looking for a change for the latter part of their career. Where employment opportunities also exist for a partner, the rural lifestyle can be appealing.

Recognition of the demographic status of potential candidates, along with consideration of the needs of partners can assist in increasing the level of interest of potential candidates. Matters such as family stage (eg partner career, children at school) impact on people differently. As one submission notes in relation to factors inhibiting suitably qualified officers seeking positions in rural councils “... *lifestyle is a major contributing factor. People do not want to leave their comfort zone and travel away from family and friends. There are greater opportunities in larger councils, along with better pay and working conditions.*” Rural communities have to compete with “family comfort zones”.

A capacity to integrate with the community, coupled with employment opportunities for a partner were seen as key ingredients for successful career development in rural and remote locations. One submission notes “... *lack of support systems to help individuals and/or families integrate into the local community ... no formalised mechanism or programs to help a spouse/partner find employment or to help school age children make a successful transition into a new school or school system; and lack of accessibility to general family support groups...*” as real issues to be resolved when considering a rural location.

The difficulties for rural communities in developing a skilled workforce, particularly from young people growing up in the local region, is highlighted by statistics on population movement within Queensland. There are now some 13,000 fewer younger people (aged less than 25) in the North West, Central West and South West Statistical Divisions than there were 20 years ago³⁷. This is significant in a combined population of only 73,000 people in these outback regions.

6.5 Continuing Professional Development

Many EHOs complained about the lack of opportunity to update skills and specialised knowledge. It was particularly noted that there is a lack of accessible training and professional development for those in rural and regional areas.

One submission proposed that there be national accredited education courses covering specific EHO functions (food, environmental protection, mosquitoes, waste management, etc).

The potential for AIEH to develop an effective role in CPD was raised in some submissions.

Others considered the resources and structure of AIEH as not likely to be able to support and maintain a relevant CPD program. LGAQ was suggested as a viable CPD provider by some respondents.

Comment was also made on the need for some form of bridging course to support inter-state or overseas EHOs seeking a position within local government in Queensland. It was considered that differences in the legislative context and functions devolved to local government between states impacted on the ability of EHOs from other jurisdictions to readily adapt to the operating environment, particularly where they were in a sole EHO position in a rural council.

³⁷ DLGP, Planning Matters, February 2002, p.2

7 Environmental Health in Indigenous Communities

7.1 Consultation and Background Research

The EHW Training Workshop held in Weipa in April 2004 enabled EHWs to provide feedback on issues and concerns for indigenous communities. In addition to discussions at Weipa, a workshop was held with TPHU staff in Cairns on a separate occasion.

Extensive background literature exists about indigenous environmental health, and at the national level, regular indigenous environmental health conferences have been held since 1998.

As a scoping paper³⁸ on indigenous environmental health notes, successful management of problems must include:-

- Community involvement in and control of environmental health systems;
- Provision of effective environmental health programs and services together with a workforce skilled to deliver them;
- An infrastructure supportive of environmental health programs;
- Adequate relevant information on and for indigenous communities;
- Enhancement of environmental health knowledge in the communities;
- Reducing cultural barriers which have the potential to affect behaviour and communication;
- Adoption of a holistic approach to health which includes education and economic development.

7.2 Scope of Functions and EHW Role

An Environmental Health Worker in an indigenous community is often called on to cover functions and activities that are not readily seen as the role of the other members of the council outdoor workforce. While a duty statement exists for the EHW position, one EHW commented that “... *we are often given jobs that are simply not appropriate.*”

The model duty statement prepared by TPHU for EHWs is appended as **Attachment D** of this report. The duty statement takes a holistic view of the environmental health functions in a community which covers promotion, education, prevention and enhancement of community health. The duty statement illustrates the significant range of competencies expected of indigenous EHWs. It also illustrates that EHW technical training may have practical application in rural mainstream communities where it is difficult to retain the services of a full time EHO.

In discrete indigenous communities, environmental health conditions are typically substantially worse than experienced in mainstream communities. This is often a function of the poor standard of housing, significant overcrowding, poor water supplies, poor solid and liquid waste disposal systems.

These infrastructure problems are compounded by other environmental problems such as poor control of food premises, poor animal health, mosquito breeding in the wet and dusty conditions in the dry. Poor operation and maintenance of infrastructure can also result in breakdowns resulting in loss of water supply or treatment and overflows of sewage.

In these conditions, an EHW is often overwhelmed by the issues and faced with a lack of resources to undertake remedial actions.

³⁸ Towards a Queensland Aboriginal and Torres Strait Islander Environmental Health Strategy, A Scoping Paper. Queensland Health, June 1999

There is also an expectation that EHWs will undertake a number of on-the-ground functions such as pest control because of the costs involved in bringing external licensed operators to the community. To be appreciated in a community the EHW needs to be able to provide the service, not simply be able to identify the problems.

This operational expectation emphasises the need for training to be hands-on, providing EHWs with capacity to be involved in mosquito control, household pest spaying, dog worming and other remedial activities. The ability to be able to access required pesticides was raised as a problem in some communities.

One EHW commented that the septic trench inspection course undertaken resulted in a feeling of competence in relation to monitoring the work of tradesmen on community housing projects. The registration for this course has since expired so this course is no longer available.

This need for multi-skilling of EHWs is in a sense similar to the needs and expectations related to the role and function of EHOs in mainstream communities.

The funding provided in Cape York for EHWs was seen as particularly important in providing a career path. Without this specific purpose funding, EHWs would still be receiving only CDEP wages. The lack of such funding for a number of mainland communities including Palm Island, Yarrabah, Woorabinda and Cherbourg was raised as an issue in terms of development of environmental health skills in these communities.

The lack of award wages for EHWs was raised as an issue in discussions. Appropriate wages were seen as necessary to improve the status of the EHW in the community, and also to assist in attracting people to the profession.

7.3 Community Support

The lack of understanding of elected councillors of the role, skills and functions of an EHW was raised in discussions. In many ways, this lack of elected member understanding was similar to that raised by a number of mainstream EHOs. Enhanced community understanding of the role and function of EHWs was also seen as necessary in raising the profile of EHWs in improving health conditions of a community. With impending changes to community governance arrangements, it would appear appropriate that this understanding of roles and responsibilities is included in capacity building programs.

Greater focus on environmental health as a key function of council in elected member induction training was seen as necessary. Support from LGAQ in undertaking such training was suggested as desirable. Development of an orientation package or information kit for new councillors was also suggested.

In some cases EHWs felt frustrated in securing council funding resources which had been allocated to environmental health, as well as access to effective office space, computers and other equipment. The low level of priority for health policy, budgets and resources in other Queensland councils has been raised previously.

Often the lack of status and job recognition in the community has resulted in trained EHWs not continuing their career and leaving the profession. As noted earlier there has been significant turnover in the number of EHWs who have attained their Diploma level or above.

7.4 Developing Skills and Capacity

In discussions with EHWs, the issue of changes to the TAFE Course offered in Cairns was raised. The changes involved combining a number of specialisations under one teacher. While this may be appropriate from an education perspective, it appears to have been poorly communicated, and may not have fully recognized some cultural considerations in training of indigenous people. As a result, a number of trainee EHWs are considering transferring their studies to the NT Batchelor College. The view was expressed that the Batchelor Course is a better stepping stone to an EHO degree than the Cairns TAFE Course.

Comment was made that Cairns TAFE no longer has a qualified EHO as a teacher in the Diploma Course, and this was regarded as a negative factor by a number of EHWs. It was also considered that the TAFE Course needs to be a bit more hands on in areas such as mosquito control.

The role of TPHU in providing support and ongoing training was strongly supported. Training workshops held every six months were seen as particularly valuable in focusing on specific topics and learning experience, as well as maintaining the support network for EHWs who often feel isolated from professional support.

The remoteness and isolation of communities, coupled with professional isolation of EHWs means that this ongoing support from TPHU and other Public Health Units is critical. The role of indigenous coordinators in a number of PHU offices was seen as crucial in providing support and mentoring for EHWs in communities.

Comment was also made that there should be opportunities for indigenous EHWs to work in mainstream local government situations. A number of larger councils indicated a willingness to participate in such programs, identifying a “win-win” opportunity for both parties. While practical skills and experience can be given to the EHW, councils with a significant indigenous population saw this as an opportunity to better address issues impacting on indigenous people in their community.

The Western Australia approach which involves local government, PHUs and communities in supporting EHWs was noted as an approach worthy of consideration in Queensland. The model includes direct support to councils as well as regional public health units working proactively with communities.

7.5 Environmental Health in other Indigenous Communities

The above discussion focuses primarily on the discrete indigenous communities in Queensland which have their own local government status. There are, however, significant indigenous populations in a number of local government areas in Queensland, and in some cases the indigenous population represents the majority of people in a small town.

In these situations, there sometimes appears to be a lack of priority given by the mainstream council to environmental health problems in these communities. However, solutions to environmental health problems in these small towns (eg Coen Sewerage, Dajarra water supply) are often beyond the resources of the local council and require significant state government funding support.

It is important in these primarily indigenous communities that QHealth plays a strong and active role in supporting the local council to address environmental health issues and concerns. The presence of indigenous environmental health coordinators in the QHealth workforce assists in achieving a more culturally appropriate approach to these issues and concerns.

8 Action Plan

8.1 Increasing Awareness and Understanding of Public Health Role

8.1.1 Councillor Training

A key issue identified in the consultation process was the perception of a lack of awareness and understanding of the public health role of local government. It was considered that this was a specific problem not only with many elected members but also included senior management as well as the community in general. This was a particular problem in smaller rural councils but it is also apparent in some larger urban situations.

The problems manifest and compound through a reluctance of some councils to require rectification of defects and, in some cases, to proceed to a prosecution. As noted earlier, this lack of action raises issues of liability in the case of adverse impacts on public health.

The problem of poor corporate governance practices in some councils was highlighted in the LGAQ/LGMA review of CEO Recruitment and Retention³⁹.

The report notes “ ... *These issues of poor corporate governance practices, poor organisational culture and inappropriate behaviour of some elected members have contributed to a somewhat negative reputation for some Councils within the industry.*”

A review of the LGAQ elected member training course content indicates that there is virtually no mention of the delegated public health functions of local government.

While functions such as mosquito control and health inspections and licensing are included in a table of activities of a council, there is no coverage of the delegated powers under the Health Act or Food Act, and in particular the potential risks to public health as a consequence of not adequately addressing this function. In contrast, the EPA, IPA and the Water Act are covered in some detail.

That LGAQ/LGMA review of CEO recruitment and retention proposed four specific actions to address poor corporate governance:-

- ❖ *Endorse introduction of the Code of Conduct for Councillors as proposed by DLGP;*
- ❖ *Candidates for Local Government election should be encouraged to attend pre-election seminars;*
- ❖ *Consider introduction of requirement for new elected members to attend relevant seminars/training in first year of office;*
- ❖ *Community to be further educated about governance issues – policy versus operations. Seek to enhance community understanding of the role and responsibilities of CEO versus Council – eg local government week, local approach.*

While these recommendations would assist in addressing some of the problems identified in this review, they are already being considered by the relevant stakeholders and have not been included as specific recommendations in this public health workforce report.

QHealth could support improving knowledge and awareness by developing information kits suitable for elected member training and community education.

Recommendation 1

Public Health/Environmental Health functions and legislation to be included in elected member training courses, with particular emphasis on risk management approaches and legal responsibilities.

³⁹ Review of CEO Recruitment & Retention in Rural & Remote Local Government in Qld, LGAQ and LGMA, Feb. 2004, p.52

8.1.2 Enhanced Corporate Planning

While enhanced training programs will raise awareness and understanding, it is essential that councils develop policy positions on public health roles as an element of their corporate planning. By actively considering public health and determining strategies, actions and performance indicators, the profile of this function would be raised and the council would be required to translate this policy into initiatives within the operational plan.

It could of course be debated as to whether it makes sense to designate a Corporate Plan process in a Finance Standard. However, this is the way the legislation is written at present.

Recommendation 2

The Local Government Finance Standard 1994 (s.16(1)) should be amended to require corporate plans to include information on the role of the local government in Public Health.

8.1.3 Improved Reporting

There are some concerns in relation to the lack of reporting by councils on public health outcomes within their communities. While s.20 of the current Health Act requires annual reports, this section is not enforced and councils currently do not provide any reports to Queensland Health. Given the legislative emphasis in the Local Government Act 1993 on the autonomy of local government, it is potentially not appropriate for Queensland Health to require specific reporting when the function has been delegated to local government. It should in reality be an element of “good practice” for the local government to provide effective reporting to the community (and other stakeholders) on their performance.

The Annual Report of a council is an appropriate mechanism for such performance reporting but the current requirements in Part 8 of the Local Government Act and s.44(1) of the Local Government Finance Standard are focused primarily on financial statements. The Annual Report could effectively become a mechanism for a “state of the environment” report by local government. In practice, some councils do include performance reporting in their annual reports. All that is required at present (s.533 of LG Act) is an assessment of performance in implementing the corporate and operational plans, with no guidance on what is expected.

Recommendation 3

The Local Government Act 1993 (Part 8) and/or the Local Government Finance Standard 1994 (s.44(1)) should be amended to require enhanced performance reporting on key functions, including public health responsibilities.

8.1.4 Clarifying Roles and Responsibilities

The current Health Act provides little guidance to councils in relation to the public health responsibilities of local government. The ability to better communicate the role and function of local government in public health would be enhanced by a more definitive statement of the role within the proposed Public Health Act.

Recommendation 4

The proposed Public Health Act should include a more definitive statement of the role and function of local government in public health.

8.2 Encouraging Robust Regional Arrangements

8.2.1 A Role for ROCs

This review has identified a significant problem for small councils in cost effectively obtaining the required resources and expertise to undertake public health functions. With around one-third of councils in the state containing less than 3000 people, the public health function for these councils requires less than one-quarter of a full-time equivalent EHO. In these situations, there is clearly a need for shared arrangements or other service delivery mechanisms if public health roles are to be effectively addressed. Other possible mechanisms include greater support from the QHealth regional network.

While there are a number of current rural EHOs with professional qualifications in addition to those required for public health functions (eg building, plumbing), these are likely to be the exception rather than the rule.

The need for recent graduates to desirably have the support of a more experienced EHO as a mentor and for their professional development, further amplifies the difficulties associated with an effective servicing of smaller rural and regional locations.

While shared arrangements with a larger council, or contract consultants will continue to assist smaller councils, some additional options should be explored and may be appropriate in some regional situations. These options include Regional Organisations of Councils (or similar regional bodies) becoming service providers for a number of councils sufficient to allow employment of two or more EHOs.

Recommendation 5

Regional Organisations of Councils (or similar bodies) to be encouraged to consider acting as a host employer for EHOs to service a number of councils in their region.

8.2.2 Other Group Employment Options

Other forms of group employer type arrangements could be viable through private or government providers. A more “arm’s length” employer being involved in inspection and regulatory functions in small communities may also assist in mitigating some of the inappropriate local “pressures” on EHOs, as identified in this report.

It is noted that LGAQ is also considering whether it could operate as a group employer for some professions⁴⁰ to better facilitate provision of required skills to rural and remote councils and enable more effective career path development and mentoring. Comment was made that this could be a conflict of interest for a body representing individual councils. This is not regarded as an issue, particularly given the number of commercial services operated through LGAQ entities.

Whilst an LGAQ role in employment could be seen as adversely competing with private enterprise, the fact remains that the gap in service provision exists. The EHO role is not being met currently by commercial arrangements with private operators to provide the desired service level on a cost effective basis.

Recommendation 6

LGAQ, as part of its current review of mechanisms to support councils experiencing difficulties in recruitment of key staff, to consider opportunities to act as a group employer providing contracted personnel to councils.

⁴⁰ Reforming Industrial Relations for Local Government in Queensland, A Roadmap for Change – 2003 to 2013, LGAQ, 2003, p.17

8.3 Increasing Skills, Knowledge and Capacity

8.3.1 On-the-job Training

Significant comment was made on the need for tertiary institutions to develop more “work-ready” graduates. In many ways, this is an unfair criticism of the role of tertiary education institutions. The problem with the EHO profession (and some other professions) is that the employing workplace is, in many cases, not an appropriate environment for a recent graduate as a sole placement.

A number of submissions pointed to the merits of the optional one-year work experience element of the Swinburne University degree course, and to positive experiences with graduates entering the profession from this background. As an option, such an approach is worthy of consideration by tertiary institutions and the profession.

Councils across the state need to support undergraduates looking for structured work experience, particularly if graduates are to be attracted to rural and regional areas. It may be possible for LGAQ to act as a clearing house for undergraduate placements, providing a link between tertiary institutions and individual councils, thus developing a more coordinated approach.

Recommendation 7

LGAQ to consider acting as a clearing house/coordinator for workplace placements for EH undergraduates, particularly for rural and regional councils, to foster a greater spread of opportunities for undergraduates to gain on-the-job experience.

8.3.2 Flexible Professional Entry

Another option presented was for a graduate diploma course to be available within Queensland to allow those with other professional qualifications, possibly already employed by a council, to gain the required public health competencies. Both Griffith University and Queensland University of Technology are considering post-graduate options. Again, increased flexibility in terms of entry to the profession whether as a graduate or through post-graduate studies should be encouraged by all stakeholders.

An additional point made in relation to greater flexibility in obtaining required competencies, particularly for those already employed in rural and regional areas, was the need for availability of distance education courses from a Queensland tertiary institution. This may depend to some extent on the market demand, but should be considered further. As noted earlier, Griffith University in conjunction with Curtin University is currently developing an environmental health post graduate program in a flexible learning mode (including distance education options), which should commence in 2005.

Recommendation 8

Tertiary institutions to be encouraged to consider a range of measures that can provide more flexible entry or multiple pathways to the profession, particularly for those in rural and regional locations. Measures to be considered include post-graduate courses, distance education options as well as an optional one year Industry Based Learning placement as a component of an undergraduate degree.

8.3.3 Bridging Courses

A number of comments were made on the need for specific training for EHOs from inter-state and overseas in relation to particular requirements of public and environmental health practice in a Queensland context. This was seen as widening the recruitment base. It is understood that such bridging courses have existed in the past.

Recommendation 9

A bridging course should be developed to allow qualified EHOs from inter-state and overseas to obtain those skills and competencies of relevance to professional practice in the Queensland legislative context.

8.3.4 Specialist Training

The way in which new legislation is written means that courses to provide specific competencies for the requirements of that particular Act (eg Public Health (Infection Control for Personal Appearance Services) Act, proposed Food Act) would also be an option. For example, it could be that a nurse in a small community could readily obtain the competencies required to undertake the role of an authorised officer under the Public Health (Infection Control for Personal Appearance Services) Act as an alternative to an EHO exercising this function.

Consultation revealed significant concern within elements of the PH/EH profession about the use of “short courses” or other targeted training being used to undertake some public health roles for specialised tasks. The view was that the broader skill set of an EHO is necessary to appreciate and identify the range of risk factors involved in any relevant setting.

While this is clearly a valid argument, the availability of specialised technicians to undertake some aspects of the public health role should be supported to expand the mechanisms by which individual councils can address public health issues. The profession may well benefit from some of the more routine technical tasks being handled by competent persons, allowing the EHO professional to focus on more strategic aspects of the role including public health planning and active education. Specialist training courses are also necessary to enable practicing EHOs to update their skills, capacities and procedures.

Recommendation 10

Registered Training Organisations to develop/deliver courses which provide an accredited qualification for specialised public and environmental health tasks.

8.3.5 Professional Accreditation

A number of submissions focused on the need to mandate qualifications within legislation. AIEH submitted that a Registration Board (as exists in some professions) should be established. This position was advocated because public health roles, in some councils, are currently being undertaken by officers without formal qualifications in PH/EH.

Based on the survey of council EHO resources undertaken as part of this project, it is estimated that such a situation exists in around 5% of councils in the state. In population and risk terms, this is not significant. In some of these cases, it is understood that authorised officers are undertaking studies to formalise relevant competencies. Greater support from QHealth to some of these smaller councils is also an option in ensuring that public health responsibilities are adequately addressed.

Given the way in which recent legislation is written, it appears unlikely that a more regulated approach to the profession will occur. The emphasis is likely to remain on the CEO of a local government appointing competent officers. However, there may be a need for guidelines or regulations on how such competency is to be determined.

In some other professions, the representative body takes a lead role in accreditation of members, with differing grades of membership, and in continuing professional development to maintain the accredited status. An industry self-regulation approach often raises the status of the organisation, and professionals recognise that membership is important in enhancing their career prospects.

This would be an option for AIEH to consider.

At present there are a significant number of EHOs in local government who are not members of AIEH. An enhanced role for AIEH in accreditation, professional development and support should be important in developing both its status and membership base.

Recommendation 11

AIEH to consider introducing an enhanced accreditation scheme that will define career path opportunities in local government. AIEH to consider a more active role in continuing professional development as part of such an accreditation scheme.

8.4 Career Paths

A number of studies of recruitment and retention of professionals for rural and regional locations have observed that people whose careers develop from within the region are more likely to stay within the area. A number of councils already offer cadetships in an attempt to encourage school leavers to consider local government as a career.

The AIEH northern branch survey reveals strong support by local government for a shared cadetship program, particularly if some external funding support was available. This may present an opportunity for QHealth to encourage EHO cadetships in rural and regional areas

Cadetships at a local level would also be facilitated by enhanced external study arrangements as identified in 8.3 above.

Recommendation 12

Encourage councils to consider scholarships and cadetships, including shared arrangements at a regional level. Queensland Health to consider funding support for cadetship/scholarship programs involving smaller rural and regional councils.

It is also likely that EHOs would give greater consideration to working in rural and regional locations if mechanisms were available for them to return to coastal locations after a two or three year term. This opportunity will only exist if an external group employer operating at either a regional or state-wide level exists as discussed in 8.2 above.

An optional one-year Industry Based Learning placement as noted in 8.3 above could also assist rural and regional councils to promote their region to those entering the profession.

8.5 Mentoring and Support

As noted previously in section 5.4, it is very difficult for recent graduates to receive appropriate mentoring and professional support in a council where that person is the only qualified EHO. While informal regional arrangements do assist in this respect, there remains a need for more formalised mentoring and support arrangements.

It is known that this matter has been raised by AIEH branches and is under consideration within AIEH. Whether it is feasible for the voluntary structure of AIEH to resource such a service is open to question.

The view was also expressed that QHealth should be more active in a support and mentoring role for EHOs. Given the regional environmental health network operated by QHealth, and the overall

responsibility for effective public health services across the state, it would seem reasonable to expect that QHealth could take a lead role in developing support and mentoring services.

It may be possible for LGAQ to increase its support role to the profession. This could only occur if additional funding resources were available.

Some of the larger urban and provincial councils can also play a role in supporting EHOs in smaller councils. Opportunities for secondments and exchanges could be considered by individual councils, and could be actively promoted by LGAQ.

While each of the key stakeholders have a role in mentoring and support services, it is considered that QHealth should play the lead role, particularly in resourcing such support.

Recommendation 13

More formalised mentoring and support arrangements should be developed by key stakeholders, with Queensland Health taking a leadership role. Such support arrangements should be detailed in the revision of the Protocol with LGAQ.

8.6 Developing Partnerships

There is a need for QHealth to take a more active role in supporting smaller rural and regional councils in performance of their public health role. While regional public health units in QHealth do provide support to council EHOs, the process is informal, and formal communication protocols are not in place.

This leads to different expectations and approaches in the way matters are handled by QHealth EHOs (eg in response to failed water sample results or in supporting local difficulties in relation to food premises), and inconsistent responses across council areas.

QHealth should also play a strong and active role in supporting mainstream councils with significant indigenous communities to address environmental health issues and concerns, as is the case for the DOGIT councils.

While a Public Health Partnership Protocol was put in place between QHealth and LGAQ in August 2000, it does not appear to have been a driver of initiatives at the regional level. All parties would benefit from developing formal liaison, consultation and communication arrangements, and in fostering shared working arrangements to minimise duplication and overlap, as articulated in the protocol.

The Protocol is currently being reviewed, and it would be appropriate to consider development of region specific working relationships that emphasise the intended partnership approach.

Recommendation 14

In the review of the Public Health Partnership Protocol, develop more formalised liaison and communication arrangements, with emphasis on region specific requirements, including working arrangements that offer more active technical support by QHealth. Particular attention should be given to rural and remote councils.

8.7 Resources and Procedures

8.7.1 On-Line Resources

EHOs, particularly in rural and regional areas, identified difficulties in staying abreast of changes in legislation and standards. An ability to readily access current policies, procedures and legislation was regarded as essential. Projects such as “*Toolbox*” developed by Brisbane and Gold Coast City Councils were seen as providing the type of resources that would be applicable to both large and small councils.

The business case for the “*Toolbox*” resource kit is currently being developed, and it is understood that the intent is to make this resource available to councils once pricing and maintenance arrangements have been determined.

It would be desirable for LGAQ to make this (or other resource material) available through “Local Government On-Line”. Funding support from QHealth may facilitate such on-line resource provision especially for the benefit of remote, sole practitioner EHOs.

Recommendation 15

Development and dissemination of on-line resources to support EHOs, particularly in rural and regional locations, should be facilitated jointly by LGAQ and Queensland Health.

8.7.2 Model Policies and Procedures

It is important that councils are encouraged to develop and adopt policies and procedures for handling public and environmental health matters rather than these being considered on a case-by-case basis at Council meetings. This is important in achieving the policy and operational split envisaged by the Local Government Act 1993. This could be facilitated by development of model policies and procedures.

Recommendation 16

Model policies and procedures for common public and environmental health tasks should be developed to assist councils in more effectively addressing their roles under delegated public health legislation. Templates would also assist councils in the transition phases during legislation changes.

8.8 Support to Indigenous Communities

8.8.1 Councillor Training

A number of issues identified in relation to indigenous community councils were similar to those identified in mainstream councils. In particular, the need to raise awareness of the public health role with elected representatives and senior management was identified, along with the need to devote appropriate resources to infrastructure and services of relevance to public and environmental health.

With DOGIT councils to come under the Local Government Act (a four year transition), it may be appropriate for LGAQ to develop some specific training programs of relevance to indigenous councils. Alternatively, this could be considered as an element of capacity building initiatives to be undertaken by DLGP as part of the transition to the Local Government Act.

Recommendation 17

In developing training programs and capacity building for indigenous councils, DLGP/LGAQ consider programs of specific relevance to these communities, including emphasis on the public and environmental health elements of their role and function.

8.8.2 Specific Purpose Environmental Health Funding

With a more substantial range of community services, needs and issues being the focus of the role of indigenous councils in comparison with mainstream councils, it is often difficult for councils to allocate appropriate funding for the provision and maintenance of services and infrastructure basic to the health of their community. While SGFA funding is intended to support all local government functions, it is often very difficult for councils to prioritise such funding to environmental health and essential service functions when it is received as an untied grant. It may be appropriate to consider converting a portion of this untied funding to specific purpose funding of key environmental health services and infrastructure.

Recommendation 18

As part of the revision of arrangements for governance of indigenous communities, consideration should be given to converting a portion of untied funding to specific purpose funding for key environmental health services and infrastructure.

8.8.3 Funding EHWs

As noted in Section 4.3, EHWs are employed by most mainland and Torres Strait DOGIT communities. Specific purpose funding available under the Cape York Partnerships arrangement for employment of dedicated EHWs in indigenous communities has played an important role in supporting the environmental health role, and enhanced the status of EHWs within the council workforce. Maintaining this specific purpose funding, and expanding it to other indigenous councils and communities is vital to a continued focus on environmental health.

Recommendation 19

Specific purpose funding for EHWs in indigenous communities should be maintained, with expansion of the program to service other indigenous councils and communities.

8.9 Action Plan Summary

Table 8.1 summarises the recommendations for key issues covered by this review. The appropriate lead agency as well as those stakeholders considered to be important in supporting each recommendation are identified in the Action Plan.

Table 8.1: Action Plan - Recommendations		Lead	Support
1	Public Health/Environmental Health functions and legislation to be included in elected member training courses, with particular emphasis on risk management approaches and legal responsibilities.	LGAQ	QHealth DLGP
2	The LG Finance Standard 1994 (s.16(1)) should be amended to require corporate plans to include information on the role of the local government in Public Health.	DLGP	QHealth, LGAQ
3	The LG Act 1993 (Part 8) and/or the LG Finance Standard 1994 (s.44(1)) should be amended to require enhanced performance reporting on key functions, including public health responsibilities.	DLGP	QHealth, LGAQ
4	The proposed Public Health Act should include a more definitive statement of the role and function of local government in public health.	QHealth	LGAQ
5	Regional Organisations of Councils (or similar bodies) to be encouraged to consider acting as a host employer for EHOs to service a number of councils in their region.	LGAQ	ROCs
6	LGAQ, as part of its current review of mechanisms to support councils experiencing difficulties in recruitment of key staff, to consider opportunities to act as a group employer providing contracted personnel to councils.	LGAQ	

7	LGAQ to consider acting as a clearing house/coordinator for workplace placements for EH undergraduates, particularly for rural and regional councils, to foster a greater spread of opportunities for undergraduates to gain on-the-job experience.	LGAQ	AIEH, Tertiary Bodies
8	Tertiary institutions to be encouraged to consider a range of measures that can provide more flexible entry or multiple pathways to the profession, particularly for those in rural and regional locations. Measures to be considered include post-graduate courses, distance education options as well as an optional one-year Industry Based Learning placement as a component of an undergraduate degree.	AIEH	QHealth Tertiary Bodies
9	A bridging course should be developed to allow qualified EHOs from interstate and overseas to obtain those skills and competencies of relevance to professional practice in the Queensland legislative context.	QHealth	Tertiary Bodies AIEH
10	Registered Training Organisations to develop/deliver courses which provide an accredited qualification for specialised public and environmental health tasks.	QHealth	LGAQ AIEH
11	AIEH to consider introducing an enhanced accreditation scheme that will define career path opportunities in local government. AIEH to consider a more active role in continuing professional development as part of such an accreditation scheme.	AIEH	QHealth LGAQ
12	Encourage councils to consider scholarships and cadetships, including shared arrangements at a regional level. QHealth to consider funding support for cadetship/scholarship programs involving smaller rural and regional councils.	QHealth	LGAQ, AIEH
13	More formalised mentoring and support arrangements should be developed by key stakeholders, with QHealth taking a leadership role. Such support arrangements should be detailed in the revision of the Protocol with LGAQ.	QHealth	AIEH, LGAQ
14	In the review of the Public Health Partnership Protocol, develop more formalised liaison and communication arrangements, with emphasis on region specific requirements, including working arrangements that offer more active technical support by QHealth. Particular attention should be given to rural and remote councils.	QHealth	LGAQ
15	Development and dissemination of on-line resources to support EHOs, particularly in rural and regional locations, should be facilitated jointly by LGAQ and QHealth.	LGAQ QHealth	AIEH
16	Model policies and procedures for common public and environmental health tasks should be developed to assist councils in more effectively addressing their roles under delegated public health legislation. Templates would also assist councils in the transition phases during legislation changes.	LGAQ	QHealth DLGP
17	In developing training programs and capacity building for indigenous councils, DLGP/LGAQ consider programs of specific relevance to these communities, including emphasis on the public and environmental health elements of their role and function.	DLGP	LGAQ
18	As part of the revision of arrangements for governance of indigenous communities, consideration should be given to converting a portion of untied funding to specific purpose funding for key environmental health services and infrastructure.	DLGP	QHealth
19	Specific purpose funding for EHWs in indigenous communities should be maintained, with expansion of the program to service other indigenous councils and communities.	DLGP	QHealth

ATTACHMENT A REFERENCES

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ATTACHMENT B CONSULTATION PROGRAM

1. Consultation Approach

The consultation program for this project included:-

1. call for submissions from all Queensland AIEH members (sent out by AIEH) and from all councils in the state (sent to CEOs by LGAQ). The initial call for submissions was made in mid March with a follow up reminders issued by AIEH and LGAQ in late April;
2. meetings with a range of stakeholders including:-
 - a. members of Queensland Health Public Health Units and other sections involved with public health;
 - b. representatives of AIEH;
 - c. representatives of Griffith University and Queensland University of Technology;
 - d. LGAQ representatives;
 - e. Gold Coast City Council EHO representatives;
 - f. Brisbane City/Gold Coast City EHOs involved in *Toolbox*;
 - g. representatives of NSW Local Government and Shires Association
3. workshops and discussions at AIEH forums for the Northern and Central Divisions;
4. workshops and discussions at Western Queensland and Darling Downs Local Government Association meetings;
5. workshops and discussions at LGMA North Queensland Conference;
6. discussions with Cape York Indigenous Environmental Health Workers

2. Submissions

In total some 50 written or verbal submissions/comments were received. These included submissions from AIEH, Griffith University, from individual councils as well as from individual EHOs and CEOs. All submissions have been treated as confidential unless presented on behalf of a group such as AIEH. While quotes from submissions have been used to illustrate points raised in consultation, the text may have been edited to maintain confidentiality.

3. Meetings with PHU Staff

Staff from the Environmental Health Services of regional PHUs were involved in face-to-face discussions. This included Cairns, Rockhampton (at Weipa), Brisbane Southside, Sunshine Coast, Toowoomba and Townsville (at Long Is.).

Discussions were also held with a number of Corporate Office staff.

4. Telephone Discussions

A number of telephone discussions were held to supplement information gathering, to follow-up on points made in submissions or to gain input from those not wishing to commit comments to writing.

5. Attendance at Conferences and Forums

The following list provides details of the attendance at each key workshop or forum where presentations were made in relation to the project.

Date	Forum	Estimated number of delegates
31 March	Wide Bay/Burnett EHO Forum with EPA	20
21/22 April	EHW Forum, Weipa	10
1/2 May	AIEH Northern Division Conference, Long Is.	30
7/8 May	Western Queensland LGA Conference, Tambo	50
10 May	Darling Downs LGA Conference, Goombungee	50
14/15 May	AIEH Central Queensland Division Conference, Gladstone	30
28/29 May	LGMA Northern Division Conference, Pt Douglas	40
3 June	SEQROC Environmental Health Group	18

ATTACHMENT C
ESTIMATED DISTRIBUTION OF EHO WORKFORCE IN LOCAL GOVERNMENT
(Estimated No. refers to positions described as EHOs not resources devoted to environmental health)

ACLG Cat.	Council name	pop 2002 (ABS)	Council area sq.kms.	staff 01/02 (Note a)	operating rev. 01/02 (Notes a & b)	EHO status	Share Host	Estimated No. EHOs available (FTE)	EHOs per 10,000 pop
RTS	Aramac	748	23,348	46	9,603,536	contract		0.025	0.33
RAV	Atherton	10,774	623	96	10,999,173	own		1	0.93
RAM	Balonne	5,605	31 140	79	6,606,000	own		2	3.57
RAV	Banana	14,374	15,755	158	18,773,068	own		1.8	1.25
RTM	Barcaldine	1,732	8 446	71	6,523,772	own	serve Jericho	1	5.77
RTS	Barcoo	463	61 982	49	7,210,352	share	Quilpie	0.05	1.08
RAM	Bauhinia	2,256	23 645	74	4,427,149	share	Emerald	0.2	0.89
UFM	Beaudesert	55,612	2,855	395	38,161,562	own		6	1.08
RAV	Belyando	10,228	30 281	93	15,633,924	own	serve Nebo	0.7	0.68
RAS	Bendemere	997	3,928	34	4,116,602	contract		0.2	2.01
RAS	Biggenden	1,541	1 316	27	NS	own		1	6.49
RTM	Blackall	1,784	16 385	54	7,151,095	contract		0.5	2.80
RAL	Boonah	8,403	1,921	101	9,314,825	own		1	1.19
RAS	Booringa	1,877	27 827	93	3,772,599	advertised		1	5.33
RTS	Boulia	567	61 123	53	9,594,000	contract		0.025	0.44
RAV	Bowen	12,518	21 180	146	18,383,000	own		2	1.60
UCC	Brisbane	917,216	1 327	6,950	1,121,430,000	own		46	0.50
RAL	Broadsound	6,483	18 545	74	11,717,153	own		1	1.54
RTS	Bulloo	469	73 850	64	9,717,549	contract		0.1	2.13
URM	Bundaberg	45,043	95	366	37,344,086	own		5	1.11
RAS	Bungil	1,951	13 337	67	5,916,504	share	??	0.2	1.03
RAV	Burdekin	18,616	5 042	215	24,404,772	own		3	1.61
RTS	Burke	501	42,121	25	5,045,154	vacant		0	0.00
UFS	Burnett	24,439	2 004	NS	NS	own		3	1.23
UFL	Caboolture	116,992	1 230	606	82,645,610	own		12	1.03
URV	Cairns	119,256	1 852	1,000	121,117,774	own		9	0.75
RAV	Calliope	15,377	6,556	113	18,708,661	own		1	0.65
URL	Caloundra	78,798	1,105	509	65,156,199	own		5	0.63
RAM	Cambooya	5,270	632	44	4,454,308	own		1	1.90
RAL	Cardwell	10,860	3 033	125	12,703,947	own		2	1.84
RTM	Carpentaria	2,360	68 334	88	12,770,284	contract		0.1	0.42
URS	Charters Towers	8,790	42	93	6,428,443	own		1	1.14
RAL	Chinchilla	6,056	8 701	78	5,802,491	own		1	1.65
RAM	Clifton	2,474	867	39	4,356,949	contract		0.1	0.40
RTL	Cloncurry	3,867	48 110	101	10,860,905	none		0	0.00
RTL	Cook	4,089	117 087	94	7,879,738	contract	advertised	0.2	0.49
URM	Cooloola	34,019	2 969	289	31,538,846	own		4	1.18
RSG	Crow's Nest	10,600	1 630	NS	NS	contract		0.2	0.19
RTX	Croydon	287	29 582	49	3,986,781	contract		0.05	1.74
URS	Dalby	10,150	47	NS	NS	own		1	0.99
RAM	Dalrymple	3,480	68 362	147	17,023,720	advertised		0.2	0.57
RTX	Diamantina	321	94 887	44	7,731,000	contract		0.025	0.78
RSG	Douglas	10,856	2 455	154	19,085,046	own		3	2.76
RAL	Duaranga	6,531	18,143	86	8,434,647	contract	share with Mt Morgan	0.6	0.92
RAL	Eacham	6,372	1 126	77	7,376,867	own		1	1.57

ACLG Cat.	Council name	pop 2002 (ABS)	Council area sq.kms.	staff 01/02 (Note a)	operating rev. 01/02 (Notes a & b)	EHO status	Share Host	Estimated No. EHOs available (FTE)	EHOs per 10,000 pop
RAS	Eidsvold	944	4,809	35	3,200,599	share	Monto	0.4	4.24
RAV	Emerald	13,251	10 351	125	13,888,210	own	serve Bauhinia	1.8	1.36
RAV	Esk	14,869	3 935	131	12,897,000	own		1	0.67
RTM	Etheridge	1,024	39,308	55	6,851,193	contract		0.05	0.49
RAL	Fitzroy	10,010	5 905	63	8,227,488	own		1	1.00
RTM	Flinders	2,072	41 536	79	10,986,874	own	serve Richmond	0.6	2.90
RAV	Gatton	16,050	1 578	139	14,275,768	own		3	1.87
RAM	Gayndah	2,883	2 709	35	4,589,823	own	serve Mundubbera/Perry	0.45	1.56
URS	Gladstone	27,099	161	239	31,078,939	own		5	1.85
URV	Gold Coast	438,473	1 404	2,468	400,810,961	own		30	0.68
URS	Goondiwindi	4,888	14	42	5,059,000	own	serve Waggamba	0.8	1.64
RAL	Herberton	5,412	9 598	69	9,657,653	own		1	1.85
URM	Hervey Bay	44,402	2 356	326	46,066,929	own		4	0.90
RAV	Hinchinbrook	12,326	2,807	154	17,364,335	own		2	1.62
RTX	Ilfracombe	370	6,577	25	2,226,795	share	Longreach	0.05	1.35
RAM	Inglewood	2,660	5,880	58	6,645,290	contract		0.1	0.38
UFV	Ipswich	128,976	1 205	1,048	108,804,392	own		11	0.85
RAL	Isis	5,900	1,702	61	7,322,715	own		1	1.69
RTX	Isisford	303	10 504	28	1,267,097	share	Quilpie	0.02	0.55
RTM	Jericho	1,099	21 876	36	4,927,690	share	Barcaldine	0.1	0.91
UFS	Johnstone	19,456	1,640	179	20,708,866	own		1	0.51
RAV	Jondaryn	13,229	1 910	88	9,858,538	none		0.2	0.15
RAM	Kilcoy	3,395	1 445	43	4,626,000	own		1	2.95
RAM	Kilkivian	3,227	3 264	63	10,651,900	own		1	3.10
RAV	Kingaroy	11,990	2 422	115	10,916,474	own		2	1.67
RAM	Kolan	4,672	2 651	49	6,095,772	own		1	2.14
RSG	Laidley	13,110	701	NS	NS	own		1	0.76
UFS	Livingstone	26,860	11 782	235	25,809,699	own		4	1.49
UDV	Logan	169,433	251	898	142,406,000	own		11	0.65
RTL	Longreach	4,033	23 560	105	11,142,829	own	serve Winton, Ilfracombe	0.85	2.11
URL	Mackay	77,157	2 895	564	69,657,434	own		9	1.17
RAV	Mareeba	18,579	53 635	200	24,757,199	own		2	1.08
UFV	Maroochy	131,395	1 164	NS	NS	own		8	0.61
URS	Maryborough	25,260	1,242	218	21,381,911	own		3	1.19
RTM	McKinlay	1,070	40 883	60	8,114,838	own		1	9.35
RAM	Millmerran	3,457	4,521	61	5,009,649	own		1	2.89
RAL	Mirani	5,309	3 280	52	7,737,838	own		1	1.88
RAM	Miriam Vale	4,620	3 784	69	9,398,815	own		1	2.16
RAM	Monto	2,511	4 322	54	5,678,511	own	serve Eidsvold	0.6	2.39
URS	Mount Isa	20,785	43 372	215	21,203,000	own		1	0.48
RAM	Mount Morgan	2,960	492	40	3,858,544	contract	share with Duinga	0.4	1.35
RAM	Mundubbera	2,320	4,193	37	NS	share	Gayndah	0.45	1.94
RAM	Murgon	3,655	695	47	5,230,458	own		1	2.74
RAM	Murilla	2,743	6 074	60	5,462,000	contract		0.3	1.09

ACLG Cat.	Council name	pop 2002 (ABS)	Council area sq.kms.	staff 01/02 (Note a)	operating rev. 01/02 (Notes a & b)	EHO status	Share Host	Estimated No. EHOs available (FTE)	EHOs per 10,000 pop
RTL	Murweh	5,030	40,743	109	10,586,000	own		1	1.99
RAL	Nanango	8,540	1 735	61	7,837,492	own		1	1.17
RAM	Nebo	2,095	10 036	51	5,768,000	share	Belyando	0.3	1.43
UFM	Noosa	45,214	868	390	52,404,902	own		6	1.33
RTM	Paroo	2,188	47,725	84	7,098,087	own		1	4.57
RAM	Peak Downs	3,254	8,127	96	12,449,490	own		1	3.07
RAS	Perry	439	2 359	22	2,159,342	share	Gayndah	0.1	2.28
UFL	Pine Rivers	127,439	774	699	100,840,000	own		10	0.78
RAM	Pittsworth	4,741	1 089	36	4,250,629	contract		0.2	0.42
RTM	Quilpie	1,094	67 613	55	NS	own	serve Tambo, Isisford, Barcoo	0.75	6.86
UDM	Redcliffe	50,718	38	269	37,936,759	own		3	0.59
UFL	Redland	120,371	537	858	113,347,748	own		8	0.66
RTM	Richmond	1,152	26 606	56	7,654,657	share	Flinders	0.4	3.47
URM	Rockhampton	59,410	189	554	62,152,857	own		10	1.68
URS	Roma	6,707	78	105	9,256,787	own		1	1.49
RAL	Rosalie	8,785	2 200	88	6,222,000	own		1	1.14
RAV	Sarina	9,862	1,445	NS	NS	share	Mirani	0.2	0.20
RAL	Stanthorpe	10,515	2,693	107	8,564,899	own		2	1.90
RTS	Tambo	618	14 114	30	4,314,040	share	Quilpie	0.1	1.62
RAM	Tara	3,917	11 680	90	13,012,262	own		1	2.55
RAM	Taroom	2,619	18 646	78	9,741,946	contract		0.2	0.76
UFM	Thuringowa	54,465	1 866	330	42,539,713	own		5	0.92
RAM	Tiaro	4,770	2,193	46	4,473,646	contract		0.4	0.84
URL	Toowoomba	91,187	117	747	75,503,000	own		9	0.99
URS	Torres	3,732	1 868	78	6,437,974	vacant	advertised	0	0.00
URL	Townsville	93,911	1 871	964	145,647,585	own		10	1.06
RAM	Waggamba	2,997	13 405	64	8,834,491	share	Goondiwindi	0.2	0.67
RAL	Wambo	5,267	5 713	124	7,411,000	own		1	1.90
RAS	Warroo	1,069	13 661	69	2,540,721	contract		0.2	1.87
URS	Warwick	21,387	4,425	215	22,794,086	own		4	1.87
RSG	Whitsunday	15,995	2,693	157	19,773,335	own		3	1.88
RTM	Winton	1,611	53 931	82	NS	share	Longreach	0.1	0.62
RAM	Wondai	4,261	3 578	64	7,102,075	own		1	2.35
RAM	Woocoo	3,061	2 006	28	3,506,593	share	Maryborough	0.025	0.08
		3,683,660		28,539				318	0.86

Note a: Source DLGP Comparative Data (provided by Councils), Note b: includes rates, grants, reimburseable works and other operating revenue. Data on EHO positions based on discussions with EHOs, Councils and PHU staff.

ATTACHMENT D ENVIRONMENTAL HEALTH WORKER DUTY STATEMENT

Developed by:

***Environmental Health Services, Tropical Public Health Unit
Primary Health Care Centre, Thursday Island***

MEANING OF TERMS

AIEH - Australian Institute of Environmental Health

BRACS – Broadcasting Remote Area Communication Service

Communicable disease – Diseases which can be transmitted to people by insects (eg mosquitoes, flies), animals or other people.

Designated officer – Works Supervisor or plumber depending on who is available and what the problem is.

EHW – Environmental Health Worker

EPA – Environment Protection Agency

EP ACT - Environment Protection Act

ESO – Essential Services Officer

ISO – Island Sewerage Officer

IWO – Island Water Officer

Nightsoil – Human waste; kuma

Nightsoil Depot – Place (compound) used to receive nightsoil for burial. It will have facilities for washing and disinfecting pans, storage of equipment and vehicles (trailer).

TPHU – Tropical Public Health Unit

Water Supply Hardware – Pipes, reservoir, scour valves, taps

1. General

Complaints

- Promptly respond to and investigate complaints and public enquiries with appropriate action, and report outcomes to Council at monthly meetings.
- Attend to complaints registered in the Council Complaints Book.

Health Promotion

- Participate in the development of health education programs that relate to environmental health issues throughout the community.

- Conduct regular presentations of health education material to the community and school by personal contact (meetings, lessons) and/or local newsletter, BRACS etc.
- Provide advice to residents regarding household and personal hygiene (eg making sure food is covered to stop flies).
- Conduct health education programs (domestic and personal) on hygiene and emphasise that it is important to the community. This may include carrying out "in-house" demonstrations of effective methods.
- Educate the community on how they should use their community dump, and the benefits of recycling.
- Educate the community members on how to prevent and reduce mosquito breeding in the community.
- Conduct an education program on care of dogs by people in the community.
- Educate people on the importance of keeping animals such as horses and pigs out of the community including roads, sports fields, water supply, school, sanitary depot etc.
- Conduct health education programs on other public health issues such as sewage systems, pest control, and storage of household poisons.

Professional Development

- Attend conferences and/or training courses on relevant public health topics.
- Subscribe to relevant journals and technical bulletins.
- Consider becoming a member of a professional organisation (eg AIEH)
- The TPHU is available for assistance with these areas .

2. Daily

note: The following duties would not necessarily be performed every day.
Some of the work would be ongoing, but may come up on a daily basis:

General

- When required, act as an adviser for the community in co-ordinating with various bodies such as government agencies and consultants in relation to community development.
- Liaise with the community to develop relevant environmental health programs by utilising knowledge and expertise.

Water

- Conduct a public health inspection of the water system (hardware) throughout the community (eg. Bores, dam, water holding tanks, intakes). Report defects to Council and the IWO or ESO. These inspections should be conducted with the IWO or ESO where possible.

Sewerage

- Report and record damaged or overflowing septic tanks to the Council/ISO or ESO/designated officer, monitor work progress, and reinspect to check work has been finished within 7 days.
- Ensure residents who are experiencing problems with their septic systems are well-educated on measures they should take when using the system to reduce health risks.
- At appropriate stages of installation, inspect the construction of new and/or replacement septic tanks and septic absorption trenches to ensure they are installed in accordance with the Australian Standards.
- Report and record defects in the reticulated sewerage system (eg backed up toilets, defective pump station) to the Council/ISO or ESO/designated officer, monitor work progress, and reinspect to check work has been finished within 7 days.

Rubbish Collection

- Ensure missing or damaged rubbish bins are replaced where necessary.
- Ensure all houses in community are provided with lidded rubbish bins and an appropriate recycling bag/bin/container.
- Educate the rubbish workers on how they should operate and maintain the dump (eg. Pushing, covering, spraying, barricades etc).
- Carry out an inspection of the dump to check litter control, fly and mosquito breeding, and the presence of other vermin (rats, cockroaches etc). If a pest problem is detected, instigate a pest control treatment. (The EHW must possess a pest control licence to carry out this work.)
- Monitor recycling program if in place. Check separation of rubbish at dump.
- Ensure sanitation workers are familiar with Workplace Health & Safety practices and ensure they are wearing appropriate protective clothing, as required by the Works Supervisor. Problems should be reported to the Works Supervisor.

General Community Environs

- Ensure overgrown grass etc on community streets and vacant land is mowed/slashed when required.
- Ensure building materials stored in peoples yards, Council works yard, and other parts of the community are stacked at least 300mm above the ground.

3. Weekly

Water

- Liaise with the IWO or ESO on a regular basis regarding field-testing and sample results to make sure any public health concerns (eg. failed sample results) are acted on by Council.

Rubbish Collection

- Organise and supervise the community rubbish collection program.
- Ensure collection vehicle (rubbish truck) is clean and well maintained.
- Ensure all litter is removed from streets.

Nightsoil Collection (If required)

- Inspect the nightsoil depot and ensure required equipment is available and being used (eg protective clothing, pans, lids).
- Ensure nightsoil in trenches is covered.
- Ensure nightsoil trenches are the correct size.
- Ensure collection vehicle (nightsoil truck/trailer) is clean and well maintained.
- Ensure nightsoil workers are familiar with Workplace Health & Safety practices, and ensure they are wearing appropriate protective clothing.

Pest Control

- Carry out fly and vermin control (eg remove horses from the community, litter clean-up, correct operation of the dump, household bins lidded, operation of nightsoil disposal).

Health Centre

- Organise to meet with Queensland Health's Health Workers to discuss ongoing health issues, and keep a record of important matters. Follow up if necessary.

4. Fortnightly

General

- Raise awareness of environmental health issues by writing articles for local newsletters and using the BRACS network (eg. Being interviewed or doing a broadcast).

Water

- In conjunction with the IWO or ESO at the community, the EHW should ensure there are adequate supplies of chlorine in stock and arrange with the IWO or ESO to reorder supplies if necessary.

5. Monthly

General

- Provide a written report and present it to the Council on monthly activities that include the major environmental health problems that require fixing or have been fixed/prevented.
- Encourage community participation in environmental health programs through suitable health promotion activities (eg. Dog program, *Mr Germ*, Dengue fever control).
- Consider contributing an article to the "EHW News" bi-annual newsletter. Contact the TPHU for assistance.

Water

- In working with the IWO or ESO at the community, the EHW should:
 - a) Ensure samples of the water supply are taken and forwarded to the microbiology laboratory in Cairns, Brisbane or at Thursday Island Hospital for analysis.
 - b) Ensure readings of pH and the level of chlorine in the water supply are taken daily from at least three different points in the reticulation system (including dead ends) and the results recorded in a log.
- Report all damage or leaks to the water supply and/or in households (eg shower, taps) to the Council/IWO or ESO/designated officer (remember the *Waterwise* program).
- Provide advice and comment to Council (preferably with the IWO or ESO) on the status of water quality/quantity including results from analysis of water samples, and the possible effects on people's health.

Sewerage

- Inspect all septic systems in the community as required (every 6-12 months should be adequate).
- Ensure sewage lagoons are maintained in a good condition (eg. Grass mowed, no mosquito breeding, fence OK).
- Ensure that effluent from sewage lagoons is tested for compliance with the EPA licence.

Rubbish Collection

- Develop a plan outlining how the community rubbish dump or tip is to be operated in accordance with the conditions imposed in the EPA licence.

Housing

- Inspect homes internally and externally to find defects that relate to an environmental health risk to the community (eg. Leaking taps, overflowing septic systems, defective septic absorption trenches, defective toilets, possible mosquito breeding places in back yards, screening of rainwater tanks).
- Provide a report to Council listing defects in houses and ensure that appropriate works are carried out to a satisfactory standard.
- Provide a report to Council on any overcrowding identified during house inspections. Overcrowding should be a major consideration when Council compiles the priority list for housing renovation or replacement.

Food Stores

- Check food stocks in relation to correct storage, packaging, stock rotation and fitness for human consumption.
- Respond to instructions listed in food recalls received from the TPHU. Discuss with food operators as appropriate.
- Investigate food complaints as required.

Pest Control

- Implement a community pest control program for houses and other likely breeding sites for pests such as cockroaches, fleas, rats (eg spraying of the sewage manholes throughout the community; internal rooms of houses – laundry, kitchen, bathroom; dump; nightsoil trenches; food stores). This of course, can only be carried out if you have a current Pest Control Operators licence issued by Queensland Health.
- Carry out a mosquito surveillance & control program - consult with vector control officers (eg at Queensland Health Public Health Units) in regard to mosquito control.

Animal Control

- Develop and implement an Animal Control Program for horses, dogs and pigs.
- Dogs
 - a) Develop and implement a dog registration program in accordance with Council By-laws and maintain a record of dog ownership.
 - b) Organise a dog desexing and culling program (Important – A veterinary surgeon (vet) will need to be involved at certain stages). If it is intended to conduct culling programs, contact the TPHU to gain necessary written approvals.
- Horses and Pigs: See sections 1.2 and 3.4

6. Annual

General

- Provide an annual report to Council listing - the achievements and other issues attended to during the year; all progress with respect to environmental health issues; and proposals for future work (goals).

Housing

- Conduct a full premises -to-premises inspection of the community prior to the onset of the wet season.

Food Stores

- Ensure that food stores offering food for sale to the public are registered by Council and comply with the *Food Standards Code*.
- Ensure that Council (in accordance with the *Food Standards Code*) licenses food store owners.