Public Health Association of Australia submission on the COVID-19 Response Inquiry

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Public Health Association
AUSTRALIA

The **Public Health Association of Australia** (PHAA) is Australia's peak body on public health. We advocate for the health and well-being of all individuals in Australia.

We believe that health is a human right, a vital resource for everyday life, and a key factor in sustainability. The health status of all people is impacted by the social, commercial, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the root causes of poor health and disease. These determinants underpin the strategic direction of PHAA. Our focus is not just on Australian residents and citizens, but extends to our regional neighbours. We see our well-being as connected to the global community, including those people fleeing violence and poverty, and seeking refuge and asylum in Australia.

Our mission is to promote better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

Our vision is for a healthy population, a healthy nation and a healthy world, with all people living in an equitable society, underpinned by a well-functioning ecosystem and a healthy environment.

Traditional custodians - we acknowledge the traditional custodians of the lands on which we live and work. We pay respect to Aboriginal and Torres Strait Islander elders past, present and emerging and extend that respect to all other Aboriginal and Torres Strait Islander people.

PHAA Submission on the COVID-19 Response Inquiry

Compared to many other high-income countries, Australia fared very well in terms of a lower excess mortality rate and excess health sector spending during the COVID-19 pandemic (see appendix 1.0).[1] During the pandemic there were certainly many efforts made by Australia's public health advisors, and the ministers who operationalised their advice, that are well worth positive recognition. One specific effort was engaging with the Aboriginal Community Controlled Health Organisation (ACCHO) sector early, resulting in successful COVID-19 management in First Nations communities.[2] Another was the vaccine program, which vaccinated (two doses) 18 million Australians over the age of 16 in one year.[3]

This submission focuses solely on three key basics of public health practice, and addresses the TOR related to broader community support and future national coordination of major events that must be addressed to ensure greater pandemic preparedness in the future.

Maintaining a Healthy Population

The interface between COVID-19 and non-communicable diseases (NCDs) has been stark.[4] People with a NCD and who become infected with COVID-19 are more likely to experience severe illness, be admitted to intensive care units (ICUs), receive mechanical ventilation, and die.[5–8]

For instance, of patients admitted to ICUs, 72% had a co-morbidity;[2] mortality risk in patients with coronary heart disease was three times that of those without heart disease;[6] people who are obese were seven times more likely to receive mechanical intubation than those not obese;[8] and the mortality rate for those with diabetes was almost twice that of people without diabetes.[5] Other NCDs that often lead to worse COVID-19 outcomes are hypertension, chronic obstructive pulmonary disorder (COPD),[5–8] chronic renal disease, chronic liver disease, and hyperglycaemia.[8] All of these conditions are largely preventable.

COVID-19 also interrupted the management of NCDs due to appointment cancellations, or delays owing to safety protocols;[9] resulting in unintended consequences, such as poorer health and increased mortality.[10]

A United Kingdom study found that cardiac-related emergency department presentations fell by 35% during the pandemic.[11] The lack of immediate treatment potentially resulted in an estimated 84 to 232 excess cardiac deaths *per week*.[11] In Australia, precautions saw preventive health programmes suspended (like cancer screening and immunisations), meaning potentially hundreds or thousands of cancers went undetected.[12] The future resulting burden of disease is yet to be estimated.

Additionally, people with low socioeconomic advantage are more likely to have worse health outcomes than those with greater socioeconomic advantage,[13] an inequitable and avoidable reality.[14] Studies clearly show that people who have a NCD and COVID-19, and are Indigenous[5,15,16] and/or have a low income, are more likely to have severe COVID-19, be hospitalised and/or die.[5]

COVID-19 infection caused greater morbidity and mortality when experienced in conjunction with an NCD, an effect noted for many communicable diseases such as Middle East respiratory syndrome coronavirus (MERS-CoV)[17] and H1N1 Influenza (Swine Flu).[18] Less chronic disease would probably mean less pressure on the health system and fewer avoidable deaths and injury.

Yet Australia's NCD epidemic continues to grow, with almost half of Australian adults (47%) having at least one chronic condition([19] and 1 in 3 Australian adults being obese.[20] Many NCDs are represented inequitably in the population, for instance COPD is most prevalent amongst those in the lowest socioeconomic group and First Nations peoples are 2.3 times more likely to have COPD than non-Indigenous Australians.[21]

The Inquiry's recommendations must include an urgent call to prevent NCD and improve health for all. This way, Australians will have more resilience against future human pathogens and there will be less burden on our health system during future pandemics.

To create a healthier population, the new Australian Centre for Disease Control (ACDC) must be established with the scope of addressing both communicable and non-communicable diseases in tandem. It is not a stretch of resources to address both as, 'many of the tools required for fighting a pandemic are also those required to fight NCDs: disease surveillance, a strong civil society, robust public health, clear communication, and equitable access to resilient universal health-care systems'.[22]

The ACDC can be the single agency that works to prevent NCDs and ensure plans are in place to maintain preventive screening and chronic disease management programs during an emergency.

COVID-19 must be seen as a catalyst for governments to invest in evidence-based policies that prevent NCDs in the first instance. Policies that we know pay for themselves many times over,[23] including strict tobacco, vaping, alcohol, and sugar controls and supporting physical activity and healthy eating patterns to curb the rise of NCDs and create healthier more resilient Australians.

The COVID-19 pandemic also highlighted the importance of preparedness. Understandably normal NCD screening, treatment and management processes were restricted initially, but they remained restricted resulting in preventable health consequences. **Preparedness includes the ability to restore and maintain programs addressing NCDs as quickly as possible** (for more, see appendix 2.0).

A strong public health workforce:

"The health of the public cannot be protected without an adequately skilled and qualified workforce."[24] The non-accreditation of public health training programmes and non-regulation of the public health workforce is a major flaw in our preparedness for future pandemics and other major emergencies.

In Australia people trained in public health and related disciplines are not specifically regulated for public health practice, and universities don't consistently maintain registers of public health graduates.

The lack of regulation makes it difficult to identify workers trained and qualified in public health, necessitating crisis recruitment from the general health workforce, departmental staffing and defence force personnel. As a result, the public health workforce's critical expertise in health promotion, health determinants and evidence-informed communication is underutilised.

With a World Health Organization Roadmap on professionalisation of the public health workforce imminent, the Government is well placed to use the guidance provided and ensure a stronger, expert and robust public health workforce is identified and can be called upon in times of emergency.

A central role of the ACDC must be to build public health workforce capacity in Australia by leading and investing in advancement of the workforce through a range of national initiatives and programs, including an Australian Public Health Officer Training Program, national and regional pandemic exercises that also support upskilling of a surge workforce, and a public health credentialling initiative.[25]

Given the likely increase of communicable zoonotic diseases due to climate change,[26] **the ACDC must expand and diversify the public health workforce to be pandemic prepared. This means including a breadth of professionals ranging from one health experts and immunologists to epidemiologists and health communicators.** For further details about public health workforce and the ACDC see our submission on the Role and Functions of an ACDC.

A single and coordinated mechanism to monitor, communicate and respond

In March 2020, as a part of the pandemic response a National Cabinet was established, consisting of the PM and State and Territory Premiers. It was critical in establishing some of the national pandemic response mechanisms, and showed how effective coordination of actions were in controlling the spread of the pandemic, particularly in the first wave.

However, much of the response was driven through individual States and Territories (as that is where the Public Health Acts sit), which highlighted the lack of a single and coordinated mechanism as a barrier to rapid pandemic response.

To ensure readiness for future outbreaks, epidemics and pandemics, **the ACDC must provide a national coordination role by driving greater and more timely data sharing between jurisdictions, encouraging greater coordination in evidence based key performance indicators and training a larger, more specialised workforce ready for response**.

To support these new and improved abilities for pandemic preparedness and response there is a need to create strong public trust in the ACDC. Features such as expertise and competence, reliable capacity made possible through adequate funding, and independence from political considerations will all be essential in generating such trust. **Securing public trust will ensure that the ACDC can successfully perform its functions in any crisis** (PHAA vision for ACDC, appendix 3.0).

In particular, the **ACDC must build confidence amongst Aboriginal and Torres Strait Islander people by formalising the relationships between the Commonwealth and the ACCHO sector** which were strengthened throughout the COVID-19 pandemic period.[(2)] We also encourage that the ACDC ensure appropriate First Nations representation within its governance.

Finally, the ACDC must seek to establish itself as a long-term cornerstone agency, a key and permanent part of the public health system in Australia. This includes **establishing an ACDC with both domains of disease prevention accounted for, namely communicable and non-communicable diseases**.

From conception, the ACDC must be mandated to address NCDs. An achievable place to start would be to utilise the widely supported, evidence-based National Preventive Health Strategy as a framework.

Conclusion

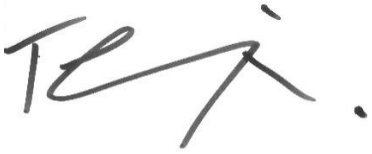
PHAA welcomes the opportunity to provide input to the COVID-19 Response Inquiry and we are keen to ensure that future emergencies are better prepared for. We are particularly keen to highlight the following:

- To give Australia a healthier underlying population, the ACDC must be established with preventing non-communicable and communicable diseases as a core function from conception.
- The ACDC must be tasked and resourced to grow, train, and diversify the public health workforce.
- The ACDC must be established as quickly as possible, with the expertise and competence, reliable capacity made possible through adequate funding, and independence from political considerations that will be essential in generating the trust of the Australian people.

Please do not hesitate to contact me should you require additional information or have any queries.

Adj. Professor Terry Slevin
PHAA Chief Executive Officer

15/12/2023



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Appendix 1.0

Overall, Australia was successful in keeping people safe and in addressing the economic challenges faced by Australians. The increase in support payments from the government during the pandemic saw a significant cohort of people begin to live above the poverty line.[27] As outlined in the body of the submission, there is a direct relationship between poorer health outcomes and socioeconomic disadvantage.[13] The increased payment meant this determinant of health was addressed, not answered by any means, but we know that the majority of these funds went to groceries,[27] meaning households were more food secure. This one factor alone sees knock-on positive health effects, from proper nourishment, to decreased anxiety, better sleep and a decreased risk of poorer health outcomes.[28–30]

Although investing in social improvements can sometimes be difficult for governments to justify, as deciding which measurement of health outcomes is a complex task,[31] some initiatives early in the pandemic (e.g., protection of income and shelter) were of enormous social benefit. This is not surprising as research shows that improvement in social conditions demonstrably lead to improvements in health status.[32]

The Australian non-governmental organisation called *Guidelines and Economists Network International* has examined the economics of pandemics, and developed methodologies that can guide government decision making during pandemics.[31] This research shows that the COVID-19 pandemic has influenced the scope of health economics literature, which will increasingly examine 'value' beyond health care interventions, including government policy and broad health system innovations. This will influence future economic evaluations and facilitate government and public health policy decisions, particularly during pandemics.[31]

Appendix 2.0

The need for coordination of resources to maintain normal services during emergencies is gaining academic and political attention.[33] Understandably, because SARS-CoV-2 was an unexpected pandemic, during the emergency in Australia, responses (prepare, practice, respond, recover, evaluate) were activated at the 'respond' phase.

Maintaining national primordial and primary services for prevention and mitigation of chronic disease can be coordinated through a single disease control agency, able to be flexible in maintaining services once initial response mechanisms have been secured. A national coordination and consolidation of resources into one agency makes economic and practical sense and supports the founding of an ACDC. An ACDC with a broader scope than infectious and communicable disease, that will also address the chronic conditions which lead to poorer health outcomes in the event of major disruptive events, including pandemics.

Appendix 3.0

Riffing on Australia's major public health issue in 2023, the ACDC: "Highway to Health" or a "Long way to the shop if you want disease control"?

Intouch article https://intouchpublichealth.net.au/riffing-on-australias-major-public-health-issue-in-2023-the-acdc-highway-to-health-or-a-long-way-to-the-shop-if-you-want-disease-control/

February 10, 2023

Adjunct Professor Terry Slevin, PHAA CEO

2023 will be a key year in the birth of the Australian Centre for Disease Control (ACDC). Like the start of any life, evidence tells us that the first year or two is enormously influential on how that life will unfold for future decades. So it will be with the ACDC.

The two milestones for the ACDC this year are the Federal Budget, due 9 May, and the legislation to bring the ACDC into effect. This will need to be completed in 2023 to allow for the Albanese Government's promised start of the agency in "early 2024".

The budget for the ACDC needs to be in the hundreds, not tens of millions of dollars, and the legislation that creates it needs to ensure it can function effectively long into the future including through periods when Executive Government does not prioritise public health.

Budget

The October 2022 Budget, the Albanese Government's first, contained a modest line for the ACDC. They committed $3.2 million, largely to facilitate the consultation and planning process.

The May 2023 Budget allocation will strongly indicate their level of commitment to the new agency. Recognising that the agency will only commence halfway through the 2023/24 financial year, that initial year's allocation is perhaps less crucial. But the Budget will also allocate estimates for 2024/25 and 2025/26.

There will also be some internal reallocation. Funds otherwise committed in the Department of Health and Aged Care budget will be reallocated to the ACDC as some existing Departmental functions are transferred. It has already been foreshadowed that the National Medical Stockpile will be transferred into the ACDC. This is a reasonable responsibility for the ACDC to hold. Its budget allocation is, I'm told, a security issue and so not publicly available. However, it's believed to be $50M+ per annum.

Naturally, the budget allocation will need to be aligned with the agency's scope and as that's not yet publicly announced, there are challenges to adequately estimate budget allocations. None the less, ACDC is likely to incorporate the roles of the Communicable Diseases Network Australia and Public Health Laboratory Network as part of its scope to plan for and, where necessary, lead response to infectious disease outbreaks. Along with addressing, and working toward preventing, the tsunami of chronic disease, the agency's budget must be substantial.

In addition, working constructively with States and Territories, where substantive public health powers lie, will also require resourcing. Co-operation with the jurisdictions is far more likely to be effective if funds are available to boost local capacity, while also maximising consistency and co-operation.

Similarly, if the ACDC is to lead the enactment of the *National Preventive Health Strategy*, to tackle issues like alcohol, tobacco, and obesity, then proper resource allocation is essential. By way of reference, looking at the modest budget of the Australian National Preventive Health Agency when it was last funded by the Rudd/Gillard government and indexing to 2023 – would be an entry point for funding this aspect of the ACDC work. We have also suggested that the $12.38 million remnant funds allocated to the Australian

National Preventive Health Agency, revealed in the recent October Budget statement, should be reinvested in non-communicable disease prevention by transferring these funds to the new CDC.

By way of reference point for previous investment in Preventive Health we can look at the National Partnership Agreement on Preventive Health signed by the Rudd government with all States and Territories in 2008. A total of $564.7 million was allocated from 2009/10 through to 2014/15. The agreement was amended around 2009 and the funding of the agency was reported in 2012 to total $932.7 million in an Australian National Audit Office report dated 2012 (see p.12). Due to the decision of the Abbott government in 2013 it was cut short. At its peak there were $218.3 million allocated under the agreement in 2012/13. That expenditure in 2012 would translate into $258 million in 2021 dollars according to the RBA calculator. And that was just on chronic disease prevention.

Developing Public Health Workforce

Like all areas of the economy, we can't provide high quality public health programs and advice without recruiting, training and developing the next generation of experts and leaders. We have recommended the creation of a National Public Health Officer Training Program built on the NSW Health model, which we believe can make an enormous contribution at a cost of around $50 million p.a.

If the ACDC is to genuinely fulfil its potential, the early budget allocations will need to be in the hundreds, not tens, of millions of dollars.

Legislation

The other key issue of 2023 is the legislation that establishes the ACDC. The ACDC needs to be both able and confident to provide independent, trusted, authoritative, evidence-based advice. It must also be both acknowledged and sustainable, irrespective of any Government's reluctance to hear such advice.

We welcome that the agency is being established by a government that expresses commitment to improving and expanding public health capacity. But the ACDC must be able to weather the storm of any future government that might be indifferent – or even hostile – to the value of public health advice and expertise.

This suggests that the CDC should be established as a new statutory body, similar in governance arrangements to entities such as the Australian Commission on Quality and Safety in Healthcare. That commission has an independent, expert governance board rather than an advisory board, with clear independence mechanisms. The Board membership should come from a diversity of disciplines and segments of Australian society, and have unassailable public health credentials and expertise. This would create the balance between the need for independence from government, while achieving accountability and jurisdictional buy-in across our federated system.

The new institution's structure should reflect a hub-and-spoke model, with a properly resourced administrative centre, to coordinate its activities and functions, and enable international collaborations. These should include jurisdictional offices for regional coordination and engagement, in much the same way as the Public Health Agency of Canada is structured, staffed with funded positions to capacitate national functions.

Background: How we've landed here

We've been thinking, talking, and writing about the ACDC for decades, and a recent push came around the time we published an editorial in ANZJPH in September 2021.

Since then, the Albanese Labor was elected in May 2022 on a platform of introducing an ACDC.

According to the party's pre-election policy platform, the CDC will:

- *Ensure ongoing pandemic preparedness;*

- *Lead the federal response to future infectious disease outbreaks; and*
- *Work to prevent non-communicable (chronic) as well as communicable (infectious) diseases.*

The government has designed and run a consultation process and released a consultation paper to which many organisations, including PHAA, have made detailed submissions. I understand about 140 submissions were made.

How much do we spend on Public and Preventive Health?

According to the AIHW, in the three years leading into the global pandemic public health spending has ranged between 1.55 and 1.77% of total health spending. No wonder spending on disease management is getting out of control! In the first year of the global pandemic, with all the PCR testing and contact tracing, and the early purchases of vaccines that moved to 3.7%. Even with a public health crisis that dominated the world we still do not reach the recommended target of 5% as suggested by the National Preventive Health Strategy. There is still a long way to go.

Conclusion

This year will be pivotal, with ramifications for Public Health infrastructure for decades. This is genuinely a once-in-a-lifetime chance to get this right. So, will it be a "Highway to Health" for people in Australia or will it be a "Long way to the shop if you want (proper) disease control"?