Public Health Association
AUSTRALIA

Inquiry into the Tasmanian Government's response to the COVID-19 pandemic

Contact for recipient:
Natasha Exel
Committee Secretary
Public Accounts Committee
Parliament of Tasmania
A: Legislative Council, Parliament House, Hobart 7000
E: pac@parliament.tas.gov.au **T:** (03) 6212 2245

Contact for PHAA:
Terry Slevin – Chief Executive Officer
A: 20 Napier Close, Deakin ACT 2600
E: phaa@phaa.net.au **T:** (02) 6285 2373
Kim Jose – Tasmanian Branch President
E: kim.jose@utas.edu.au **T:** (03) 6226 7835

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The **Public Health Association of Australia** (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public's health in Australia.

The PHAA works to ensure that the public's health is improved through sustained and determined efforts of our Board, National Office, State and Territory Branches, Special Interest Groups and members.

We believe that health is a human right, a vital resource for everyday life, and a key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people's health. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

Our mission as the leading national organisation for public health representation, policy and advocacy, is to promote better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health. Members of the Association are committed to better health outcomes based on these principles.

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, improving and promoting health and wellbeing for all.

The reduction of social and health inequities should be an over-arching goal of national policy, and should be recognised as a key measure of our progress as a society. Public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

Summary of recommendations

The Tasmanian Government should:

Workforce issues:

- Continue to support the national Public Health Physician training program and the MPH program at UTAS
- Ensure all public health staff, both employed and in surge capacity, should be formally trained in public health, rather than just a health-related discipline
- Support expansion of training in public health
- Invest in critical infrastructure required to support the public health response
- Develop a range of strategies to address single-person dependency
- Build capacity of the local government workforce, such as environmental health officers to assist in future responses

Communication issues:

- Provide funding for research in communication and behavioural insights into aspects of public health management, to inform and improve future communications. Particularly, increasing our understanding of how different population groups such as young people, rural communities and the migrant population in Tasmania have sourced information during the pandemic.
- Ensure coordination with a national communication strategy and information, with clear and logical explanations for differences where they exist.

Border control and quarantine issues:

- Conduct a thorough evaluation of the health and social impacts of border restrictions on:
    - access to health services
    - impact of quarantine expectations for returning 'health travellers'
    - psychosocial impacts of border control measures
- Review how the travel and quarantine exemptions have been applied for health travellers
- Evaluation the costs and benefits to the health sector of the policy response in order to identify ways the policy response can be optimised (in the event of future similar outbreaks) and to identify public health policy options going forward.

Introduction

PHAA's Tasmanian state branch welcomes the opportunity to provide input to the Inquiry into the Tasmanian Government's response to the COVID-19 pandemic. This submission focuses on health expenditure with specific reference to preparation and response to the COVID-19 pandemic.

Public health practice is about 'Protecting Health, Saving Lives – Millions at a Time' [1]. Public health is built on prevention activities, rather than health care and its focus on treating illness. Optimal health is about more than just not being unwell, but about the ways in which whole populations behave and interact and stay healthy. Public health responses during a pandemic are therefore critical to the maintenance of health in large populations.

To date, the response to the COVID-19 pandemic has focused on reducing the immediate health and economic impact. This has included a portfolio of action across all 11 recognised public health intervention types – public policy development, legislation and regulation, resource allocation, engineering and technical interventions, incentives, service development and delivery, education, communication, collaboration and partnership building, community and organisational development and advocacy.

The response and efforts of local and national community members; health, community and service workers; the national advisory group and state and federal governments generally in Australia and more specifically in Tasmania should be recognised and celebrated. This has demonstrated the extraordinary capacity of the community to deal with a significant health threat.

In Tasmania we have been well-served by a small but highly skilled core public health workforce. This workforce has been led by the Tasmanian Director of Public Health, Dr Mark Veitch who has extensive experience in communicable diseases surveillance and control, food-borne and vaccine-preventable diseases, blood-borne viruses, and tuberculosis and has been a member of the Communicable Diseases Network of Australia from 2010 to 2017 (serving as chairperson 2015-17). Dr Veitch has been well supported by the Deputy Director of Public Health Dr Scott McKeown.

The Premier Peter Gutwein and other political leaders in Tasmania are to be commended for listening to and responding to the public health guidance provided and for using Tasmania's natural geographic isolation to protect the health of Tasmanians. However, subsequent health and social impacts associated with this border closure need to be thoroughly evaluated.

Compared with international and national rates, Tasmania has maintained low population and case fatality rates, and has contributed only a very small number of cases and deaths to the national and international burden of disease. This has been in part due to Tasmania's additional local geographic isolation on top of Australia's relative isolation, but the efforts made by Australia's and Tasmania's public health advisors and the ministers who operationalised their advice has also been critical. Distancing has clearly worked so far – some of the best evidence being the huge reduction in influenza and other seasonal communicable diseases cases this year. Comprehensive contact tracing has also made a significant contribution to the local effort of containing the virus. However, we must be mindful that this is far from over.

Globally, the virus is spreading faster now than early in the pandemic, and some parts of Australia are experiencing a significant second wave.

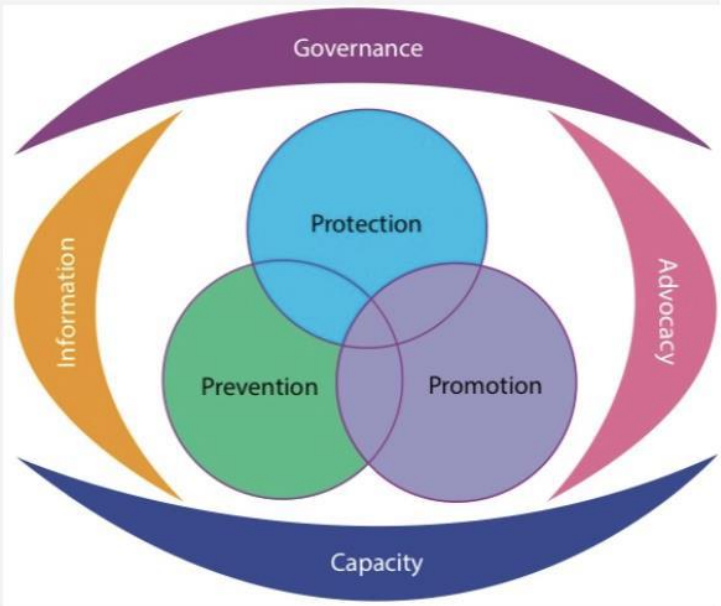
We are aware that prior to this pandemic major outbreak exercises had been conducted and response plans formulated and updated as a result. We know that this had made Australia as prepared for an outbreak as other countries (such as the UK and the USA), the major difference being that when the outbreak happened, the plans were activated. This is very much to Australia's credit. PHAA has recognised

this through our special PHAA President's Award for Members of the Australian Health Protection Principal Committee (AHPPC) on 12 May 2020, of which Dr Mark Veitch is the Tasmanian representative.

Context

Assessing the response through the WFPHA lens

The World Federation of Public Health Associations (WFPHA) has developed a Charter, endorsed by the World Health Association. A helpful lens through which to examine public health activities, all Charter elements were relevant to Australia's response to COVID-19, although some elements were better activated than others. Core prevention-protection-promotion elements were activated quickly using pre-existing mechanisms including standard public health surveillance notification and contact tracing, public education and more. Laboratories and notification systems performed well.



(Diagram from the WHO-endorsed WFPHA *Charter for the Public's Health)*

Internationally, the World Health Organization (WHO) and Johns Hopkins University provided excellent and timely international information, and Australia utilised these sources at all stages. National and local information was updated in a timely way with regular local briefings provided directly to the public by the Premier Peter Gutwein and the Director and Deputy Director of Public Health. Australian public health legislation was activated to good effect; nationally, public health unit capacity was upgraded; and advocacy for many constraining aspects of emergency management was disseminated effectively.

Sustainable Development Goals

The United Nations Sustainable Development agenda is the shared blueprint for peace and prosperity for people and the planet, now and into the future. The 17 Sustainable Development Goals (SDGs) are an urgent call for action by all countries as part of the global partnership. They recognise the linkages between ending poverty, improving health and education, reducing inequality, protecting the environment, and encouraging economic growth. Most SDGs, each of which has several target indicators, are relevant to the issue of COVID-19 and the response, particularly those relating to: No poverty, Zero hunger, Good health and well-being, Quality education, Gender equality, Decent work and economic growth, Reduced inequalities, Life on land and Peace, justice and strong institutions

From a broad and immediate public health response perspective, the response to the pandemic cannot be de-linked from the SDGs. Food security, income protection, and secure housing are directly relevant as determinants of health: this pandemic has generated some major negative changes for many people in the areas of income and work, food security, gender and safety issues, and has highlighted and exacerbated many inequities. Contracting COVID-19 has had negative health consequences for some Australians, and the effects of separation from other people has generated mental health consequences for many.

On the other side, there are also a number of positive outcomes that have been reported as a result of the lockdown and distancing measures taken by countries. For example, there has been a measurable reduction in many health conditions, in particular other communicable and infectious diseases (especially influenza and influenza-like illness) and reductions in road traffic accidents.

Public health professionals and their role

The COVID-19 pandemic has highlighted the necessity for a skilled public health workforce to lead the response and protect public health. The extraordinary need for surge capacity of the local and national Public Health Workforce during the COVID-19 pandemic has involved functions such as sample taking and testing, case investigations, contact tracing, data analysis, household-level public communications, and many other tasks. Such functions depend not only on frontline clinicians, nurses and other allied health, but epidemiologists and other public health professionals and have highlighted the scale of the challenge facing governments and their agencies.

Nationally, Federal investment in public health education has been reduced over the last decade, particularly with the loss of Public Health Education and Research Program (PHERP) funding. The Federal Government invested in a set of Foundation Competencies for Master of Public Health Graduates in Australia[2] however not all Australian public health degrees are based on these. The lack of accreditation seen in other degrees complicates this issue, reducing oversight.

Tasmania does offer a dedicated public health medicine training program for medical public health specialists via the Australasian Faculty of Public Health Medicine (AFPHM), which is a Faculty of the Royal Australasian College of Physicians (RACP). The University of Tasmania offers an online Masters in Public Health (MPH) course that is open to local and international students. This course contributes to public health education and training locally, nationally and in the region.

Nationally and locally investment in the public health workforce has reduced significantly over recent decades. Nationally, for the financial year 2017/18, 1.6% of total health expenditure went to public health activities, which include prevention, protection and promotion (AIHW, 2019[3]). PHAA recommends that the spend on public health be increased to 5% of total health expenditure.

The Tasmanian and national government could increase public health knowledge requirements by requiring public health staff to have relevant public health qualifications and experience. For medical doctors, they should be public health medicine specialists, and other public health professionals should have qualifications in their particular fields. This is currently not the case consistently. Also, public health department surge capacity for an outbreak such as COVID-19 should be built on people with public health training. The value of public health expertise as a speciality must be recognised and enhanced.

Response

Public health workforce

In Tasmania, the capacity to respond to and operationalise the range of functions required for an immediate response to COVID-19 has tested the local public health workforce. The local response has required the short-term secondment and employment of people from outside the core public health workforce. To date, at least 40 additional staff have been required to provide support to the core public health teams with up to 24 staff from the Menzies Institute for Medical Research, University of Tasmania. This additional capacity has included epidemiologists and biostatisticians to assist with surveillance and cluster management.

However, the pandemic has highlighted gaps in the current public health workforce such as the limited numbers of nurses with training in public health to support response efforts and manage testing processes, limited numbers of trained field epidemiologists who can provide critical contextual information for managing local clusters such as occurred in the north-west of Tasmania, and outdated information and data systems that were unable to meet the requirements for supporting an effective response of the scale required. Local government involvement in the response has been limited, with the potential of locally based staff, such as environmental health officers not fully realised. In addition, many public health roles in Tasmania are single-person dependent – something that is not unexpected in a small jurisdiction such as Tasmania – but in an event of such scale and complexity this places significant stresses on individuals to coordinate and respond appropriately.

Like most jurisdictions in Australia, resourcing of basic public health infrastructure has not been maintained in Tasmania. This has left shortfalls in capacity to respond as well as to carry out basic induction and training of the necessary additional staff to undertake work such as contact tracing as the COVID-19 pandemic has unfolded. To date Tasmania has not experienced major COVID-19 outbreaks in residential aged care, but the experience of other states has shown the need for this sector to be better prepared for this possibility. Specific education and training related to infection control are needed, but some of the current issues are also linked to long-standing workforce issues related to casualisation of the workforce which have been highlighted in the Royal Commission into Aged Care Quality and Safety.

While responding to the COVID-19 pandemic public health officials have also been required to continue other key functions, such as monitoring of the 71 other notifiable diseases in Australia, licensing and compliance checks and key prevention activities such as screening activities for preventable non-communicable disease.

In light of these pre-existing resource constraints the Tasmanian response to date has been commendable. However, as the pandemic continues, and preparations are being made to respond to a potential second wave in Tasmania, the capacity of the core workforce to maintain its responsiveness and staff wellbeing over the long-term will be challenging.

The Tasmanian Government should:

- Continue to support the national Public Health Physician training program and the MPH program at UTAS
- Ensure all public health staff, both employed and in surge capacity, should be formally trained in public health, rather than just a health-related discipline
- Support expansion of training in public health

- Invest in critical infrastructure required to support the public health response
- Develop a range of strategies to address single-person dependency
- Build capacity of the local government workforce, such as environmental health officers to assist in future responses

Communication on issues

Communication in a time of crisis is always complex. Even more so when the crisis is rare, global and evolving quickly. There will be elements of uncertainty, and mistakes will inevitably be made. Lessons can be learned from this experience to make improvements for the next event. From COVID-19 so far, there are two areas relating to communication from which lessons may arise – planning and consistency.

The Australian Health Sector Response Plan included strong provisions for communication. Putting these into practice in real time has highlighted issues and areas for improvement. Mechanisms for consultation are limited, and the Plan has not been implemented in its entirety. The lack of consultation with various stakeholders demonstrates the need for a stronger set of mechanisms for consultation to be established pre-pandemic, rehearsed and refined. Policies adopted in the crisis phase and thereafter lack evidence of consultation, such as via stakeholder reference groups. This was clearly evident in the recent response to the outbreak in the public housing towers in Melbourne.

Information dissemination to the public has come from multiple official sources, with a Federal response from the Prime Minister with medical information provided by Professor Paul Kelly on public health and epidemiology and Professor Brendan Murphy on medical and logistical issues, followed by State and Territory level leaders and chief health officers. There is definitely a logic to this, as people ask both "What is Australia doing about this?" and "How does it affect me?". The challenge lies in managing differences in advice from these various sources, to ensure that information is not disjointed and confusing.

In Tasmania, the general surveys undertaken as part of the University of Tasmania's Tasmania Project[4] in April/May and in June provide some information about how the Tasmanian public has sourced information about the pandemic, although it must be noted that survey respondents are not representative of the Tasmanian population (approximately two thirds of respondents were female and two thirds had a bachelor or postgraduate qualification compared to 12% in the general population). In June, respondents' top five sources of information were Premier Gutwein's media briefings (65%), television news (57%), the Tasmanian Government's Coronavirus website (57%), ABC radio (42%) and the National Chief Medical Officer (29%). It is likely that younger members of the Tasmanian population may have used different sources.

Survey respondents indicated that they sought information from Tasmanian government and local health authorities, much more than from Prime Minister Scott Morrison and they reported high levels of trust in information provided by government and health officials about COVID-19. Older age groups had more trust than younger age groups. [5]

It is noted that the more vulnerable members of the Tasmanian population and younger Tasmanians aged 18 – 24 years have not been captured in these surveys. It is critical that the Tasmanian government understands more fully where and how these population groups are sourcing information about the pandemic and identify mechanisms of communication that could be adopted in the current and any future outbreaks.

The importance of effective crisis communication is highlighted here. Communication and behaviour change are central components of pandemic management. While Tasmanians appear to have been well-

served by Premier Gutwein and the Chief Public Health Officer, Dr Mark Veitch, at times clear explanations of variations in response and restrictions may have eased concerns and confusion, and increased confidence in the overall response. It is critical that the Tasmanian government has mechanisms in place to ensure effective communication with all population groups during such events.

Tasmanian Government should:

- Provide funding for research in communication and behavioural insights into aspects of public health management, to inform and improve future communications. Particularly, increasing our understanding of how different population groups such as young people, rural communities and the migrant population in Tasmania have sourced information during the pandemic.
- Ensure coordination with a national communication strategy and information, with clear and logical explanations for differences where they exist.

Impact of Border Control Measures and Quarantine

As previously noted, the early implementation of border control measures, ongoing travel restrictions and quarantine measures in Tasmania have contributed to very low case numbers and limited community transmission. However, border closures have highlighted gaps in the general health workforce in Tasmania. Specifically, the reliance on locums to provide acute health services in some parts of the state and the inability or reluctance of these health workers to travel during this time has directly impacted the states capacity to provide a full complement of acute health services in all regions of the state. The full impact of this is unknown.

Furthermore, border closures and ongoing travel and quarantine regulations and expectations has impacted on Tasmanians ability to access to specialised health services interstate. Quarantine restrictions have also compromised follow-up care for those returning to Tasmania with some returning 'health travellers' also required to undergo quarantine in hotels where access to appropriate follow-up medical care has not always been available.

The broader social and psychological impact of the border control measures, travel restrictions and quarantine measures are currently unknown. Many Tasmanians have family members living in other states and the limited capacity to connect with them over the past six months will have a range of social and psychological impacts that will need to be investigated.

Tasmanian Government should:

- Conduct a thorough evaluation of the health and social impacts of border restrictions on:
    - access to health services
    - impact of quarantine expectations for returning 'health travellers'
    - psychosocial impacts of border control measures
- Review how the travel and quarantine exemptions have been applied for health travellers
- Evaluation the costs and benefits to the health sector of the policy response in order to identify ways the policy response can be optimised (in the event of future similar outbreaks) and to identify public health policy options going forward.

Other options to advance the Public Health Workforce in Tasmania and Australia

Increase support for specialised field epidemiology training and capacity

With the existence of an established and successful specialist Field Epidemiology Training Program in place (in the form of the Masters of Applied Epidemiology (MAE) at the Australian National University), it is opportune to rapidly increase the capacity and places for students undertaking this program which has direct relevance to the response to communicable disease outbreaks as well as more generally in field epidemiology. The MAE program is a two-year program where students are placed in a relevant health organisation (e.g. state health department, Commonwealth, and some NGOs) and attend intensive academic blocks to build expertise in the essential skills required to lead field epidemiology initiatives, e.g. establishing surveillance programs, managing outbreaks etc.

The program was established in 1991. Of the 231 graduates, 15% are Indigenous. Graduates have leading positions in health nationally and internationally. The MAE was accredited by the international Training Programs in Epidemiology and Public Health Interventions Network (TEPHINET) in 2019.

Invest in or expand Public Health Officer Training or similar programs

There is a successful long-standing Public Health Officer Training Program established in NSW that has operated for 30 years and has trained around 200 public health professionals. This three year long program is designed to meet the needs of public health program and service delivery at state government level through rotating trainees through a range of public health workplaces. All trainees must have completed a Masters of Public Health at entry to training. The program has been evaluated and shown to perform strongly on measures including contribution to surge capacity need, and publications in peer reviewed literature. The program reports a 78% completion rate, with 95% of graduates employed in the public health workforce generally and 74% of graduates specifically employed by NSW Health.

NSW Health has also developed similar programs to address specialist areas within the PHW, including Aboriginal Health and Biostatistics, and has successfully increased capacity in NSW in both of those fields.

A national scheme through which states and territories acted together would allow economies of scale which would assist a smaller jurisdiction such as Tasmania to participate.

A more consistent commitment and investment from the Australian Government and from all states and territories is vitally important to systematically improve the capacity and skills of the Public Health Workforce in Australia

Conclusion

The PHAA appreciates the opportunity to make this submission, and we would be happy to elaborate further in public hearings should the committee wish.

Please do not hesitate to contact Tasmanian Branch President Kim Jose should you require additional information or have any queries in relation to this submission.

Terry Slevin
Chief Executive Officer
Public Health Association of Australia

Kim Jose
PHAA Branch President
Tasmania

30 July 2020

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