The Public Health Association of Australia (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. 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.[1] Another was the vaccine program, which vaccinated (two doses) 18 million Australians over the age of 16 in one year.

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. 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.[2,3,4,5]

For instance, of patients admitted to ICUs, 72% had a co-morbidity;[3] mortality risk in patients with coronary heart disease was three times that of those without heart disease;[3] people who are obese were seven times more likely to receive mechanical intubation than those not obese;[5] and the mortality rate for those with diabetes was almost twice that of people without diabetes.[2] Other NCDs that often lead to worse COVID-19 outcomes are hypertension, chronic obstructive pulmonary disorder (COPD),[2-5] chronic renal disease, chronic liver disease, and hyperglycaemia.[5] 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; resulting in unintended consequences, such as poorer health and increased mortality.

A United Kingdom study found that cardiac-related emergency department presentations fell by 35% during the pandemic.[5] The lack of immediate treatment potentially resulted in an estimated 84 to 232 excess cardiac deaths *per week*.[5] In Australia, precautions saw preventive health programmes suspended (e.g., cancer screening and immunisations), meaning potentially hundreds or thousands of cancers went undetected. 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, an inequitable and avoidable reality. Studies clearly show that people who have a NCD and COVID-19 and are Indigenous and/or have a low income, are more likely to have severe COVID-19, be hospitalised and/or die.

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

---

[1] Finlay, S., Wenitong, M. Aboriginal Community Controlled Health Organisations are taking a leading role in COVID-19 health communication https://doi.org/10.1111/1753-6405.13010

[2]Gutierrez JP, Bertozzi SM. Non-communicable diseases and inequalities increase risk of death among COVID-19 patients in Mexico. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7544063/

[3] Nikoloski Z, et al. Covid-19 and non-communicable diseases: evidence from a systematic literature review. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8178653/

[4] Pal R, Bhadada SK. COVID-19 and non-communicable diseases. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10016830/

[5] Katsoulis M, et al. Estimating the Effect of Reduced Attendance at Emergency Departments for Suspected Cardiac Conditions on Cardiac Mortality During the COVID-19 Pandemic. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7819531/

(MERS-CoV) and H1N1 Influenza (Swine Flu). 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 and 1 in 3 Australian adults being obese. 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.

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'.[6]

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, 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 which resulted in preventable health consequences. **Preparedness includes the ability to restore and maintain programs addressing NCDs as quickly as possible**.

A strong public health workforce:

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.

[6] The Lancet. COVID-19: a new lens for non-communicable diseases. The Lancet. 2020 Sep;396(10252):649.

Given the likely increase of communicable zoonotic diseases due to climate change, **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, 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.

The largely State and Territory-based response highlighted the lack of a single and coordinated mechanism as a barrier to rapid action. To ensure readiness for future outbreaks, epidemics and pandemics, **the ACDC must provide a national coordination role through greater and more timely data sharing between jurisdictions, encouraging harmonisation 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**.

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.[1] 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.

For a longer version of this submission with full references, please follow this link.

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

[redacted]