Public Health Association
AUSTRALIA

Rebuilding a Healthy Society

Supplementary submission on strategic directions for the 2020-21 Commonwealth Budget

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24 August 2020

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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.

Prior submissions

We draw your attention to our initial 2020-21 Commonwealth Budget Directions submission in January 2020, which focussed on the economics of illness prevention, and offered a range of useful, low-cost public health initiatives for the government to consider.

In addition, we draw your attention to our submission to the ongoing inquiry of the Senate Select Committee into COVID-19 (committee website submission No 448), which deals with a wide range of aspects of public policy relating to Australia's overall response to the present pandemic.

We suggest that these two earlier submissions be regarded as attachments to the current submission.

Summary of recommendations

The following recommendations, from the body of this submission, address both the framing of the coming 2020-21 Commonwealth Budget, and Commonwealth policy directions generally.

Rec 1. Put people first, and protect their health and wellbeing equitably; this is not the time to allow inequality in Australia to increase.

Rec 2. Take major measures to increase Australia's public health prevention and response strength; we have been caught short in our resourcing for public health protection, and this must urgently be corrected.

Rec 3. Lay the foundation for Australia to 'build back better', creating an Australian society and economy that is healthier for all our future personal and economic strength; Budget measures to address COVID-19 emergencies are necessary, but they are not the only program that this Budget must address.

Rec 4. Remove barriers between state and federal budgetary responsibilities; recognizing that the Commonwealth government has the dominant share of capability to raise revenue and deploy other assets and finance-raising potential, if circumstances require, the Commonwealth must provide adequate financial support for state and local governments.

Rec 5. Ensure ongoing coordinated investment in equitable public welfare systems and other structural determinants of health.

Rec 6. Ensure more equitable income support for all groups, including those self-employed, and in recent casual employment.

Rec 7. Undertake better identification and coordination of services to vulnerable groups for all emergencies.

Rec 8. Maintain a strong income support mechanism sufficient to minimise poverty on an ongoing basis; current plans for a step-down of JobKeeper and JobSeeker from September 2020 must be reconsidered with that end in mind.

Rec 9. The Australian welfare system must ensure that all people have minimum income resources to prevent poverty, and prevent the increases in ill health that flow from poverty.

Rec 10. Adopt industrial workplace practices and welfare support policies, including temporary measures as appropriate, to reduce any behavioural drivers which create risks to community safety in regard to infections disease transmission.

Rec 11. Consider the totality of equity among all Australians to ensure that the overall response to the pandemic does not leave a legacy of increased inequality across Australia.

Rec 12. A thorough review of public health workforce be commissioned with a view to establishing a long-term strategy to strengthen Australia's public health capacity for future generations.

Rec 13. National, state and territory governments should establish (or expanding existing) Public Health Officer training programs or similar programs aimed at increasing the pool of trained public health workers.

Rec 14. Increase the number of specialist training program places for Public Health Physician training to 70, and establish a minimum of 50 per year on an ongoing basis.

Rec 15. Support an expansion of the Masters of Applied Epidemiology (MAE) program at ANU.

Rec 16. Establish a program to ensure easier participation in established international programs which respond to communicable disease outbreaks by meeting the cost of relevant public health professionals to participate.

Rec 17. Reinstate the Public Health Education and Research Program (PHERP).

Rec 18. Fund and establish a Public Health Employment Agency.

Rec 19. Establish an Australian independent public agency to provide scientific advice and education, and coordination assistance on communicable disease control, including all diseases of public health importance.

Rec 20. Undertake a review of the Commonwealth institutional arrangements with a view to strengthening their capacity to carry out their appropriate roles.

Rec 21. Ensure that States and Territories are actively engaged in considering national arrangements and entities relating to public health, and have active involvement in the structure and potentially the resourcing of new agencies or arrangements.

Rec 22. Give high priority in this Budget to resourcing not only for Commonwealth public health agencies, but also for state Governments, to support the extraordinary requirements for an effective national pandemic response.

Rec 23. Signal, through resourcing decisions for 2020-21 and beyond, strong support for the WHO's core functions, and for specific international exercises which the WHO undertakes in response to COVID, including aid to under-resourced nations and peoples.

Rec 24. The Budget should include anticipation that the National Preventive Health Strategy will be finalised in the near term, and that it will present both strong policy directions as well as adequately resourced programs of investment in better health.

Rec 25. Capital spending in the Budget, in particular spending which is deliberately designed to stimulate construction sector activity as a short-term economic stimulus program, should be directed towards investments that are environmentally sustainable and health-focused.

Introduction

PHAA welcomes the opportunity to further contribute to the Budget development process for the coming year.

We again draw your attention to our initial submission in January 2020, which focussed on the economics of illness prevention and offers a range of useful, low-cost public health initiatives for the government to consider. Despite the pandemic, nothing in that submission is any less correct or desirable. Indeed, the pandemic has only underlined the national strategic need to maintain a healthy population and to contain future resource demands on our health system and our economy.

But needless to say, much has changed since the beginning of 2020, and the coming Budget is being framed in truly extraordinary circumstances. It is no exaggeration to say that the government faces perhaps its greatest ever non-wartime responsibility to preserve the health and wellbeing of Australia's people. Our leaders have in fact compared the fight against coronavirus as the equivalent of a war. COVID-19 has been described as a hidden, deadly enemy.

> "*We are in a war against this virus and all Australians are enlisted to do the right thing*." – Prime Minister Scott Morrison – 22 March 2020
>
> "*We are at war…everyone has a role to play…we can't afford any holes in our defences*."– Treasurer Josh Frydenberg – 2 August 2020

The COVID-19 outbreak has highlighted to us all that the 'old normal' in Australia – where investment in public health has been allowed to run down over the past 20 years – cannot continue unchanged.

Long-term underinvestment in our preventive public health resources has exposed serious weaknesses in Australia's defences. Just as we have invested heavily in our defence forces and in protecting our people from the growing threat of foreign aggression and cyber-crime, Australia needs to invest now in rebuilding our defences against our next pandemic or health emergency.

If the health and safety of the Australian people is our governments' number one priority, we need to start building back from COVID-19 to become a healthier nation, a nation with the resources, the expertise and the people on the front line to counter the current – and inevitable future – 'health wars'.

Through the events of 2020 the costs of failing to address current public health challenges have become apparent. An important component in re-establishing Australia as one of the healthiest places to live on the planet is significant new investment in public health.

We now have an economy at depression-like levels, with unemployment rising and tens of thousands of businesses closed or struggling to survive. The impact on the mental health of millions of Australians should not be underestimated, with reports of increased suicides and domestic violence reaching near record levels. Our vulnerable, rapidly ageing population, so exposed by the pandemic, will continue to grow and put an increased strain on our already stretched services over the next two decades. All the while, COVID-19 has diverted public health experts from vital roles in cancer prevention, immunology, nutrition, and other functions, with costs to our nation's health that may not be known for a decade or more.

Australia's governments have a sound record of planning for the future. We have long-term plans in place for defence and cyber security investment, housing, infrastructure and even sport. As Australia struggles to deal with the many challenges coming from the shock and impact of COVID, emerging from this crisis presents an opportunity for government to quickly renew our National Health Plan, developed prior to the pandemic, factoring in how to rebuild capacity and to ensure our nation's health system is best placed for the challenges ahead.

Australia's 'new normal' will look quite different to our past. Governments must determine which elements of the 'old normal' to abandon, and which new policy directions will contribute to a 'new normal' that will protect the health and wellbeing of all Australians.

Assessing the pandemic response through a public health framework

The World Federation of Public Health Associations (WFPHA) has developed a ***Charter for the Public's Health***, which has been endorsed by the WHO.[1]

All the Charter's 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. Our laboratories and notification systems performed well. Internationally, the WHO and Johns Hopkins University provided excellent and timely international information, and national and local information was updated in a timely way. 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.

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 ***United Nations Sustainable Development Goals*** (SDGs)[2] 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 are relevant to the COVID-19 response, particularly those relating to:

- Goal 1: No poverty
- Goal 2: Zero hunger
- Goal 3: Good health and well-being
- Goal 4: Quality education
- Goal 5: Gender equality
- Goal 8: Decent work and economic growth
- Goal 10: Reduced inequalities
- Goal 15: Life on land
- Goal 16: 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. This pandemic has generated some major negative changes for many people in the areas of income and work, food security, gender and safety issues, which are all directly related to health, 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), reductions in road traffic accidents, and other countries have reported a reduction in cardiac events directly linked to a reduction in air pollution which might be repeated in Australia.

The COVID-19 pandemic defines this Budget

The public health emergency of COVID-19 is the largest single economic event since World War 2. Its scale in terms of costs to government, to individuals and to businesses, its generation of large-scale unemployment, and its impact on international travel all dwarf any other single short-term economic event in our history other that the major world wars. Yet the COVID-19 'event' is - at the time of writing - barely 30 weeks old. The COVID-19 story has a long way yet to go.

The annual Budgets of government are statements of policy direction and of policy choices relating to economic policy and fiscal management. They must address the challenges of their times, and in 2020 the most urgent challenge of our time is our public health emergency and its many impacts. Other economic imperatives and ideological goals are overwhelmed by the importance of dealing with the public health emergency.

Policy-making to address the current situation does not in any way benefit from framing public health issues as in competition with economic issues. ***Public health IS a major component of economics.*** A society which is in the grip of lethal illness, constraints on movement, and fear cannot hope to function at its full economic potential.

Put simply**, a government which is not on top of public health is not on top of economic management**.

Strategic directions for the coming Budget

The Budget, and all other aspects of government policy, must put people first, and must protect their health and wellbeing equitably.

PHAA urges the government to develop the coming Budget with four overriding principles in mind:

Rec 1. Put people first, and protect their health and wellbeing equitably; this is not the time to allow inequality in Australia to increase.

Rec 2. Take major measures to increase Australia's public health prevention and response strength; we have been caught short in our resourcing for public health protection, and this must urgently be corrected.

Rec 3. Lay the foundation for Australia to 'build back better', creating an Australian society and economy that is healthier for all our future personal and economic strength; Budget measures to address COVID-19 emergencies are necessary, but they are not the only program that this Budget must address.

Rec 4. Remove barriers between state and federal budgetary responsibilities; recognizing that the Commonwealth government has the dominant share of capability to raise revenue and deploy other assets and finance-raising potential, if circumstances require, the Commonwealth must provide adequate financial support for state and local governments.

After the Budget is handed down, and into the following year, **the 2020-21 Commonwealth Budget will be judged by the extent to which it helped protect, preserve and give confidence to Australia's people**. It must be a document that inspires people to believe that their Government is managing the very big picture, and is putting people first. Concern with the Government's short-term fiscal position, or with ideological framings of economic and fiscal policy, must become secondary.

Fiscal, economic and industrial policy

Principles of equity

Unfair barriers to accessing decent health care reflect weaknesses in healthy system design, structural forces which maintain inequalities in income and wealth, and various forms of discrimination and marginalisation.[3] Unfair health chances reflect inequalities in exposures due to economic or political inequalities, and heightened vulnerabilities as a consequence of discrimination or marginalisation.[4]

Health inequities exist both within and between countries. Avoidable and remediable health inequities persist in Australia and are widening globally.[5, 6] Relative equality in access to material resources, a culture of security through solidarity, and fulfilment through contribution are major determinants of population health status.[7] Promoting health equity calls for policy initiatives in all sectors and at all levels of government.[3]

The systemic, unfair and avoidable health and social impacts experienced from policy responses (in this case to COVID-19) provides the moral basis for health equity. Equity is about pre-empting harms to society from policy decisions before they eventuate, just as much as identifying particular vulnerable communities and providing assistance.

National and international COVID-19 policy responses highlight the multiple connections within and between societies that have had a profound and ongoing impact on social wellbeing and vulnerability for groups at all levels of society.

With around one-third of people in Australia reporting that their household finances have worsened due to COVID-19,[8] the impacts are broad, but not universal. An extensive list of some potentially affected population groups includes workers in, and suppliers to: food and groceries, transport, waste management, overseas students, delivery drivers, emergency services, self-employed people such as people working in the arts, all workers in healthcare institutions and those who provide care for the elderly.

People with pre-existing inequities who are likely to be further significantly adversely affected are also numerous, including homeless people, chronically unwell people, elderly and infirm people, socially isolated, low income and less educated people, culturally and linguistically diverse communities, asylum seekers and others with no social protections.

Rec 5. Ensure ongoing coordinated investment in equitable public welfare systems and other structural determinants of health.

Rec 6. Ensure more equitable income support for all groups, including those self-employed, and in recent casual employment.

Rec 7. Undertake better identification and coordination of services to vulnerable groups for all emergencies.

The government's direct control over practical poverty

It is well understood that health and wellbeing is underpinned by a range of drivers or 'determinants'.[9] One of the most basic drivers of difference is the economic and social resources available to each person and household. Those with very low material resources clearly experience heightened rates of illness.

The events of recent months have revealed just how greatly in practical reality our Governments – especially our national government – through their financial and welfare policy choices, have direct control over the proportion of the population living in poverty. This has been seen very visibly as Governments

have taken measures to prevent widespread unemployment. The bulk of this burden has fallen upon the Commonwealth government, as the natural holder of key welfare policy mechanisms and delivery agencies.

The state and territory governments, responsible for general patterns of economic 'lockdown' as well as being capable of smaller programs of social welfare spending, have a subordinate but still significant role. But in terms of financial policy, at times such as this the Commonwealth Government unavoidably has the primary responsibility for national fiscal and economic management.

The Morrison Government's novel JobKeeper program, long-advocated increases to the payments through JobSeeker, and to a lesser extent additional pensioner payments, have directly prevented what would otherwise have been a sharp increase in poverty. These policies have also injected fluidity into the circulation of cash in the economy, in turn reducing the shock to the wider economy. PHAA places on record its support for these large-scale welfare spending choices. We note that the Government made them urgently and decisively, and that they appear to have largely achieved their goals to date.

Even absent a crisis, allowing a proportion of the population to exist in conditions of poverty is both a moral failing as well as economically counter-productive. The framing of our current income underlying support, JobSeeker, in a punitive character is also counter-productive. Come the crisis, the Australian population clearly called on their governments to ensure that no Australian would be left behind, and that all people were of equal inherent dignity and worth in our society. PHAA shares these principles, which are embedded in international conceptions of public health such as the 1986 Ottawa Charter for Health Promotion.[10]

Rec 8. Maintain a strong income support mechanism sufficient to minimise poverty on an ongoing basis; current plans for a step-down of JobKeeper and JobSeeker from September 2020 must be reconsidered with that end in mind.

Rec 9. The Australian welfare system must ensure that all people have minimum income resources to prevent poverty, and prevent the increases in ill health that flow from poverty.

The coming Budget will place on record the government's position on these funding policies into the next full financial year, with projections beyond. The Budget should not signal that policy on preserving equity and preventing an increase in poverty might imminently be reversed. Australia has strong asset resources and a strong position to operate in deficit for an extended period. The government should use these resources to create confidence in Australia's people in a time of economic anxiety.

Workplace policy for safer behaviour and 'pandemic leave'

As the pandemic proceeds, it is becoming increasingly common that many behavioural drivers in workplaces are presenting real risks to public health. The ability of governments (largely, state and territory governments) to enforce public health and safety directions is challenged by:

- uncertainties and risk in existing policy and public advice about whether it is generally safe for all workers to return to places of work
- specific needs of insecure workers to maintain attendance at work even where there are indications that they carry infection, including pressures to conceal infections which there is an urgent public health need to reveal
- specific practices whereby key workers in exposed workplaces (such as quarantine facilities, health system workplaces, and aged care settings, among others) work shifts at multiple sites, despite the obvious potential for spread of infection arising from such work patterns

Carefully crafted employee income support policies, as well as appropriate support for employers, should be adopted to ensure that working practices and behaviours that are dangerous to the wider public health can be avoided, with the willing cooperation of employers and workers. Additional financial support should be provided by the Commonwealth government if required.

The problem of adequate sick leave for workers to ensure that those who should be in isolation or quarantine do not physically attend workplaces, needs to be comprehensively addressed. Since March many stakeholders, PHAA included, have highlighted to government the pressing need to financially enable workers manifesting symptoms of illness which might involve COVID-19 to refrain from attending workplaces. Staying home when sick is one of the core messages promoted to the public to reduce the spread of this coronavirus. However, workers will often attend when they have only mild symptoms, and the risk of attending whilst sick increases in workers who have little or no access to paid sick leave.

The WHO reported that in 2009, when economic crisis and the H1N1 pandemic occurred simultaneously, an alarming number of employees without the possibility of taking paid sick leave attended work while sick. This allowed H1N1 to spread throughout their workplaces, causing the infection of 7 million co- workers.[11] In Australia approximately 35% (more than 3.6 million) workers have no access to paid sick leave.[12, 13]

In the absence of new policy, pressures of insecure work, insecure hours of work, and related issues provide great pressure on too many employees to ignore warning signs, overlook precautionary responses and even conceal symptoms from employers and workmates. This presents a major direct threat of increasing community spread of COVID. In Victoria during the crucial July-August period, ensuring that people showing symptoms stay away from workplaces was identified by the Victorian Health Department as a key element in the restrictions necessary to reduce the spread of COVID-19.[14]

However, no practical solution to this problem can be delivered if the burden of the response remains simply on employees and their employers. Declarations of additional sick leave entitlements may provide short-term help, but leave the burden of lost labour on already struggling employers. The situation is a community epidemic-control problem, and it calls for a public solution which spreads the burdens of cost.

We therefore urge the Government to take advice from public health authorities in the states and territories regarding any workplace practices which are hindering safe behaviour, and craft industrial and welfare support policies to respond. Policies must ensure that no worker in under workplace or financial pressure to attend work in circumstances which risk increased community transition.

Rec 10. Adopt industrial workplace practices and welfare support policies, including temporary measures as appropriate, to reduce any behavioural drivers which create risks to community safety in regard to infections disease transmission.

The cost of such support to the Commonwealth, should – as with so many other present expenses – be considered alongside the cost of NOT taking such measures, which will surely include higher levels of community transmission, with all the mortality and economic costs which follow.

JobSeeker job searching obligations

At present, despite any success which the JobKeeper program achieves in maintaining job positions during this time, more Australians are being diverted onto the JobSeeker welfare support platform.

At the same time, the availability of job vacancies has obviously shrunk dramatically.

In the circumstances, PHAA recommends that policies on JobSeeker job search obligations need to address practical reality. It is pointless to ask people to apply for jobs when none is available.

In addition, it presents a public health risk to ask people to move around in the community seeking work where the prospect of finding any is very low. In such circumstances, the public health risk of community transmission outweighs any policy merit in forcing people to seek work.

PHAA notes that the Government has taken a practical approach to work-seeking obligations during the early stages of the pandemic crisis. This practical approach should continue.

Inequality, a key social determinant of illness, must be avoided

The practical realities of work attendance during the pandemic is also an equity issue. Many categories of workers, together with their employers, have developed models of working from home. But this is not an option that is equitably available to all categories of work, workplaces, or (depending on home circumstances) all workers even where the nature of work indicates working from home is effective. Effective work from home tends to be available to individuals engaged in 'white collar' work and with manageable household responsibilities, but much less so for blue-collar and other workers who are practically tied to their workplace, and workers with broader household responsibilities, or with limited means of operating effectively in their homes. It is apparent that some categories of workers are experiencing only limited impact on their incomes, while others are under great stress.

Rec 11. Consider the totality of equity among all Australians to ensure that the overall response to the pandemic does not leave a legacy of increased inequality across Australia.

Financial and economic policy into the future

If the price is that future policy will need to find new ways to raise revenue or otherwise support ongoing expenditure, then so be it. Australia has strong mechanisms to raise revenue if our leadership is prepared to argue for such policies and win public support for them, justified by the widely accepted need to react to what has happened in 2020.

It should be clear now that a low-revenue, low-expenditure, ideologically austere vision of financial policy is insufficient to provide for our nation's needs in a crisis, or in a post-crisis period. It is striking how the 'orthodox' fiscal policies of recent decades were cast aside within just weeks of a genuine world crisis emerging, not merely in Australia but across the globe.

Australia's economic policy for the future must be one which assures people and nations of health and economic wellbeing. The challenge confronting governments is to identify a new overall economic and financial policy framework and move towards it, bringing the public alongside.

A new economic framework should have public health and wellbeing at its heart. In future, it should be accepted that a government that is not on top of public health is not on top of economic management.

Public health services

Urgent public health workforce needs

Australia's public health workforce has been stretched beyond capacity by the pandemic. This is in no way the fault of the workforce itself. It was simply too small and too under resourced for the sudden tasks required of it to address the pandemic. Moreover, diverting workers from a variety of other public health tasks, such as cancer screening, community preventive health, and so on, risks a range of increased health problems for the future.

The Commonwealth and state and territory governments must work together to ensure that Australia's public health workforce can maintain all that it was already doing outside of communicable disease control, as well as grow rapidly to deal with COVID.

In June 2020 the PHAA, together with the Australian Epidemiological Association and the Council of Academic Public Health Institutions of Australia, prepared an executive paper for the Commonwealth Health Department on the situation facing the nation's public health workforce. The paper included key

recommendations which will remain current as the 2020-21 Budget is developed, and these appear below as recommendations 12-18 of this submission.

Expanding the current workforce

Significant gaps in the size, training, structure and credentialing of the public health workforce have been exposed as a result of the demands generated by the COVID-19 pandemic. This problem has been highlighted by the need to scale up to levels of activity never previously required by a communicable disease outbreak in Australia.

However, the demands on the nation's public health workforce go beyond the management of a communicable disease outbreak alone. With the heavy and growing burden of preventable Non-Communicable Diseases (NCDs), workforce shortages are perhaps less urgent but just as real. Government capacity should be adjusted in line with this increasing threat and disease burden.

There is a broad scope of practice in public health, from epidemiologists and biostatisticians, through to contact tracers, community health promoters, transmissible disease experts, health economists, environmental health, nutrition and food safety workers, Aboriginal Health workers, nurses, physicians, policy analysts, policy makers and more. A clearly agreed definition of those to include and exclude remains difficult. One size will not fit all in terms of training needs, employment options and support. There will also be differing demands depending on the extent of workforce and skills shortages.

Current best estimates[15] suggest that about 80% of the public health workforce is employed by government[16], academia and the not-for-profit sector. What little data we have suggest that the pre-COVID rate of growth of public health professionals currently in the workforce was very low to zero. Certainly, it has been behind that of most other health professions, and indeed most other professions generally.

The 2017 Joint External Evaluation of Australia's compliance with the International Health Regulations (JEE), addressed the issue of the public health workforce, commenting that "An Australian Government Health Workforce Strategy is currently being prepared, but it will not identify public health and its related workforce as an area that needs attention".[17]

To the best of our knowledge work is yet to commence on the three workforce recommendations in the JEE report or in our own *National Action Plan for Health Security*:

- "Use existing data sources, including relevant accreditation schemes, to define the public health workforce in order to conduct forward planning, recruitment of appropriate categories of staff (including toxicology and radiation specialists) and development of future credentialing schemes.
- Work with states and territories to ensure sustainable mechanisms for epidemiologists and other public health professionals at state, territory and local level.
- Develop a long-term strategy that uses current and new channels to increase the international experience of the public health workforce."

The pandemic has now generated an extraordinary need for surge capacity in functions, such as sample taking and testing, outbreak investigations, contact tracing, data analysis, targeted, efficient and effective public communications, highlighting the scale of the challenge facing governments and their agencies.

PHAA has proposed a coordinated way forward to address these problems for the medium term, while offering some short-term options for consideration.

A major Strategic Review of the Public Health Workforce in Australia

Many issues underlie the current gaps and problems relating to the public health workforce in Australia. Similar to other health and medical workforces, it is not a conventional workforce driven solely by supply

and demand forces, but is significantly affected by controls on entry levels and numbers for training programs.

Any thorough review would need to establish the clearest possible understanding of the current public health workforce. Who are these people, how many are there, what do they do, what is their skill set and what's missing?

It also must engage with all the stakeholders to establish current and anticipated needs, and assess existing investment in staff, programs and training initiatives.

It is vital to examine the current training infrastructure including the capacity, throughput and standards of tertiary education and other providers, and competencies, accreditation, registration at the level of individuals, training providers and employing institutions.

Models from similar professional groups within Australia and public health workforce accreditation structures overseas should guide recommendations. Perhaps most importantly it should make clear recommendations relevant to all stakeholders aimed at improving the quantum and standard of the public health workforce in Australia for the medium and long term.

Alongside the proposed review, there should also be an appetite for immediate action. Below are some options which are in no particular order of priority and are complementary rather than competing options. There will no doubt be many more options to consider.

Invest in or expand Public Health Officer Training or similar programs

A successful long-standing Public Health Officer Training Program in NSW has operated for 30 years and trained around 180 public health professionals.[18] This three-year 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.

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

While not perfect, many believe this program resulted in NSW being better prepared for COVID-19.

Some other jurisdictions have had various forms of such a program, but on a smaller, less consistent basis. A national scheme through which states and territories acted together would allow economies of scale.

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.

Revisit the Specialist Training Program to boost the number of Public Health Physician training positions

The current Specialist Training Program has supported over 1,000 medical specialist training program (STP) places around Australia.[19] Fewer than 30 go to public health physician training through the Australasian Faculty of Public Health Medicine.

Now seems a logical time to substantially increase the number of STP positions for public health medicine around Australia, without having to increase the total number of positions funded.

Increase support for specialised field epidemiology training and capacity

The specialist Field Epidemiology Training Program in place at the Australian National University (in the form of the Masters of Applied Epidemiology) is established and successful. Graduates of this program have achieved leading positions in health nationally and internationally. Notably, of the 231 graduates, 15% are Aboriginal and Torres Strait Islander Australians.

The two-year Program could rapidly increase its capacity and student places and has direct relevance to communicable disease outbreak response. It places students in a relevant health organisation (for example, health department, and some NGOs) with intensive academic blocks to build expertise in the essential skills required to lead field epidemiology initiatives.

Increase training via placement in international programs

The expertise of Australia's public health workforce would be increased by improving access to placements and real-world experience in communicable disease management via existing initiatives.

By supporting the cost of backfilling positions for the public sector public health workforce, the Australian Government could quickly increase the experience and expertise of Australians with skills to contribute to public health challenges outside Australia.

Various initiatives offer such experience, including the Centre for Indo-Pacific health security training expansion[20], the Global Outbreak Alert and Response Network[21] and National Critical Care and Trauma Response Centre.[22] But these offerings mostly do not meet the costs for staff to attend. For those unable to forgo income – especially in current circumstances – this is a significant barrier.

Reestablishment of the PHERP-like funding program

The Public Health Education and Research Program (PHERP), which operated from 1987 to 2010, included designated federal government funding for capacity-building in the public health workforce through higher education.

Reinstatement of this type of funding would focus on the education and training of the public health workforce by funding high quality postgraduate education, improving research infrastructure, and improving Australia's biosecurity and pandemic preparedness.

A Public Health Employment Agency

COVID-19 highlighted the need for a surge workforce. The existing public health workforce could not be effectively mobilised on the scale required at a single location.

Establishing an entity to efficiently lead the identification, recording and, where necessary, recruitment and mobilising of the existing workforce is relevant to the National Cabinet's 26 June announcement agreeing to a new plan for Australia's Public Health Capacity and COVID-19.[23] Under the plan developed by the AHPPC, six actions for state, territory and Commonwealth governments will improve long term sustainability of the public health workforce for the remainder of COVID-19 and beyond by:

- strengthening a formal surge plan for the public health response workforce and review the ongoing structure of the public health units
- progressing the national interoperable notifiable disease surveillance system (NINDSS) project and prioritise appropriate interfaces
- establishing a national training program for surge workforce
- better support the Communicable Disease Network of Australia (CDNA), including shared costs
- prioritising enhancing the public health physician workforce capacity, and
- considering options for developing a formal public health workforce training program.

Notwithstanding the current situation in Victoria, Australia has been relatively successful in managing the first wave of COVID-19.

The experience has nonetheless shown a significant problem with the national public health workforce, raising serious concerns about our capacity to deal with the present pandemic, future communicable disease outbreaks and other public health issues including NCDs.

Our experience with COVID-19 and other public health crises such as bushfires has highlighted the importance of a solid public health response.

As with investment in national defence, investment in public health capacity is vitally important as a precaution. Recent events suggest the likelihood of calling further on public health capacity is high, and may be needed sooner than we would plan or hope for.

Recommendations

The PHAA-AEA-CAPHIA paper's recommendations, which follow, remain valid:

Rec 12. A thorough review of public health workforce be commissioned with a view to establishing a long-term strategy to strengthen Australia's public health capacity for future generations.

Rec 13. National, state and territory governments should establish (or expanding existing) Public Health Officer training programs or similar programs aimed at increasing the pool of trained public health workers.

Rec 14. Increase the number of specialist training program places for Public Health Physician training to 70, and establish a minimum of 50 per year on an ongoing basis.

Rec 15. Support an expansion of the Masters of Applied Epidemiology (MAE) program at ANU.

Rec 16. Establish a program to ensure easier participation in established international programs which respond to communicable disease outbreaks by meeting the cost of relevant public health professionals to participate.

Rec 17. Reinstate the Public Health Education and Research Program (PHERP).

Rec 18. Fund and establish a Public Health Employment Agency.

Institutional public health systems

Building a new national disease control institution

As our existing state and national institutional arrangements for public health protection, and specifically disease control, have come under their greatest strain ever, attention has turned to proposals for institutional re-design.

Despite the extreme pressure of events, Chief Health Officers and their agencies have performed the roles expected of them, and the public health legislation (including the state and territory legislation as well as the federal Biosecurity legislation) has been used by governments to make powerful and largely effective legal declarations to govern public, economic and law enforcement activity during the pandemic.

Indeed, PHAA places on record its appreciation that the political leaders of our nation have acted together to ensure that the right advice from expert authorities has been placed at the heart of government decision making during the crisis, and that the authoritative voices of the experts in position have been supported

publicly. This broadly uniform messaging from leading health officials and political leaders has no doubt played a major role in comforting an anxious and uncertain public.

However, some attention should be given to options for institutional reform. Australia is unusual in that its central national public health institutions are relatively underdeveloped. Our model is highly 'federal' and the bulk of public health institutional activity occurs within the state and territory governments.

The establishment of an Australian version of a centre for disease control (CDC) or its equivalent has been sought by public health experts for many years, but long resisted by Australian Governments. This would be one way for a more coordinated approach to communicable disease control and environmental health issues, and pulling together the emerging evidence as pandemics unfold.

In 2018, the Australian Government released its response to the 2013 House of Representatives Standing Committee on Health and Ageing report: *Diseases have no Borders: Report on the Inquiry into Health Issues across International Borders*.[24] Following the COVID-19 crisis, the Government may wish to review some of the responses to recommendations in that report. Recommendations in this report regarding workforce development (recommendation 13), and an audit of agency roles and responsibilities (recommendation 14) were noted rather than supported. Significantly, a recommendation for an independent review to assess the case for establishing a CDC in Australia was not agreed, citing the development of the National Communicable Disease Framework to improve coordination and integrated response "without changing the responsibilities of government".

The COVID-19 crisis has also renewed calls for this type of designated public agency to provide scientific advice. Australia is the only country in the Organisation for Economic Co- operation and Development (OECD) without such an agency.[25] The apparent success of Australia in minimising the number of cases and deaths from COVID-19 may be interpreted by some as evidence that we have no need for a CDC. However, there are many factors which worked in our favour in controlling COVID-19, including our geography and the dominance of travel-related cases as opposed to community transmissions in the first phase. While the Australian Health Protection Principal Committee (AHPPC) mechanism was pre-existing and able to be utilised quickly, our response would have benefitted from having a centralised agency to support and advise the AHPPC.

An independent agency to provide advice and education to the public about COVID-19 (in this instance), and to coordinate relevant health advice to the public would assist with protecting against inconsistent information and misinformation.

The Office of Health Protection was established in 2005 within the federal Department of Health as an alternative but less well-resourced approach, and it too has had to endure significant resourcing constraints and loss of specific expertise in public health.[26] This can in turn impact upon the quality and adequacy of support to other key national advisory groups and networks such as CDNA or enHealth (the cross-jurisdictional Environmental Health Committee that also reports to AHPPC). Nevertheless, calls for an Australian CDC continue.[27] [28]

PHAA believes that we need to be equipped with the best institutional arrangements to face the ongoing and future public health challenges. Therefore, the Government should examine this question, and the Budget should include provision for a review of arrangements and for the essential and inevitable increased resourcing of national institutional arrangements, as well as support for any changes at state level.

Rec 19. Establish an Australian independent public agency to provide scientific advice and education, and coordination assistance on communicable disease control, including all diseases of public health importance.

In regard to intergovernmental coordination, PHAA acknowledges that in recent months the quality of coordination between governments and agencies has been broadly effective, indicating that current institutional connections are strong. The Australian Health Protection Principal Committee has proved to be an effective mechanism for expert official coordination of information and advice to governments from the start. PHAA recognised this entity's vital work with our President's Award in May 2020.[29] At the level of governments, the National Cabinet, supported by effective interpersonal relations between individual political leaders, has been exemplary at providing strong coordination from very early in the pandemic.

Put simply, the keyinstitutional design issue is the need for more strength in the roles best allocated to the Commonwealth government. This, combined with greater public health resourcing at all levels of government, is the actual issue to address in the current budget.

Rec 20. Undertake a review of the Commonwealth institutional arrangements with a view to strengthening their capacity to carry out their appropriate roles.

Rec 21. Ensure that States and Territories are actively engaged in considering national arrangements and entities relating to public health, and have active involvement in the structure and potentially the resourcing of new agencies or arrangements.

Rec 22. Give high priority in this Budget to resourcing not only for Commonwealth public health agencies, but also for state Governments, to support the extraordinary requirements for an effective national pandemic response.

International cooperation for public health

The international dimension should also be recognised by the Commonwealth government. Australia is quite incapable of addressing the COVID-19 pandemic, or any similar future pandemic, alone. International institutions and cooperation are essential.

Earlier this year we witnessed a short period of significant international criticism of the WHO. While no organisation is perfect, and while the series of events between December 2019 and March 2020 hold vital lessons for our future wellbeing, much criticism of the WHO was simply a by-product of international tensions or of blame shifting in some nations (not notably including Australia).

There is no reason to exclude the WHO from ordinary processes of criticism and regular organisational review. Indeed, following the greatest pandemic in a century, criticism, review and lesson-learning should absolutely occur. However, the WHO is a vital world organisation performing essential functions in the interest of the Australian people and of all people worldwide.

For these reasons the PHAA urges the Australian Government to maintain the most positive for constructive interactions with WHO, and to ensure that both its core funding, as well as resourcing for additional functions in the current emergency, are provided. The protection of the world population from the pandemic is entirely connected to the wellbeing of Australians.

Rec 23. Signal, through resourcing decisions for 2020-21 and beyond, strong support for the WHO's core functions, and for specific international exercises which the WHO undertakes in response to COVID, including aid to under-resourced nations and peoples.

Non-COVID investment in a healthier society

In our Budget Directions submission in January 2020, we urged the Government to consider the logic of illness prevention as a fundamental strategic driver of health policy, for both social and economic reasons.

We also raised for consideration a range of potential investments in short-term, positive impact public health measures. This included proposals relating to preventing obesity, reducing alcohol harm, reducing harms caused by tobacco products, and the health impacts of bushfires.

We also advocated for a substantially more organised, long-term structural process for selecting and funding public health initiatives, through a system analogous to the MBS and PBS schemes which have served Australia so well.

All the investment proposals in that earlier Submission remain valid. For brevity, we will not repeat them in this document. But we urge the government to find room for such initiatives in the coming Budget. They are investments in future health and in the reduction in future Commonwealth expenditure on health services. In terms of illness reduction, the proposals we made are Budget-positive in the short, medium and long term.

Instead, the impact of COVID-19 in fact strengthens the case for stronger policy measures on the underlying health of the Australian population.

COVID-19 has dramatically stretched, distracted and burdened our health systems, service providers and workforces. From distracting public health workforces from standing public health preventive tasks such as cancer screening and campaigns, to primary care workers unable to perform their normal functions, to GPs unable to provide normal attention to their patients, to cancelled secondary and hospital treatments , to the unavoidable fact that health workers everywhere are more exposed to COVID-19 infection itself than the general public, the impacts have been enormous.

We need to fight back against this wider impact of COVID-19 on our overall health. The case for preventive health, and for striving to reduce health harms in our society, is stronger than it already was. If we do not take steps to prevent the rise of future illness, the burden of such illness will fall on the very health system and workforce which we see under great strain now.

Governments directly impact the extent of illness and wellbeing in our community, through the investments which they make, or fail to make, through government decisions, including annual Budgets.

The Government, under the stewardship of Health Minister Greg Hunt, has been working towards a National Preventive Health Strategy, which was due for release between April and July this year. COVID has delayed its finalisation, as it has so many other government activities. However, it was approaching completion when COVID struck, and its directions should be incorporated into the coming Budget.

PHAA urges the Government to send a clear message through the coming Budget that it has a vision for a healthier society, and in particular that it realises the powerful national need to take steps to take burdens of illness of the Australian people and the overstretched Australian health system into the future.

Rec 24. The Budget should include anticipation that the National Preventive Health Strategy will be finalised in the near term, and that it will present both strong policy directions as well as adequately resourced programs of investment in better health.

Capital investment for a healthier society

The Budget is, of course, always the vehicle for changes in the Commonwealth's capital program, including grants to the state and territory government capital programs.

Where the government chooses to direct capital investment can make a powerful impact on the public's health. A near-term program of improvements to the orientation of capital works spending towards energy, transport and amenity works that are health-oriented would be flexible, easy to deliver, create jobs at local levels, and constitute an investment in future health and wellbeing.

Our nation's strategic needs have been changed by COVID. Programs for transport infrastructure within cities will need to be reviewed to recognise the massive changes to work mobility that have come. Meanwhile, capital investment in energy, water, environmental preservation and other priorities will need to continue.

Recognising the strategic need of government to keep the construction sector as active as possible in the near term, and noting the difficulties of workforces assembling on large worksites and/or moving around the country with the former degree of flexibility, PHAA urges the government to consider economically stimulatory capital investment programs around the following categories of works:

- At the local government level, programs of investment that improve health-focused community amenities, including recreational areas, active transport facilities, and local environmental remediation and other improvements.
- Programs to encourage investment in renewable energy, and energy-saving, investments at the household level.
- Energy generation systems for renewable energy, which should be a national priority, including support for larger-scale capacity systems through existing renewable energy support funding mechanisms.

Rec 25. Capital spending in the Budget, in particular spending which is deliberately designed to stimulate construction sector activity as a short-term economic stimulus program, should be directed towards investments that are environmentally sustainable and health-focused.

Conclusion: building back to a healthier future

Summary of strategic directions

We opened this submission by recommending four overarching strategic principles for the coming Budget:

1. Put people first, and protect their wellbeing equitably; this is not the time to allow inequality in Australia to increase
2. Take major measures to increase Australia's public health prevention and response strength; we have been caught short in our resourcing for public health protection, and this must urgently be corrected
3. Lay the foundation for Australia to 'build back better', creating an Australian society and economy that is healthier for all our future personal and economic strength; Budget measures to address COVID-19 emergencies are necessary, but they are not the only program that this Budget must address.
4. Remove barriers between state and federal budgetary responsibilities; recognising that the Commonwealth government has the dominant share of capability to raise revenue and deploy other assets and finance-raising potential, the Commonwealth must provide financial support for state, territory and local governments, if required.

Inspiring us with a vision for a healthy society

Australia's government, civil society, academic, business and community leaders have cooperated mightily to address the urgency of COVID-19, for Australia and the world. It could have been so much worse, and in some countries it has been. Unity of spirit, and a political landscape largely free of blame and division, have been of great value to our nation.

It now falls to our leaders to take the next steps in maintaining national spirit and direction. It also falls to governments to manage the great challenge of maintaining public trust, both through their continuing public messaging and through their major policy pronouncements. This Budget will be a key moment.

The 2020-21 Commonwealth Budget will be judged by the extent to which it helped protect, preserve and give confidence to Australia's people. It must be a document that inspires people to believe that their Government is managing the very big picture, and is putting people first.

The PHAA appreciates the opportunity to make this submission. Please do not hesitate to contact us should you require additional information or have any queries in relation to this submission.

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24 August 2020

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