Inquiry into the Victorian Government's COVID-19 Contact Tracing System and Testing Regime

Mr Terry Slevin

Organisation Name: Public Health Association of Australia
Your position or role: CEO

YOUR SUBMISSION

Submission:
Please see attached submission PDF

FILE ATTACHMENTS

File1: 5fb70b8f6307c-PHAA submission on Vic contact tracing and testing regime.pdf
File2:
File3:

Confidentiality:

Signature:
Terry Slevin

Public Health Association
AUSTRALIA

Committee Secretariat
Legal and Social Issues Committee
Victorian Parliament

20 November 2020

Dear Committee Secretary,

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, and seeks to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

PHAA welcomes the opportunity to provide input to the Inquiry into the Victorian Government's contact tracing and testing regime. Given the very short timeline for preparing a response to this Inquiry, PHAA would like to refer the Committee to the findings of the recent National Contact Tracing Review report for Australia's National Cabinet. Findings in this report which specifically relate to Victoria include[1]:

- Victoria's recent move to a decentralised approach for regional cases has advantages in embedding teams in a local community, allowing some independence while retaining resources from the central health department and public health units, and twinning of public health units to meet surge demands. This approach still requires centralised technology for case allocation, interviews and outbreak management, balancing local knowledge with contact tracing expertise to achieve rapid and high quality outcomes.
- A State of Disaster was required to enable the Chief Health Officer to issue necessary orders. Clear lines of accountability for the public health response and the broader pandemic health system response are critical, and best achieved with the Chief Health Officer leading the public health response, and the Secretary of the Department of Health and Human Services leading the pandemic health system response, with collaboration and joint reporting to the Health Minister to ensure a well-coordinated health system approach.
- Surge workforce in Victoria was enlisted through contracted providers, allowing existing health department experts to focus on complex aspects of contact tracing. However, this model presents a challenge to give contracted providers access to jurisdictional database systems to enter contact tracing data.
- Conducting drills and simulation exercises is the most effective way to test and evaluate emergency preparedness plans.
- Other jurisdictions noted that providing support to Victoria during the outbreak was a good opportunity for their contact tracing staff to practice and refine their skills.

[1] Finkel, A., et al. (2020). National Contact Tracing Review: A report for Australia's National Cabinet. https://www.health.gov.au/sites/default/files/documents/2020/11/national-contact-tracing-review-national-contact-tracing-review.pdf , Commonwealth of Australia.

- Software to provide advanced analytics and assist with linking cases is under development in Victoria.
- Victoria aims to perform genome sequencing for almost every identified case. This can enable enhanced disease control and accurate national and international pathogen characterisation and comparisons. Using genomics to enhance surveillance and investigate clusters and transmission of the virus across Australia results in better informed public health decision making.
- Victorian Test Tracker – uses a QR code to digitise information and data collected at the point of COVID-19 specimen collection and improve accuracy. This system has saved time in notification of confirmed cases and contact tracing. The inclusion of information on language spoken at home, country of birth and occupation has improved interviews and contact tracing through for example, ensuring the presence of an interpreter prior to interviews commencing. Analysis of these data has also enabled the identification of targeted 'calls to testing' through directed community engagement, working with community leaders and local health care services, as well as engaging with industry to bolster testing levels in underrepresented cohorts. Victoria aims to have 85% of COVID-19 tests using the Tracker system by the end of the year.

Moving from paper-based systems to standardised tools and using digital epidemiology is clearly an imperative. In regard to reforms and developments in Victoria, such as contact tracing software, any such software should seek to be done cooperatively across jurisdictions to ensure national consistency. It is important to avoid the "railway gauge" problem. We note the recommendation in the National Review for the development of a "Data Exchange" and encourage all jurisdictions to participate in this process.

Relatively early in the pandemic, the United Nations produced a report with principles for building a culture of solidarity, trust and kindness, with a response grounded in the realities of people's lives, and focused on eliminating the barriers people face in being able to protect themselves and their communities. The 'seven takeaways' in this report may provide a good reference point in assessing Victoria's contact tracing and testing responses[2].

PHAA acknowledges the availability of translated information about coronavirus and note the importance of community engagement, including through local community leaders, to improve awareness and understanding of recommendations for testing and quarantine in people who speak a language other than English.

The introduction of the COVID-19 test worker support payment is an important feature to encourage participation in testing, particularly among those with insecure work. Efficient notification of test results is another important system factor to enhance community participation (including during 'COVID19 normal).

PHAA would also like to note the exceptional circumstances under which Victorian health staff have recently been working. Contact tracing can be a time-consuming process – up to 5 hours per case. From a starting public health staff of only a few dozen officers, we understand that around 1,000 Victorian Public Service officers were seconded at short notice to various tasks in DHHS as part of the state government's COVID response. At present this surge capacity is beginning to wind down. Many of these officers have worked in demanding conditions characterised by urgency, stress, high

[2] UNAIDS. Rights in the time of COVID-19: Lessons from HIV for an effective, community-led response. https://www.unaids.org/en/resources/documents/2020/human-rights-and-covid-19: UNAIDS; 2020.

levels of responsibility and uncertainty about their own deployment future. It may be helpful to keep a register as formal surge capacity with names, contact details, roles and experience, for future planning an to maximise the use of appropriate skills.

PHAA working with the Australian Epidemiological Association, was pleased to be able assist DHHS in this challenging time by rapidly establishing a voluntary mentoring program for DHHS officers (including surge officers). We identified about 200 public health experts from across Australia who volunteered their time and were matched in mentoring relationship with almost 200 DHHS officers, providing advice, support and counsel to these staff operating under difficult conditions. We urge the Committee to make public acknowledgement of the great efforts of all the VPS staff involved in this extraordinary effort.

The experience with COVID this year, and particularly in Victoria, has highlighted the importance of a public health workforce. PHAA has drafted a proposal for a Public Health Officer Training Program for Victoria for consideration by the Victorian Government. The proposed program is broadly based on a similar program operating in NSW, to recruit, train, place and assess both medically and non-medically trained staff to undertake a 3 year training program. Entrants would likely be already trained at post graduate level, and undergo further academic and on the job training in the broad aspects of public health work in Victoria. This is designed to create a "pipeline" of senior and highly trained public health professionals who will eventually become an important source of expert senior officers in public health leadership positions in Victoria into the future. For example, devolved public health units need to be headed by people with public health training and experience. Details of the proposal are found in Attachment A to this submission.

Such a program would clearly require resources, and this year has also demonstrated the urgent need to increase investment in prevention. As well as infectious diseases and viruses like COVID-19, we must address the tsunami of chronic disease emerging from an aging population and unhealthy lifestyles, where the most disadvantaged experience the worst health outcomes. Currently, less than 2% of the health budget is invested in population and preventive health. PHAA recommends that one in every twenty dollars (5%) spent in health is invested in prevention, with an accompanying embedded infrastructure similar to the Medical Benefits Scheme and the Pharmaceutical Benefits Scheme, to assess the efficacy and cost effectiveness of these investments.

We have had a range of successes, with progress on tobacco, immunisation, SunSmart screening and our relative success with this pandemic. With a greater commitment we can achieve more with the goal of making Australians the healthiest people on earth, and our health system the most prepared for the challenges that lie ahead.

Please do not hesitate to contact us should you require additional information or have any queries in relation to this submission.

Yours Sincerely,

[redacted]

Terry Slevin
Chief Executive Officer
Public Health Association of Australia

[redacted]

Dr Anna Nicholson
PHAA Branch President
Victoria

Attachment A:

Public Health Officer Training Program for Victoria

An outline of options

Introduction

COVID-19 has highlighted the poor state of public health infrastructure in the DHHS in Victoria. This proposal is a broad outline of a Public Health Officer Training Program (PHOTP) that might be given consideration by the Victorian Government.

What follows is broadly based on the NSW PHOTP and should be appropriately adapted to the Victorian circumstances. Similarly, there may be some machinery in place in Victoria on which a program of this kind can be built. But a building of the public health workforce is a clear and vital priority that must be urgently addressed in Victoria.

What is needed?

A program must be established to recruit train, and place and assess both medically and non-medically trained staff to undertake a 3 year training program (which might be run over four years – allowing a year for an unpaid sabbatical) to create a "pipeline" of senior and highly trained public health professionals who will eventually become an important source of expert senior officers in public health leadership positions in Victoria into the future.

Entrants to the program are likely to be already trained at post graduate level, from both medical and non-medical backgrounds who undergo further academic and on the job training in the broad aspects of public health work within Victoria. The program would take on a competency based approach, working in real policy and service delivery settings. This might include but not be restricted to working on:

- PH Data design, capture and reporting functions,
- Infection disease outbreak management
- sexually transmitted disease tracing and management
- chronic disease prevention and control
- immunisation
- screening
- health promotion
- PH regulatory functions,
- Environment health
- Disaster management
- cross government liaison on social issues of relevance to public health including housing, transport, working with high needs populations

…and much more.

Placement in various agencies undertaking specific outcome related projects is combined with an ongoing professional development program is at the core of this initiative.

How might it operate?

Core Administrative Infrastructure

To run a program of this kind there is a need for a core unit of ongoing staff who have the responsibility to establish and administer the program. That might include a program manager, 2 senior project staff and some admin support function. A core staff of cost of approx. $500 – 600Kpa might be allocated.

Their role is to design, document, and oversee the program, recruit participants. Establish and manage all HR related to the program. Arrange and quality control the placements across the system, trouble shoot, manage financial aspects of the program and support the officers within the program.

Funding trainee positions

The program should aim to recruit a minimum of ten high quality trainees per year who have a minimum entry requirement which might include an undergraduate program, a Masters in Public Health and a minimum of 3 – 5 years in the health sector.

For the purposes of projecting some costs, some estimated unit costs for salary, oncosts and necessary infrastructure are stated below. These might be more precisely calculated by DHHS staff using current costings, salary scales and related costs and allowances.

- Medical Trainee - $200Ka
- Non-Medical Trainee - $150Kpa

On the assumption that the annual cohort would be split as three medical trained and seven non medically trained recruits (this may vary from year to year based on the necessary merit-based assessment process) an annual cost per cohort might be $1,650,000.

The second-year cohort would add $1,650,000 pa to the cost until in full operation level of three active funded positions plus 10 on unpaid secondment and a total of 40 trainees in the program on an ongoing basis, reaching a trainee staff and related costs of $4,950,000.

Total program costs

This estimate should be CPI indexed and the core administrative cost bring the peak annual cost in **2020 dollars to $5.5mpa**.

Additional considerations

Establishing senior Public Health roles

For the program to be sustainable there a need to maximise the prospect of relevant employment beyond the period of the training program. There is little point stablishing such a training initiative unless the health system in Victoria finds relevant mid to senior PH roles for graduates of the program. This has been achieve in NSW, where such a program has operated for 30 years and 50% of all Trainees form the program remain to this day employed by NSW Health, many in very senior PH roles.

Regional structures

The establishment or Regional Public Health units is I understand under consideration in Victoria. This system has served NSW well during the current and in previous outbreaks, and in terms of serving a variety of important ongoing public health functions within NSW.

Should such structures be developed, the PHOTP could engage via offering placement during training and providing strong candidates for senior roles in Regional Public Health units post training program.

Conclusion

There are a wide range of initiatives and efforts required to rebuild and improve the public health infrastructure in Victoria so as to make the system more robust and effective in protecting the health of Victorian in the future. This proposal may be one piece of that puzzle. It is offer as a constructive step towards building a stronger, sustainable and long term public health capacity for Victoria to ensure preparedness for the future anticipated and unanticipated public health assaults that will no doubt have to be faced.