We've all had to learn fast

PHAA CEO Terry Slevin

We’ve just rounded out perhaps the most tumultuous time in Australia or even the world – of the last century.

COVID-19 was just looming ominously at the time our last InTouch was published (Feb), but who could have predicted the way it would unfold?

And public health has been front and centre.

We all know the world has changed and it is important to acknowledge – as many around me have – that Australia, very much driven by public health leadership, has dealt with the crisis better than most nations.

For that reason PHAA recently bestowed its Presidents Award on the membership of the Australian Health Protection Principal Committee (AHPPC).

Of course, the pandemic story is far from over, and there are lessons to learn and improvements to be made, but we should reflect at least for a moment on the extraordinary public health success story to be told about the Australian response to COVID-19.

The pandemic has prompted lots of changes, and PHAA itself has been very much riding the waves of change. We have now run one national and one international conference (which is still going) virtually. We have established a webinar series, and the change will mean all our conferences in future are likely to have a virtual component.

Another innovation is a Virtual Edition of ANZJPH (two in fact). The idea is that conference delegates get a special Journal issue capturing papers relevant to the main themes of the conference. A kind of “what we know so far” look over the shoulder at what has been in our own Journal.

We have all had to learn fast.

I’ve been amazed with the capacity of our people – staff, members and others – to embrace new ways of doing things. And do them extraordinarily well. The Prevention Conference attracted more than 360 delegates and the feedback has been extremely positive so far, with lots of highlights. The Gordon Oration by Associate Professor Lisa Wood highlighted the issue of homelessness as a major public health challenge. More on that inside this edition of InTouch.

And we have established a new blog – InTouch Public Health – which will replace the PDF version of InTouch. InTouch has been an Institution of PHAA. I recall the excitement of the chance to write about my work on alcohol policy in Western Australia in a 1991 edition of InTouch, back in the dark ages when hard copy was printed and sent snail mail. The emailed PDF was the next innovation. Faster, cheaper and more environmentally friendly.

Less than three months old, our blog is already attracting thousands of views. Each week we publish several pertinent and timely stories relating to public health. Only members can contribute, although anyone can comment.

If you have not checked InTouch online out – click here, and as Molly Meldrum might say “Do yourself a favour”. Subscribe to the email list to make sure you don’t miss a story.

We are committed to celebrating Reconciliation Action Week each year. This year we have launched a report outlining the work PHAA does to advance Aboriginal and Torres Strait Islander health. On Mabo Day – 3 June – we held a webinar featuring Professors Tom Calma and Fiona Stanley. We also opened nominations for our important Aboriginal and Torres Strait Islander Health award.

Thank you for reading our final PDF version of InTouch. Stay safe.
Reconciliation Begins with Recognition

By PHAA President David Templeman

"It begins, I think, with that act of recognition", said Paul Keating in his famous 1992 Redfern Speech. Like millions of Australian people and organisations, our members and staff commit an important act of recognition almost every day at the commencement of conferences, speeches and meetings, when we acknowledge the country on which we meet and the elders of the Peoples who were, and remain, its traditional custodians.

Acknowledgement of country and elders are not a small matter, nor just a formality. It has become one of the most constant and immediate ways in which all Australians normalise recognition of First Australians’ past, present and future on this continent.

In these small, regular acts, we are also recognising the facts of past harm to the First Peoples, as Keating said.

Justice is an international concern. Coinciding with Reconciliation Week in Australia we have seen the disastrous impact of decades of injustice and divisive political policies, and harmful community attitudes, in the United States. But the problem of racial unfairness is a global one. Australia certainly has its own unreconciled history of injustice still to face.

Recognition of the unfair conditions of many First Australians, and the history which has brought it about, is a very important value held by PHAA and its members.

As public health experts, we see clearly the integral connection between reconciliation and wellbeing. We are active in promoting measures to improve the underlying conditions in which First Australians live - in terms of justice, housing, income, education and many other domains - because these are direct determinants of health and wellbeing.

In 2019 PHAA adopted a Reconciliation Action Plan, by working with Reconciliation Australia, our members and other organisational allies to clarify what we stood for. We worked actively in promoting measures to improve the underlying conditions in which First Australians live - in terms of justice, housing, income, education and many other domains.

It’s clear that our annual conferences - a major part of our public health activity - are featuring more frequent presentations not only about Aboriginal and Torres Strait Islander health matters, but by Aboriginal and Torres Strait Islander presenters. It’s hugely significant that public health is a field which many young First Australians are choosing to enter.

And it’s striking and impressive how much professional, peer-reviewed writing about Aboriginal and Torres Strait Islander health matters is finding its way into our well-respected and highly cited Australia and New Zealand Journal of Public Health.

In Reconciliation Week 2020 we hosted a webinar on Reconciliation and Public Health, featuring Professors Tom Calma AO and Fiona Stanley AC, two distinguished Australians who shared their thoughts on how reconciliation can improve health and wellbeing, and how the health of First Australians - slowly improving, but still with so many challenges - can contribute to national reconciliation.

In 2017 The Uluru Statement From The Heart gave us a rich and deep call to action on reconciliation. I urge you to read it often, and ponder its poetry and power.

I’m immensely proud that PHAA has made First Australians’ health, and national reconciliation, central threads of our work and our advocacy. At the national elections in mid-2019 we listed the health of Aboriginal and Torres Strait Islander Australians - especially young people - as one of our five core themes demanding government policy action. We won’t let up in this drive.

In 2019 PHAA President David Templeman

Honouring Reconciliation Week is a major part of that plan, so we released our Reconciliation at PHAA report to highlight what we have been doing, and to acknowledge and encourage everyone who has been active.

I’d like to highlight two successes in particular.

● On nearly every measure of health inequality, people experiencing homelessness are vastly over-represented. This is grimly seen in an average life expectancy of less than 48 years. Among people experiencing homelessness, and particularly those sleeping rough, we see the most extreme examples of poor health driven by adverse social, economic and often traumatic circumstances. That many of our public health and prevention success stories in Australia have left behind this often invisible group is confronting. The majority still smoke, mental health and AOD issues are pervasive, and accessibility to preventive screening and oral healthcare is sparse.

● Even COVID-19 has starkly shown the heightened vulnerability of people who are homeless, not only due to the high prevalence of the chronic disease conditions associated with COVID severity and death, but also because this is a vulnerable group unable to follow the precautions the rest of us can take to ‘stay home’ and social distance.

Dr Lisa Wood

Lisa Wood is Associate Professor, Faculty of Health and Medical Sciences, School of Population and Global Health, The University of Western Australia. This is an excerpt of her Douglas Gordon Oration at the Preventive Health Conference 2020.

On nearly every measure of health inequality, people experiencing homelessness are vastly over-represented. This is grimly seen in an average life expectancy of less than 48 years. Among people experiencing homelessness, and particularly those sleeping rough, we see the most extreme examples of poor health driven by adverse social, economic and often traumatic circumstances. That many of our public health and prevention success stories in Australia have left behind this often invisible group is confronting. The majority still smoke, mental health and AOD issues are pervasive, and accessibility to preventive screening and oral healthcare is sparse.

Even COVID-19 has starkly shown the heightened vulnerability of people who are homeless, not only due to the high prevalence of the chronic disease conditions associated with COVID severity and death, but also because this is a vulnerable group unable to follow the precautions the rest of us can take to ’stay home’ and social distance.

Douglas Gordon, in his seminal 1975 text Health, Sickness and Society, stressed that if we believe that social change prevents disease and promotes health, then we are compelled to be advocates for change. He went on to say that “some fire in the belly is a necessity”, but importantly noted also, that emotional drives to advocate for the health and welfare of society need to be supported by data and evidence. This is timeless advice, and sums up the way in which over the years I have sought to bring a public health lens to social justice issues.

In this oration, my focus is not on convincing the audience that homelessness is and should be seen as a public health issue per se. This speaks for itself in the enormous burden of preventable disease, and the raft of social, economic and political factors that compound this.

Rather I want to focus on how ending homelessness and its health inequalities in Australia is already benefiting in practice from a public health way of thinking, of building evidence, of framing advocacy, and of working across sectors and silos.

This will be illustrated by some of reflections from the past four years of leading a growing body of work that encapsulates the intersection of homelessness and public health, and how policy-relevant research and evidence driven advocacy can help to reduce health inequalities among people experiencing homelessness.

Homelessness is both a driver and consequence of poor health and exposes deep fault lines in our healthcare system, our housing, justice and welfare systems.

But, one of the things I love about being part of the public health fraternity is that we do not shy away from ‘wicked problems’. Along with the moral and humanitarian urgency to end homelessness, there is a compelling public health imperative, and scope for us all to make an enormous and real difference to the health disparities they face.

,[Note: Preventive Health Conference 2020 participants can hear the full address through the conference webpage.]
Where do you fit? Tokenistic, ally – or accomplice?

This National Reconciliation Week is a good time to decide where you fit – how can you support the future of Aboriginal and Torres Strait Islander people.

Just 3% of the Australian population, are Aboriginal and Torres Strait Islander people. We need the other 97% to do the heavy lifting if we are ever to see true reconciliation.

Summer May Finlay

Summer May Finlay is a Yorta Yorta woman, Lecturer at the University of Wollongong, Research Assistant at the University of Canberra, a contributing editor at Croakey Health Media, and a Vice President of PHAA.

I have a lot of conversations with non-Indigenous people about how they engage in the Aboriginal and Torres Strait Islander space and most see themselves as allies. Yet some are challenged, and even defensive, if it is suggested that their behaviour is not appropriate.

During National Reconciliation Week (NRW) and other significant Aboriginal and Torres Strait Islander events, many non-Indigenous people come together to acknowledge and celebrate our peoples, cultures and histories. Yet many of these people are missing in action at other times of the year.

While many offer genuine acknowledgement of and respect for Aboriginal and Torres Strait Islander cultures, some reveal their attitudes are little more than tokenism.

Non-Indigenous people often fall into one of three groups: those who are tokenistic, those who are allies, and those who are accomplices in engaging with Indigenous and Torres Strait Islander people.

In my experience, those with a tokenistic attitude are unlikely to read to the end of this article. Allies will read and consider seriously what I am about to write. The accomplices? Not only will they read this article, but they will join Aboriginal and Torres Strait Islander people and act with us.

NRW is an ideal time for non-Indigenous people to stop and reflect on how real they are about engaging with Aboriginal and Torres Strait Islander issues.

So, if you are non-Indigenous which category are you? Tokenistic? An ally? Or an accomplice?

Tokenists

Tokenists are those who know, on a superficial level, that they need to be “seen” to be engaged in Aboriginal and Torres Strait Islander issues and celebrate our cultures.

They probably attend a NAIDOC event every year, possibly even one they have organised. But that’s where it stops: at being seen.

Tokenists are also likely to have an Aboriginal painting in a prominent location in their office or house. But when a difficult conversation about Aboriginal or Torres Strait Islander issues occurs, members of this group will disappear as quickly as Wile E Coyote.

They tell themselves that they have other things to worry about and this is ultimately Aboriginal and Torres Strait Islander business.

They do, however, pat themselves on the back for their excellent effort on behalf of Indigenous people; and wait for the praise to roll in. If it doesn’t, they are prone to throw up their hands in frustration and ask themselves, “why bother?”. Tokenists also sometimes talk as if they know it all because they have an Aboriginal friend, or may even be married to someone who is Indigenous.

Does this sound like you? If you do one or more of these things, I’m sorry to say you are a tokenist.

We really need you to become an accomplice. This will require some deep and probably difficult personal reflection. The first step may be to become an ally.

Allies

An ally is more proactive in the Aboriginal and Torres Strait Islander space. Allies promote Aboriginal and Torres Strait Islander voices above their own.

When someone is blatantly racist, they will say something but may struggle to call out microaggressions and may not even be able to identify them.

They appreciate that Aboriginal, and Torres Strait Islander people have been discriminated against and are still marginalised, and allies will therefore promote this issue among their friends and colleagues.

Allies tend to highlight positive stories about the successes of Aboriginal and Torres Strait Islander people and will post videos of Indigenous people participating in ceremonies: they don’t want to upset their friends or make them feel guilty by sharing negative stuff from the past or inequities occurring today.

But allies may also be “late adopters” when it comes to supporting Aboriginal and Torres Strait Islander matters. Perhaps they aren’t sure where Aboriginal and Torres Strait Islander people stand on issues like the Uluru Statement from the Heart. This is because they are not immersed within Aboriginal and Torres Strait Islander people and it also means that allies often don’t recognise their own privileges.

When they hear phrases like “white privilege” or are accused of demonstrating this privilege they can become uncomfortable and even defensive.

Allies mean well and do the right things most of the time. Ally-ship and is an excellent first step towards supporting Aboriginal and Torres Strait Islander people. I have written for, WhyT? on how to be a good ally.

While allies get their hands dirty from time to time, they often aren’t ready to stand with us no matter what. If this is you, consider how you can take the next step and become an accomplice.

Accomplices

Accomplices are people who stand and act with Aboriginal and Torres Strait Islander people.

Accomplices are prepared to allow Indigenous people to define the issue and the required action. Unlike allies, who often step away when things get tough, accomplices stay. They are 100 per cent committed to addressing inequities, regardless of the personal or professional cost.

Accomplices don’t try to defend or minimise bad behaviour by non-Indigenous people, whether it is blatant or unconscious racism. They call it out. And of course accomplices always promote the voices of Aboriginal and Torres Strait Islander people rather than their own.

They celebrate our successes rather than worry about their own lack of recognition. They know their boundaries and understand that some spaces are Aboriginal and Torres Strait Islander domains.

They also know that regardless of how long, or how sustained their involvement in Aboriginal and Torres Strait Islander affairs is, they are always benefitting from dominant culture privilege.

Accomplices never lose sight of their own privilege and are happy to point out to others when their privilege is on show.

Accomplices may not always get it right, but they are always ready to listen and to learn.

We need more Aboriginal and Torres Strait Islander accomplices.

As just three per cent of the Australian population, Aboriginal and Torres Strait Islander people need the other 97 per cent of Australians to do the heavy lifting if we are ever to see true reconciliation.

Accomplices are prepared to allow Indigenous people to define the issue and the required action.

This National Reconciliation Week is a good time to decide where you fit.

And if you are tokenistic, or an ally, ask yourself what are you ready to listen and to learn. If you do one or more of these things, I’m sorry to say you are a tokenist.

We really need you to become an accomplice. This will require some deep and probably difficult personal reflection. The first step may be to become an ally.

Talking terminology

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Australian Public Health Conference 2020

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For more information view this video - Talking terminology.

This article was first published in Croakey.
Evidence from China indicates that irrespective of age, the full picture is still evolving. The data emerging from countries such as China, Korea, Italy from COVID-19. Factors are more likely to experience severe outcomes or death due to COVID-19. It suggests that chronic disease prevention and addressing health inequities must be a critical component in the post-pandemic response.

There is also emerging data about the major risk factors for chronic disease and the likelihood of experiencing more severe outcomes from COVID-19. Early reports from England and the USA suggest that obesity is a risk factor for severity of COVID-19 – even for younger populations. Smoking is also associated with COVID-19 severity. Furthermore, public health emergencies like COVID-19 can exacerbate existing social and economic vulnerabilities and widen inequities in health. This has consequences for chronic disease prevention and management.

As researchers working in chronic disease, systems thinking and public health policy, we propose that reducing inequity and preventing chronic disease should inform our post-pandemic response in Australia.

Another kind of epidemic: inequities in health and chronic disease

Prior to the current pandemic of COVID-19 Australia was already experiencing a different type of epidemic – that of chronic disease. One in two Australians has a chronic disease or condition such as diabetes, asthma, heart disease or cancer. Chronic disease is driven – and made worse – by social and economic inequities; disadvantaged communities and groups experience higher rates of chronic disease and poorer health outcomes.

Emerging evidence from the US, UK and China indicates that populations with a higher prevalence of chronic disease and associated risk factors such as tobacco smoking and obesity are also more likely to experience severe outcomes and death due to COVID-19. It suggests that chronic disease prevention and addressing health inequities must be a critical component in the post-pandemic response.

The coronavirus pandemic is a public health emergency for Australia and the world. This new strain of coronavirus, SARS-CoV-2, causes the disease known as COVID-19. This coronavirus is particularly concerning because it spreads easily, impacts significantly on the health system, and a vaccine is not currently available.

The coronavirus pandemic is also worrying because some populations have a greater risk of experiencing more severe illness from COVID-19. Much has been written about the risks from COVID-19 for older people. There is also is emerging evidence that people with chronic disease and associated risk factors are more likely to experience severe outcomes or death from COVID-19.

COVID-19 and chronic disease

The data emerging from countries such as China, Korea, Italy and the US suggests that chronic disease may be associated with more severe outcomes from COVID-19, though we note the full picture is still evolving.

Evidence from China indicates that irrespective of age, a person with a chronic disease is at increased risk of dying from COVID-19. Similar evidence has come from an Italian study where half the patients who died of COVID-19 had hypertension. Another study from China found though 20% of admissions to hospital with COVID-19 were patients with a chronic disease, this group made up nearly 60% of those progressing to intensive care.

There are also emerging data about the major risk factors for chronic disease and the likelihood of experiencing more severe outcomes from COVID-19. Early reports from England and the USA suggest that obesity is a risk factor for severity of COVID-19 – even for younger populations. Smoking is also associated with COVID-19 severity.

Furthermore, public health emergencies like COVID-19 can exacerbate existing social and economic vulnerabilities and widen inequities in health. This has consequences for chronic disease prevention and management.

As researchers working in chronic disease, systems thinking and public health policy, we propose that reducing inequity and preventing chronic disease should inform our post-pandemic response in Australia.

Australia’s COVID-19 rate is currently low, we remain concerned about the growing evidence that links chronic disease with worse outcomes from this coronavirus. For a significant proportion of the population, COVID-19 is already exacerbating existing health and economic inequities.

Our post-pandemic response must include priority measures to alleviate the acute magnification of existing social and economic inequities, and to address the structural and systemic drivers of our underlying epidemic of inequities in health.

The 2008 Marmot Review sets out key areas for addressing inequities in the UK, and many of these policy priorities are relevant for an Australian context. By applying principles such as ‘proportionate universalism’ we can ensure all in the population will benefit, but with greater benefit for those experiencing greater disadvantage.

Our post-pandemic priorities must include alleviating poverty, social exclusion, low levels of education, poor housing, low levels of workforce participation and lack of access to services. Retaining policy measures that address poverty, such as increasing Newstart (JobSeeker) is a promising action to address both acute and longer-term socio-economic disparities in Australia.

Other important policy measures include ensuring a fair and equitable education system for children and young people, particularly during times of crisis like COVID-19. This is important because lower levels of educational attainment are associated with increased risk for poor health such as cardiovascular disease.

The other key area in the Marmot Review is to strengthen and invest in prevention. Actions to promote health and prevent chronic disease require a systems approach that can have co-benefits for other areas of public policy. These actions include promoting healthier urban design with improved walkability, liveability and social engagement. COVID-19 has reminded us of the importance of investing in liveable neighbourhoods – but this needs sustained investment and planning by local, state and territory governments.

Prioritising healthy, equitable and sustainable food systems is another priority action for prevention. Policy measures include ensuring that fresh food and produce continue to be exempted from the GST. This is particularly important to help address problems such as food insecurity in Australia.

We also need to continue investing in health-promoting laws and regulations, such as tobacco taxes and warning labels. This is particularly important given that Australia’s smoking rates vary amongst different groups depending on level of disadvantage, and tobacco use still causes about 21,000 preventable deaths every year in Australia.

Reducing inequality and preventing chronic disease will not stop pandemics like COVID-19, but by addressing the inequities highlighted by COVID-19 we can build a healthy and fair Australia.

This article was first published on the Intouch online magazine.
The surprising positives about COVID

As the extraordinary health toll mounts around the world it might seem perverse to be talking about the positive impacts of the pandemic crisis that has changed our lives.

Terry Slevin

As the extraordinary health toll mounts around the world it might seem perverse to be talking about the positive impacts of the pandemic crisis that has changed our lives. But the changes are enormous, real, immediate and many have potential benefit worth reflecting upon. Some to the good.

1. Governments working together across the political divide: The national cabinet has clearly been a valuable tool to deal with this crisis. States working together. Jurisdictions working co-operatively with the Commonwealth. Genuine – albeit not perfect – national leadership, with oppositions seeking to be constructive rather than opposing for the sake of it.

2. A more realistic social wage is born: With the doubling of “Jobseeker” to create “Job seeker”, the government has set a more realistic wage. Let’s hope the living wage outlasts the virus.

3. Childcare is valued: The introduction of free childcare in certain circumstances, and the recognition of its importance as a key piece of community infrastructure is another welcome development.

4. Physical Activity: Exercise is one of only a few reasons we are allowed to leave our homes. All ages shapes and sizes are looking at ways to “find 30”. Yoga and aerobics in front of the large screen telly, walking the dog’s paws off, public push ups, tai chi by the river – it is all out and on display. Physical activity researchers will no doubt be looking to capture the impact of COVID19 on the activity levels of the nation.

5. Sleep: Are we all getting a little more sleep? Fewer people are undertaking the long commute to work and those still doing so are presumably doing it in record time. Similarly, going out at night has pretty much stopped. Perhaps a little more sleep is an upside? I hope the data capture is in place to test this theory.

6. Less of the things that do us harm: While no one is happy about the impact on employment of those working in these organisations and in this sector, will closed pubs, clubs, pokie venues, and gun shops result in less social harm? Or will there be more alcohol consumed in the home, causing major problems? We’ll see what the data says, but let’s make sure the data is captured.

7. Reduced travel, congestion, reduced impact on the environment: Decongested roads, airports and airways due to COVID-19 might be recognised as highly beneficial as it will slow down CO2 emissions and the subsequent inhabitability of the planet. Who knows, perhaps we will be more determined to tackle these issues seriously.

8. We are buying less “stuff”: This experience where “lock down” means we have less chance to buy “stuff”, might jolt some into wondering if it is necessary to return to old “buy first ask questions later” habits. A flip side of this however cannot be forgotten. Retailers reliant on sales for their livelihood should not be forgotten. Nor should those in low and middle income countries who rely on the unacceptably low income they earn from the production of some of these items.

9. We are all learning new skills: By necessity we are all learning how to stay in touch via new means. My 85-year-old mum joins in on the family “Zoom pub” gathering on Sunday night (5pm all round the nation – don’t miss it). With a big family scattered across the time zones, Christmas was the only time of year most of us could see each other at one time. Now we can set it up to do anytime (almost). How will these newfound skills influence our post COVID world?

10. More people “get” Public Health: Everyone’s understanding of what Public Health really is seems to have been boosted. Perhaps we will be better placed to argue that public health issues might sensibly be given consideration in the big public policy issues in the medium and maybe even the long term. Will there be calls to establish “Public Health Australia”, or the Australian CDC? How might this work and what will it look like? What resources will be needed?

11. Roy and HG are back on the public Broadcaster: If you are not familiar with their work, it would be too hard to explain.

12. Isolated but connected?: Perhaps the big one – we will all have an acute appreciation of the value of contact with other people in our lives. If nothing else comes from this, it seems to me worth doing all we can to never lose sight of that lesson. More than anything else that has occurred to the whole community, we all now have a slightly better understand what loneliness and isolation does to people. And it is awful.

It seems wise that researchers with an interest in almost any area of public health will be ensuring their data capture processes are well entrenched and solid, so as to best capture and report on the impacts, for better and worse of this pandemic.

There are without doubt vitally important lessons to learn from this crisis. We in public health must be ready to apply our lens to those lessons so as to better understand and influence the post COVID19 world for the better.

This article was first published on the intouch online magazine.

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The PHAA would like to acknowledge and thank all sponsors for their support and contribution to upcoming PHAA events in 2020.

World Health Organization

Preventive Health Conference 2020

13-27 May 2020, Virtual Conference

Governing Health: Systems and Solutions for Better Health
Imagine you have just been told you have COVID-19. We know this is infectious, so the chances are, you may well have given it to others already. You’ve been asked – who have you been in contact with over the past 14 days?

With the current distancing guidelines in place, answering that question may well have given it to others already. You’ve been asked – who have you been in contact with over the past 14 days?

With the current distancing guidelines in place, answering that question is easier than it would usually be. But 14 days is a long time. You starting thinking – I went to the supermarket a few days ago. I was in the check-out queue a long time. Who did you come into contact with while in the queue? Impossible to say, isn’t it?

What if it wasn’t? What if current technology could answer that question? If, at the press of a button, you could produce a list of people you had been in proximity to, who should now be quarantined and tested in case you gave them the virus, wouldn’t you want to press that button?

That is what the COVIDSafe app is all about. Yes, there are important practical and privacy issues which must be addressed. PHAA understands the privacy concerns that the public may have and will always advocate on the public’s behalf for appropriate protections to be included, as part of its support. Government has developed the app to ensure that no unnecessary data are being collected; and introduced legislation to ensure that the data cannot be used by anyone else and for any other purpose.

The app works using Bluetooth to record when the phone comes close to another phone with the app on it. That encrypted data is stored on the handset, and stays there either until it is automatically deleted after 21 days, or until it is uploaded by the phone owner to a central server, where it is decrypted. GPS is not used to track location, and the decrypted list of names, mobile phone numbers, postcodes and age ranges, will only be available to local health authorities, and used to advise those who have been in proximity to someone diagnosed with COVID-19.

This is very similar to the contact tracing that is done currently by state health departments and public health units, but they will in addition have access to these digital contacts their mobile phone number. News reports indicate that it has been tested by the Cyber Security Cooperative Research Centre, who are supportive and comfortable with the security and privacy settings in place. Most importantly, the app is voluntary to use. It’s a long way from the kind of surveillance state China relied upon to control the virus.

But the app will only be effective if enough of us are prepared to use it – the more people use it, the safer we all are. Studies from Oxford University in the UK show that if 60% of the population use the app, it will limit the number of cases in the population to below the threshold where hospitals and ICUs become overwhelmed. This is far higher than the 20% uptake seen in the Singapore version, and relies on other elements of the package of responses including speed of testing.

Public health principles outlined in the Ottawa Charter for Health Promotion in 1986 say that –…

“If it’s possible to engage technology to help us with that task, we’d need a really good reason not to do it.”

“people cannot achieve their fullest health potential unless they are able to take control of those things which determine their health… Health is created by caring for oneself and others, by being able to take decisions and have control over one’s life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members”.

This would not ordinarily involve using an app in this way. But, these are not ordinary times. The contact tracing app is not only a tool for health authorities. It is a tool for us, the people, to take control of things which are currently determining our health, and to enable us to care for others, and beat the virus as a community.

This article was first published on the InTouch online magazine.

Editors note: When this article was published on the 28 April, the COVIDSafe contact tracing app had been downloaded 2 million times. The number of downloads is over 6 million as of early June.

SAVE THE DATE
Preventive Health Conference 2021
10-12 May 2021
Pan Pacific Perth, WA
#Prevention2021
Alcohol minimum unit price reduces harm in the Northern Territory

An evaluation of the initial impacts of an alcohol minimum unit price in the Northern Territory has found that alcohol-fuelled harms have significantly reduced, and it’s helping to create healthier and safer NT communities.

The minimum price of $1.30 per standard drink was introduced in the NT as part of a suite of measures, including a banned drinkers register and police auxiliary liquor inspectors. While the contributions of each measure to the outcomes cannot be completely separated, Professor Peter Miller noted that, “the methods used in this report have allowed for an assessment of changes across a range of outcomes and the staggered implementation of different policy elements in different locations allows for some teasing out of differential impacts.” The researchers concluded that the MUP complemented and significantly added to the impact of the other measures to further reduce harm in many communities.

Two other findings are worth noting as they relate to common areas of industry opposition to MUP:

- Moderate drinking patterns showed no change; and
- Tourism in the NT was not affected — the numbers of visitors and tourism expenditure remained stable.

While longer term evaluations will paint a clearer picture, in the meantime, this report shows that a comprehensive approach to alcohol policy can bring important benefits for the health and safety of the community, and bringing in a reasonable alcohol floor price didn’t cause the sky to fall in. So why is this evaluation important? Should we be surprised when a policy with as substantial an evidence base as MUP does exactly what it’s intended to do? Well, no, but the NT is the first jurisdiction in Australia to put a floor price on alcohol and this is the most comprehensive, real-world evaluation of a MUP in Australia to date. Other jurisdictions will be watching the NT experience closely. The successful outcomes there cannot be completely separated, Professor Peter Miller noted that, “the methods used in this report have allowed for an assessment of changes across a range of outcomes and the staggered implementation of different policy elements in different locations allows for some teasing out of differential impacts.”

An evaluation report was enthusiastically welcomed by a chorus of those working to reduce the impacts of alcohol on the community, including the National Alliance for Action on Alcohol, FARE, Alcohol and Drug Foundation, and Cancer Council WA.

The NT experience closely. The successful outcomes there should encourage other governments to follow and will bolster advocacy by health and community organisations at the jurisdictional level.

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An increase in the rate of alcohol and other drug treatment episodes was found, which may support longer-term downwards trends in harms.

An evaluation of the initial impacts of an alcohol minimum unit price in the Northern Territory found that alcohol-fuelled harms have significantly reduced, and it’s helping to create healthier and safer NT communities.

The evaluation report was enthusiastically welcomed by a chorus of those working to reduce the impacts of alcohol on the community, including the National Alliance for Action on Alcohol, FARE, Alcohol and Drug Foundation, and Cancer Council WA.

The NT experience closely. The successful outcomes there should encourage other governments to follow and will bolster advocacy by health and community organisations at the jurisdictional level.

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Prevention conference goes virtual

With physical conferences impossible to hold during the COVID-19 community restrictions, new ways of bringing people together had to be found.

PHAA’s first ever virtual Preventive Health Conference got off to a cracker start on 13 May with a Welcome to Country and an address by Dr David Russell-Weisz.

Registrations were high, with 358 participants signed up to the virtual conference.

An inspiring plenary on environment and health was led by Nick Watts and Chris Bowen. During the plenary Nick noted that if we don’t act on climate change a child born today will experience a world that is 4°C warmer than the preindustrial age. While Chris Bowen said “we’ve been guided by the evidence on COVID-19 - let’s be guided by the evidence on climate change and its impact on health”.

Dr Muecke told us about the links with sugar and Type 2 diabetes, how sugar was highly addictive, readily available and why governments need to act with policies including a sugar tax. Dr Demaio reminded us of the importance of food waste, saying “If food loss and waste were its own country it would be the third-largest greenhouse gas emitter after China and USA”.

Dr Lisa Studdert delivered the closing plenary on Wednesday 27 May. Afterwards we held virtual networking for small groups, which was well received judging by the response on Twitter.

Participants of the virtual conference are reminded to have a look at our first virtual conference ANZJPH journal edition, which consists of a curated collection of papers based on the 2020 conference themes. Many of the sessions were recorded which was well received judging by the response on Twitter.

Thanks again to our sponsors - @HealthwayWA @mentalhealthwa, @WAHealth, @TAPPCentre, @healthgovau, @CancerCouncilWA @heartfoundation, and @VicHealth.

PHAA Communications Manager

Rebecca Blackburn, PHAA Communications Manager

We invite abstract submissions for long oral, rapid fire and e-poster presentations at the virtual Australian Public Health Conference 2020 to be held from Monday 19 to Friday 30 October 2020.

The theme responds to a series of realities which, in different ways, are ‘crises’ impacting on public wellbeing. The public health sector has much to contribute to developing responses to these crises which are measured, effective and socially equitable, and are based on evidence and scientific thinking. Each of our conference’s three headline themes represents serious public and community challenges. They bring risks of lost wellbeing, illness, and even death. They damage our environment, disrupt our economy and diminish social equity creating a significant impact on physical and mental health. “2020” now feels like a tipping point into a new world. One of the dominant societal reactions is anxiety, felt individually and collectively, and this anxiety itself emerges as a public health issue.

What will be the public health response to these events? How do we influence government and private decisions for the better wellbeing of our community? How do we marshal scientific evidence to build persuasive cases? How do we communicate public health messages quickly and effectively? These and other issues will be the subject of this year’s virtual Australian Public Health Conference, at which a range of national and international experts will share wisdom with Australia’s public health community.

For more information on the call for abstracts, and the virtual conference visit www.austph2020.com

Abstract submission closes on Sunday 28 June 2020, at 11:59pm AEST
6 countries, 6 curves: how nations that moved fast against COVID-19 avoided disaster

To understand the spread of COVID-19, the pandemic is more usefully viewed as a series of distinct local epidemics. The way the virus has spread in different countries, and even in particular states or regions within them, has been quite varied.

Hassan Vally

PHAA member Hassan Vally is Associate Professor, La Trobe University

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A New Zealand study has mapped the coronavirus epidemic curve for 25 countries and modelled how the spread of the virus has changed in response to the various lockdown measures.

The research, which is yet to be peer-reviewed, classifies each country’s public health response using New Zealand’s four-level alert system. Levels 1 and 2 represent relatively relaxed controls, whereas levels 3 and 4 are stricter.

By mapping the change in the effective reproduction number (Reff, an indicator of the actual spread of the virus in the community - see diagram below) against response measures, the research shows countries that implemented level 3 and 4 restrictions sooner had greater success in pushing Reff to below 1.

R0 can be viewed as an intrinsic property of the virus, whereas the Reff takes into account the effect of implemented control measures.

An Reff of less than 1 means each infected person spreads the virus to less than one other person, on average. By keeping Reff below 1, the number of new infections will fall and the virus will ultimately disappear from the community.

Conversely, the larger the Reff value, the more freely the virus is spreading in the community and thus the faster the number of new cases will rise. This means a higher number of cases at the peak of the epidemic, a greater risk of the health system becoming overwhelmed, and ultimately more deaths.

On the following pages are some of study’s findings from states and nations around the world. [Editors note: this article was originally published on April 30; obviously outcomes have advanced since that time.]

New South Wales, Australia

The effect of Australia’s strict border control measures, implemented relatively early in the pandemic, can clearly be seen in the graph below. Federal and state governments introduced strict social distancing rules; schools, pubs, churches, community centres, entertainment venues and even some beaches were closed.

This prompted the Reff value to drop below 1, where it has stayed for some time. Australia is rightly regarded as a success story in controlling the spread of COVID-19, and all states and territories are now mapping their paths towards relaxing restrictions in the coming weeks.

“...places that moved quickly to implement strict interventions brought the coronavirus under control much more effectively, with less death and disease.”

Italy

Italy was relatively slow to respond to the epidemic, and experienced a high Reff for many weeks. This led to an explosion of cases which overwhelmed the health system, particularly in the country’s north. This was followed by some of the strictest public health control measures in Europe, which has finally seen the Reff fall to below 1.

Unfortunately, the time lag has cost many lives. Italy’s death toll of over 27,000 serves as a warning of what can happen if the virus is allowed to spread unchecked, even if strict measures are brought in later.

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The UK’s initial response to COVID-19 was characterised by a series of missteps. The government prevaricated while it considered pursuing a controversial “herd immunity” strategy, before finally ordering an Italy-style lockdown to regain control over the virus’s transmission.

As in Italy, the result was an initial surge in case numbers, a belatedly successful effort to bring Reff below 1, and a huge death toll of over 20,000 to date.

New York City, USA

New York City, with its field hospital in Central Park resembling a scene from a disaster movie, is another testament to the power of uncontrolled virus spread to overwhelm the health system.

Its Reff peaked at a staggeringly high value of 8, before the city slammed on the brakes and went into complete lockdown. It took a protracted battle to finally bring the Reff below 1. Perhaps more than any other city, New York will feel the economic shock of this epidemic for many years to come.

Sweden

Sweden has taken a markedly relaxed approach to its public health response. Barring a few minor restrictions, the country remains more or less open as usual, and the focus has been on individuals to take personal responsibility for controlling the virus through social distancing.

This is understandably contentious, and the number of cases and deaths in Sweden are far higher than its neighbouring countries. But Reff indicates that the curve is flattening.

Singapore

Singapore is a lesson on why you can’t ever relax when it comes to coronavirus. It was hailed as an early success story in bringing the virus to heel, through extensive testing, effective contact tracing and strict quarantining, with no need for a full lockdown.

But the virus has bounced back. Infection clusters originating among migrant workers has prompted tighter restrictions. The Reff currently sits at around 2, and Singapore still has a lot of work to do to bring it down.

Individually, these graphs each tell their own story. Together, they have one clear message: places that moved quickly to implement strict interventions brought the coronavirus under control much more effectively, with less death and disease.

And our final example, Singapore, adds an important coda: the situation can change rapidly, and there is no room for complacency.

This article is republished from The Conversation, and was also published on the InTouch online magazine. All charts are from the Conversation.
Do companion animals spread Q fever?

Q fever is an important human disease that is transmitted from animals. Most cases in Australia occur after exposure to farm animals, especially cattle, sheep, and goats. A recent increase in human Q fever cases in northern NSW in people without direct farm animal exposures raised concerns about alternative routes of infection, including from companion animals.

Gemma Ma

Gemma Ma is a PhD candidate, Sydney School of Veterinary Science, University of Sydney.

Dogs and cats are a significant part of the home environment and therefore an important consideration for public health. Australia is a pet loving nation; almost two thirds of Australian households have a pet, with 40 percent owning dogs and 27 percent owning cats. Many of our pets are considered important members of our families, enjoying access indoors, sharing outings, even sharing our beds.

When companion animals are considered from the perspective of public health, the conversation rarely goes beyond investigating dogs and cats as the source of zoonotic diseases and parasites. Dogs and cats can transmit diseases and parasites to humans, however, this over-simplifies often complex epidemiological relationships. This is exemplified in findings from our recent research into the role of dogs and cats in Q fever epidemiology, which sheds light on potentially important sources of the disease for humans.

Q fever is an important human disease that is transmitted from animals. Most cases in Australia occur after exposure to farm animals, especially cattle, sheep, and goats. The organism that causes Q fever, the bacterium Coxiella burnetii, multiplies to very high numbers in reproductive tissues and is mainly excreted in the placenta and birth fluids. However, because the bacterium is highly stable in the environment – able to survive for a long time and lead to people becoming infected by environmental contamination, even in the absence of animal contact. Coxiella burnetii is highly infectious and a single organism is sufficient to cause infection. Given that there are multiple transmission pathways, a One Health approach is required.

Our findings suggest both pets and people in northern NSW acquire Q fever infections from a shared environmental source, challenging assumptions that only people exposed to livestock through their occupation are at risk of Q fever. This finding agrees with other epidemiological studies, particularly from Europe, which have highlighted the potential for Q fever infections to occur down-wind of intensive livestock production. The bacterium survives in dust and can be spread by wind for up to five kilometres, making it plausible that anyone living in sheep, cattle or goat producing areas, even if they do not have direct contact with animals, is at risk of Q fever infection. This risk is likely to be exacerbated by drought and dust storms and may also be increased by proximity to higher densities of livestock such as along major transport routes.

We found no C. burnetii DNA from any dogs or cats. This suggests that none of the 475 pets had a current infection and therefore did not pose a risk to their human families.

We conclude that people are very unlikely to acquire Q fever from pet dogs or cats. It appears the only time dogs and cats present an important risk of Q fever infection to people is in the days surrounding the birth of puppies and kittens. We therefore recommend that cat and dog breeders be vaccinated against Q fever.

This study highlights the value of considering our canine and feline family members in studying communicable disease epidemiology. It is worth considering what else we might be able to learn about our own health from the other animals that share our homes.

Citation: Ma GC, Norris JM, Mathews KD, Chandra S, Šlapeta J, Bosward KL, Ward MP (2020) New insights on the epidemiology of Coxiella burnetii in pet dogs and cats from New South Wales, Australia. Acta Tropica. 205. The published manuscript is available here.
Navigating COVID-19 social distancing rules

Social distancing is largely self-regulated, with people generally doing the right thing on their own. The police are enforcing these important public health guidelines, notably in public places. But are police enforcing restrictions equally, without any racial discrimination?

Dr Michael Doyle

Michael Doyle is the co-convener of the PHAA Aboriginal and Torres Strait Islander Special Interest Group.

As the Coronavirus situation continues, we all need to do our part with physical distancing and limiting outdoor activity. At the time of writing the ‘curve’ of infections is indeed flattening. But our individual, family and community efforts need to continue if we are to avoid a public health crisis from COVID-19.

These efforts are largely self-regulated, with people generally doing the right thing on their own. The police are enforcing these important public health guidelines in some cases, notably in public places.

But are police activities in enforcing restrictions being applied equally, without any racial discrimination? There were continuing reports about unequal policing in respect of Aboriginal people before COVID-19, so it is not surprising there are reports of the same problems during the community policing of COVID-19 public health orders.

To illustrate the issue, let’s look at a (pre-COVID) media report in February headlined ‘Aboriginal drivers in WA more likely to get fines from police officers than traffic cameras’. A review of police data showed that Aboriginal drivers were 1.75 times more likely than the WA population average to be issued a fine in roadside incidents where an actual police officer pulled over the speeding driver.

This example is not related to COVID-19 public health order policing, but it does show a precedence for disparity in the use of discretion by police officers. There are undoubtedly issues of racism in Australia’s justice system, and while it would be unfair and untrue to say that all police engage in racist discrimination, an issue of unconscious bias may be at play.

The speed with which the public health regulatory response to COVID-19 has been mounted has been impressive, and is currently showing very welcome results in terms of containing the spread of disease, benefitting all Australians. But the pandemic could still develop ‘second waves’ or local outbreaks. Local outbreaks in locations with significant Indigenous communities would be devastating because Aboriginal and Torres Strait Islanders people they already have poorer health and less resources than most other Australians, So, protective measures certainly need to be continued.

But there needs to be clarity of what social distancing rules all people must follow, and officials need to maintain public confidence the police are enforcing the social distancing laws in an equitable way. A key part of the problem is that police are empowered to exercise discretion in overlooking infringing behaviour, and such discretion can very easily be exercised inequitably, without any effective means of accountability or recourse.

In New South Wales people can be fined $1,000 for breaching these rules. In one case reported in the media a 15-year-old boy was fined for going to visit a friend. This might seem a straightforward case but, 15-year olds are allowed to go to school with several hundred other children, so they might be a bit confused about social distancing rules outside the school yard. Greater clarity and consistent messaging would help.

And friends, but that is assuming we have wifi at home, or has enough credit on our mobile phone. For socio-economically disadvantaged people these options are not as available.

There are certainly higher levels of unemployment for Aboriginal and Torres Strait Islander Australians. Furthermore, ABS data (2015), shows that Aboriginal and Torres Strait Islanders Australians tend to work in lower paid positions, including pastime and casual work. It is therefore likely they may have been disproportionately affected by COVID-19 economic impacts. This limits options to spend time with family members they do not live with, and that in turn impacts on social and emotional health.

The mental health of many people – not just Aboriginal people – is being strained, and we all need to be kind and patient with each other. Aboriginal people have been subjected to a lifetime of racism, often in the form of micro aggressions. As minorities in their town, suburb or even just apartment building, living with physical distancing rules can consolidate feelings of marginalisation for Aboriginal people.

There needs to be concerted effort to ensure that everyone knows the social distancing rules, that exercises of police discretion are fair, and that penalties for infringements are used sparingly, and only in the most serious cases. There is already a problem with imprisonment of Aboriginal people for unpaid fines. Some Aboriginal people have tragically died while being held for unpaid fines.

Post COVID-19, it will be important to determine how many infringement notices were given in the wealthy suburbs of Sydney and other capital cities compared to the working-class suburbs, regional cities and towns, and whether there were any racial discrepancies in such policing.

This article was first published on the Intouch online magazine.
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June 2020

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PHAA Welcomes New Members

PHAA is very pleased to welcome 172 new individual members and 3 new organisational members since 1 March 2020.

In the ACT
Laura Clayton
Thelma Ejigou
Lucy Kirk
Amanda Lax
Alexandra Marmor

In New South Wales
Harshita Anra
Zoe Baldwin
Sally Boardman
Timothy Broker
Maria Cabrera Aguas
Lillian Chan
Jeremy Cheam
Natala Gounevour
Michelle Green
Yuxin Gu
Claudia Gunawan
Raquel Henson
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Lisa Hughes
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Alexandra Janusick
Jemma Keat
Erik Kerr
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Deborah Mason
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Eunice Stiboy
Alexandra Uy
Cara van Wyk
Natalie White
Elizabeth Williams
Daniel Winter
Rupa Zaman

In the Northern Territory
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Joanne Barrett
Heather D’Antoine
Marita Helfer
Subash Heraganahally
Casey Luttrell
Matthew Stevens

In Queensland
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Taylor Anderson
Sarah Ashby
Siobhan Clancy
Belinda Conway
Fiona Crawford-Williams
Marguerite Dalmau
Kaeleen Dingle
Elaina Elder-Robinson
Christan Fernando
Neil Harrison
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Madirda Islam
Ethan Kettyle
Philipa Lyons
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Brad McCulloch
Taya McLaren-Hedwards
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Larissa Rodrigues
Courtney Thorpe
Rosa Viraga

In Tasmania
Thomazi Khali Chetrey
Gillian Mangan
Anthea Maynard
Sue Pearson
Kate Pennington

In Victoria
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Gulsan Bano Ali
Muffi Alkinhar
Roberto Enrique Aciui
Aparicio
Catherine Bennett
Catlin Bennett
Eloise Brownie
Eleanor Burns
Melissa Butler
Rhiamon Chipperfield
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Babajide Fapojuwo
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Ashley Leek
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Benefits of Individual Membership

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- Attend world class conferences and events with significant discounts on registration fees.
- Networking with senior public health professionals at branch, special interest group meetings and conferences.
- Mentoring program for students and young professionals
- Contribute articles to our blog Intouch Public Health
- Eligibility to apply for PHAA scholarships and awards

Access to public health news, research, and jobs
- Early online access to the Australian and New Zealand Journal of Public Health, Australia’s premier public health journal.
- Discounted author publication rates in the Australian and New Zealand Journal of Public Health, if the lead author is an active individual PHAA member.
- Receive The Pump, our members only weekly digital newsletter
- Read the latest opinion pieces and research articles on Intouch Public Health blog
- Stay up to date with COVID-19 news on our website and blog
- Access to weekly email list of public health job vacancies via The Pump newsletter

Contribute to public health advocacy and policy development
- Participate in developing public health advocacy programs and policies.
- Contribute to PHAA policy position statements on a range of public health issues
- Join one of 18 Special Interest Groups which help develop policy (fees apply)
- Contribute to PHAA submissions to Parliamentary Inquiries and Government consultations
- The right to vote and hold office in PHAA
- Access to PHAA forums

Benefits of Organisational Membership
- Up to two staff members may attend PHAA Annual Conference and special interest conferences, workshops and seminars at the reduced member registration rate.

Member Information Pack
For a summary of member information, benefits and ways to get involved, download the Member Information Pack.

Articles appearing in Intouch do not necessarily reflect the views of the PHAA but are intended to inform and stimulate thought, discussion and comment.
Contributions to the Intouch online magazine are welcome and should be sent to: communications@phaa.net.au