Public Health Association of Australia submission on COVID-19: Appendix to main submission

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Introduction

This appendix to the PHAA submission provides further detail, primarily on the impacts on COVID-19 for particular population groups, and addresses specific issues for consideration in moving into the recovery phase. Material from the main submission is not repeated here, so this appendix should be read in conjunction with the main submission.

Climate change

We know that the health consequences of climate change are real and severe. Increasing levels of pollution impacting the quality of our air and water have been systematically increasing our vulnerability to disease for decades, just as deforestation and unabated climate change have been increasing a broad number of health risks to humans. Air pollution from traffic, pollution from inefficient energy use for cooking and heating, emissions from coal-fired power plants, and pollution from the burning of solid waste and agricultural practices, all combine to weaken the respiratory and circulatory systems. These harms account for 7 million worldwide premature deaths each year.

As one of the most exposed countries in the world, particularly to the effects of our biggest environmental killer – heat, Australia’s policy responses on climate change to date have left us in an increasingly vulnerable position.

COVID-19 has provided a rare glimpse of cleaner air in some of the most polluted cities and countries in the world. We have been shown what is possible, and fortunately, feasible policy options to pursue this path exist. We must take the opportunity we have been given, and economists around the world have shown that it would be not only the most environmentally responsible course of action, but would also be economically responsible.

With unprecedented fiscal stimulus packages, and the Australian Government advice being inappropriately dominated by the resources sector, there is a real and serious risk that the recovery from COVID-19 could take Australia further down the fossil fuel dependent path, and exacerbate climate change.

However, the recovery also presents an unprecedented opportunity to boost action against climate change through a recovery led by renewable energy and environmentally sustainable economic solutions.

There is emerging evidence that the pandemic is already leading to reductions in the deployment of renewable energy, and reduced investment in renewable energy research and development. We need to recognise this risk, and choose not to let it be Australia’s path. Stimulating the economy needs to be done urgently, and solar and wind farms can be constructed more rapidly than coal or natural gas facilities, making them ideal for short-term stimulus.

A study from Oxford University surveyed over 200 central bank officials, finance ministry officials and other economic experts from G20 countries, and identified 5 recommended directions of policy action:

- clean physical infrastructure
- building efficiency retrofits
- investment in education and training
- natural capital investment for ecosystem resilience and regeneration
- clean research and development

Action in these policy domains would deliver large economic multipliers quickly, while also shifting the trajectory of our emissions towards net zero.
Groups representing over 10 million health professionals globally have come together to call for a healthy recovery which:

- looks after the most vulnerable people
- provides workers with access to well-paying jobs that do not exacerbate pollution or nature degradation
- prioritises pedestrians, cyclists and public transport over private motor vehicles in cities
- ensures that water and air is protected and clean.

It has been estimated that decarbonisation would lead to global GDP gains of US$ 100 trillion by 2050, and in doing so quadruple the number of renewable energy jobs as part of net job gains in the energy sector, offsetting job declines in fossil fuel operations.

Locally, similar reports and policy proposals for Australia have shown that a green recovery is an economically as well as environmentally sensible recovery. These reports confirm that gas is not an appropriate, environmentally or economically viable option to drive a recovery because of its high emissions and price volatility. Instead, we can and should replace fossil fuels and instead power Australia with renewable energy, use the opportunities provided by Australia’s natural renewable resources to become a global zero emissions exporter of energy, products, minerals and services, and build resilience in our land and coasts.

The Australia Institute has recommended that stimulus packages to come should:

- have high direct employment
- target those most impacted by the crisis
- provide useful projects with co-benefits
- target regional disadvantage.

The Institute’s analysis of a range of policy options against these criteria found that while major projects such as addressing public housing stock, housing for the homeless, maintenance of public buildings, cancelling ‘robodebts’, electricity grid infrastructure for renewables, health messaging and mass tree plantings address most of these criteria, recently favoured policy options such as big business tax cuts, wages freezes and building coal fired power stations address few, if any of those criteria.

Alcohol

For many people the fear, uncertainty, economic pressures and social isolation brought by COVID-19 may contribute to an increased likelihood of alcohol being used at riskier levels and in riskier ways.

Recent information indicates that 14-40% of young Australians are drinking more alcohol since the COVID-19 restrictions started. Data collected by YouGov Galaxy on behalf of the Foundation for Alcohol Research and Education (FARE) found that of those people who are drinking more alcohol:

- 37% have been drinking daily
- 32% were concerned about their or someone in their household’s drinking
- 29% were drinking on their own more often
- 32% were drinking to cope with anxiety and stress and
- 24% had started drinking and ended up drinking more than they thought they would.

A Hall and Partners’ survey taken in April 2020 shows commonly reported reasons for drinking more during COVID-19 are boredom (53%), anxiety and stress (45%), being tempted due to more time at home (43%), to keep spirits up (39%) and loneliness (20%).
Already there has been increased demand for services, including general mental health services and alcohol-specific support services. The National Alcohol and Other Drug (AOD) Hotline has seen a doubling in calls in early 2020 compared with early 2019. An online early intervention and support application has seen a 28.6% increase in member engagement and a 35.2% increase in new registrations.9

There has also been a reported growth in alcohol-fuelled harms. A Women’s Safety NSW survey of frontline domestic and family violence specialist workers found that since COVID-19 restrictions were introduced, 47% reported an increase in their caseload and about half (51%) reported an increase in involvement of alcohol in family violence situations.

A sharp increase has been seen in online sales10,11 and increased engagement with alcohol advertising. A study from the Cancer Council WA and FARE revealed that over one hour on a Friday evening, one user was bombarded with an alcohol ad every 35 seconds, with nearly three quarters referencing the pandemic, and 16% encouraging people to use alcohol to cope, survive or feel better.12

It is important the Government messaging supports people to reduce their drinking during COVID-19. Some Government messaging, aimed at decreasing social isolation during distancing, may have inadvertently encouraged alcohol consumption.13

Access to medicines, vaccines, tests and medical devices: trade and intellectual property issues

Rules negotiated under trade agreements, patents and other intellectual property protections can lead to shortages of life-saving products like medicines, vaccines, diagnostic tests and medical devices during a public health emergency.

We have already seen examples where patents have created obstacles to access. Hundreds of patents on N95 face masks held by a US company have resulted in critical shortages of this vital personal protective equipment needed by health workers.14 One hundred and fifty civil society organisations including Médecins Sans Frontières recently called on Gilead Sciences, maker of the potential COVID-19 treatment remdesivir, to release the patents it holds on the drug in more than 70 countries.15 In fact the company had recently applied for an extra period of exclusivity from the US Food and Drug Administration, and only dropped its application after a public outcry.

The Commonwealth Patents Act 199016 includes some important safeguards that enable patented inventions to be exploited without the consent of the patent owner. These are its compulsory licensing and Crown use provisions. Use of these provisions is permitted under the World Trade Organization’s Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS),17 and Australia should be prepared to use them to prevent shortages of medical supplies.

Under the Act, the Federal Court can order that a compulsory license be granted for a patented invention under certain conditions, meaning that a third party (e.g. generic medicines manufacturer) can produce copies of the patented invention without the permission of the patent owner. However, one of the conditions for issuing a compulsory license is that “the applicant has tried for a reasonable period, but without success, to obtain authority from the patentee to exploit the original invention on reasonable terms and conditions” (Section 133, Para 3(c)). This condition may slow down the process if negotiations with the patent owner take a long time. Canada has passed emergency legislation18 to remove its requirement that negotiations with the patent owner take place before a license is issued during the COVID-19 pandemic. Australia should consider doing the same.
The Patent Act’s Crown use provisions provide another mechanism allowing Federal, State and Territory governments, or a party authorised by a government to over-ride a patent in an emergency in order to provide a service primarily provided or funded by the Commonwealth or a State or Territory. These provisions may be faster and easier to use because they only require ministerial approval rather than an application to the Federal Court.

In addition to preparing to use the provisions in the Patents Act, the Australian Government should also ensure that we can import drugs manufactured under compulsory license in other countries, in cases where there is insufficient manufacturing capacity in Australia to produce them locally. To do this, Australia will need to revoke an earlier decision at the World Trade Organization to declare itself an “ineligible importing member”.¹⁹

To ensure equitable access to COVID-19 medicines, vaccines and tests at a global level, and in line with the World Health Assembly COVID-19 Response resolution,²⁰ the Australian Government should:

- commit to ensuring the open sharing of intellectual property, knowledge and data that will enable timely and affordable access for people of all countries to medical products to combat COVID-19, and join 37 other countries in endorsing the WHO’s COVID-19 Technology Access Pool;
- use enforceable provisions in funding arrangements to ensure that publicly-funded research outcomes are affordable and accessible to all on a global scale
- utilise safeguards to facilitate in the TRIPS Agreement, as confirmed by the Doha Declaration on the TRIPS Agreement, and support other countries’ rights to use these flexibilities.

Criminal justice system

People incarcerated in prisons and youth detention centres are in a number of higher health risk categories, with increased rates of chronic conditions including diabetes, cardiovascular disease and asthma.

The profile of the Australian prisoner population is also ageing. On 30th June 2019, there were almost 6,000 prisoners aged 50 years or older,²¹ which is considered elderly because of the generally poor health of prisoners.

An outbreak of COVID-19 in prisons would have a substantial flow-on effect in the community. Prisons have significant number of people moving through them daily, including correctional staff, health workers, lawyers, educators, non-government support workers, and visitors. Many prisoners revolve in and out of the system regularly, with many of those entering prison being held on remand, and almost half of new admissions have been in prison in the previous 12 months.²²

Healthcare in prisons is often overstretched, and security issues mean that ensuring all people living and working in prison have their health monitored closely and regularly enough, and then quickly isolating those who contract the virus, is logistically challenging. The kinds of self-isolation and increased hygiene practices available in the community are not practicable in prison, where large groups often share bathrooms, laundry and eating areas. Air circulation may be poor where prisoners do not have the option to open windows. Alcohol-containing hand sanitiser may not be available.

Decarceration, as is occurring elsewhere globally,²³ is a sensible emergency public health measure at this time to protect the health of prisoners, people working in prisons, and the wider community. While this has not been happening in Australia as a COVID response so far, alternative measures have included isolation for new prisoners, decreased time out of cells, and severe restrictions on visits. These measures may amount to prolonged periods of solitary confinement, resulting in unrest and mental ill-health.
There are reports that the Courts are taking the pandemic into consideration, including in the
Government’s duty of care to prisoners.\textsuperscript{24} Responses such as increased availability of personal protective
equipment and safe travel plans for newly released prisoners are welcome,\textsuperscript{25} but the responses must
include decreasing over-crowding and enabling distancing and hygiene recommendations to be put into
practice without solitary confinement conditions.
Forensic mental health services providing treatment to persons on a forensic order who have experienced
issues with the justice system and have been impacted by mental health issues are at considerably higher
risk for COVID-19 symptoms. This is due to comorbidity of severe mental health diagnosis and its
intersection with legal stressors for persons experiencing institutionalisation in forensic hospitals and
mental health units within the prison system.\textsuperscript{26}

**Mental health**

Social and structural determinants of health (SDOH) influence the health and wellbeing of individuals,
groups and communities. Key SDOH impacted by COVID-19 include socioeconomic position, social
exclusion, social capital, employment and work, housing and residential environment (AIHW, 2016).
Structural determinants include broader political and economic issues that impact on equity, justice and
wellbeing. Undue pressure on one or more of these social determinants is known to have deleterious
effects on an individual’s mental health status.
Sub-optimal mental health is an established leading factor that can have adverse consequences on a wide
range of biopsychosocial health outcomes (AIHW, 2016). Mental health can impact access to services and
create a disjoint between the person in their environment; therefore, it is essential that accessible services
redress stigma, enable and enhance access to mental health care in a variety of clinical, non-clinical and
peer-based spaces.
Comparisons can be drawn from the Great Depression to the COVID-19 pandemic, but it is also clear that
how individuals and systems interact and function in modern society is quite different. Therefore, our
responses to the current pandemic must also be different. Despite social determinants impacting mental
health the primary response for treatment continues to reflect a biomedical response that fails to address
the trauma associated with distress, highlighting the need for sensitive and trauma informed services.
Some population groups have an increased risk of developing adverse psychosocial outcomes as a
consequence of the COVID-19 pandemic and Government response. This includes those with a heightened
risk of infection such as the elderly, people with compromised immune function, people with disability,
health care providers and people with pre-existing medical, psychiatric or substance use problems.\textsuperscript{27} As
such, significant media coverage has been given to mental health issues due to COVID-19, including
promotion campaigns to encourage the general public to reach out to friends, family and mental health
professionals and services for support. Quite rightly, focused attention has been given to people with
existing mental health conditions, due to estimated significant increases in suicidal and other high risk
behaviours, such as drug use.\textsuperscript{28}
Mental health risk is further amplified by the fear and uncertainty associated with the pandemic increasing
anxiety and stress, which intensifies the symptoms of those with pre-existing psychiatric disorders.\textsuperscript{29} In
addition, the social isolation caused by the pandemic increases the time spent with family members and
reduces access to normal support networks for those with pre-existing mental health conditions further
increasing mental health risk.\textsuperscript{30}
The COVID-19 pandemic may worsen existing mental health problems and lead to more cases among children and adolescents. Many young people are socially isolated, have had their education interrupted and are anxious about their future. Further, schools play an important role in providing mental health support and counselling to students. This support is at risk with school closures, and so is the long-term health of students without access to this support. In addition, with university campus closures and the move to online learning, university students are expected to have a range of mental health effects including: feelings of frustration and anxiety, loneliness and isolation, loss of access to on-campus counselling services, suffer mental health issues as a result of the disruption, and experience financial issues as a result of having to travel home or losing employment opportunities. To-date the Federal Government has not provided additional support specifically to universities to ensure affected students are adequately supported during the COVID-19 pandemic.

In response to the pandemic, the Federal Government announced $74 million dedicated to mental health services to support increased capacity and accessibility of care, including the delivery of mental health services via telehealth. While this is a welcome decision, as evidence suggests that telemental health services are similarly effective as in-person services, uptake has historically been slow, and not all Australians have the technology or Internet services available to participate in this model of care. In addition, evidence has found that the effectiveness of telemental health commonly differs between people with depression, anxiety and PTSD.

Despite these barriers, telemental health provides a welcomed opportunity for mental health care services to continue to be delivered while social distancing regulations are in place to ensure services continue to be available for the community. Many clinicians and professional organisations including the WHO have expressed their support in increasing the availability of mental health care services throughout the pandemic, with support to sustain the expansion of telemental health services post-pandemic.

Due to the scale of the pandemic, the influence of social and structural determinants upon health and wellbeing outcomes for individuals, groups and society, especially the onset and consequences of existential crises, must not be underestimated. The contemporary definition of an existential crisis refers to a state of psychological being that can engender a sense of meaningless, emptiness or purpose seeking.

Existential crises can broadly present as:

- Crisis of freedom and responsibility
- Crisis of death and mortality
- Crisis of isolation and connectedness
- Crisis of meaning and meaningless
- Crisis of emotion, experiences, and embodiment

Existential crises often result in elevated psychological distress, anxiety and/or depression, and can inhibit everyday functioning. It is commonly triggered by major life events such as a job loss, relationship breakdown (especially divorce), death of a friend or relative, diagnosis of a serious illness and experiencing a traumatic situation. Australians are currently experiencing or witnessing multiple events such as these due to COVID-19. Consequently, it is essential that we not underestimate the importance of preventative mental health strategies, and working over the long-term with Australians without an existing mental health condition, whose world has been turned upside down by the emergence of one or more of the major life events described.

A caring and compassionate society that cares for others is the best approach to suicide prevention. Australian governments need to prioritise promotion of mental health understanding and service provision to that end.
Preliminary data released by the Australian Bureau of Statistics (2020) and other agencies, such as ACOSS (2020), who work on the frontline with regards to social determinants of health, points to an impending mental health crisis if we do not successfully engage both the general public (who would not ordinarily seek help) and health care professionals who would not ordinarily screen for or address SDOH or existential crisis symptomology. This is particularly important as new modelling has predicted a 30% increase in new cases of common mental disorders a year in Australia.  

We need to prioritise mental health promotion through a caring and compassionate society that cares for others – this is the best approach to suicide prevention. New modelling integrating economic and mental health data has shown that suicide will increase between 25 and 50 per cent if we fail to act. Suicide is likely to become a more pressing concern as the pandemic spreads and has longer-term effects on the economy and in particular unemployment, reduced pay and economic recession. There is evidence that suggest these types of challenges have an established link with attempted suicide and increased psychological distress.

Many of the general risk factors for increased suicidal behaviour and suicide are relevant during times of pandemic such as domestic violence, alcohol consumption, social isolation, entrapment, loneliness and access to means but also stigma towards individuals with COVID-19 and their families. It is likely that suicide risk factors among individuals residing in rural areas will be exacerbated during the COVID-19 epidemic and suicide rates may subsequently increase.

Key challenges for those in rural areas are exacerbating interpersonal risk factors due to social distancing, ready access to firearms, and onset or exacerbation of mental health symptoms. Suicide increases are not inevitable if national mitigation efforts are put in place. The mental health system, including support hotlines, evidence-based online interventions should be supported to respond to this expected increase.

Finally, given the need for a rapid and high-volume response, we need to ensure there is accurate modelling as well as transparency of model codes to guide health policies.

The WHO recommend public policy solutions including:

1. Apply a whole-of-society approach to promote, protect and care for mental health.
2. Ensure widespread availability of emergency mental health and psychosocial support.
3. Support recovery from COVID-19 by building mental health services for the future.

Consistent with these recommendations governments should prioritise:

1. Promotion of access to mental health services
   - Awareness campaigns around COVID-19 impact on distress and information/education on help seeking. Access to mental health services has reduced by people with a chronic mental health condition.
   - Effective public health messaging and risk communication to reduce uncertainty and anxiety about the health and economic risks.
   - Continue telehealth Medicare item numbers following COVID-19

2. Strengthen mental health service capacity.

Mental health systems are at risk for losing capacity due to hospital spill over and clinic closure to promote social distancing. Innovative models to deliver mental health support to communities in the midst of a pandemic are needed to prevent a mental health crisis. In addition, access to crisis services has increased (including kids helpline, 1800 respect and Men’s Helpline. A comprehensive public health response to the pandemic must include:
• Attention to the psychological aspects of hospitalisation for patients, families, and staff affected by COVID-19
• Planning for emergency and acute psychiatric patient care if hospitals become overwhelmed with COVID-19 patients, and
• Innovations for providing mental health care in communities while social distancing is required and health system resources are strained.
• Improved access to alternative mental health services such as peer run services, groups and therapeutic communities
• Improved access to digital technology mental health services, including telemental health. The shift to telehealth represents a major pivot of the sector, which would have longer-term benefits.
• Additional support to university to ensure they can counter the mental health impacts by ensuring curriculum planning and guidance sessions are available and providing telemental health services where required.

3. Increase investment in primary prevention and promotion of mental health and wellbeing using a whole of society approach that seeks to address the social, economic and environmental determinants of health.
   • Increase community resilience to enable adaptation in times of uncertainty
   • Implement strategies to increase community connectedness
   • Implement strategies to increase social and economic support

**Longer term impacts on young people**

Casual employment makes up about 25% of the Australian workforce, with 54% of these workers aged under 25. Young people are also more likely than older workers to have been with their casual employer for less than 12 months, rendering them ineligible for JobKeeper benefits. Industries with the highest prevalence of casual workers, such as hospitality, retail and accommodation, were among the first and hardest hit by the distancing restrictions in response to the virus.

Grattan Institute analysis has found that those on lower-incomes are twice as likely as high-income earners to be out of work, and that young people and women are likely to be most affected because they are more likely to be employed in the occupations and industries most affected. More than half of young people indicate that COVID-19 has affected their purchasing decisions – higher than any other age group.

Lost income flows through to impact other essential areas of life such as housing. The Australian Government has announced a moratorium on evictions due to tenants being unable to pay their rent because they have lost or reduced employment during COVID-19. While this is a sensible measure, further measures have been suggested including a moratorium on rent increases, direct financial assistance to tenants in hardship, and rent price controls.

One of the measures the Government has taken in response to COVID-19 has been to allow early release of superannuation funds. This measure has been widely taken up by the public. By 25 May 2020, $10.6 billion had been taken from superannuation funds from 1.59 million applications. There are reports that of these, almost 500,000 have been from young people, with those aged under 30 being the most likely to apply, despite a potential long-term reduction of $100,000 in their retirement.

Simultaneously, Governments during this crisis have produced lists of ‘essential workers’- health care workers, teachers, supermarket workers, delivery and garbage truck drivers, cleaners and service station attendants. Notably absent from such lists were highly paid occupations such as merchant bankers, stock brokers, hedge fund managers, sports stars and internet marketing influencers.
One of the lessons Australia should take from this experience is to consider who in our society we value in terms of financial reward and security, compared with who we value in terms of being essential to our society. There is currently a serious mismatch between those, and casual workers, many of whom are young people, are consistently on the wrong end of that mismatch in values.

**Infant Feeding**

The World Health Organization states that Infant and Young Child Feeding emergency preparedness should be a priority for all nations. In 2010 the World Health Assembly urged member states, including Australia, to ensure that they had national emergency preparedness plans in line with the OG-IFE. The 2019 Australian National Breastfeeding Strategy acknowledged this and included it in their priority areas for action. However, an audit of Australian National and State/territory emergency plans found that there was a dearth of planning dealing with the needs of infants and young children. This included in pandemic preparedness plans.

The development of policies and clinical guidelines regarding infants in infectious disease outbreaks is challenging. For the general population, isolation of the uninfected from the infected, and the avoidance of sharing bodily fluids, are fundamental in preventing disease transmission and achieving good health outcomes. The situation of mothers and infants is different to that of other adults and older children, and necessitates a weighing of the risks of disease transmission against the importance that breastfeeding and maternal proximity plays in supporting infant and maternal physical and mental health. That infants and children cannot care of themselves, cannot employ risk mitigation strategies such as hand washing, avoiding touching the mouth etc and that they interact with others who may be vulnerable also makes things challenging.

It was concerning that in the early stages of the pandemic there was little if any, coordinated, authoritative communication from a national level to the state health departments regarding appropriate care and management of mothers and babies in the early post-natal period, or even from the health departments to the hospital health services. This meant that many hospitals were writing their own guidelines with lack of expert input. Unfortunately, in Australia, some hospital practices, not based on evidence, have contributed to the unnecessary separation of the mother and the baby after giving birth. Some state health departments and hospitals were turning to the Australian Breastfeeding Association (ABA) for guidance. Similarly, information regarding implications for early childhood centres was needed. Fortunately, ABA was very quick to create resources for both health professionals and families and kept this up to date with the information coming from the World Health Organization, UNICEF and RANZCOG.

Motivated expert academics, volunteers and organisations like the ABA have exerted efforts and provided immediate support to ensure that correct, unbiased and evidence-based recommendations, clinical practices and messages for the health services, and families were disseminated to the largest possible audience. When a deadly virus is rampant the mother and baby relationship should be protected at all costs. Babies are safest when kept with their mother and breastfeeding supported.

As in all emergencies where food security is a concern, there needs to be messages explaining the importance of not weaning from breastfeeding at this time. Breastfeeding IS food security. There should also be widespread public messaging around the process of relactation and where to go to get support to do this. ABA noticed an increase in calls from mothers who were wanting to relactate to protect their baby from the virus and to ensure a supply of food in the situation of panic buying of formula.

Breastfeeding continues to be ignored as a practice that provides resilience in all types of emergencies, including pandemics.
Early Childhood Education and Care

The challenges highlighted throughout the current emergency suggest significant vulnerabilities for the ECEC sector for both children and staff. Many centres closed down completely with children being kept at home. Cash flow in ECEC centres was a factor for some centres unable to make up-front wage payments for eligible Job Keeper employees.

Many workers in the ECEC setting are employed in casual and temporary contracts, and as widespread centre closures occurred, many workers in the sector were stood down and ineligible for Job Keeper wage support. The current plight of ECEC centres presents obvious challenges for families and ECEC providers when services are required to return to pre-COVID-19 availability as containment restrictions are relaxed.

Factors affecting family wellbeing that have attracted media attention have included employment and domestic violence reports. Other factors such as food security, directly impacted by family income, have received sporadic attention in the form of reports of higher levels of reliance on charitable meal provision. The early childhood education and care (ECEC) sector provides an established, regulated and funded support to optimise children’s lifelong potential, across many facets including a healthy food environment.

An example of an undesirable outcome of COVID-19 restrictions has been the demise of cook-provided food for centre-based childcare. ECEC food services have potential to provide a protective mechanism for children from developing non-communicable diseases through promoting lifelong healthy eating and other healthy lifestyle habits. Most of our children attend centre-based childcare where they can receive up to two-thirds of their daily nutrition, provided by mostly cook-supported centres. In response to the containment measures required for COVID-19 containment, centres are replacing cook-provided services with lunchboxes provided by parents. Evidence from Australia and internationally is unanimous that food provided from home is not consistent with national dietary recommendations, and services can influence this.53

Systematic reviews show that nutrition best practices and healthy food environments are related to positive dietary outcomes in children attending ECEC settings, and that healthy eating habits learnt during this small developmental window, track into adulthood.54 Healthy nutrition is supported by ECEC national accreditation requirements but is not legislated or formalised as policy. A small investment by Governments in ECEC settings as protected places for preventative health will have positive, long-term outcomes to children’s health and wellbeing. Moreover, ECEC services support parents and their wellbeing by ensuring children receive healthy food that meets children’s development needs while also developing long-term healthy food preferences and eating habits. Stress experienced by working parents with young children is associated with poorer family food choices and fewer family diets that meet national dietary guidelines.55-57 Providing children with cooked meals and a healthy food environment while in care is associated with healthier nutrition at home, food security and less burden for already-stressed families.

Plans that include a safe return to usual care and re-uptake of services, ensuring availability of places for working families and vulnerable families should be part of the National COVID-19 response agenda and appropriately monitored. State and Commonwealth co-ordination of sector support models should be orientated towards sector sustainability with transparent ongoing oversight and review as the lifting of containment restrictions continues. By undertaking an orderly response and review of ECEC sector support in the wake of the COVID-19 phenomenon ongoing stability for children’s health, education and wellbeing will be ensured and demonstrate effective governmental actions in times of emergency.
People with disabilities

Mental health impacts have been identified as negative outcomes associated with containment measures in response to COVID-19 as families have had disrupted access to usual specialised clinical supports, participation in research studies and specialist education services. The emergence of the NDIS and challenges associated with the rollout and access has highlighted the tensions and often artificial distinctions between separate health and disability services, making it very confusing for many people to navigate. Therefore, understanding these issues for families will support better design, less duplication and better clarity for families of children with disabilities. This has never been more relevant than at times of crisis as experienced by families during the emerging reorientation of services responding to the COVID-19 pandemic.

A reliance upon TeleHealth options for delivering care has posed additional constraints as families and caregivers grapple with unfamiliar technology solutions, cancelled appointments, additional requirements to be flexible and to have access to up-to-date, often costly technology. Financial challenges have meant that access to phone and internet has also been limited for some therefore limiting connection with health and support services. As many caregivers managing those with a disability are identified as also having a disability, for many, this imposes compounded complexity with potential for additional economic, health and education implications.

In meeting the complex health needs of our patients and families, particularly those managing disability, there is potential for the provision of fragmented care that is system-centric, not patient or family-centred. In recent weeks, the emergence of a serious threat to our health service provision, in the form of the COVID-19 pandemic has prompted all service providers to rethink current systems, reorienting front line services to address consumer needs as evolving disaster management strategies have become necessary. Core values identified at the centre of health service providers highlight a commitment to patient and family-centred care. However, opportunities may exist for improvement in the way our services are delivered, in particular, the involvement of consumers in planning and messaging changes would be imperative.

Families managing a patient with a diagnosis of a disability often require a range of health and social services to meet the needs associated with the diagnosis. Compounding this issue, for many, the existence of co-morbid conditions and disability of the carer has the effect of complicating the requirements of individuals and their families managing disability. It is estimated that 80% of people with a disability are likely to experience a mental health problem at some stage, and that they are extremely vulnerable at times when health and mental health services are relying on technology to deliver services.

The recent Statement of Concern by experts in human rights, bioethics and disability outlines a framework of human rights principles for ethical decision-making for people with disability, which is consistent with the Convention on the Rights of Persons with Disabilities:

1. health care should not be denied or limited to people with disability on the basis of impairment
2. people with disability should have access to health care, including emergency and critical health care, on the basis of equality with others and based on objective and non-discriminatory clinical criteria
3. health care should not be denied or limited because a person with disability requires reasonable accommodation or adjustment
4. health care should be provided on the basis of free and informed consent of the person with disability
5. health care should not be denied or limited based on quality of life judgements about the person with disability
6. ethical decision-making frameworks should be designed with close consultation and active involvement of people with disability and their representative organisations.

In the wake of the COVID-19 national disaster response, prioritising a review of impacts for people diagnosed with disability and their families and carers is urgently called for.

**Sex workers**

The COVID-19 epidemic has both revealed and exacerbated vulnerabilities among different populations, and an obligation arises to specifically consult with vulnerable and marginalised populations to avoid epistemic injustice.\(^{64,65}\) COVID-19 and the consequential business and travel restrictions in Australia have reduced work available, and impacted sex workers’ workplace health and safety strategies. Scarlet Alliance, the national peak sex worker organisation in Australia, has identified wide ranging impacts of COVID-19 on sex workers which include housing, food and financial insecurity, barriers to access essential health care, as well as other impacts consequential to lost earnings.\(^{66}\)

State based peer sex worker organisations in Australia have long-established networks of trust with sex workers, as well as a history of strong partnership with state and territory health departments. These have included the distribution and development of COVID-19 specific resources for sex workers in Chinese, Korean, Thai and Vietnamese, skills development programs for sex workers to adapt their businesses to provide online rather than in-person services, and information about accessing the government’s JobSeeker and JobKeeper programs.\(^{66,67}\) A community funded emergency support fund for sex workers has been set up and by early May 2020 had raised and distributed to sex workers over $50,000 from more than 600 donations.\(^{68}\)

Australian sex worker organisations call for the provision of crisis funding to Scarlet Alliance and state and territory member sex worker organisations, and removal of barriers to access income support, healthcare, prevention of workplace and housing evictions and other essential services.\(^{66}\)

The involvement of sex worker organisations in the development of return to work timelines and health guidelines is critical\(^{69}\) and New Zealand’s government and industry discussions provide a consultative model for Australia to emulate.\(^{70,71}\)

**Gambling**

Australia’s 194,000 electronic gaming machines (EGMs) are mainly located in hotels and clubs, and in casinos. These venues also provide other forms of gambling, including Keno, wagering (often using terminals to place bets) and in casinos, table games. All these gambling venues have been closed during the restrictions arising from the COVID-19 pandemic.

State governments, heavily lobbied by the gambling industry and venue owners, are planning to reopen these venues. However, there are a number of public health issues to address to ensure reopening these will not endanger the health and wellbeing of those who use or work in these venues.
Transmission of infectious diseases

As part of our comprehensive measures to prevent infectious diseases spreading, it is essential that gambling venues reopen only when all changes to physical layout and cleaning procedures are fully implemented, in accordance with the best advice from qualified public health experts, and with the approval of State and Commonwealth Chief Medical or Health Officers and their delegates.

This includes arrangements for physical distancing, calculation and effective enforcement of a maximum occupant capacity for each gambling room to be reopened, and cleaning procedures for EGMs or other equipment utilised for gambling activities (chips, cards, wagering terminals, terminals for keno or automated table games etc). It may also be desirable to impose ‘session limits’ on patrons to limit time spent in specific gambling rooms and thus reduce likelihood of transmission of pathogens.

The health and safety of staff is also of paramount concern, both for their own protection and to avoid the transmission of disease to others. All necessary measures should be taken to ensure this, including the supply and use of personal protective equipment where required. Again, such arrangements and procedures must be subject to approval by State and Commonwealth Chief Medical and Health Officers and their delegates.

Mental health issues

There is a well-established association between the incidence of mental health conditions and the use of EGMs and other forms of gambling. Habitual or addictive use of EGMs exacerbates existing mental health issues, and may also precipitate the onset of some mental health conditions. People with established habitual or addictive gambling behaviours have been constrained from using many forms of terrestrial gambling for some time. Some may have migrated to, or increased, online gambling activity. However, it appears that this has not substituted for more than a fraction of terrestrial gambling activity. For example, there are reports that online gambling activity appears to have increased by about two-thirds (equivalent to $2 billion per annum) compared with $15 billion per annum lost to electronic gaming machines.

As with other addictive products, some people with mental health issues utilise gambling as a means of ‘self-medication’, as it appears to stimulate release of neurochemicals that provide temporary relief of some symptoms. However, the costs of gambling – particularly EMG gambling – are very high, and any relief is both short-lived and likely to exacerbate existing disorders.

It is important therefore, that when EGM and other gambling venues reopen, due consideration is given to the likelihood that a significant number of gamblers will be drawn to gamble in order to relieve symptoms of anxiety and stress. This may include some who have been ‘casual’ gamblers in the past.

There is also a strong likelihood that gamblers with mental health conditions who have modified their gambling behaviour during the COVID-19 restrictions will relapse in response to the availability of EMGS or other gambling, and to escape temporarily from the anxiety and stress of the current situation.

Disadvantage and stress

EGM venues in particular are disproportionately located in areas of social disadvantage and stress. These locations are highly lucrative for gambling operators, for reasons noted above. In some Australian jurisdictions, very large and highly lucrative EGM venues are located in the most disadvantaged suburbs and towns (e.g. Fairfield in Sydney or Dandenong in Melbourne).
The impact of the COVID-19 restrictions on the social distribution of disadvantage and income is not yet clear. It is unlikely to be evenly distributed across society, and there is a likelihood that already disadvantaged workers (for example) will be further disadvantaged by the impact of job losses and business closures. The stress and heightened disadvantage of such impacts will induce a proportion of those affected to engage in risky behaviour, including gambling, in order to either (mistakenly) seek to improve their financial position, or to relieve stress and anxiety. People who have no or reduced income as a result of the loss of casual employment, for example, will be disproportionately affected.

The potential for gambling to greatly exacerbate disadvantage and stress in already disadvantaged communities is greatly heightened by this continuing situation.

**Family violence**

The relative density of EGMs in local areas is also a risk factor for family violence. Access to EGM venues in the current economically difficult situation is only likely to lead to further increased rates of family violence.

**State and Territory Government responsibilities**

Gambling harms many people. Most gambling revenue, for example, comes from people with significant or major gambling disorders. There is a significant likelihood that reopening gambling venues will make the current difficult situation worse for many people. Most likely to be affected will be those already experiencing significant disadvantage, stress, and associated impaired health and wellbeing.

For these people, their dependents and friends, employers and neighbours, existing impacts of the COVID-19 pandemic will be greatly heightened. This in turn will lead to increased rates of illness, suicide and significant detrimental impacts across affected communities.
References


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