PUBLIC HEALTH COMMUNICATION CENTRE AOTEAROA

COVID-19 in Aotearoa: what does public health do now?

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Belinda Loring, Ruth Cunningham, Polly Atatoa Carr

Public health activities have collectively made an incredible contribution to minimising the impact of COVID-19 in Aotearoa. But the work for public health is not over. As the situation in Auckland heralds a transition point in our approach to the pandemic, the challenge now is to be bold and clear about how we prioritise our public health resources and effort going forwards to the activities that will make the greatest impact on protecting and improving population health.

Through Aotearoa's elimination strategy, an estimated 10,000-20,000 deaths have been

averted by keeping COVID-19 largely out of our communities until now. Critical to this success has been the intensive efforts of the public health community – providing policy advice on which control measures offer the biggest impact, the vaccination strategy, and intensive case and contact management. With increasing levels of vaccination, and Delta forcing our hand a little earlier than we hoped, we are now moving to the next stage of the pandemic, particularly in Auckland. In this transition, the priorities and approaches of the public health response must also be reconfigured. The current outbreak in Auckland and Waikato is already requiring a national response. Public health units around the country are involved in case and contact management for Auckland cases. How long COVID-19 can be kept out of further regions is unclear, but while Auckland may be further along the pathway, there is a national need now for transition planning and reorientation. It is not simply about scaling our current approach to meet demand. We need to reorient our model to ensure our scarce public health capacity and workforce are directed to the activities that will make the greatest impact on protecting and improving population health.

This reconfiguration needs us to think more deeply than the rising case numbers. The type of response required for 500 or 1000 cases a day depends greatly on who they are. Based on our experience with this present Delta outbreak, we can already see the picture emerging of COVID-19 becoming concentrated in the most marginalised and underserved. The bulk of cases (and the necessary focus for our response) are in Māori, Pacific, young and poor communities, those with high levels of unmet health needs, and those with bad experiences with health services and government agencies. A pro-equity and Treaty-compliant response demands us to place saving Māori lives at the centre, however this is best achieved. The public health unit response in Auckland has had to rapidly pivot to establishing Māori-led mobile teams, as the standard contact tracing model proved ineffective at responding to increasingly complex cases without phones, homes or trust. A belief that the caseload moving forwards will reflect the composition of the general population is false and will lead to the development of an inappropriate response.

We also need to reflect on and prepare for what a transition to living with COVID-19 means in terms of public health need. Even if elimination can still succeed for longer in pockets of the country, this will be a national public health crisis. Yes, we will see more cases and hospitalisations with COVID-19. We will have more people with COVID-19 at risk of deteriorating and dying at home. But we will see other significant health issues too as primary care and hospital services become stretched. We will see people becoming seriously unwell from their life-threatening long-term conditions, presenting to hospital later or not at all. Unmet need for preventative, screening and diagnostic services will exacerbate the burden from cancer, avoidable child health conditions and mental health issues. Māori and Pacific communities, and those living in socioeconomic deprivation, who already bear the brunt of these conditions, will be most severely affected.

A reopening of our borders in the coming months will predictably reintroduce the same infectious diseases that we regularly battle to keep away, including measles. As the COVID-19 response has disrupted our immunisation programme, now we have a cohort of children and families even more vulnerable. In the most recent coverage data just over 50% of Māori children were fully vaccinated by 4.5 years of age. The review into the serious 2019 measles outbreak recommended an urgent national measles catch-up vaccination programme to boost immunity, which has been delayed due to COVID-19. Our public health interventions need to work in the context of poverty, housing and employment insecurity, colonisation, abuse in state care, and systemic racism in our health, social and justice systems.

Taking into account this broader picture, how do we reconfigure our public health response now to prepare for the coming rise in COVID-19 cases and make the greatest contribution to achieving equity, protecting and improving population health?

1. We need to provide strategic intelligence.

Our approach needs to move beyond forecasting case numbers and hospitalisations, modelling the impact of control measures, and vaccination coverage. To prioritise our public health response going forward, we need the answers to different questions. What is the expected distribution of cases, and how does this overlay with other public health vulnerabilities such as immunisation status, residence in transitional housing or disconnection with primary care? What are the expected impacts on public health burden? How do we tailor public health intelligence to the needs of providers delivering services?

2. We need to reprioritise and adapt our COVID-19 public health interventions.

This involves reconfiguring our current model of case and contact management, based on what activities will make the most difference over the coming months, rather than just let capacity dictate what gets "dropped off" the existing list. Alongside the question "at what caseload do we stop doing things" we also have a responsibility to be asking now "at what caseload do we start doing things"? Going forwards, how do we rapidly identify those at highest risk? Can we rely on responding to positive COVID-19 tests as an effective strategy to reach those cases most at risk of transmission and serious illness? What else can we do now in areas of the country without COVID-19, to protect and prepare those we know will be most at risk?

3. We need to urgently implement public health actions for more than just COVID-19.

Our pandemic response needs to avert more than COVID-19 morbidity and mortality. How do we quickly immunise against measles (and other childhood immunisations) in advance of borders reopening? How do we offer opportunistic screening/assessment for other long-term conditions when we are in contact with communities in order to manage COVID-19 risk? How do we prioritise our capacity to meet the most critical welfare, social and health needs? How do we ensure people with COVID-19 are safe at home? How do we transition from a clinical public health focused on cases and contacts to a population health approach focused on community health need? Public health services still have an active role and responsibility in this space.

4. We need to prioritise models that reach underserved communities.

Public health services have a responsibility to provide a model that works for all, and need to be flexible, collaborative and open in our approach to achieving this. In some situations, this means devolving more public health power and resources to community providers who can deliver an effective response. In other situations, it means adapting our response within public health services to engage with groups our traditional approach is failing. We need to be less rigid on who does what, and clearer on what needs to be done. At this point, it should not matter if the "service" that can reach a high-risk whānau is from a public health unit, NGO or primary care. That service needs to be able to make the most of the often fragile and fleeting contact to deliver as much public health benefit as possible – whether that means providing food, phones, vaccination or diabetes medication. Referrals to different agencies, and transitions between agencies are a high risk of failure and

exacerbation of inequitable outcomes.

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Author details:

Dr Belinda Loring, Public Health Medicine Specialist, Senior Research Fellow, Te Kupenga Hauora Māori, Department of Māori Health, Faculty of Medical and Health Sciences, The University of Auckland b.loring@auckland.ac.nz

Dr Ruth Cunningham, Public Health Medicine Specialist, Senior Research Fellow, Kairangahau, Department of Public Health, University of Otago Wellington

Associate Professor Polly Atatoa Carr, Public Health Medicine Specialist at Waikato District Health Board, Training Programme Director for the NZ College of Public Health Medicine and Associate Professor at the National Institute of Demographic and Economic Analysis at the University of Waikato.

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