

On entering Australia's third year with COVID-19

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We cannot let complacency encumber how we live with the virus: vigilance and a planned recovery are essential



In 2022, Australia will enter its third year with COVID-19, the coronavirus disease caused by infection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). If 2020 was characterised by the fight for “COVID-zero”, and 2021 by the drive to vaccinate Australia, 2022 and beyond could be the start of the inter-pandemic period: if all goes well, community vaccination levels will be high enough that the occasional COVID-19 outbreak will not require lockdowns or other strict public health measures.



The caveat concerns the nature of the virus. All viruses mutate, new dominant strains emerge. We do not know whether the next SARS-CoV-2 strain will be nastier than its predecessor, or whether a new vaccine will be required and could be developed quickly. At this stage, we also still don't know whether

everyone will need booster vaccination shots or whether lessons learned during the messy 2021 vaccination rollout will improve the management of a booster shot program.

But the 2022-and-beyond vaccine program is but one of the policy challenges Australia needs to consider. More broadly, all governments need to be involved in planning the recovery phase, to ensure that they can manage the impact on health systems and protect public health during the inter-pandemic period.

The missing recovery phase

The National Cabinet COVID-19 roadmap (released in July 2021) ends with the “final post-vaccination phase”, which includes border re-openings and living with COVID-19 in the community without lockdowns.¹ Disappointingly, the roadmap includes no explicit recovery phase: it as if we could all soon heave a sigh of relief and simply move on.

The recovery phase after public health emergencies normally includes addressing their economic effects and managing their mental health impacts.² COVID-19 became a disease of low income workers — those who couldn't work from home — and their families and communities. It affected Australia very unevenly, with poorer outcomes for those at greatest disadvantage.³ The recovery phase needs to rebuild community and system resilience and redress disadvantage exacerbated by COVID-19. Planning for workforce responses, especially preparing for burnout and the needs of staff for time out to recover, will be critical. It should also include governments, hospitals, and primary care services learning from the crisis: what went well, what went badly? From a public health perspective, this should not be a witch hunt, but rather an exercise



in learning and improvement. The learning process should be undertaken at both local — what were the changes, what was their impact and cost, what did staff and patients think about them? — and at state and national levels, including formal inquiries.

Health system lessons

The Australian health system adapted remarkably well during the acute phase of the pandemic. Hospitals responded very flexibly, boosted hospital-in-the-home services, and expanded telehealth options for outpatient clinics. General practitioners also embraced telehealth. Hospitals established mass vaccination hubs rapidly, and managed them well. But all was not perfect. Staff were under enormous pressure, and symptoms of limitations to hospital capacity were evident in most states.

2022 will bring new challenges. The continuing mental health effects of disruptions to life during 2020 and 2021 are already being seen in the health system, and, as with natural disasters, they will need to be managed for years, not weeks.⁴ Deferred care (system-deferred, such as elective procedures, or patient-deferred, including care missed because patients with troubling symptoms postponed seeking help) will need to be resumed. “Long COVID” is also a serious and, to some extent, still undefined phenomenon.^{5,6} The reporting of some signs, such as parosmia (for which there is currently no effective treatment), has increased dramatically.⁷ The long term effects of COVID-19 on cardiac and respiratory function are still being assessed. Health services will need to plan for staff who need to recover from COVID-19-induced burnout.⁸

Decision makers in health systems will need to spend early 2022 assessing and developing strategies in response to these problems, and this situation will be more confronting if new vaccine-resistant virus variants emerge, or the effectiveness of current vaccines wanes.^{9,10} The federal government will need to finalise a policy on permanently incorporating telehealth into primary and specialist care in the community. It also needs to share the increased health care costs caused by the pandemic; and not just the direct costs, which it has already agreed to share with the states on a 50:50 basis, but also the costs of deferred care in 2022

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and possibly even 2023. Under current arrangements, these costs will be borne entirely by the states because of the cap on federal funding.

Public health during the inter-pandemic period

Public health is the art and science of protecting and improving the health of people and communities by promoting healthy behaviours, workplaces, and communities, and preventing or responding to communicable and non-communicable environmental and lifestyle diseases and other hazards. In 2022, public health will need to concern itself with the emerging burden of disease and avoidable harms linked with the profound effects of the COVID-19 pandemic over the past two years.

The real lesson of the pandemic, however, is the huge impact of inequality and structural disadvantage on its course and outcomes. It is convenient to imagine that respiratory viruses are randomly transmitted from one person to another. The reality is that they find all the social, demographic, and economic vulnerabilities within and between populations: differential effects related to sex, overcrowding, essential but casualised work, public housing, homelessness, poverty, poor health literacy, cultural marginalisation, and stigmatisation. These are not individual human behavioural problems as much as “causes of the causes”.^{11,12}

Such fundamental disparities across the social spectrum apply as much to non-communicable disease as to pandemics: we see it in inequitable health outcomes during extreme heat, in congenital syphilis, and in people exposed to environmental hazards, such as poor air quality. COVID-19 vaccination rates have been much lower for First Nations people than other Australians, despite their priority status during stages 1b and 2a of the vaccine rollout,¹³ and are at greater risk of both transmission and severe illness if infected.¹⁴

In 2022, public health practitioners and organisations must seek to better understand these social drivers of health in the COVID-19 era, and receive the resources to redress disparities exacerbated by the crisis. How has prolonged remote learning affected children and communities differently? How have young people fared, a group particularly exposed to mental health problems, loss of employment, and casual work hours? And how can they best be helped in the years ahead?

Conclusion

Australia weathered the COVID-19 storm well. Our death rate was among the lowest in the world, and the impact on the economy was also relatively mild. But these successes may have hampered our vaccination rollout. We cannot allow complacency to similarly encumber how we live with COVID-19. We must be vigilant, to ensure that our first-rate public health capacity is not run down as part of public sector belt tightening. We must ensure that our health system has the capacity to respond to the shadow pandemic of mental health problems caused by the viral pandemic and its management,¹⁵ and that we are well placed to face the challenges of both long COVID and future pandemics.

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