While we have your attention…

Felicity Dumble, Jim Miller, Maria Poynter, Phil Shoemack

In normal times, public health professionals work in the background to ensure that the myriad health risks faced by our population do not see the light of day. Pandemics and other major outbreaks or health emergencies remind the public of the importance of public health services. We are fortunate that we have, during the COVID-19 crisis, had leadership that includes public health expertise and that understands the need for swift and decisive public health action. The aid of the hundreds of additional health professionals that have temporarily joined the Ministry of Health and public health units within DHBs to help out over this period has been greatly appreciated.

But the COVID-19 response has exposed an extremely concerning reality—that there is a massive and hugely problematic shortfall in New Zealand's public health investment.

The lack of capacity within public health has been noted by Dr Ayesha Verrall's report into contact tracing.[1] It is also evident in the number of public health events over the past few years, including the Havelock North campylobacter outbreak and the 2019 measles epidemic—both of which were preventable had the health system had capacity to manage upstream risks.

Despite this under-resourcing and under-investment over many years, our depleted public health professionals and public health units have responded amazingly well to the size of the challenge that COVID-19 has given us. But this has required substantial emergency investment. You cannot make up for more than a decade of underfunding with emergency funding. Now that the money has started to flow to public health, we need to maintain this financial momentum and make wise investment decisions. Some of the current spending is just to see us to the other side of the crisis—what we really need is a long-term public health investment strategy, both regionally and nationally. This strategy needs to build on the rapid innovation that is currently happening, but still be focused on creating a world-class public health service that will see us through the next generation.

This future needs to be co-designed with those public health professionals who understand it intimately and who can avoid repeating the mistakes of the past and current systems and embedding a whole new set of flaws.

Nationally, we need information systems that can capture all our data needs, from clinical and laboratory notification through to case and contact management, as well as real-time monitoring and centralised reporting. Clinicians from around Aotearoa should be able to electronically report all notifiable diseases to Medical Officers of Health, in the same way they can refer a patient for a specialist service. As well as being electronic this notification pathway should be similar to the electronic system already used by laboratories to notify cases to Medical Officers of Health that uses the EpiSurv (the national notifiable disease database) system. This would ensure that data from clinician notifications can be automatically entered into EpiSurv and the collated information will be available to be seen locally, regionally and nationally as is currently available from this dataset. Case and contact management needs its own information system to adequately capture and link cases, contacts and their management—and if the system works well, this should be operated around the country so that workload overflows can be taken up by other areas when a local outbreak outstrips local capacity. Such a system would need to work very differently to the current case/contact split in COVID-19 management, whereby the national hub takes contacts without the linked case; this is a stop-gap measure only and should absolutely not be the longer-term approach.

Like IT infrastructure, the workforce infrastructure also needs investment. The New Zealand College of Public Health Medicine has advocated for more public health medicine training positions for several years. Because of the scope of public health, workforce development also requires more people skilled in areas such as epidemiology and statistics, geospatial epidemiology, social marketing, informatics and emergency management. Related specialist areas including occupational health, health protection and drinking water assessment require similar investment.

While much can be invested nationally, there will always be a need for public health service delivery at the local level. We do not know whether the forthcoming Health and Disability System Review report will include a recommendation to (re-) establish a central public health agency; there are arguments both for and against one. Public health is about people and contexts; regional services have much greater ability to be sensitive to the local populations than a remote national service. This is particularly true for ensuring any public health response addresses and removes inequities and can work with mana whenua to distribute power appropriately.

Public health crises have historically been used to drive reform in the public health sector, such as with the 1988 Acheson Report in the UK.[2] The COVID-19 pandemic is the opportunity to move public health service design in New Zealand out of the 19th century and into the 21st century. We must have excellent and collective foresight to plan the services we need to deliver into the future, rather than repeating past mistakes of responding with 'just enough' to see us through the current crisis. While we are focusing at present on communicable disease control, this design opportunity exists for all aspects of population health. First and foremost, this must achieve health equity for Māori. Health equity for Pacific People must also be addressed. Additionally, addressing risks related to social and commercial determinants of health, non-communicable disease threats, environmental health and climate change are all part of the agenda, and would benefit from a Health in All Policies approach. Public health needs capital infrastructure investment to deliver information systems and workforce development to meet current demands, as well as an increase in baseline funding for both national (Ministry of Health and ESR), and regional (public health unit) service delivery.

The co-ordinated response of Aotearoa to COVID-19 represents a refreshingly powerful example of our government seeking, and following, the advice of public health experts. Many of the most effective public health levers are held by politicians. Our hope is that national and local decision-makers continue to commit to acting on the evidence.

Competing interests:
Dr Miller, Dr Poynter and Dr Dumble report affiliation with the New Zealand College of Public Health Medicine.

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