

2004 Chief Health Officer Seminar Series

Seminar Seven – 9 November 2004

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Abstract:

Current Issues in Health Protection

Dr Charles Guest will speak of recent health protection challenges faced at the jurisdictional level and explore matters in health protection that relate to disaster protection including issues of preparedness and warning systems.

Transcript:

I'm going to speak about on the ground issues in health protection today, starting a little bit globally, working down to local, and then with a dash of international benchmarking at the end.

We'll look at events since SARS and since September 11, but as September 11 was occurring, the World Health Organisation brought out a report with the title 'Reducing risk, promoting healthy life'.

It's interesting to look back at the report now as a marker of risk management circa 2001–2002 and see how far we have come from there.

The study in the WHO report actually presents some empirical data on how we factor risks and how we manage them.

It has some empirical data measuring known to unknown, low dread to high dread, and I've just picked off a few topics that are of interest to us at the moment — vaccination, and alcohol, both interesting and familiar to us.

Low dread doesn't tend to drive the risk management agenda even though the burden of disease related to excessive alcohol consumption is of course marked.

Then there's asbestos, topical this year in the ACT, which does tend to drive our risk management agenda.

We also have a very high degree of risk associated with terrorism, and that's probably the phenomenon above all that's driving our risk management agenda in a public health agency these days.

The lessons for governments from this empirical WHO study, things that we all know that are worth going over again, begin with the notion that for credibility you require trust.

Trust only comes from openness. Openness requires recognition of uncertainties. Our scientific investigations need to be transparent, the committees that we set up to advise us need to have

transparent processes and trust is what we must not jeopardise to work in the field of risk management.

Now the WHO report emerged before September 11, with the WHO recommending governments play a larger part in risk reduction and risk management, and risk management has become the mantra for us working in public health now.

Cost effectiveness comes into it too, analyses of course and then a balance between government, community and individual action is necessary in risk management as a field of work.

So, no surprises here. Risk management is everyone's business and risk management is part of business as usual. So that's the global understanding of risk management as a field of work now.

Let's go to what we learnt from a disaster that occurred since that report - what did we learn from SARS that affected all jurisdictions in Australia? Well, we learnt that world-wide surveillance is critical, that we need a capacity to respond to disasters – a capacity that's not there every day.

We need a timely reporting mechanism with rapid communication – that's something we've been working on steadily since September 11.

But particularly with SARS, we didn't know at the start of that outbreak how the disease was spread. It was critical to do research which was published in record time in peer review journals enabling evidence-based health advice to be provided.

In Australia we had good leadership and I think we should acknowledge here the role, for example, of the Commonwealth Chief Medical Officer, Professor Richard Smallwood at the time.

Responses were quick. There was a greater cooperation between jurisdictions and the Commonwealth on a public health matter than we've usually seen, more than we often see. There has been some increased investment in public health because of those events which, from where I sit, is a favourable development.

We can update quarantine and other legislation and furthermore, infection control has come to the centre of much of what we do in health protection in the ACT with a lot of concerns in primary health care.

One thing that we've done is investigate how well we were prepared in general practice and today I'm sharing with you some of the very preliminary results from that survey.

This is unofficial information at this point. But the objective was to see how well GPs were prepared for a serious emerging disease, what information sources they were using, and how able were they to get involved in containing this problem.

Where did GPs get their information about the SARS outbreak? They got a lot of it from print media – divisional faxes, newsletters, the medical press and the popular press – but websites much less so.

We had something of a reality check with this because we were putting out information all the time, on the internet, through email, rapidly updated websites and the like. But in fact the people who were doing the work at the front line were significantly dependent on print media.

How well were the guidelines on infection control implemented in general practice in Canberra? We had telephone triage. That meant when you called your GP for an appointment, you were supposed to be asked whether you'd been travelling or whether you'd had fever. In fact, only 30 or 40 percent of practices were doing this.

On actually arriving at a GP's surgery you were supposed to be asked whether you'd been travelling or had fever and for this the proportion's only about 50 percent.

So the message here is that although we accelerated the development of evidence-based health advice very profoundly during the SARS crisis, the implementation was actually very patchy and we'll need to address that.

A good proportion of practices made available surgical masks as required. But a lot didn't. Advisory signs should have been placed at entrances as specified by the Commonwealth guidelines. Sixty percent of practices were doing that.

Those practices with a person who could be identified by this survey as able to check where SARS was at the time only made up about 40 percent. So the reality check of this project is that although we are mounting a lot of evidence-based health advice, the implementation lags behind it.

What about equipment purchases? This was a measure of our surge capacity and where the people in a general practice were actually able to cope with SARS and had the necessary equipment on hand. Twenty percent of practices had to go out and buy masks. The specified PT2 N95 masks? Only eight percent of practices had actually made those available.

Some 16 percent had bought disposable gowns and so on, so there had been a lot of equipment purchases, and yet still a lot of practices really weren't equipped to deal with this problem. Luckily we only ever had suspect cases.

The delivery of public health advice clearly requires further investigation.

Here we are in one of the most affluent, educated places in Australia and that's the level of uptake of guidelines. It's clearly not adequate yet.

With the implementation of guidelines, GPs are going to need a lot of help. Continuing professional development will be needed to identify and reduce barriers with clarification of roles and equipment and other costs.

There was a lot of debate in the primary health care setting about whether we should have response teams or centralised assessment centres and that debate I think will continue. Obviously it's dependent on the specific problem that we're dealing with.

So that was one response to SARS here in the ACT - to go out and get further information on implementation and guidelines. What else are we doing?

We're continuing and are now speaking more generally across protection. We're doing a lot of planning - for disasters, for influenza pandemics, for SARS skills and mass casualties and the public health emergency plan.

We also try to practise what we develop policy about. This year we ran an exercise where the health portfolio of the new emergency services authority tested the health emergency management sub-plan.

All these things are undertaken in the context of a high demand now for preventive services.

I pulled a series of headlines off *The Canberra Times* during February, March and April showing the expectations of prevention. They refer of course to the January bushfires 2003 – ‘no extra jobs done to prepare’, ‘the threat was there, but no alert’, ‘officials had early warning’, ‘bushfire victims in the dark’, ‘warning the ACT is not my job’ and ‘the forces were marshalled but no warning’.

So we have a very high demand now for preventative, pre-emptive activity in emergency managements and the courts are actually finding failure to prevent now is actionable as negligence.

Well, how are we doing? How would we judge whether our capacity is sufficient, whether it is sustainable, and whether we have particularly surge capacity?

We have routine capacity in the ACT. Whether we have enough surge capacity to cope with, for example, an influenza pandemic, would we have the reserves remains a big question.

We are improving our laboratory diagnosis and surveillance with integrated information systems and we have been working on communication systems. At the national level we’re developing a bio-security surveillance system to detect syndromes.

Are we able at the national level to detect, for example, when there is a surge of cases of, let’s say, fever and cough - the two defining characteristics of SARS?

Can we in real time put together information about a surge in cases of a syndrome? We are working at the national level to look at all sorts of things - bio-terrorism prevention, early detection, natural emerging or existing disease detection and to improve our surveillance. That’s a national and international project now.

Just outside London is a new conglomerate of centres for infections, for environmental health and emergency response, all under the one roof. It’s interesting to see how much convergence there is at the international level where people are putting emergency services together.

Back in sunny Canberra we’ve recently had launched a new piece of public sculpture – the emergency services memorial down on Commonwealth Park – a nice place for a picnic.

It’s interesting to see how the values of emergency services as inscribed on this memorial basically line up with our own mission statement in ACT Health - ‘from vigilance through to resilience and hope’.

Hope is the important word on the path to resilience. Resilience, I think, is a key word for these times, implying continual renewal and renovation and improvement. And that’s where our emergency services are now.