Aboriginal Health Council of Western Australia

Submission to the Commonwealth Government COVID-19 Response Inquiry Panel

14 December 2023

AHCWA is the peak body for 23 Aboriginal Community Controlled Health Services (ACCHS) in Western Australia (WA). WA ACCHS' are located across geographically diverse metropolitan, regional, and remote locations. They deliver the most effective model of comprehensive primary health care for Aboriginal people[1] and are in a unique position to identify and respond to the local, cultural, and health needs of Aboriginal people and their communities.

This submission responds to three of the Inquiry's terms of reference; governance, key health response measures, and mechanisms to better target future responses to the needs of particular populations. AHCWA, with its Members, is currently undertaking a comprehensive review of the COVID-19 response from the perspective of the WA ACCHS Sector. The information and recommendations within this submission draw from that work.

A Summary of AHCWA Members' Experience of the COVID-19 Pandemic

The Aboriginal and Torres Strait Islander-led response to the COVID-19 pandemic has been described as [redacted]. Aboriginal people experienced considerably lower infection rates than non-Indigenous people in the early stages of the pandemic, averting hospitalisations and deaths[3]. The National Aboriginal Community Controlled Health Organisation (NACCHO), Aboriginal Community Controlled Health Organisations (ACCHOs), and the Aboriginal and Torres Strait Islander Advisory Group on COVID-19, established by the Commonwealth Government in March 2020, were central to providing this leadership.

Recommendation 1: Aboriginal and Torres Strait Islander leadership must be authentically embedded in all Government-led emergency health responses.

The WA and Commonwealth Governments both took specific steps to protect remote Aboriginal communities in the early pandemic, with First Nations people appropriately recognised as a priority population. The Commonwealth's Biosecurity Determination, which restricted travel into the Kimberley, parts of the East Pilbara, and the Shire of Ngaanyatjarraku, successfully limited transmission of COVID-19 into these regions and was supported by ACCHS as a key protection measure at the time. These measures did, however, result in significant increases in workload for ACCHS, particularly due to their heavy reliance on fly-in-fly-out (FIFO) staff, including from overseas.

In March 2020, there was an initial scramble to access very limited supplies of Personal Protective Equipment (PPE). A very small number of masks were made available by the Commonwealth through the WA Primary Health Network (WAPHA), however, it was clear that stores were inadequate to support safe service delivery at the outset of the pandemic. AHCWA and its Members subsequently reached out to philanthropic partners to help plug this shortfall. The lack of available PPE to primary care was a key early failure of the early pandemic response.

Recommendation 2: A rapid supply of quality PPE from the Commonwealth must be readily accessible to primary care from the very start of an epidemic or pandemic response.

Despite the challenges, WA ACCHS successfully maintained routine primary care services, in addition to the work of the pandemic. Data from the latest Australian Institute of Health and Welfare (AIHW) report shows that there was no decline in WA ACCHS delivery measures over the four 12-month reporting periods between 2018 and 2022[4]. In fact, there was a rise of 15% in both "episodes of care" and "client numbers" in 2021-2022, likely reflecting the significant additional role played by ACCHS in administering COVID-19 vaccines and providing ambulatory care for cases. The introduction of a range of new Medicare Benefits Schedule (MBS) items to support and encourage the use of telehealth in March 2020 was certainly one of the major systems benefits to occur due to COVID-19. Telehealth was not new to the WA ACCHS Sector with many remote and regional ACCHS already moving to a telehealth model for hospital specialist consultations before the pandemic. However, these efforts had been frustrated by poor

[1]Throughout this submission, AHCWA uses the term 'Aboriginal' to respectfully refer to all Aboriginal and Torres Strait Islander people across WA.
[2]Stanley F, Langton M, Ward J, McAullay D, Eades S. Australian First Nations response to the pandemic: A dramatic reversal of the 'gap'. J Paediatr Child Health. 2021 Dec;57(12):1853–6.
[3]Eades S, Eades F, McAullay D, Nelson L, Phelan P, Stanley F. Australia's First Nations' response to the COVID-19 pandemic. The Lancet. 2020 Jul;396(10246):237–8.
[4]Australian Institute of Health and Welfare. Australian Institute of Health and Welfare. 2023 [cited 2023 Nov 23]. Aboriginal and Torres Strait Islander specific primary health care: results from the OSR and nKPI collections, Data. Available from: https://www.aihw.gov.au/reports/first-nations-people/indigenous-primary-health-care-results-osr-nkpi/data

connectivity and restrictive MBS rebates. AHCWA had been advocating for years for improved access to telehealth, and COVID-19 finally made this possible and financially viable.

Recommendation 3: MBS telehealth items must be here to stay to enable access to primary and specialist care for Aboriginal people throughout WA. Items for patient-end support (for GP and specialist telehealth consultations), and initial specialist telehealth consultation (particularly for MM2-7 locations) must be available.

Communication and transparency are paramount in any emergency response. While the Commonwealth and state shared official responsibility for public communication during COVID-19, it was clear to ACCHS that a community-driven, localised approach would be necessary to reach Aboriginal communities. The ACCHS Sector's ability to respond rapidly to this need was one of the great success stories of the pandemic. AHCWA and its Members developed posters, Facebook posts, radio promotions, video clips and television advertisements. While content was based on official government requirements, the messages themselves were much more engaging and community-focused emphasising cultural values and personalised through the use of local imagery, familiar voices and translation where appropriate. Many of these communication resources were equally popular with the non-Aboriginal community, with ACCHS-developed posters displayed at road houses and public spaces across the state. ACCHS also played an important role in countering misinformation, particularly around vaccination. While communication to primary care through the Commonwealth's COVID-19 Primary Care Response was regular and helpful in supporting services to navigate the COVID-19 landscape, the Commonwealth failed to recognise the vital role ACCHS play in disseminating important COVID-19 information in effective and trustworthy ways.

Recommendation 4: The ACCHS Sector must be resourced by the Commonwealth to communicate important health information effectively to Aboriginal communities, especially during a health emergency.

Isolation and quarantine mandates were, arguably, the most challenging element of the pandemic. COVID-19 exposed all of the social determinants of health that disproportionately affect Aboriginal people, but it particularly exposed the lack of safe adequate housing. The Government's pandemic response was built on the assumption that most individuals could safely isolate in their homes, with promises that safe alternative accommodation for isolation could and would be provided for those who needed it. However, in reality, large extended families frequently live in houses that are too small for their day-to-day needs and have no 'separate room' to isolate. In remote communities, houses often need urgent refurbishment and repair, with basic plumbing not working. Alternative accommodation was scarce, often due to the competing demands from tourism and industry, or simply did not exist.

Recommendation 5: Plans for accessible, safe, feasible, and culturally-appropriate isolation and quarantine options in all WA regions are urgently required before the next pandemic, alongside Government investment to improve housing and health outcomes for Aboriginal people now.

WA ACCHS' played a critical role in providing COVID-19 testing in both regional and metropolitan WA. Of the 14 Commonwealth GP respiratory clinics (GPRCs) established in WA, four were run by ACCHS (29%). Two of these were in metropolitan Perth and provided a culturally safe testing option for the largest Aboriginal population in the state. We heard from one Member that *"there were a lot more patients coming in. We found that they weren't being tested at the state-based services. They didn't feel safe or comfortable"*. Several other WA ACCHS ran similar 'respiratory clinics' but chose not to be part of the formal Commonwealth program as COVID-19 testing in regional and remote areas was permitted within ACCHS (where elsewhere it was restricted in the early pandemic by state authorities). These 'respiratory clinics' benefited communities by providing a way for symptomatic people to be tested at a trusted health service while keeping them separated from asymptomatic people seeking routine primary care. AHCWA's Members were also Australia's earliest adopters of the Commonwealth-funded GeneXpert COVID-19 point-of-care testing (POCT) program, which was a game-changer in providing access to COVID-19 testing for Aboriginal people in regional and remote WA. This program provided reassurance and confidence for communities, as COVID-19 could be rapidly ruled out in people with respiratory symptoms, and FIFO staff could be screened when returning from potential hotspots (before Rapid Antigen Testing was available). Importantly, the need for several days of isolation while awaiting results (due to long turn-around-times for results, with samples only being analysed in Perth) was eliminated.

In 2022, all WA regions experienced the first major wave of COVID-19 in the state. Access to oral anti-viral medications through pre-placement from the National Medical Stockpile by the Commonwealth, and via the state, to WA ACCHS was exceptional and likely saved lives and prevented hospitalisations throughout WA. Prior to the WA border opening, however, no agreement was reached to ensure access to the intravenous medication, Sotrovimab

in remote areas, perhaps due to government's oversight in recognising that ACCHS are equipped and experienced in administering intravenous medications routinely.

Recommendation 6: Future health emergency responses must ensure ACCHS are appropriately resourced and equipped to respond by funding programs that support testing (e.g. POCT programs) and treatment (e.g. pre-placement of medications).

All ACCHS in WA were committed to being COVID-19 vaccine providers and most were well prepared and trained to begin the 1b rollout. Advice provided by the Australian Technical Advisory Group on Immunisation (ATAGI) was generally timely and well communicated. The programmatic change which preferenced Pfizer's vaccine for those under 50 years was challenging for WA ACCHS, particularly in regional and remote areas, due to the ultra-cold chain requirements. Despite initial anxiety around the Commonwealth taking responsibility for vaccine supply logistics, vaccine was delivered successfully with only a few mishaps. The Commonwealth's contract with the Royal Flying Doctor Service (RFDS) enabled safe transport of the Pfizer vaccine to remote areas across WA. A clear deficiency in the Commonwealth's vaccine prioritisation strategy was its implementation, with Perth-based residents aged over 30 years able to access vaccination through mass vaccination clinics ahead of most regional and remote Aboriginal people of any age. An "all comers" mass vaccination strategy, implemented by the state in limited parts of Perth and the South West, effectively replaced the original state-wide focus on groups most at risk as outlined in Australia's COVID-19 vaccine national roll-out strategy, with the state Government seeming to view vaccination for Aboriginal people as a Commonwealth responsibility. Access to vaccination depended not on need but on where a person lived.

Recommendation 7: Where priority populations are identified within a strategy, its implementation should ensure the population is *actually* prioritised.
Recommendation 8: Where specific responsibilities within an emergency health response are divided between the Commonwealth and state/territory governments, this should be clearly articulated to ensure accountability is understood.

The dissemination of reliable and accurate information and data, in real-time, is essential to effective health responses. A serious concern for the ACCHS Sector was the way that vaccine coverage data was calculated and reported by the Commonwealth. Coverage reports used different denominators for Aboriginal (Australian Immunisation Register (AIR) population) and non-Indigenous populations (Australian Bureau of Statistics Estimated Resident Population) and had caveats in reports for remote and very remote locations. The basis for why reports were presented in these ways remains unclear. These decisions had impact. AIR population estimates can be inaccurate for a variety of reasons (such as completeness of Medicare enrolment and Indigenous identification, and duplicate cards), and 36% of WA Local Government Areas (LGAs) are classified as remote or very remote. Public 'naming and shaming' of low coverage LGAs was not helpful, and may have contributed to stigmatisation of some populations or locations. The accuracy and timeliness of uploading vaccinations to AIR, particularly outside of the ACCHS Sector, is of concern and an audit to review this, for example by the Australian National Audit Office, is warranted.

Recommendation 9: Methods for vaccination coverage reporting must be reviewed (inclusive of auditing the accuracy and timeliness of uploads to AIR), and Indigenous data sovereignty principles must be embedded in the collection, analysis and reporting of vaccination data.

The ACCHS Sector is a key and unique part of the broader Australian health system, underpinned by a highly skilled and unique workforce that delivers culturally secure health and wellbeing services for Aboriginal people and their communities. The ACCHS Sector's response to the COVID-19 pandemic demonstrated its strength, resilience, capacity to collaborate with a wide variety of stakeholders, and willingness to go above and beyond to keep Aboriginal communities safe and healthy. Governments must recognise the vital and unique role the ACCHS Sector has in health emergency planning and response, and ensure the ACCHS Sector is embedded as a valued partner in future responses.

Recommendation 10: The ACCHS Sector must be recognised as an essential partner in emergency health responses. This includes being; formally included in response plans, recognised as shared decision-makers[5], trusted through timely and accurate data sharing[5], and financially resourced to do the operational work of the response that the Sector is better-placed than government agencies to do[6].

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[5] Closing the Gap: Priority Reforms https://www.closingthegap.gov.au/national-agreement/priority-reforms
[6] For example, communications, testing, vaccination, treatment, case management, etc.