AMA

AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T I 61 2 6270 5400
F I 61 2 6270 5499
E I ama@ama.com.au
W I www.ama.com.au
39 Brisbane Ave Barton ACT 2600
PO Box 6090 Kingston ACT 2604

SUBMISSION

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AMA Submission to Commonwealth Government COVID-19 Response Inquiry

Online submission

The AMA is the peak body representing Australia's doctors who worked on the frontline of Australia's pandemic response in every setting at every stage of their career. This submission will limit its focus to governance and the health response measures due to the requested length of submission, however we strongly encourage the taskforce to engage with individual clinicians to understand their experiences of the pandemic. The AMA would be glad to facilitate this.

The AMA's view of Australia's response to the pandemic was that we were broadly quite successful. This is supported by the literature which has shown that Australia had among the lowest excess mortality rates of comparable nations despite relatively low additional health system spending during the pandemic. Australia also achieved world leading rates of vaccination by the end of the first year of our vaccine rollout which saved an estimated $181 billion to the Australian economy.

The key reason Australia was so successful is because governments generally listened to the advice of the medical and scientific community, particularly in the first eighteen months of the response. The AMA engaged strongly in the development of policy and the response at all levels and aided with communication to clinicians. As we learn from the successes and missteps of our response, it is essential that this engagement with experts is built into responses consistently at all levels of government.

Governance

Australia's pandemic response was most effective when the federal government and the National Cabinet coordinated and cooperated to manage the impact of the pandemic. The AMA was broadly supportive of measures, policies and programs implemented including lockdowns, mandatory isolation periods, social distancing and income support to name a few. However, there were many examples of inconsistencies in policies between jurisdictions which hindered the public health response. When different advice and policies were in place, such as mask mandates and venue capacity limits, the public messaging was undermined.

In the early stages of the response these were relatively minor and the government, opposition, and minor parties played an important role in depoliticising the response to COVID-19. This was one of the key features in Australia's success – putting politics aside for science. The prominence of the Chief Medical Officer and Chief Health Officers (CHOs) throughout the pandemic was an important demonstration of this reliance on the medical and scientific advice. As the pandemic continued, we saw this prominence wane, and we also witnessed premiers undermining their CHOs in public. This was regrettable as it not only undermined the public's trust in the policies, it undermined the medical profession's faith in their politicians to make the right decisions.

The AMA also witnessed a painful lack of collaboration among jurisdictions during the initial stages of the vaccine rollout, with disputes over funding and the allocation of vaccines. The COVID-19 Partnership Agreement dealt with funding arrangements yet the debate deteriorated into a funding squabble that undermined public confidence and particularly impacted on health workers who were at the front line and required early access to vaccination.

The AMA was generally impressed by the collaborative and constructive approach from the Commonwealth Department of Health. The department was genuinely consultative and provided the AMA and other health peaks to provide direct feedback on the impacts of policies from members. While not always as flexible as required, the rapid implementation of telehealth and quick changes to vaccine rollouts are positive examples of how a health department can and should engage with health professional bodies during a pandemic.

Expert advice from the Australian Health Protection Principal Committee (AHPPC) has operated efficiently and made key decisions quickly to guide Australia through the crisis. However, this advice has not been transparent to the community.

At the jurisdictional level, personal protective equipment (PPE) shortages, National Medical Stockpile shortages, mixed messaging, failure of health departments to properly engage with their workforces and the longstanding failure to properly integrate general practice into pandemic planning processes meant there was a lot of initial confusion and that the health and wellbeing of front-line health professionals were at significant risk. The AMA also observed the initial national pandemic response plan did not mention primary care at all, an oversight that was quickly addressed but one that should not have ever occurred.

Centre for Disease Control

An Australian Centre for Disease Control (CDC) would have aided in the preparation for the COVID-19 pandemic. In 2017, the AMA released a position statement calling for the establishment of an Australian National CDC. An effective CDC will play a key role in bringing together science with real time monitoring of diseases and must draw upon the expertise of clinicians on the frontline.

To be effective, a CDC must be adequately funded and resourced over the long-term to undertake its multitude of functions, including rapid risk assessment, scientific briefings, public education and disease prevention. An Australian CDC should be situated as the most trusted source of independent expert advice for pandemic preparedness, other public health emergencies and communicable and non-communicable disease prevention. It requires all states and territories to commit to its success and meaningfully include general practice in policy and planning.

Health response

Australia moved early to activate its pandemic plan and progressively close its borders. These high-level decisions played a significant role in limiting the spread of COVID-19. Unfortunately, it quickly became clear our planning was inadequate and our reserves of PPE and critical medical supplies were inadequate.

A key failure was the aged care sector, which was hit very hard as operators did not have the capacity to implement effective infection control strategies and support arrangements at state/territory and Commonwealth levels were non-existent.

Our public hospital sector was already under strain before the pandemic, with inadequate funding from governments at both state/territory and Commonwealth levels. COVID-19 exposed problems with hospital funding, with elective surgery cancellations the only tool to manage workforce and resource demands. While the AMA at times supported these strategies, a better funded and prepared public hospital sector could have avoided this. For example, in Canada many public hospitals are prepared to set up fever clinics at short notice in the advent of a pandemic. Australian public hospitals are not. The lack of understanding of how private hospitals function and no central coordination of these resources exacerbated these issues.

Telehealth

Telehealth ensured Australians had continued access to healthcare while reducing avoidable use of PPE. Prior to the telehealth agreement, doctors required PPE for any patient with symptoms suggesting potential COVID-19.

The AMA worked constructively with the Government, the Department and other stakeholders throughout the pandemic to build a functional telehealth model. In general, the AMA supported most of the evolutions of telehealth, with issues often quickly addressed. While broadly positive, there are important lessons to observe from the use of telehealth.

The Government was too willing to limit access to telehealth by telephone during times of increased spread in the community. For example in July 2021 telehealth by telephone items were significantly restricted while Sydney was experiencing a severe outbreak, then again in January 2022 during the Omicron wave. The AMA had to repeatedly intervene to seek extensions or changes to ensure doctors could provide telehealth to patients who required it.

A key frustration was also the late communication on policy changes. For example in one instance telehealth item extensions were announced on 18 September for an effective date of 31 September. Practices often book patients weeks or months in advance, and the lack of certainty meant planning was not possible. This was during a time where many practices were experiencing difficulties already due to the pandemic.

Vaccination

Australia's COVID-19 vaccine program was not perfect, but in general the AMA observed a campaign that was well planned and implemented. We recognise this was not the view of the public, but this view was largely perpetuated by the media. For example, the AMA spent days responding to individuals frustrated they could not receive an initial vaccine for up to six weeks in the initial phase of the rollout. While we respect this would have been frustrating, the initial phase was intended to last twelve weeks.

Australia's rollout was initially slower than many other countries due mostly to lack of supply, concerns surrounding the Vaxzevria (formerly AstraZeneca) vaccine, and global competition for vaccines. Australia also waited on full approval of COVID-19 vaccines from the Therapeutics Goods Administration (TGA) – we understand Australia was the second country in the world at the time to do so. The common approach at the time was to utilise some form of emergency authorisation. The AMA remains strongly supportive of this decision.

There was some loud criticism of the decision to use Vaxzevria as the primary vaccine in the initial plan. This was a logical decision given the ability to produce the vaccine in Australia and that it could be deployed using the regular cold chain arrangements. However, transparency around the advice provided to Government on the procurement of vaccines could have been improved.

The decision to commence the rollout in general practice was the right one. With limited supply and high demand, the prioritisation of vulnerable and high-risk populations was the right decision. Using general practice to administer initial doses particularly to the elderly and people with chronic health conditions was the right decision as it utilised the existing relationships between doctor and patient. This was even more important during the uncertainty around the Australian Technical Advisory Group on Immunisation (ATAGI)'s changing guidance on Vaxzevria in response to Thrombosis with Thrombocytopenia Syndrome (TTS). The initial lack of a vaccine consultation item was frustrating and meant many general practices were not appropriately funded for this work. While an item was eventually introduced, proper planning would have included it from the commencement of the rollout. As vaccine supply began to outpace demand and lower risk cohorts became eligible, expanding the locations for vaccinations was sensible.

Conclusion

We are concerned that governments are all too willing to put the past behind us and not seek to properly evaluate and learn from Australia's response to the COVID-19 pandemic – likely because this might invite criticism of their actions. It is imperative upon the Taskforce to ensure that the this does not occur. There are important lessons still to learn and there are still improvements to be made. Depoliticising our response, listening to experts and consistency across jurisdictions are vital for successful public health responses. An appropriately resourced and supported CDC can perform some of these roles, but our future responses will also rely on our future politicians learning the lessons of the COVID-19 pandemic response too.

Contact

[redacted]@ama.com.au