

## School of Population Health, UNSW Sydney submission to COVID Inquiry

The School of Population Health at UNSW Sydney is ranked in the top 50 globally for public health research and coordinates the largest health management teaching program in Australia. Expertise within the school ranges from responding to emerging public health crises to training the future health workforce, with a common focus to achieve social justice and better health for all.

During the emergency phase of the pandemic many staff and affiliates from the School were seconded to NSW Health and provided significant contributions to pandemic responses in NSW. School staff also contributed through national committees such as ATAGI, via modelling expertise in state and national roadmaps out of lockdown and in regular public facing expert commentary to national media. Below we provide commentary and selected recommendations in relation to several of key focus areas for the inquiry.

**Governance:** The response to the pandemic even from the limited perspective of health interventions was a massive and complex exercise involving multiple levels of government, almost all government sectors, many expert groups and community organisations as well as wide-ranging interactions with industry. We feel it is of great importance that attention be given to assessing governance and for the inquiry to provide advice to ensure more streamlined and transparent arrangements in future.

While the overall health response in Australia was very effective, greater transparency would have been beneficial. In particular, there was limited public disclosure of scientific evidence underpinning critical decisions and limited transparency in terms of publication of minutes and technical advice for publicly funded committees such as AHPPC and ATAGI. In respect to pandemic response, this contrasts with e.g. UK SAGE, where detailed minutes and technical papers were made available. In respect to advice on immunisation, this stands in contrast to ACIP in the US in which full meeting papers are available in advance, with meetings live-streamed publicly.

*Recommendation:* Commit to implementation of transparent reporting of meeting minutes and agendas and ideally supporting technical documents by relevant publicly funded health committees (e.g. AHPPC, ATAGI, CDNA). This should be implemented in the inter-pandemic period so that processes are well-established in advance of any future pandemic events.

Given both the scale and regularity of policy change during the pandemic it is not surprising that coordination between state and territory governments and expert committees/agencies was complex and challenging. We note here the tremendous opportunity the inquiry has to review the many examples of these interactions and provide guidance on future arrangements. To be effective, however, we strongly believe any future governance arrangements should be tested in advance, through a commitment to regular simulation exercises.

*Recommendation:* Establish and exercise as part of pandemic planning the clear definition and delineation of roles of key operational, policy and advisory actors including the Australian CDC, federal and state government, CDNA, defence forces

Applied population health research is a critical tool in developing and refining the scientific basis for policy decisions during a pandemic. Australia has an excellent reputation in health and medical research but was relatively slow to publish local evidence on the pandemic. This was partially a case of opportunity, given the limited population exposure to COVID-19 until the Omicron wave. However, publication of important evidence, such as local vaccine effectiveness studies was slow even post Omicron<sup>1</sup>. We feel there are two related aspects that need attention to improve this situation for future pandemics.

*Recommendations:* (a) establish simplified processes for rapid ethical approval and funding provision for important studies in the context of a pandemic, which could include clinical studies<sup>2</sup>, implementation research and enhanced surveillance. (b) establish data use policies and mechanisms that protect health data

privacy and confidentiality without providing unreasonable barriers to generating the evidence required in emergence response situations.

**Health response measures:** Australia entered the pandemic without detailed prior consideration of many of the elements that were eventually implemented to reduce transmission risk. These include but are not limited to strict border closure (both international and jurisdictional), hotel quarantine, movement restrictions and large-scale quarantining of community members as part of outbreak response. While evidence in regard to effects of these measures has been published both within Australia and in the international context<sup>3</sup>, assessment of their role in future planning remains limited. In addition, studies had (understandably) greater initial focus on benefits, as opposed to harms and unintended consequences. We believe it is important responsibility of the inquiry to distil current evidence and outline future research to clarify the role of these interventions in revised plans.

*Recommendation:* to review evidence regarding population non-pharmaceutical interventions, regarding effectiveness, cost, feasibility and acceptability. Explicit consideration of equity is needed, given that there was an unequal distribution of benefits and harms across population groups.

A striking early pandemic observation was the large difference in transmission risk between indoor and outdoor settings, reflecting differing risks of transmission through the air. Relevant interventions such as masks have been heavily investigated in experimental studies examining correlates of transmission reduction, with promising results. However, epidemiological evidence of effectiveness remains contested, with an inconclusive Cochrane review<sup>4,5</sup> regarding to the effects of mask wearing on the spread of respiratory viruses. Unlike pharmaceutical interventions, a clear pathway from experimental evidence to evaluation through randomised controlled trials seems absent in this area.

*Recommendation:* Evidence regarding mask and ventilation interventions on transmission be carefully considered, with a view to guiding strategy to address gaps in evidence. In particular, attention to behavioural factors that influence effectiveness would appear a high priority.

**Government response capacity:** At both national and jurisdictional levels very significant increases in public health capacity were needed during the pandemic. Particularly in areas like contact tracing, staff numbers scaled by factors of 10-100, with other areas also requiring significant increases in staff. An important requirement in areas such as surveillance, health protection and health promotion was evidence generation, where additional staff were often seconded from academic institutions, becoming integrated into operational aspects of the response. We believe processes for enabling efficient scaling of public health capacity in future should be an important focus of the inquiry.

*Recommendation:* To identify the likely areas of key important in terms of scaling public health response capacity, to consider where such staff would be drawn from and to give consideration to adverse consequences for the source sectors.

At the outset of the pandemic, notifiable disease data systems were not effectively designed to inform many of the subsequent policy and response choices. These systems evolved during the pandemic and became much better aligned with response objectives. For instance, in the context of NSW, systems were augmented to facilitate detailed collection of contact-tracing information that allowed for near real-time assessment of test and trace performance<sup>6</sup>. However, now that the emergency pandemic phase is over, there is danger that these improvements are not sustained in the inter-pandemic period, nor designed to be effective in the next pandemic.

*Recommendation:* Effective data systems for conducting real-time epidemiological analysis in support of emergence response objectives should be embedded in the inter-pandemic period, including increased capacity for and responsiveness of relevant data linkage.

**Community supports for people affected by response measures:** Culturally and Linguistically Diverse (CaLD) communities in Australia experienced greater risks of negative outcomes from COVID-19 disease, a greater burden of COVID restrictions and have achieved a lower uptake of pharmaceutical interventions such as vaccines and antiviral drugs. There is a human rights obligation for governments to act on the needs of CaLD communities during pandemics and other health crisis periods. This includes ensuring available resources and supporting community understanding and capacity to engage with recommendations. However, communication is still characterised by large-scale exclusion of linguistic minorities from timely, high-quality information. These communities can also be left behind in their access to and understanding of recommendations, compounded by cultural discordance and mistrust of health institutions. Communication and engagement efforts with CaLD community members have been hampered by lack of access to or ineffective communication channels, lack of trust in authority, literacy, lack of timely and culturally responsive materials, poor quality of materials and poor engagement strategies.

*Recommendations:* (a) A dedicated management plan to support the response efforts focused on CaLD communities. (b) Specific strategies to communicate with linguistic minority communities, especially those that do not have local outreach services. (c) Dedicated funds to support surge capacity for bicultural workers and small grants available for community controlled organisations and NGOs in the sector to support local dissemination of information and community engagement efforts

Australian citizens situated abroad encountered many difficulties in returning home during the pandemic. More than a year into the pandemic it was estimated that over 35000 citizens were stranded overseas and required assistance to return home. Closure of borders and vast reductions in international flight capacity meant long delays in obtaining a flight to Australia, with high levels of financial distress and clinically significant depression. Parallel situations for domestic travellers arose with the sudden closure of state borders in response to outbreaks in other, leaving citizens stranded interstate. While closure of international border undoubtedly contributed very significantly to Australia's successful suppression of transmission across 2020-21, we argue that the impacts on citizens attempting to return home was unacceptably high and a more humane approach needs to be developed in advance of future pandemic events.

*Recommendations:* Consideration be given to effective ways of reducing the time to return home and financial and mental impacts of travel restrictions on citizens living abroad, in the event that border closure is used again in future pandemic responses.

Prepared by Prof James Wood, A/Prof Holly Seale and A/Prof David Muscatello on behalf of The School of Population Health UNSW Sydney.

## References

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