Submission to Commonwealth Government COVID-19 Response Inquiry

Introduction

The Australasian Epidemiological Association (AEA) is the only professional society in Australia and New Zealand dedicated to developing and promoting the discipline of epidemiology. Representing over 700 members we do this through:

- promoting excellence and innovation in the practice of epidemiological methods
- communication of issues relevant to epidemiologists
- advocating for funding, capacity building and policy development
- strategic alliances with related organisations to maintain high standards in teaching and research and to promote the use of evidence in health-related policy making and clinical practice.

As part of these activities, we engage in advocacy on key issues related to the discipline of epidemiology. Addressing the issues arising from the Commonwealth Government's response to COVID-19 is an important aspect of this given the central role of epidemiology and epidemiologists in the pandemic from its initial occurrence, during the emergency phase, and presently as it continues.

The 3-page restriction placed on submissions to this Inquiry do not, in our view, enable a full appreciation and study of the Commonwealth's response to COVID-19. Resultantly, this submission only addresses a few areas, not necessarily more important than others, but ones which AEA has previously identified as pandemic preparedness, response, and management issues that have and continue to be poorly addressed. Our recommendations would provide a significant enhancement to Australia's pandemic threat and response capability and capacity.

We welcome this opportunity to provide these recommendations and would request participation at future roundtables, workshops, or hearings that this Inquiry may hold to discuss this submission and related matters.

Public Health Profession

At the commencement of the pandemic, it became very clear to AEA members working or seconded as part of State and Territory government surge workforces that there was a lack of central, strategic, coordination of the response. In particular, the lack of support, for epidemiologists and biostatisticians working in challenging and novel environments became a source of frustration for those on the frontline[1].

Responding to a pandemic of this scale and impact was a new experience for many. Additionally, this pandemic presented problems because there were rigid beliefs based on transmission dynamics of previous coronaviruses that prevented earlier adoption of more effective public health interventions. These issues highlighted that there were, and continue to, be systemic challenges and problems, stemming from the underfunding of public health.

Greater investment in public health not only builds professional capacity but also system capacity in relation to pandemic preparedness and response measures. This investment is critical to improve the current surveillance systems to facilitate the rapid detection and appropriate response to cases. Of additional benefit, not only would this enhance Australian capacity but given our role in Oceania it would also assist in preparing, protecting, and responding to communicable disease outbreaks in our region.

Recommendation 1: That a central body (such as the proposed Australian Centre for Disease Control (ACDC)) be utilised in the development, training, and upskilling of epidemiological surge workforces for use in public health emergencies or disasters.

Recommendation 2: That a support and mentoring program be developed for use during the deployment of epidemiological surge workforces during public health emergencies or disasters.

Policy cohesion and data integration

A major source of frustration, confusion, and potentially serious negative consequences was the disparate nature of COVID-19 public health information that was provided by the various jurisdictions. Whilst some of this may be accounted for by differing circumstances within these jurisdictions at various times during the pandemic there were many instances where settings were similar (or appeared similar) but the advice was sometimes at odds.[2] Confusing or inaccurate health information is not only detrimental to the advancement of public health protections but also serves to potentially undermine trust in public health and public health professionals.[3]

Ultimately, being able to bring together national, state and local health agencies to serve as a trusted source of guidelines to ensure consistency in processes for public health, emergencies and disasters, not only serves as an expert point of reference but to also reduce silos in public health. However, Australian health data are fragmented and challenging to access. At present, there must be pre-approval from custodians for data use. The idea that every use of data requires project specific custodian approval is too slow and disjointed impacting on the health of the Australian population.

Facilitating harmonisation of data collection, management, linkage and analysis to support timely, consistent and accurate epidemiological insights relating to disease prevention and control efforts can provide significant benefits to population health and safety at times of an emergency, disaster, or as is current, a pandemic. Together with investment to develop Australia's public health research environments, enabling the use of linked data in clinical trials, observational studies and other public health and clinical research to generate policy-relevant intelligence, will enhance the nation's capacity to respond to future pandemics.

A legal framework to inform how national data linkage is conducted, who can access these data and how would need to be developed.

Recommendation 3: That a central body (such as the proposed Australian Centre for Disease Control (ACDC)) be utilised in the provision of independent advice on public health interventions relating to public health emergencies or disasters.

Recommendation 4: That funding be provided for the integration and linking of relevant health related data systems and that such systems be made accessible for national surveillance, research, analysis, planning, and response to public health emergencies or disasters.

Recommendation 5: That a community engagement program be established to ensure that community voices are represented in the development of public health policy, surveillance, and research plans using routinely collected data.

Inclusivity

Populations and communities who are at risk of the worst health outcomes have historically been excluded from public health policy development. Likewise, health information is often inaccessible and/or culturally irrelevant to marginalised and under-served populations. Recent data showed that in Australia, those living in disadvantage or poverty were three times more likely to die from COVID

compared to those in more privileged positions.[4] The AEA believes it is important that the Commonwealth government works in partnership with such populations/communities in the development of health policy and information, including in the design of policy evaluation. Bioethicists are also central to ensuring that public health policy considers the immediate and long-term affects of different interventional strategies.

Additionally, the COVID-19 pandemic has increased fear and anxiety of minorities heightening their experience of racism.[5] Structural racism is commonly regarded as a critical global public health problem but there is a lack of guidance and leadership from governments to address power imbalances that underpin it. The AEA believes that the Commonwealth must be positioned to address racialised health inequalities given its impact during public health challenges.

Importantly, in relation to First Nations peoples, the AEA believes that the Commonwealth Government should seek to enagage with leadership from Aboriginal and Torres Strait Islander peak health organisations, such as the Lowitja Institute, the National Aboriginal Committee Controlled Health Organisation, Australian Indigenous Doctors' Association, and the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives as part of addressing these challenges. Supporting Indigenous peak health organisations and leaders to take charge of the COVID-19 response for First Nations peoples and listening to these voices at each level of Government proved to be a shining example of how health services can meet the needs of First Nations peoples and reduce gaps in health outcomes.[6]

Recommendation 6: That a consumer and community engagement framework, which must be underpinned by, and promote, genuine partnership and include processes and support for building the capacity of communities to contribute public health emergencies or disasters policy development, be established relating to public health emergencies or disasters.

Recommendation 7: That CALD communities and First Nations peoples be a high priority in the development of communication and engagement strategies relating to public health emergencies or disasters.

On behalf of the AEA Council

Dr Abbey Diaz, PhD
President
15 December 2023

References

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[3] [redacted]. COVID-19 Misinformation Trends in Australia: Prospective Longitudinal National Survey. J Med Internet Res. 2021 Jan 7;23(1):e23805. doi: 10.2196/23805

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[6] [redacted] (2021), Australian First Nations response to the pandemic: A dramatic reversal of the 'gap'. J Paediatr Child Health, 57: 1853-1856. https://doi.org/10.1111/jpc.15701