Australian Government's COVID-19 Response Inquiry Submission

Introduction

As an independent, statutory office holder the National Rural Health Commissioner welcomes the opportunity to provide principles and recommendations to this COVID-19 Response Inquiry. The Office of the National Rural Health Commissioner (the Office) participated in several COVID-19 committees and networks during the pandemic; the Commissioner chaired one network and was a member of others to advocate for rural consumers and primary healthcare providers. This submission is informed by that activity and complements the Department of Health and Aged Care's response to this Inquiry. It is anticipated these recommendations will be considered in the establishment of the Australian Centre for Disease Control.

Recommendations

1. Develop systems for consistent communication between all levels of government, Primary Health Networks (PHNs), public health departments and primary health services, including private practices, to the general public and other sectors
2. Gain national consensus on what constitutes essential cross-border traffic during pandemics and emergencies
3. Allied health practitioners must be recognised as essential workers
4. Ensure collaboration occurs between sectors of health care, focussing on shared activities and goals, without constraint by funding streams in planning and undertaking pandemic responses
5. Maintain effective co-design of policies, programs and local workforce with rural and remote Aboriginal and Torres Strait Islander and culturally and linguistically diverse (CALD) communities
6. Invest in culturally safe and appropriate quarantine facilities outside of metropolitan areas
7. Ensure rural health student placements are maintained wherever possible during pandemics and supported with access to personal protective equipment (PPE)
8. Maintain supports for telehealth initiated during the pandemic (Medicare item numbers and referral pathways), as these increase access for rural and remote communities to services during times of disruption
9. Include rural and remote General Practitioners (GPs) and other primary healthcare providers in local, state or territory, and national planning for pandemic and disaster response and recovery
10. Ensure that medical supply planning includes rural and remote primary and secondary health services

Rural General Practice Respiratory Clinics (GPRC)

The Office established a National Rural GPRC Leaders Network to support a community of practice during the pandemic. This was chaired by the Commissioner and supported by departmental employees. The network convened weekly, or as required, to discuss and troubleshoot emerging issues, receive updates on vaccines, treatments and supplies. When issues could not be solved by the membership, issues were taken by the Commissioner and departmental staff to the relevant sections in the Department of Health and Aged Care for resolutions. In this way for example, securing rapid antigen test stocks were obtained for members at a time of shortage. The network provided streamlined problem solving in the rapidly changing circumstances.

Funding mechanisms for GPRCs enabled GPs to rapidly adapt their workforce and service delivery to protect their local communities throughout the overlapping pandemic stages of testing, diagnosis, triage, treatment and vaccination. It provided universal healthcare without gap fees for patients and kept patients out of hospital.

GPRC contract management was burdensome for small clinics. This was exacerbated by last minute communication about the program. Delayed contract extensions impact staff retention. It would be wise in future to stage and plan contract negotiations to maximise staff retention recognising complexities of cross government financing.

Communication between governments, sectors and communities

Throughout the pandemic, the Office worked closely with peak rural health bodies. It was evident communication between primary healthcare providers, public health networks and units and governments had its challenges. Planning and response operations did not adequately consult primary healthcare providers, resulting in ineffective communication between public and private health systems. In other cases, professions and sectors[1] with limited history of on the ground collaboration exhibited increased communication and collaboration.

Federal, state and territory governments provided public health advice for people to visit their GP for testing, vaccinations, and positive COVID-19 case management, yet GPs were not adequately involved in the response development[2] and often were unready for the ensuing demand. Further, the messaging was inadequately targeted to rural and remote communities, even when there were concurrent crises such as natural disasters. Insufficient pre-briefings meant rural primary healthcare providers had limited time to effectively plan and resource[2].

Allied health

Place-based, multidisciplinary team models of care provide excellent high-quality care in rural and remote communities. Where these existed, there was more flexibility to respond to system stresses brought about by the pandemic. Allied health professionals are essential in primary care and are essential participants in rural and remote multidisciplinary teams[3], and must therefore be included as essential workers in pandemic responses. There was great frustration and disillusionment within allied health professions when they were not classified as essential workers. This has had ongoing ramifications within the allied health workforce, with anecdotal reports of numerous practitioners leaving the healthcare sector.

Border communities and border restrictions

The federation of Australia was challenged during the pandemic by the juxtaposition of differing public health orders at state borders. This created serious challenges for residents of border communities who frequently access services in their adjacent jurisdiction but could not do so when borders were closed. Health workforce personnel who work across a border from their residential community were initially refused passage, leaving some health services severely understaffed[4]. Subsequent introduction of exemptions and border passes allowed passage for some specified health professions, but rapidly changing rules created confusion and slow provision of exemptions left stretched health services frustrated.

Border restrictions had major impacts on Australia's medical and food transport logistics. For rural and remote communities often at the farthest reach of transport networks, this was particularly acute and further compounded existing food insecurity[5]. Australia's major food supply comes from rural and remote areas, and the imposition of restrictions on this workforce decreased food security, caused loss of income, impacted mental and physical health outcomes, and reduced productivity in rural and remote Australia.

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[1] Hughes, P. (2022, February 21). How unified communications has helped Australia's pandemic response. *The Mandarin.* https://www.themandarin.com.au/181853-how-unified-communications-have-helped-australias-pandemic-response/

[2] The Royal Australian College of General Practitioners. (2023). Alternative Commonwealth Capabilities for Crisis Response Discussion Paper. https://www.racgp.org.au/getmedia/de409640-d8f6-4fa2-931f-be321aa9b3c4/RACGP-Response-Alternative-Commonwealth-Capabilities-for-Crisis-Response.pdf.aspx

[3] Office of the National Rural Health Commissioner. (2023). "Ngayubah Gadan (Coming together) Consensus Statement: Rural and Remote Multidisciplinary Health Teams," Australian Government Department of Health and Aged Care, Canberra.

[4] McCann, L., et al. (2022). "Police, permits and politics: Navigating life on Australia's state borders during the COVID-19 pandemic." *Australian Journal of Rural Health*, 30(3), 363-372. https://doi.org/10.1111/ajr.12845

[5] Louie, S., Shi, Y., and Allman-Farinelli, M. (2022). "The effects of the COVID-19 pandemic on food security in Australia: A scoping review." *Nutrition & Dietetics*, 79(1), 28-47. https://doi.org/10.1111/1747-0080.12720

Cultural considerations of the COVID-19 response and intersectionality with natural disasters, and barriers to healthcare

Delayed virus transmission in rural and remote Aboriginal and Torres Strait Islander communities can be attributed to the rapid implementation of public health measures and entry restrictions employed. This allowed a period to build local workforce capacity in contact tracing[6], case management, and infection control methods. These measures were introduced because Aboriginal and Torres Strait Islander people were identified as a priority population in pandemic responses. It is pertinent to acknowledge Indigeneity itself is not a 'risk' factor[7,8]. The success of these approaches is in no small part a product of their co-design with First Nations communities.

The co-design of COVID-19 policies and programs with rural and remote Aboriginal and Torres Strait Islander communities should be maintained and replicated for other health issues and be further utilised in CALD communities to ensure appropriate service design and accessible messaging for communities.

Quarantine facilities outside of metropolitan areas are needed. Such facilities are currently lacking. Any facilities and the staffing must be culturally safe and appropriate. This would afford rural and remote populations to quarantine closer to home.

Utilisation and appropriateness of digital health technologies in rural and remote Australia

There was a commendable expansion of digital technological solutions for service provision during the pandemic. But technology is only as good as the data that underpins it, and digital triage services were not helpful in rural and remote Australia due to lack of accuracy or sensitivity of data on social and geographic barriers.

Swift uptake of telehealth across the health sector assisted primary healthcare services, but not without challenges[9]. Telehealth is not new in the bush but the increased supports for telehealth raises concerns that funding for face-to-face services will diminish. The Office strongly recommends that telehealth is not seen as a replacement for face-to-face consultations.

Health workforce education and training

During the pandemic, university student rural placements for health sciences and medicine decreased. This was due to border and community restrictions, and failure to fund and direct PPE to training sites. Longer rural placements of medical students were seen as beneficial by communities, but other health science students with shorter placements garnered less support. There are many educational and pandemic cognoscente reasons to extend the duration of all health students' rural placements.

[6] National Aboriginal Community Controlled Health Organisation. (2020, September 1). "Tens of thousands train in contact tracing for the bush" https://www.naccho.org.au/tens-of-thousands-train-in-contact-tracing-for-the-bush/

[7] Thurber, KA., et al. (2021) "Risk of severe illness from COVID-19 among Aboriginal and Torres Strait Islander adults: The construct of 'vulnerable populations' obscures the root causes of health inequities." *Australian and New Zealand Journal of Public Health* 45.6, 658-663.

[8] Finlay, S., Wenitong, M. (2020) "Aboriginal Community Controlled Health Organisations are taking a leading role in COVID-19 health communication." *Australian and New Zealand journal of public health* 44.4, 251.

[9] Dykgraaf, S, et al. (2021) ""A decade's worth of work in a matter of days": the journey to telehealth for the whole population in Australia." *International journal of medical informatics* 151: 104483. doi:10.1016/j.ijmedinf.2021.104483