DEPARTMENT OF HEALTH AND AGED CARE
Submission to the Commonwealth Government's
COVID-19 Response Inquiry

Contents

1. Introduction

Australia's response to the COVID-19 pandemic is internationally and domestically considered to be strong, largely well-coordinated and having saved lives.

The Australian Government's (the Government) immediate response to stopping transmission of the virus was focused on active and early suppression. The strategy featured restrictions on international travel, domestic test and trace and quarantine interventions. Decisions were made quickly, and COVID-19 response measures were implemented rapidly to manage what was a fast moving and uncertain health crisis.

The initial response was multi-faceted. It focused on ensuring access to essential health services for its citizens both in Australia and the eventual repatriation for citizens who were overseas. The initial response also involved the planning and establishment of infrastructure to manage the increased pressure the health system was likely to face. The response was continually updated to remain fit for purpose based on emerging global evidence.

The response shifted when the pandemic evolved and vaccines became available, ensuring widespread vaccination whilst monitoring health system capacity to manage outbreaks and protecting those most at risk.

Australia's health response was supported by an integrated suite of social, economic and education programs such as Jobkeeper, JobSeeker, Pandemic Leave Disaster payments and supports to facilitate remote learning. These programs contributed significantly to the health response's success.

In addition to the Government response to COVID-19, Commonwealth-State relations became crucial, with the National Cabinet playing a key role in coordination efforts. The pandemic required unprecedented collaboration between jurisdictions and the Commonwealth to ensure health services across the country were able to be mobilised during the pandemic.

A key priority for the Government and the Department of Health and Aged Care (the Department) is to ensure that Australia can respond to any future pandemics. There have been many learnings throughout COVID-19 that have led to new policies and programs of work that increase Australia's preparedness for any future pandemics. Many of these are already underway in the Department and across Government.

The Government has established the interim Australian Centre for Disease Control (CDC) to continue to prepare for public health emergencies through:

- multi-jurisdictional training exercises,
- improving the national public health surveillance system, and
- building capability in One Health and health security.

The Australian CDC will further leverage the lessons from COVID-19 and be fundamental to Australia's capacity to deal with future pandemics. It will boost national communication, co-ordination, and collaboration across jurisdictions, as well as build emergency response capacity, strengthen prevention, detection and monitoring of communicable disease.

The nexus between public health, social and economic system capabilities will be key for the Australian CDC. Future pandemic response mechanisms must again be seen as broader than a health response. Further consideration is needed on what capabilities are developed, including onshore and sovereign manufacturing, and emergency response provision of key health and aged care supports.

Nevertheless, to ensure we are well positioned for any future pandemic it has been important to examine both what went well and look for opportunities for improvement.

1.1. Submission scope

This submission addresses Terms of Reference relevant to the Department. It provides a holistic view of Australia's health response through the input of the Department portfolio agencies, advisory groups, and committees.The Department's health response during COVID-19.

2. The Department's health response during COVID-19

> *Relevant Term(s) of Reference:* Governance including the role of the Commonwealth Government, responsibilities of state and territory governments, national governance mechanisms (such as National Cabinet, the National Coordination Mechanism and the Australian Health Protection Principal Committee) and advisory bodies supporting responses to COVID-19.

This section will include:

- 2.1 - The Department's COVID-19 response
- 2.2 - Portfolio agencies
- 2.3 - Other relevant agencies
- 2.4 - Expert bodies/advisory groups and committees
- 2.5 - Commonwealth/State relationship
- 2.6 - Key response outcomes

2.1. The Department

Australia has a well-established and strong health protection framework. COVID-19 tested every aspect of this framework. Professor Brendan Murphy AC, then Chief Medical Officer (CMO), declared COVID-19 a 'Communicable Disease Incident of National Significance' (CDINS) on 18 February 2020. This was almost a month ahead of the World Health Organization (WHO) declaring COVID-19 a pandemic. This CDINS declaration lasted 1,340 days, ending on 20 October 2023, making it the longest health emergency in Australia's history.

The size, scale and length of the pandemic was unlike anything the Department had dealt with. The Department embraced two roles in response. The first was the primary national coordination point and advisory body for the health response. The second involved implementing measures to bolster the capacity of the health and aged care sectors to respond to the pandemic. The Department worked with Government to rapidly secure additional funding for the health and aged care response, ensuring measures were proportionate and scalable. This saw the Department take on new and expanded responsibilities including sourcing and distributing personal protective equipment (PPE), COVID-19 tests and treatments, and managing the National COVID-19 Vaccine Program.

The National Incident Centre (NIC) (formerly the National Incident Room) in the Office of Health Protection and Response (OHPR) led the Department's early response in the pandemic. The NIC was staffed by expert medical advisers, epidemiologists, pandemic policy, communications, public health and logistics specialists. OHPR acted as the National Focal Point (NFP) for Australia, fulfilling our obligations under the WHO *International Health Regulations* (IHRs) as the conduit between all levels of government and our international partners.

The Department then repositioned as the response expanded, mobilising staff from across the organisation to areas of priority and pausing all non-critical work. In the early stages of the pandemic in 2020 movements and secondments from across Australian Public Service (APS) supplemented the Department's workforce. Recruitment in the Department accelerated by mid-2020. An additional 776 ongoing and non-ongoing employees were recruited in that year. In 2021, a further 1,688 employees were employed to primarily support the Aged Care Group and the COVID-

19 Vaccine Taskforce. This represented an 18% and 32% increase in headcount across these two years.

The Outbreak Response and Aged Care COVID-19 Vaccine branches in the Aged Care Service Delivery Division are examples of new branches established to manage the threats to vulnerable population groups. The Department's role in supporting residential aged care homes (RACHs) required a workforce available 24 hours a day, 7 days a week across Australia. At its peak in March 2022, the Department had a surge workforce of 1,006 people.

2.2.   Portfolio Agencies and Statutory Office Holders

The Health and Aged Care portfolio has 20 agencies, eight statutory office holders and five regulators. These authorities work alongside the Department to collectively deliver the Government's health policies and programs. The roles of the Agencies were varied and strengthened Government's ability to respond quickly and appropriately to the multitude of challenges that were faced each day of the pandemic.

For example, the Aged Care Quality and Safety Commission (ACQSC), the national regulator of aged care services, played a central role in protecting the lives of older Australians in RACHs. ACQSC did this by providing COVID-19 related resources. This included information for providers, monitoring services and compliance with infection control arrangements. In addition, ACQSC developed clinical advice on vaccination and the appropriate use of antiviral medications specific for aged care settings. ACQSC also provided targeted education and monitoring to support higher risk residential services during outbreaks.

The Australian Digital Health Agency, in partnership with the Department, accelerated the adoption of digital products and information services including electronic prescriptions. Australia achieved significant growth in consumers and clinicians viewing test results and vaccination information in the My Health Record application and website.

The Australian Institute of Health and Welfare (AIHW) leveraged existing State and Territory relationships to:

- monitor, report and provide advice in 'real time' on the impact of outbreaks,
- restrictions on health system capacity, and
- mental health service use.

The National Blood Authority assisted through developing rapid access to blood products to treat thrombosis with thrombocytopenia, when this emerged as a rare side effect of COVID-19 vaccination. This reduced the incidence of death and severe morbidity.

Other portfolio agencies adjusted their role to add value to the Australian health response. For example, the Australian Industrial Chemicals Introduction Scheme worked with the sector to pivot their role. This allowed distillers who would normally only produce alcohol products for consumption to redirect their efforts into formulating these alcohol products for non-therapeutic hand sanitisers.

More information on the Health Portfolio response is available in **Attachment 1**.

2.3.   Other relevant agencies

It was important for the Department to formally and informally partner with other Government and jurisdictional agencies. This ensured the COVID-19 health response aligned with the broader COVID-19 response.

In early 2020 the Department provided advice to numerous agencies and sectors to support them to respond to the pandemic. As well as across the APS, this included advice related to airlines, supermarkets and other essential retailers, schools and universities, and public transport services.

The Government and the Victorian Government established the Victoria Aged Care Response Centre (VACRC) later in 2020 to support the outbreaks in RACHs in Victoria, The VACRC, in collaboration with the Australian Medical Assistance Team (AUSMAT), brought together agencies,

experts and stakeholders in a coordinated effort to create a safe environment for residents. This collaborative model was adopted in similar forms in other States and Territories.

The Department also received significant support from other Government departments. For example, formal partnerships were established with the Department of Defence (Defence), to execute Operation COVID Shield. The Department worked closely with the Department of Foreign Affairs and Trade (DFAT) to assist with COVID-19 vaccine international donations. The Australian Defence Force (ADF) supported the aged care response providing on the ground support for the VACRC and RACHs in other aged care outbreaks across Australia. The Department worked with the National Indigenous Australians Agency and relevant State and Territory agencies to prepare for and respond to outbreaks in First Nations communities.

The Department hosted Department Liaison Officers from the Australian Border Force (ABF), ADF, the Department of Agriculture, Forestry and Fisheries (DAFF), DFAT and the Department of the Prime Minister and Cabinet (PM&C).

The Department continues to work with the Department of Social Services (DSS), the National Disability Insurance Agency (NDIA) and the Australian Bureau of Statistics (ABS) regarding the impact of COVID-19 on people with disability.

This collaboration was central to the success of the Government's national COVID-19 vaccine rollout in reaching many diverse and vulnerable population groups. In addition. It helped identify where uptake in particular geographic areas lagged behind the broader population.

Critical to these arrangements is clarity of purpose, an understanding of the capabilities required to support the response and clear lines of accountability.

2.4.   Expert bodies/advisory groups and committees

On 29 May 2020, the then Prime Minister announced a new Commonwealth/State governance architecture with National Cabinet at the centre. The Council of Governments (COAG) and associated structures, including COAG Health Council, were replaced with the exception of the continuation of the Australian Health Protection Principal Committee (AHPPC).

Australian Health Protection Principal Committee (AHPPC)

Following the establishment of the new National Cabinet, the AHPPC reported directly to National Cabinet for most of the COVID-19 pandemic. It no longer reported through the Australian Health Ministers Advisory Committee or Health Ministers. It met over 580 times. The committee played a vital role in supporting national cohesion, particularly early in the pandemic. While there were occasional differences among jurisdictions, the collaboration was genuine and consistent.

The reorientation of the AHPPC away from reporting through Health Chief Executives and Health Ministers, meant the AHPPC was sometimes the sole adviser on health matters to National Cabinet and the primary Commonwealth/State coordination body. This change in scope for the AHPPC required the committee to meet up to three times per day. It also resulted in COVID issues sometimes being considered in isolation from broader health system issues. There was no formal governance arrangement involving Health Ministers in relation to the COVID health response. Health CEOs and Health Ministers informally came together to progress priority issues.

Other key committees

The Department leant on many of the existing expert committees and created new ones to ensure policy and program advice for COVID -19 responses were driven by expertise. In total more than 80 committees were formally or informally used to guide the Department's COVID-19 response.

The Australian Technical Advisory Group on Immunisation (ATAGI), established in 1997 to provide advice in relation to immunisation policies and procedures, became the publicly trusted source of evidence-based advice on COVID-19 vaccinations. Other groups such as the AHPPC Aged Care Advisory Group, APPHC National Aboriginal and Torres Strait Islander Health Protection, COVID-19

Disability Advisory Committee and COVID-19 Culturally and Linguistically Diverse (CALD) Advisory Committee were newly established to progress COVID-19 issues and have become enduring features of the Department's consultation and engagement approach.

A detailed list of many of the committees and advisory groups that supported the COVID-19 pandemic response is at **Attachment 2.**

Key Learnings

Clarity of leadership, roles and clear governance structures are critical to support effective emergency responses. This clarity is essential given the pace at which governance and advisory committees work during health emergencies. In establishing the Australian CDC, it will be important to ensure appropriate and clear governance mechanisms are in place to support independent advice, across all emergencies, including health emergencies.

Governance mechanisms need to adopt a whole of government focus to ensure a 'person centred' approach to pandemic planning and response. This supports an integrated response, while protecting vulnerable cohorts. This will be a central consideration in the establishment of the final Australian CDC.
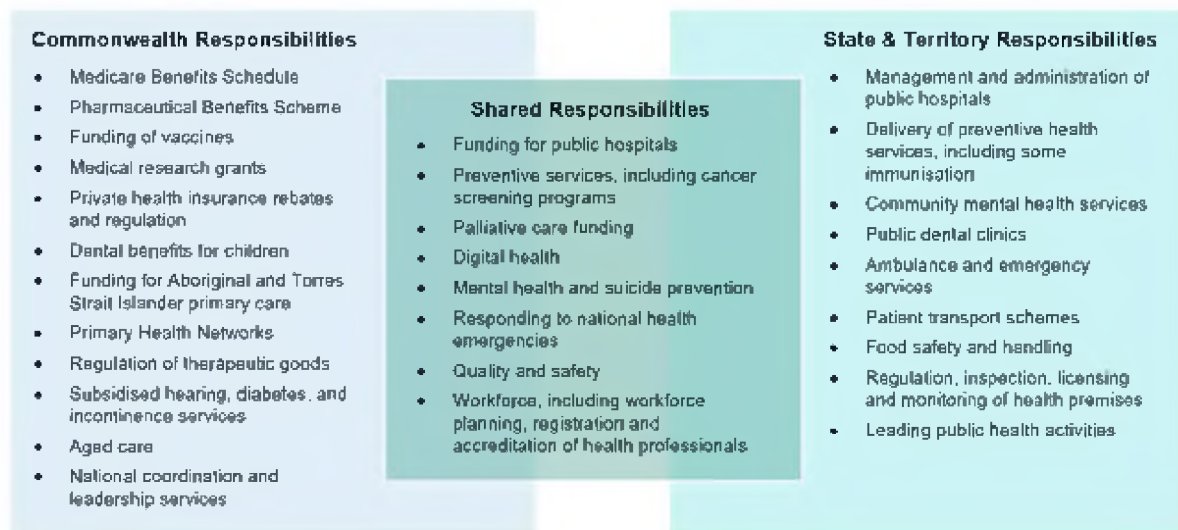
2.5. Commonwealth/State relationship

Australia has a world class health care system based on universal access to quality services. Responsibility for the health system is shared between the Commonwealth and State and Territory Governments as shown in **Table 1.**

Table 1:

Australian Health System: Government Roles and Responsibilities *pre-pandemic*
The Australian, state and territory, and local governments share responsibility for running our health system.

Commonwealth Responsibilities
- Medicare Benefits Schedule
- Pharmaceutical Benefits Scheme
- Funding of vaccines
- Medical research grants
- Private health insurance rebates and regulation
- Dental benefits for children
- Funding for Aboriginal and Torres Strait Islander primary care
- Primary Health Networks
- Regulation of therapeutic goods
- Subsidised hearing, diabetes, and incontinence services
- Aged care
- National coordination and leadership services

Shared Responsibilities
- Funding for public hospitals
- Preventive services, including cancer screening programs
- Palliative care funding
- Digital health
- Mental health and suicide prevention
- Responding to national health emergencies
- Quality and safety
- Workforce, including workforce planning, registration and accreditation of health professionals

State & Territory Responsibilities
- Management and administration of public hospitals
- Delivery of preventive health services, including some immunisation
- Community mental health services
- Public dental clinics
- Ambulance and emergency services
- Patient transport schemes
- Food safety and handling
- Regulation, inspection, licensing and monitoring of health premises
- Leading public health activities

Commonwealth responsibilities include setting national policies, contributing funding for public hospital services, and funding and regulating the aged care system. It also involves managing the Medicare Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS) and other targeted health funding programs. State and territory governments manage and fund a large proportion of the health care system, including managing public hospitals and service delivery, including public community-based health care services.

Under the Australian Constitution, State and Territory Governments have primary responsibility for public health, including surveillance and response for human health. States and Territories have

legislative powers enabling them to implement biosecurity arrangements within their borders that complement Commonwealth biosecurity arrangements as well as a broad range of other legislated public health and emergency response powers.

Commonwealth-state relations for the management of public health and emergency responses were transformed during COVID-19, with the National Cabinet playing a pivotal role in coordinating the response to both the health and economic crisis.

The pandemic required the Australian and State and Territory Governments to work together more closely than ever before to ensure the health system was able to respond to the pandemic. The National Partnership on COVID-19 Response (COVID-19 Partnership) was central to this collaboration.

The National Partnership on COVID-19 Response

The COVID-19 Partnership commenced in March 2020 and ceased on 31 December 2022. The COVID-19 Partnership provided States and Territories with immediate financial assistance for additional costs incurred by state health systems in responding to the COVID-19 pandemic. The COVID-19 Partnership was the biggest health response measure, accounting for almost a quarter of COVID-19 Commonwealth health spending ($14.26b).

Under the COVID-19 Partnership, the Commonwealth paid 50% of costs incurred by States and Territories to diagnose, treat and manage COVID-19 in public hospital settings. The COVID-19 Partnership also covered 100 % of costs associated with aged care prevention, preparedness, and response activities. This was in recognition that responsibility for aged care is primarily a Commonwealth responsibility. Under usual public hospital arrangements, as defined by the National Health Reform Agreement (NHRA), the Commonwealth contributes 45% of the efficient growth of services.

These arrangements provided flexible Commonwealth support that allowed States and Territories to adopt local responses that changed over time. Key measures funded under this agreement included mass vaccination and testing clinics operated by the States and Territories and the private hospital viability guarantee program. The below table outlines what the COVID-19 Partnership funded, including how the Commonwealth funded new activities or bolstered Commonwealth/State public health, hospital and aged care funding.

			Not traditionally Cwlth funded	Increase in Cwlth funding
Hospital Services Payment	Surveillance PCR testing: costs include pathology, test administration and clinic set up and running costs			✓
	Services to Medicare ineligible patients where there is no other non-out-of-pocket means of funding the services		✓	
	All public hospital services to treat COVID-19			✓
	Rescheduled elective surgery subject to a 2018-19 baseline			✓
State Public Health Payment	Private hospital equipment and workforce redeployment in public hospitals		✓	
	Additional costs for public health activities, including communications, operations, responses to COVID-19 outbreak		✓	
	Stockpiling of medical supplies: include treatments, PPE, RATs, medical equipment (e.g. ventilators).		✓	
	Minor capital expenditure: supports creation of surge wards and changes to ventilation for negative pressure rooms.		✓	
	Upgrades to ICT systems related to COVID-19 activity		✓	
	Services Provided in a Primary Care and/or Community Health Setting to manage outbreak of COVID-19, including to rural, remote and/or First Nations Patients			✓
	Emergency Public Health Response Staffing for Aged Care Facilities			✓
	Additional non-clinical costs (e.g. increased hospital cleaning and cleaning of public transport)		✓	
	Costs associated with state and territory support for Commonwealth border force and airport screening			✓
Vaccine Schedule	Vaccine Dose Delivery Payment		✓	
	Vaccine Roll-out Support Payment		✓	
Aged Care Schedule	Support for Infection Protection and Control Training in Aged Care			✓
	Outbreak Management and Preparedness			✓
Paramedic and Ambulance Service Expenditure (subject to a 2018-19 baseline)			✓	
Private Hospital Viability Guarantee			✓	

The COVID-19 Partnership leveraged existing public hospital funding governance and financial arrangements. This included using the Administrator of the National Health Funding Pool, as well as National Health Funding Body (NHFB) and the Independent Health and Aged Care Pricing Authority (IHACPA), to estimate, reconcile and ensure transparency and accountability for this investment.

This complemented the other most significant Commonwealth/State health funding arrangement, the NHRA, and allowed public hospital funding to increase. The COVID-19 Partnership did not impact the NHRA's long term spending as it was not structurally included into ongoing payments to States and Territories.

The detail of the COVID-19 Partnership was varied through the pandemic emergency response to ensure it supported the health response as it evolved. This included the agreement of dedicated schedules for vaccine delivery funding and residential aged care support.

In January 2023, the COVID-19 Partnership was replaced by the National Partnership for Priority Groups COVID-19 Testing and Vaccination (PGTV) as the emergency phase of the COVID-19 pandemic subsided. The Commonwealth contributed 50% of the costs associated with COVID-19 testing and vaccine dose delivery through the PGTV. These were considered the two most significant measures from the previous COVID-19 Partnership. The PGTV focused on priority population groups who were most at risk of severe COVID-19 infection or death. The PGTV expired on 31 December 2023.

Key learnings

The COVID Partnership was highly successful in providing necessary additional funding to States and Territories for public health activities however it resulted in the Commonwealth funding activities which were not traditionally funded by the Commonwealth. Consideration should be given to how to best provide funding for jurisdictions in a future public health emergency and enabling greater transparency in the public health funding component of the NHRA to ensure public health units across Australia are able to respond to future pandemics.

The additional expenditure that States and Territories quickly invested in the pandemic to lift their public health capacity suggests insufficient pre-existing capability and capacity. The new

Australian CDC may need to monitor capacity across all part of the system to ensure appropriate levels of preparedness.

2.6. Key response outcomes

In November 2023, the AIHW published *Health system spending on the response to COVID-19 in Australia 2019-20 to 2021-22*[1]. This report found Australia ranked seventh lowest out of 36 Organisation for Economic Co-operation and Development (OECD) countries in terms of additional health spending. Despite this, however, it found that Australia had the fifth lowest excess mortality during 2020 to 2022.

COVID-19 Mortality

The Department took many effective steps to safeguard and protect Australian lives but, tragically, the effects of COVID-19 were felt.

In 2020, Australia recorded approximately 35 COVID-19 deaths per million of the population. In terms of international comparators, the United States had 1,041 deaths per million and the United Kingdom had 1,382 per million.

Excess mortality is typically defined as the difference between the observed number of deaths and the expected number of deaths in a specified period and can be used to quantify changes in patterns of expected mortality.

Australia's comparatively low COVID-19 associated excess mortality rate reflects the effectiveness of public health measures and the resilience of the healthcare system. Continued vigilance, vaccination efforts, effective communication strategies and adherence to preventative health measures remained crucial as Australia navigated the pandemic. In addition, other factors such as influenza cases were also down in 2020, indicating public health and social measures had an impact on all circulating respiratory viruses in the community, not just COVID-19.

During 2020, Australia recorded lower than expected total mortality rates (excluding coroner-certified deaths) compared with age-standardised mortality rates for the previous five years. This may be the result of Australia's public health response limiting the general spread of disease during this period. This contrasts with other countries where excess mortality was observed in 2020 due to the impact of COVID-19.

In December 2023, the ABS released updated official excess mortality estimates, detailing the number of deaths during the COVID-19 pandemic (2020-2023). This report compared to the number of deaths expected based on historical trends and adjusted for population changes. This report examined mortality due to all causes and found that COVID-19 was the main contributor to the recorded excess mortality from 2021 to 2023. Mortality experienced 11.7% higher than expected levels in 2022, however for the first eight months of 2023 reduced to 6.1%, meaning a move closer to expected levels.

Some RACHs experienced significant outbreaks of COVID-19 early in the pandemic that included large numbers of resident deaths. International evidence confirmed this was not unique to Australia, given the high risk setting of communal living conditions compounded with an already more vulnerable population. However, emerging evidence suggests there was not a substantial increase in the overall burden of disease for those in RACHs when compared to pre-pandemic fatal burden, due to the suppression of non-COVID related illnesses (such as influenza). Although COVID-19 cases numbers increased substantially in the community and RACHs in the later years of the pandemic, COVID-19 survival rates also increased. This was likely due to decreasing disease severity with new virus strains, high uptake of COVID-19 vaccines and the increased use of antiviral treatments. In addition, the Government's response to the Royal Commission into Aged Care

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[1] https://www.aihw.gov.au/reports/health-welfare-expenditure/health-system-spending-on-the-response-to-covid-19/contents/about

Quality and Safety recognised the aged care sector as having been underfunded for decades and has taken strong action to address this.

To understand vaccine effectiveness against COVID-19 and all-cause mortality, in October 2022 the department commissioned research from the National Centre for Immunisation Research and Surveillance (NCIRS). The study focused on approximately 3.8 million people aged 65 years and over - almost the entire Australian population in that age group, including those in RACHs. It found that, in the first half of 2022, COVID-19 vaccination and boosters were effective in protecting against death from COVID-19[2] by up to 93% compared to those who were unvaccinated. While vaccine effectiveness wanes over time, the effectiveness of boosters remained above 50% six months after receipt.

3. Key health response measures

This section will cover:

> **Relevant Term(s) of Reference:** *Key health response measures (for example across COVID-19 vaccinations and treatments, key medical supplies such as personal protective*

- 3.1 - National medical stockpile (incl. PPE provision)
- 3.2 - COVID-19 testing and pathology
- 3.3 - COVID-19 tracing
- 3.4 - COVID-19 vaccination
- 3.5 - COVID-19 treatments
- 3.6 - Government run COVID-19 quarantine/repatriation arrangements
- 3.7 - COVID-19 communications campaigns

Please refer to the relevant section for:

- Other Primary Care response measures and supports (Section 4)
- International partner engagements on COVID-19 vaccine and treatments (Section 5.3)

3.1. National Medical Stockpile

Established in 2002, the National Medical Stockpile (NMS) is Australia's strategic reserve of supplies for national health emergencies. It includes PPE, drugs and vaccines. Supplementary stocks of these goods are held by State and Territory health authorities. Prior to the pandemic, the NMS typically made up to 10 deployments a year, mostly to State and Territory Governments for short periods of time (e.g. one-off deployments of antivenom in response to a single event).

The NMS's role expanded during the COVID-19 pandemic. Additional supplies of PPE, ventilators, primers, probes and reagents for COVID-19 testing, test kit components, and sample collection swabs were required. The COVID-19 pandemic has transformed the role of the NMS from short-term surge capacity to a large-scale, long-term, multi-product support for a significant proportion of the population.

From the start of the pandemic the NMS made more than 260,000 deployments containing 700 million units of PPE and other supplies. Deployment went to residential aged care providers, Aboriginal Community Controlled Health Organisations (ACCHOs), Government agencies, State and Territory Governments, National Disability Insurance Scheme (NDIS) providers, the Royal Flying Doctor Service (RFDS) and public hospitals. Further deployments were made via Primary

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[2] The NCIRS *"Effectiveness of COVID-19 vaccination against COVID-19 specific and all-cause mortality in older Australians: a population based study.*

Health Networks (PHNs) and the Living with COVID-19 program to GPs, GP-led Respiratory Clinics (GPRC) and pharmacies. This supported Australians to receive face-to-face health care including for COVID-19 vaccination and treatments.

The Department had to manage extreme supply chain disruptions and unprecedented global demand and competition from other countries throughout 2020 and 2021. The Government and Department took measures to ensure preparedness, including:

- undertaking 'worst case' scenario modelling, particularly for procuring ventilators for hospitals,
- conducting substantial market intelligence research into global demand and supply chain volatility to ensure adequate procurement of essential PPE and other equipment (such as ventilators),
- ensuring adequate supply and low wastage of PPE as a percentage of total procurement despite the challenges of unreliable supply chains in Australia and overseas, and
- effective pre-deployment of standard packs of PPE to RACHs ahead of subsequent waves of COVID-19.

This allowed the Department to manage stakeholder expectations and streamline the management of deployments, while ensuring provision of adequate supplies required by each jurisdiction.

The Department, through the Therapeutic Goods Administration (TGA) ensured the stockpile met appropriate PPE standards, including undertaking laboratory testing to validate safety and performance. the Department used the Commonwealth Procurement Rules (CPRs) to facilitate commerce with legitimate sellers while safeguarding against potential scammers.

States and Territories initially continued to purchase their own PPE and other supplies. However, the national approach to the NMS soon reduced jurisdictions and Government duplication of effort and supported stabilising demand through a deflationary effect on PPE price. It strengthened Australia's ability to secure an adequate supply of PPE and other equipment, while also ensuring jurisdictions had access to supply as needed.

Data and stock management are core requirements in health emergency management, particularly when the NMS is drawn upon for extended periods. For the Department, the significant and sustained procurement of PPE necessitated an interim solution to support the financial accounting for NMS COVID-19 products. By mid-2020 the Department had deployed the Finance Inventory Management Solution system which initially supported year-end reporting for FY 2019-20. This was progressively enhanced over the following year to become the core inventory management system for the NMS. From October 2021, the Department commenced use of a more advanced system, Microsoft Dynamics, which enhanced the NMS' inventory management capability.

The Department supported DFAT in their international regional health security efforts. This included deploying a range of NMS supplies as humanitarian aid to countries in our region affected by COVID-19 including Indonesia, India, Papua New Guinea, Fiji, Vietnam, Tonga and the Republic of the Marshall Islands.

Following the release of the National COVID-19 Health Management Plan in late 2022, the NMS continued to provide a safety net for essential equipment and treatments. The NMS is an enduring capability that will continue to play a strategic role in responding to future health emergencies.

Key Learnings

The challenges of the COVID-19 pandemic have helped the Department identify areas of improvement in the management of the NMS. These learnings have been supported by internal and external reviews, including by the Australian National Audit Office (ANAO).

Australia must have access to adequate and reliable supply channels for PPE and other critical equipment in a pandemic or other health emergency. This may include considering Australia's sovereign capabilities to produce those goods.

NMS procurements were largely successful during the pandemic. However, a stronger preparedness and established emergency procurement process will further support the Government's ability to respond quickly with PPE and other NMS supply[3]. There has been significant progress on this within the Department. The Department has secured sovereign supply and the preparation of procurement arrangements for the supply of PPE and associated medical supplies.

Preparedness is not limited only to COVID-19 and other respiratory diseases. The Department is also considering how to ensure the NMS is prepared for other emergencies.

A successful NMS requires clear understanding of roles and responsibilities, particularly when considering large scale coordination, procurement and deployment activities. Eliminating duplication of effort and having pre-agreed stockpiling governance in place with all jurisdictions will support effective outcomes in a future health emergency. In addition, transparency and availability of inventory between the Commonwealth and jurisdictions is critical to mitigate risk and ensure available product is supplied where most needed.

The Department has commenced work with all jurisdictions to strengthen the NMS as an enduring capability, able to respond to any future pandemics and other health emergencies.

3.2. COVID-19 testing and pathology

Australia has an extensive network of public and private laboratories. Through this network, the pathology sector was able to progressively upscale testing capacity as caseloads increased.

Testing was fundamental to Australia's COVID-19 suppression strategy and integral to the Test, Trace, Isolate and Quarantine (TTIQ) principles to contain the spread of COVID-19.

Testing enabled case surveillance and genomic sequencing, assisting health authorities to better understand COVID-19 and any variants of concern. The National Pathology Accreditation Program supported the nationwide delivery of high-quality testing.

The aim of the Government was to provide all people in Australia with free access to adequate and appropriate COVID-19 testing, irrespective of Medicare status.

The Department's testing response was strengthened by financial support for public and private sector testing capacity, increased investment in testing technology and supplies, and the creation of new temporary MBS items for pathology testing. Shared funding with State and Territory Governments for COVID-19 testing[4] was also provided under the COVID-19 Partnership.

Australia's technical advice on COVID-19 testing[5] was provided by members of the Public Health Laboratory Network (PHLN), a sub-committee of AHPPC. This expert network published 11

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[3] https://www.anao.gov.au/work/performance-audit/planning-and-governance-covid-19-procurements-to-increase-the-national-medical-stockpile

[4] https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-04/covid-19_response_vaccine_amendment_schedule.pdf

[5] https://www.health.gov.au/committees-and-groups/phln#publications

guidance statements over the course of the pandemic. This ensured that as new evidence became available, best practice testing methodologies and techniques were communicated.

Polymerase chain reaction (PCR) and Rapid Antigen Tests (RATs)

PCR testing played a critical role in identifying COVID-19 cases particularly prior to RATs becoming readily available to the public. In partnership with State and Territory Governments, mass PCR testing clinics were established. PCR testing was essential when access to more sensitive testing was required. Australians were, and still are where applicable, able to access bulk-billed COVID-19 tests under the temporary MBS items developed for COVID-19 pathology.

In January 2022, RATs were embedded as a diagnostic test in Australia's testing regime following a joint statement by the PHLN and the Communicable Diseases Network Australia (CDNA), and support by the AHPPC. The TGA assessed over 100 RAT kits to ensure safe and effective kits were available to Australians.

The Government, in partnership with States and Territories, provided free testing clinics with access to PCR testing and free RATs for those who needed them under public health orders.

Up to 31 December 2023 the Government has funded:

- 77.9 million COVID-19 PCR tests:
    - 39.6 million MBS funded COVID-19 PCR tests, and
    - Around 43 million COVID-19 PCR tests under the COVID-19 Partnership
- Around 169 million COVID-19 RATs distributed to eligible sectors from the NMS.

COVID-19 testing for those most at risk of severe disease

The Government maintained a commitment to ensuring those most at risk of severe disease or illness had access to COVID-19 testing. The Department developed targeted PCR testing programs for vulnerable groups, including:

- Prioritised PCR testing for RACHs,
- Point of care testing for remote First Nations communities, and
- In-reach testing services to support those unable to attend a testing facility, as well as in RACHs or supported independent living disability settings (SIL) where outbreaks were a higher risk.

Further, RATs were directly provided to RACHs, ACCHOs, GPRCs, SIL disability care and RFDS to enable additional and easy access to screening in those settings.

<u>The COVID-19 Remote Point of Care Testing</u>

The National Aboriginal Community Controlled Health Organisation (NACCHO) and the Department identified early the need early to take action to reduce transmission and the possible outbreak of COVID-19 in First Nations communities. The COVID-19 Remote Point of Care Testing (POCT) program and use of RATs managed the detection of COVID-19 in First Nations communities. The POCT program was and remains highly successful. An independent review of the POCT program estimated that the Program prevented up to 122,000 infections and avoided between $337 million and $1.8 billion in healthcare costs[6].

<u>Pathology in-reach testing in residential aged care</u>

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[6] https://www.health.gov.au/sites/default/files/2023-05/evaluation-of-covid-19-point-of-care-testing-in-remote-and-first-nations-communities_0.pdf

The Government engaged Sonic Healthcare from April 2020 to April 2023 to provide PCR testing services in RACHs that have active COVID-19 outbreaks. Over the life of the contract, over 2.8 million COVID-19 PCR pathology laboratory tests were provided at over 3,200 RACHs.

Once the program ended, the Department provided targeted communication to support aged care residents access COVID-19 testing via Medicare.

Under the 2023 National COVID Health Management Plan, emergency in-reach COVID-19 PCR pathology testing services for RACHs was still available on request from 1 May 2023 to 31 December 2023.

The COVID-19 Rapid Test Concessional Access (CRTCA) Program

From 24 January to 31 July 2022, the CRTCA Program provided eligible concession card holders access to up to 20 COVID-19 rapid antigen tests at no cost. The program was established within weeks of the revised PHLN/CDNA position recommending rapid antigen diagnostic testing be incorporated into Australia's testing regime. The Program was delivered by over 5,600 community pharmacies and provided almost 70 million RATs. The funding was cost shared (50-50) with the Commonwealth and State and Territory Governments.

Current COVID-19 testing strategy

In 2022, Australia expanded testing for COVID-19 to include other respiratory illnesses (influenza and respiratory syncytial virus). This testing model increases efficiency by allowing prompt identification and treatment for respiratory illnesses with similar symptoms to COVID-19. The temporary COVID-19 MBS items were restructured to allow for this.

Since late 2022, COVID-19 tests are no longer primarily a surveillance tool, but a diagnostic strategy to support access to antiviral treatments.

Genomic sequencing strategy

The Department relied on enhanced expertise to guide Australia's national approach to COVID-19 genome sequencing to support the COVID-19 response. Over the course of the pandemic the sequencing analysis was used to inform decision-making.

Key Learnings

The need for testing as a function of pandemic disease control, at the scale and capacity required during COVID-19, was unforeseen and unprecedented in Australia.

Testing capacity

The PHLN COVID-19 After Action Review' noted the pressures on laboratory systems to maintain high daily testing rates. These challenges were exacerbated by overseas supply chain interruptions and limited capacity to produce critical reagents in Australia on a large scale. The report identified poor connectivity between different laboratory information systems that inhibited rapid information sharing. Limited access to an expanded trained workforce and inadequate surge support were other core challenges.

The new Australian CDC needs to play a role to ensure these issues are considered when planning for future emergency responses.

3.3. COVID-19 contact tracing

Contact tracing, or 'Trace', was essential to Australia's COVID-19 suppression and contain the spread strategies, playing an integral role connecting all the TTIQ principles. The value for contact tracing pivoted, depending on low or high caseload environments across the pandemic. In the suppression phase, effective contact tracing allowed for appropriate and precise quarantine and isolation policy. During a high caseload environment, the identification of priority populations and those most at risk of infection and/or severe disease, saw contact tracing shift to automated processes. This included a focus on high-risk settings such as aged care and First Nation communities.

A team of epidemiologists coordinated and funded by the Department and seconded to State and Territory health departments, support the data strategy, quality, transmission, and analysis of COVID-19 contact tracing and surveillance. This network of staff provided a link between jurisdictional and national epidemiological and policy review.

COVIDSafe app

The COVIDSafe app was launched in April 2020 to assist State and Territory health officials with manual contact tracing. From commencement to decommission on 16 August 2022:

- around 7.9 million users registered on the app, and

- 792 users who had tested positive consented to upload their app data, resulting in 1.7 million handshakes and 2,829 potential close contacts.

The intent of the app was to reduce manual contact tracing; however, it faced many challenges. A 2022 effectiveness evaluation[7] of the app found that while it was well developed for consumer usability, it was perceived as burdensome for public health staff who undertook contract tracing. The app generated a large volume of data creating additional workloads. Public criticism of the app included fears of government tracking personal information. Despite taking privacy considerations seriously, management of this public perception could have been stronger to alleviate these concerns.

Use of the app also declined over time as jurisdictions developed their own apps, including with integrated QR code systems.

> **Key Learnings**
>
> There was variability of contract tracing among States and Territories which impacted the overall national COVID-19 approach.
>
> COVIDSafe App
>
> Future development and implementation of a similar COVIDSafe App would require a feasibility review and evaluation. While a national system in theory should be effective, data access, technical challenges, and cross jurisdictional overlap would need to be considered and assessed.

3.4. COVID-19 vaccination

The National COVID-19 Vaccination Program (the Program) was fundamental to Australia's COVID-19 response. The Program was the first population level national vaccination rollout in Australian history, with the Government investing over $18 billion in vaccine and COVID-19 treatment supply.

The first COVID-19 vaccine was administered on 21 February 2021 and by 31 December 2021, 91.4% of people aged over 16 years in Australia were fully vaccinated. Approximately 78% of the population were vaccinated in 264 days. Australia achieve one of the highest COVID-19 vaccination rates in the world.

As of 17 January 2024, almost 70 million COVID-19 vaccinations have been administered.

The National COVID Vaccination Program

The Program was guided by *Australia's COVID-19 Vaccine and Treatment Strategy*[8] (the Strategy). The Strategy was released in August 2020, and supported early access to, and delivery of, safe and effective COVID-19 vaccines. It highlighted five areas of focus: research and development; purchase and manufacturing; international partnerships; regulation and safety; immunisation administration and monitoring.

This approach included centralising the purchasing, logistics and operations, as well as changes to the administration of the vaccines. The need to take a different approach was driven by the need to vaccinate the population quickly.

The Program received considerable Ministerial oversight. The then Prime Minister announced Australia would achieve 4 million vaccinations by 31 March 2021. After several challenges, this target was not met (600,000 were achieved). Some of the challenges included:

- the schedule of vaccine deliveries could not be brought forward,
- vaccine distribution challenges such as cold chain breaches (CCBs),

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[7] Effectiveness evaluation of digital contact tracing for COVID-19 in New South Wales, Australia - ScienceDirect
[8] Australia's COVID-19 Vaccine and Treatment Strategy (health.gov.au)

- the recalibration of the program following ATAGI recommendation regarding the AstraZeneca vaccine,

- more complex vaccine administration protocols for the Pfizer BioNTech vaccine that had the potential to increased vaccine administration errors,

- complexities in providing vaccinations for priority populations,

- insufficient cultural communication support for mobile, in reach vaccination clinics, and

- difficulties gaining access to the data required to report on program performance.

Operation COVID Shield

In June 2021, Lieutenant General John Frewen was appointed to lead Operation COVID Shield (OCS) to accelerate the vaccination rollout. OCS was a collaboration with ADF and existing Departmental staff. The military led planning and assessment teams worked with the existing taskforce to develop a Campaign Plan to meet the targets set out in the Government's National Plan to transition Australia's National COVID-19 Response.[9] This Campaign Plan was underpinned by modelling undertaken by the Doherty Institute.

The rate of residential aged care workers receiving their first COVID-19 vaccine increased from 50% to 99.4% over a six-week period in 2021. Over the remainder of 2021, vaccine uptake increased significantly, particularly for at-risk groups. By 31 December 2021 over 91.4% of eligible people over 16 years in Australia had completed a primary course[10], an increase of nearly 65% since mid-August 2021[11].

In addition to the work of OCS, there are several potential reasons for the improved uptake including the improved vaccine supplies.

Adverse events

Australia's first case of thrombosis with thrombocytopenia (TTS) was reported in April 2021 following an individual receiving the AstraZeneca vaccine. As a result, on 8 April 2021, the Government accepted ATAGI advice that the Pfizer vaccine be used in those under 50 years of age given the increased risk of TTS in younger people. The vaccine program was recalibrated to bring forward additional cohorts to make use of the available AstraZeneca vaccine.

Recalibration compounded program delays as most of the vaccine available in Australia at that time was AstraZeneca while most of the Australian population now required the Pfizer vaccine. Fears of adverse events from the AstraZeneca vaccine also increased vaccine hesitancy in the community.

Logistics

The vaccine rollout logistical operation required the capacity to act rapidly and flexibly to address new waves and virus variants as they emerged. The Department had not required logistical capability of this nature prior to the pandemic and built this capability over time.

Preparedness for future pandemics will need to consider how the Government builds and maintains the capability to deliver end-to-end logistics and operations of this nature in an emergency. This may include drawing on the expertise across the Commonwealth and the private sector.

Vaccine wastage

Global demand outweighed supply of vaccines in the early stages of the Program, and vaccine wastage needed to be minimised. Challenges were faced due to vaccines arriving in multi-dose

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[9] https://pmtranscripts.pmc.gov.au/sites/default/files/2022-06/national-plan-060821_0.pdf
[10] https://www.health.gov.au/sites/default/files/documents/2021/12/covid-19-vaccine-rollout-update-31-december-2021.pdf
[11] https://www.health.gov.au/sites/default/files/documents/2021/08/covid-19-vaccine-rollout-update-16-august-2021.pdf

vials which could not be stored once opened. Wastage rates were very low, at 0.72% in June 2021; and 5.12% in December 2021.

Since mid-2022 demand for vaccination has fallen, resulting in Australia having an oversupply of vaccines. The priority has shifted from minimising wastage to ensuring vaccines are readily available. In January 2024 Australia's wastage rate was 35.41%, remaining within the WHO acceptable levels (15% to 40%) for multi dose vials.

The Department developed and implemented the COVID-19 Vaccine Administrative System (CVAS) to reduce waste and manage stocks. The program included agile procedures to reallocate excess stock to minimise wastage, working closely with manufacturers to align supply of vaccines, and facilitate international donations.

Onshore mRNA manufacturing capability

In March 2022, the Government signed a strategic partnership with Moderna, strengthening Australia's capability to respond in the event of a future pandemic. This partnership establishes a domestic mRNA vaccine manufacturing capacity and capability. Under the agreement, the Government may purchase locally manufactured mRNA vaccines. Moderna will also have the capacity to supply the Government with non-pandemic vaccines through a supply agreement.

Construction of the facility is underway, with mRNA respiratory vaccines expected to be available from the Melbourne facility in approximately August 2025.

More information on COVID-19 vaccines is at **Attachment 3**.

Key Learnings

Program design

Vaccination programs need to be capable of enabling vaccine delivery to scale up and down based on the phase of a pandemic and demand for the vaccine. For example, the Program took a whole of population level approach at the start of the pandemic and has now moved to a more targeted model. This is achieved by ensuring flexibility in approach across supply, distribution, and access models.

It is also critical that vaccine programs have access to relevant data and intelligence. The supporting data and reporting system that was at the core of the Program's end-to-end distribution model allowed vaccines to be directed to where they were needed.

A portfolio approach to vaccine purchasing, across brands, technology and establishing a sovereign supply may also safeguard against the uncertainty of pandemic conditions. In an emergency phase of a pandemic consistent vaccine supply is critical to protect against severe disease or illness.

Engaging a wide range of health professionals across the private and public sector supported Australia's whole of population vaccination goal. Health professionals need to be supported by adequate training and advice to enable safe vaccine administration.

Supporting priority populations

As the pandemic progressed not all measures were equally effective across all population groups. For example:

- Some culturally and linguistically diverse communities were receiving different guidance from family and friends in their country of origin, and
- the needs of people with intellectual disability in terms of vaccination were quite different from those with other disabilities.

The Department engaged the ABS to link Australian Immunisation Register data with the Person-Level Integrated Data Asset to generate insights on vulnerable cohorts. These insights were

presented to advisory committees (including people with lived experience) and allowed the COVID-19 Vaccine Program to be tailored appropriately to reach all segments of the population.

Consultation with at risk populations and diversity groups in the early stages of any health response is essential to ensure measures are accessible and appropriate to meet their needs. Engaging early with people with lived experience to design health responses will ensure responses are appropriately informed. Consideration of a culturally appropriate response, health liaison roles and community-based programs will enable better reach to at risk people.

3.5.   COVID-19 treatments

As noted in *Section 3.4*, early work occurred to understand potential COVID-19 treatments for Australian purchase. Australia procured and implemented treatment options that worked alongside the vaccination rollout to help prevent serious disease, hospitalisation and fatality.

Like the vaccine landscape, supply pressures and a competitive global market drove early procurement of treatment options and remaining informed about of clinical trials and research around the world. In some cases, supply arrangements were entered into while the treatments were in the end stages of clinical trials. It was unknown which treatments would be found safe and effective in clinical trial or if they would receive regulatory approval in Australia. How the COVID-19 virus would develop was also unknown. Australia's adaptability and prompt actions secured access to treatments as soon as they were commercially available and approved.

The Department secured a diverse portfolio of COVID-19 therapeutics to treat different stages of the disease. Advanced purchase agreements (APAs) were established with six pharmaceutical companies. The APAs supplied hospitals with intravenous treatments such as remdesivir (Veklury®) for the treatment of moderate to severe COVID-19. The APAs also supplied oral antivirals nirmatrelvir and ritonavir (Paxlovid®) and molnupiravir (Lagevrio®), for the treatment of patients in the community at high risk of severe COVID-19 disease with mild to moderate symptoms.

Access to Treatments

Since February 2022, over 745,000 COVID-19 antiviral treatments have been deployed from the NMS to State and Territory health departments and other government departments, ACCHOs, RACHs and the RFDS. Stocks of Lagevrio® were pre-deployed to all RACHs.

The NMS will continue to hold and distribute COVID-19 treatments until 30 April 2024. Oral antiviral treatments will then be provided through the PBS. State and Territory Governments will manage In-hospital treatments.

The eligibility criteria for PBS subsidised antivirals focus on those most vulnerable to developing severe COVID-19 including older Australians (particularly those in RACHs), First Nations people and those who are immunocompromised. This ensures treatments are accessible and affordable and are provided to people at risk of severe illness, hospitalisation or death due to COVID-19.

From 1 November 2022, medical practitioners and nurse practitioners were approved to add Lagevrio and Paxlovid to their Prescriber Bag supplies. This allowed swift commencement of treatment for aged care residents pre-assessed and deemed suitable for the administration of COVID-19 oral antiviral treatments.

Pharmaceutical Benefits Scheme (PBS)

Two oral antiviral treatments, Lagevrio® and Paxlovid® were listed on the PBS on 1 March 2022 and 1 May 2022. As at 31 December 2023, over 1,244,090 PBS prescriptions for COVID-19 oral treatments have been dispensed, with over 819,090 prescriptions of Lagevrio® and 425,000 prescriptions of Paxlovid. The total cost of these prescriptions to the Government is more than $1.4 billion. As at 5 January 2024, 86,909 prescriptions for Lagevrio (Molnupiravir) have been issued to residents in RACHs, with a further 8,048 prescriptions issued for Paxlovid (nirmatrelvir + ritonavir).

Consistent with its PBS-related functions under the *National Health Act 1953*, the Pharmaceutical Benefits Advisory Committee (PBAC) continues to assess the effectiveness and safety of these medicines and the epidemiology of COVID-19. Several updates have occurred to the eligibility criteria for accessing COVID-19 antivirals in response to emerging evidence.

Refer to **Attachment 3** for further information.

Provision of sound and evidence-based advice for clinicians on treatment options for COVID-19

The National COVID-19 Clinical Evidence Taskforce (CET) was established in April 2020 to improve clinician confidence and adherence to best practice when managing COVID-19 cases. The CET was an independent group funded by the Department.

The CET developed 'living' guidelines and recommendations for disease modifying treatments for the management of patients with suspected or confirmed COVID-19. Hospitals, the community and State and Territory health departments used these guidelines extensively in the development and prioritisation of COVID-19 care pathways.

Funding for the CET was ceased by the Department on 31 December 2022, as part of the transition to managing COVID-19 within usual funding mechanisms,

Compliance oversight to ensure consumer safety

Part of the TGA's role, is to investigate alleged importation, advertising, and supply contraventions of the *Therapeutic Goods Act 1989* and relevant regulations. This includes prohibiting the advertising, import and supply of unapproved therapeutic goods and ensuring there is no unapproved advertising of therapeutic goods.

The TGA exercised its full range of regulatory powers to protect the safety of Australians from false or misleading advertising practices of COVID products. This included:

- Issuing 166 infringement notices,
- issuing 153 direction notices (requiring certain steps be taken in relation to advertising)
- entering into two enforceable undertakings, and
- initiating other civil or criminal court proceedings[12].

Examples of specific cases undertaken by the TGA during COVID-19 can be found in **Attachment 4.** The full library of cases is also available on the TGA website[13].

Ensuring only safe and effective COVID-19 treatments were available in Australia

The TGA put a range of restrictions in place to ensure only safe and effective COVID-19 treatments were access by Australians. This included preventing the availability of COVID-19 treatments where there was limited or no evidence to support their efficacy.

For example, the CET and the Advisory Committee for Medicines Scheduling provided advice that resulted in restrictions on the prescribing of oral ivermectin from 11 September 2021. The TGA medicines scheduling delegate lifted this restriction on 1 June 2023, noting the TGA still does not endorse off-label prescribing of ivermectin for the treatment or prevention of COVID-19.

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[12] Infringement notices are an alternative to court action. Payment of such notices is voluntary and not an admission of guilt, however it can be an effective way of addressing non-compliance. The new regulatory framework has parallel criminal offence or and civil penalty provisions (for the same types of behaviour), and in general either approach may be taken by TGA investigators seeking to take regulatory action. Criminal offences have a higher burden of proof and tend to attract smaller pecuniary penalties but may have serious impacts on the ability to do business and may attract jail time. Civil contraventions tend to attract higher penalties and are particularly useful in relation to corporations.

[13] https://www.tga.gov.au/

> **Key Learnings**
>
> Early access to treatments for people in high-risk settings and at-risk populations remains a key priority. Continuing to encourage high-risk patients to discuss treatment options with their GP before testing positive to COVID-19 is important as new, more effective treatments become available.
>
> Pe-deployment of COVID-19 oral antiviral treatments such as Lagevrio to RACHs ensured older Australians in residential aged care received prompt and effective treatment.
>
> Creation of a rapid Health Technology Assessment (rHTA) pathway enabled the prompt assessment of the effectiveness, safety, and cost-effectiveness of COVID-19 therapeutics. The TGA's full assessment of these therapeutics ensured safety was not compromised.
>
> The rHTA pathway streamlined consideration by the PBAC of COVID-19 treatments for potential PBS listing. Without the rHTA oral antivirals would have taken much longer to be listed on the PBS.

3.6. Quarantine/repatriation arrangements

While the majority of returning Australians quarantined in hotel quarantine run by States and Territories, the Department supported the Government's quarantine efforts.

Repatriation Program

The Department's role in repatriation and quarantine arrangements provided essential support for vulnerable Australians stranded overseas. The Centre for National Resilience (the Centre) at Howard Springs in the Northern Territory (NT) provided a safe and effective environment to quarantine on entry to Australia. The facility supported Australia's suppression strategy and enabled the Government to maintain tight quarantine at the border to protect Australians while vaccines and treatments were being developed.

Established in October 2020, the Repatriation Program supported more than 22,000 stranded Australians and humanitarian visa holders across 141 flights to Australia. This was done with no incursions of COVID-19 between cohorts or into the Australian community. The Government provided support through a bilateral agreement[14] that was varied several times to increase the facility's capacity. This increased the quarantine capacity from 500 people to 2000 people per fortnight.

The Centre was used to quarantine over 1400 humanitarian entrants, primarily from Afghanistan. Other humanitarian evacuees were uplifted and quarantined in other jurisdictions under separate arrangements. The Centre also supported the quarantine of the Australian Paralympic team following the 2021 Tokyo games.

Prior to the Department's engagement, the Government, via DoD, used Howard Springs to quarantine passengers repatriated from the Diamond Princess cruise ship docked in Japan, as well as Australians evacuated from Wuhan.

Between 2020 and 2022, over 60,000 people quarantined at the Centre (both through the Repatriation program and to support the NT's state-based quarantine).

The Department also supported the Tasmanian Government hosting a repatriation flight; however, this arrangement was discontinued to allow Tasmania to focus on its state-based quarantine needs.

The role of AUSMAT

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[14] https://federalfinancialrelations.gov.au/agreements/provision-covid-19-quarantine-arrangements-northern-territory-centre-national-resilience

AUSMAT initially provided quarantine services at the Centre under an arrangement with the NT Government. Management of the Centre transitioned from an emergency health response to a larger, more sustainable recovery operation once capacity increased.

The NT developed a state-led model for quarantine delivery, designed to meet the needs of the expanded Repatriation Program. The NT Public Health Unit and Emergency Management Centre assumed responsibility for managing the Centre, aligning with quarantine arrangements in other States and Territories. Around 65% of the clinical workforce previously contracted by AUSMAT remained at the Centre under NT Health management.

The South Australian home quarantine app

As the pandemic evolved, the Department partnered with jurisdictions to develop solutions for modified quarantine settings based on risk tiering. For example, the South Australian Home Quarantine Application (the SAHQ app) was developed by the South Australian Government to monitor home quarantine in South Australia. In late 2021, the app was expanded to act as a toolkit to guide those in home quarantine through testing, symptoms, support referrals and the quarantine itself.

The SAHQ app was made available for Apple and Android users and adapted to meet home quarantine policy requirements of participating jurisdictions. Support was provided to relevant jurisdictions to operate trials. The trial concluded on 31 December 2021 with 157,253 people having used the app.

An assessment of the trial found the app assisted in supporting the management of home quarantine and should be considered for future emergency responses.

Key Learnings

Genuine partnerships with jurisdictions and Commonwealth agencies need to be established with clear definitions of roles and responsibilities.

The Commonwealth's responsibility for overseeing the operations of quarantine facilities may better sit with an agency whose remit covers other border controls. The Department's role would then be advisory, such as advice on incubation periods of virus or infection prevention and controls.

The staged increase of quarantine capacity proved to be effective in supporting the repatriation of Australians, while also balancing the risk to the community. This also helped to build a workforce. For example, 145 additional nursing staff were upskilled as part of the Repatriation Program and subsequently took up roles within the NT health system.

The quarantine experience at the Centre was largely well received with people having access to support and other facilities not available in other arrangements (such as external balconies).

For future emergency responses, the establishment and use of quarantine facilities may again be a critical function. The National Coordination Mechanism proved valuable when coordinating issues that required multiple agencies operational and policy insights to implement quickly, like quarantine arrangements.

3.7.   Communication

From the outset of the COVID-19 pandemic, the Department's communication functions addressed issues in real-time with solutions implemented quickly. The Department's communication capability and channels strengthened throughout the pandemic.

The Department was the source of truth for mainstream media in the early stages of the pandemic. Daily press conferences, regular media appearance of Departmental spokespeople and other communication from the Department became usual practice. The Department's website and social

media channels surged in popularity with Australians and people from other countries. Key messages were disseminated widely and quickly, shaping community behavior.

As the pandemic progressed, this approach was complemented by the development of multi-channel, integrated approaches to communicating consistently and regularly with specific parts of the community. This included older people, aged care providers, recipients and residents, those living with disability, First Nations peoples, those from diverse cultural communities and relevant support bodies.

A Department key priority was making information available and accessible. For example, closed captioning and Auslan interpreters were used during updates and media briefings. Tailored communication products and channels were developed in collaboration with stakeholders, and partnerships were established with community leaders to support them with messaging for their community.

The Department also managed the COVID-19 communication strategy. The strategy had 30 advertising phases and delivered an integrated and ongoing communication mix of owned, paid and stakeholder channels to maximise engagement with public health behaviors. Advertising was adapted and/or translated to ensure relevance to and accessibility by First Nations and culturally diverse communities.

Weekly meetings with State and Territory Government counterparts linked strategies with state and territory communication activity. The Department was also a key contributor to weekly meetings of communication teams from across the Commonwealth. This enabled key messaging to be provided to agencies to share with their sectors and stakeholders, linkages to be made between communication strategies and content, and emerging issues to be identified and addressed quickly. Most advertising encouraged people to access the health.gov.au website, which was positioned as the 'source of truth'. As Government messaging began to expand beyond health issues, Australia.gov.au was introduced as a single gateway to information about the pandemic and response measures. Health alert pages and resources have attracted over 160 million page views since the pandemic started.

In close collaboration with jurisdictions, the Department published daily national COVID-19 cases along with other key indicators to complement the communications strategy and provide the public access to COVID-19 related data. As the pandemic progressed, the cadence of this reporting was adapted, eventually tapering from daily to weekly to the now-monthly reports.

Initial communications focus

The messages supporting the early phases of the COVID-19 communication program in 2020 focused on increasing awareness of the importance of physical distancing, good hygiene, support for vulnerable groups, and COVID-19 testing information for Australians returning from overseas and at international borders.

With the arrival of COVID-19 vaccines in early 2021, communication priorities shifted to promote the availability and importance of vaccines and how to access them. To support the Department's vaccine communication program, the first phase of the COVID-19 vaccination advertising campaign provided Australians with information on the vaccine safety, testing and TGA approval process. Later phases focused on promoting eligibility cohorts for each phase of the rollout.

Ongoing communications response

As RATs became available in late 2021, communication focused on changes to testing requirements. Messaging promoted the availability of free RAT and PCR tests at testing facilities for people who were a close contact, had symptoms, or were instructed to test by a health authority. The Department maintained regular communication with the aged care sector on the importance of RAT test surveillance screening for all staff, workers and visitors.

In July 2022, the Department began promoting the availability of COVID-19 oral treatments to eligible cohorts, including specific targeting of the aged care sector. This effort was supported by

advertising with messaging focused on eligibility, prescription requirements to access the medication, and how the treatment can be taken at home.

All phases of the advertising program were rigorously concept tested and ongoing public sentiment tracking informed future phases of the campaign. This monitoring demonstrated the shifts in community attitudes and behaviors that were achieved over the course of the pandemic.

Maintaining engagement

The Department used in house medical and healthcare expertise, to support over 90 press conferences, 200 media interviews and countless Facebook live updates (E.g. the Top 3 at 3) and webinars. Key departmental spokespeople included the CMO, Deputy CMOs, leadership of the TGA and the Chief Nursing and Midwifery Officer. The Department responded to over 4,000 media inquiries and 150,000 COVID related emails and received over 50,000 calls from vaccine clinics, GPs and pharmacies.

Since January 2020, the Department published over 19,000 COVID-19 related posts on social media channels (Facebook, X, LinkedIn, Instagram and YouTube). This resulted in more than 1.6 billion impressions and over 49.5 million direct interactions. The Department's social media pre-pandemic audience grew from 159,223 followers to over 1 million followers during, and since, the COVID-19 pandemic.

The Department translated key health and vaccine information in 63 languages and established a priority line to support interpreter requirements for appointment bookings. The Department procured multicultural public relations strategists (Cultural Perspectives) and engaged with multicultural peak bodies to tailor resources and drive grassroots improvements in vaccination uptake.

The Department partnered with social media and community organisations to produce engaging, educational videos featuring people with profile and well-known brands. Partnerships included Australian music group Teeny Tiny Stevies, podcasts like Happy Families, the V8 supercars and the ACT Brumbies.

The Department attended more than 300 events to promote COVID-19 messaging. There were more than 9,300 shopping centre information kiosks helping more than 34,000 Australians with COVID-19 enquiries and vaccinations. To improve local communication efforts, population insights have been shared with jurisdictions since October 2021.

Ensuring access to information

The Department launched the "Vaccination update" newsletter for citizens as COVID-19 vaccinations became available in Australia. At its peak, the newsletter was sent to more than 37,000 subscribers weekly, sharing crucial advice relating to COVID-19 vaccines, oral antiviral treatments and protective behaviors. The newsletter has been leveraged to share information on other topics including winter preparedness and influenza campaign messaging.

The Aboriginal and Torres Strait Islander Advisory Group on COVID-19 and its Communications Working Group were established to provide cultural insights and recommendations. First Nations communication products were developed and delivered to First Nations communities, including via:

- web pages dedicated to First Nations people – the COVID-19 vaccine web page and a COVID-19 information web page,
- audio and video materials translated in up to 15 Indigenous languages,
- partnerships with Indigenous community leaders to communicate vaccine information, tackle hesitancy and dispel misinformation,
- case study and spokespeople videos, videos featuring GP and health care workers, social media content and radio scripts, and

- an e-newsletter with 1,039 subscribers providing updates on COVID-19 vaccination information, COVID-19 facts, stories and resources.

The pandemic highlighted the diversity of people with disability. The Department developed capability and established networks to ensure information and messages were shared in multiple formats, engaging disability organisations to help develop tailored messaging. For example, the Department engaged the NSW Council for Intellectual Disability and Down Syndrome Australia in September 2021 to develop targeted communication resources. The Department also published information in Easy Read.

The Advisory Committee on the Health Emergency Response to COVID-19 for People with Disability, and its communications working group, were a key to developing tailored health messaging and identifying appropriate channels to share information.

Between 7 February 2020 and 5 July 2023, over 540 aged care COVID-19 specific *Protecting Older Australians* newsletters were distributed, to support those in RACH. Over 80 aged care COVID-19 webinars were held, that included ministers, department executives, in-house experts and key external stakeholders such as the Older Person Advocacy Network (OPAN).

The Department used an evidence-led approach to communication and engagement, leveraging data to refine tactics and channels to better meet the needs of older people. This included radio advertising featuring family or carers, communicating through community groups, local councils and consumer advocates. Plain English, older voices (the Senior Australian of the Year and Aged Care Council of Elders members) and images of real people also increased engagement and relevance of communication activities for this audience.

Further information on the aged care response can be found in *Section 4.2.*

The Department established the national Culturally and Linguistically Diverse Communities COVID-19 Health Advisory Group to ensure effective engagement with multicultural communities. On 14 February 2021 the Department launched the *COVID-19 Vaccination Program – Culturally and Linguistically Diverse Communities Implementation Plan*[15]. This plan, informed by advice from the advisory group and support of specialist multicultural communication agencies, set out principles to ensure information was delivered in appropriate languages, formats and locations.

From 1 January 2023, the group was renamed to the CALD Communities Health Advisory Group to reflect its expanded role to provide advice to shape health and wellbeing policies and programs for CALD communities across the Health and Aged Care portfolio.

The Department also partnered with the Department of Home Affairs (DHA) to leverage the relationships between their community liaison officers and culturally diverse communities across Australia. The community liaison officers provided insights into local community sentiment and information needs and the Department provided them with messaging and products they could share with communities.

Mental Health campaigns

In response to reports of increased personal stress and anxiety in early 2020, several communication campaigns were developed. The "How's Your Head Today?" campaign addressed the significant physical, mental, and economic challenge and included videos, animations, radio advertisements and how-to guides were developed. Products featured themes of emotional wellbeing, keeping connected, recognising signs of poor mental health, seeking help, maintaining physical wellbeing and supporting young people.

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[15] https://www.health.gov.au/resources/publications/covid-19-vaccination-program-culturally-and-linguistically-diverse-communities-implementation-plan

Trust in government messaging

Community sentiment showed high initial trust in Government and the COVID-19 messages. Through the first half of 2020, published monitors indicated that the perception the Government was doing a good job managing COVID remained high before declining in mid-2020. Confusion about messages primarily occurred when there was variation among jurisdiction in relation to the public health and social measures and vaccination requirements that differed with the nationally agreed guidance.

Tackling COVID-19 misinformation and vaccine hesitancy

The Department worked with peak bodies and other government agencies to distribute credible COVID-19 information to counter misinformation and address vaccine hesitancy. Social media ads were run and formally moderated throughout the public campaign. Comments were responded to on social media posts, correcting misinformation and directing people to the correct information on the health.gov.au, TGA and WHO websites. Prompt moderation of social media posts ensured the Australian public had access to safe and reliable information. The Department received and moderated over 50,000 comments per month during the peak of the pandemic.

Key Learnings

Early in the pandemic, the Department struggled to reach and engage younger audiences. Identification and partnership with key social media platforms, enabled the Department to reach these audiences in novel ways. Other key learning include:

- Managing COVID-19 fatigue: As the pandemic progressed and 'COVID fatigue' set in, maintaining engagement became challenging. The department realigned messaging to focus on priority groups, promoting ATAGI's updated recommendations on vaccination and oral antiviral treatments to high-risk communities. The Department is still communicating key messages about COVID-19, but the approach is similar to other communicable diseases like influenza.

- Communicating with diverse audiences: Leveraging existing channels and partnerships with peak organisations, local influencers and trusted voices, is critical to effectively deliver information to diverse audiences.
- Use of data to target communications: The Department's strategic use of COVID-19 vaccine data to identify locations and population groups with low vaccination uptake allowed a highly targeted media buy through geo-targeted advertising placement.
- Use of trusted experts: the CMO, CNMO and Deputy CMO provided a team of trusted voices. Given the protracted COVID-19 emergency it was important to have more than one person to allow for sustainability.

National Consistency: Establishing mechanisms to agree positions and an understanding of the impact of differing messages on the community is necessary, especially where decisions are made to deviate from agreed position.

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4. Broader health measures

Relevant Term(s) of Reference: Broader health supports for people impacted by COVID-19 and/or lockdowns (for example mental health and suicide prevention supports, and access to screening and other preventive health measures).

This section will include:

- 4.1 – Health care supports
- 4.2 – Mental health and suicide prevention supports

- 4.3 – Aged care supports

- 4.4 – Screening and preventative health measure access

Please refer to the relevant section for:

- 3.1 – National Medical Stockpile including PPE provision

- 3.2 – COVID-19 testing and pathology

- 3.4 and 3.5 – COVID-19 vaccine and treatment rollouts

- 5.1 and 5.2 – Travel restrictions and requirements, outbreak response and international surveillance

- 5.3 – International partner engagement on COVID-19 vaccine and treatments

4.1.   Health care supports

The COVID-19 pandemic accelerated health reforms that may not have been achievable without the collective efforts of various governments, stakeholders and community groups. The pandemic also highlighted the need for flexible and scalable models of care, particularly within primary care.

The Government invested in a range of health and care supports to reduce the spread of COVID-19 and improve the resilience and performance of the health system. Many of these measures have improved health care access across Australia including access to virtual and other healthcare channels not previously available.

The primary healthcare system, largely the responsibility of the Commonwealth, continues to play an essential role in the COVID-19 response. This includes assessing, testing and managing infectious respiratory disease patients, administering COVID-19 vaccinations and prescribing COVID-19 treatments. Primary care services continue to provide care for COVID-19 patients, including escalation to hospitals, managing patients after discharge from hospital, providing front line mental health services, and supporting patients with Long COVID symptoms.

Some of the supports introduced in response to the pandemic have become embedded elements of the health system, such as expanded MBS telehealth items and electronic prescribing. Other enduring features include the national triage services through Healthdirect, better infection prevention and control (in primary and aged care) and the increased capability of PHNs to coordinate care in the community. Other elements, which provided temporary additional health system capacity to support the emergency response, were progressively scaled back over time.

Medicare Benefits Schedule and Pharmaceutical Benefits Scheme amendments

During the pandemic, the Government introduced a wide range of additional services under the MBS and PBS to support healthcare provision via virtual/digital channels. These adjustments were aimed at reducing the risk of community transmission of COVID-19 and provide protection for both patients and healthcare providers. These changes ensured patients had access to essential health services, and relieved pressure on hospitals by enabling healthcare providers to manage COVID-positive people in the community. This also supported GPs, allied health providers and specialists to continue providing essential health care services during periods where patient or provider movement was restricted by lock downs.

MBS Telehealth

From March 2020 to 31 December 2023, 169.3 million services have been provided to more than 20 million patients. Over the same period, more than 100,000 health professionals have provided MBS telehealth services and $8.4 billion in benefits have been paid.

Many amendments were made to the MBS to support access to health services and mitigate the risk of COVID-19 transmission. The rapid deployment of MBS telehealth measures aligned with the 'Australian Health Sector Emergency Response Plan for Novel Coronavirus'.

The rapid expansion of telehealth services (which included video and phone consultations) was staged according to the health needs of the community. It was also informed by regular consultation with stakeholders including experts, patients, and the latest available research. Implementation of targeted items for smoking cessation, mental health, and blood borne virus and sexual reproductive health occurred alongside general telehealth items. Support for admitting health professionals to consult with their patients in hospital via telehealth also occurred.

Refinements were made to a range of telehealth services as COVID-19 impacts and use of telehealth items were observed. Consideration was given to quality of care, and how telehealth can support equivalent outcomes to in-person care, given common clinical requirements for telehealth and face-to-face services.

Telehealth evolved over time, with most of the telehealth items introduced now becoming a permanent feature of the health landscape. This included increased access to a broader range of telehealth compared to before the COVID-19 response, particularly for GPs, specialists, nurse practitioners and allied health professionals.

Telehealth measures specific to the COVID-19 response have also evolved over time. Current temporary telehealth measures include:

- long telephone consultations for eligible patients' assessments for suitability of COVID-19 oral antiviral medicines.
- Patients with a recently confirmed COVID-19 diagnosis or suspected infection requiring confirmation via PCR pathology tests can access MBS telehealth services from any available GP.

These measures will cease 30 June 2024.

Lessons from the COVID-19 response have informed the MBS' response capability for future natural disasters. Legislated provisions now enable increased access to MBS GP telehealth services in affected regions, as identified by States and Territories.

On 1 March 2023, the MBS Review Advisory Committee (MRAC) formally commenced a post-implementation review of telehealth arrangements. The scope of the post-implementation review of telehealth included:

• Permanent and temporary MBS funded telehealth services.

• The MBS Review Taskforce's Telehealth Principles, which were published in 2020 and have informed policy to date.

• The appropriateness of current settings for video and telephone consultations to ensure the right balance of access, quality, and safety.

The review has been informed by targeted and public consultation as well as engagement with health experts, peak organisations, researchers, and consumers who have provided evidence and advice. Interim advice from MRAC was provided to the Government in late 2023, and final recommendations will be provided by 31 March 2024. The Government will consider MRAC's final advice and recommendations in due course.

Other MBS changes

From 8 November 2021 to 31 December 2022, a temporary MBS item was available to support medical practitioners providing clinically relevant face-to-face treatment to COVID-19 positive patients.

The Government also made available temporary MBS items to improve multidisciplinary care access, to support residents of aged care homes deconditioning due to COVID restrictions and inactivity. These items included up to an additional 5 physical therapy sessions and up to 2 additional exercise physiology group services per calendar year.

E-prescribing

E-prescribing was originally part of the 2018/19 Budget. The intent was that by 2022 all prescribers and pharmacists would have access to electronic prescribing and dispensing. The COVID-19 pandemic saw this measure brought forward for implementation in May 2020. This expedited roll-out, alongside a growth in pharmacy delivery services, enabled patients to access medications without being limited by lockdowns, COVID-19 infection, or location. It also reduced the risk of infection among health professionals by limiting exposure to COVID-19 positive patients.

From March 2020 to 31 December 2023 over 191 million electronic prescriptions (e-scripts) were issued, by more than 78,000 prescribers (GPs and nurse practitioners). E-prescribing has become a permanent feature of the Australian health system with over 98% of pharmacies across Australia now able to dispense medication to patients via e-prescriptions.

General Practice-led Respiratory Clinics (GPRCs)

GPRCs were established early in the pandemic to conserve PPE and divert people with mild to moderate respiratory symptoms from other general practices and public hospitals, particularly emergency departments.

The initial purpose of GPRCs was to assess patients with respiratory symptoms and carry out PCR tests to confirm diagnoses. Although not part of the original objectives, disease surveillance became an important component of the program. GPRC scalable capacity was an important part of Australia's response, successfully reducing the burden on key parts of the primary care infrastructure.

From January 2022, GPRCs began providing treatment services to COVID-19 positive patients through face-to-face and telehealth consultations, including the prescription of anti-viral medications.

At the peak, there were 150 GPRCs nationally providing primary care services to individuals, including those ineligible for Medicare, at no cost to the patient. Gap analysis and needs assessments determined the site locations. Equitable access to relevant care during COVID 19 was the key criterion. During the program, which ran from March 2020 to February 2023, GPRCs collectively delivered more than:

- 3.5 million consultations for patients presenting with respiratory illness,

- 3 million tests for COVID-19,

- 2.3 million COVID-19 vaccine doses, and

- 80 thousand COVID-19 positive consultations.

GPRCs serviced people from 2,540 postcodes nationally, covering 99.8% of the population.

General Practice-led Respiratory Clinic Panel

The GPRC Panel includes 111 existing accredited general practices with suitable infrastructure, infection prevention controls and workforce. It will be held in reserve to respond at short notice to a future respiratory health emergency, if necessary.

In non-emergency times, participating practices provide their usual services through standard MBS items.

Primary Health Networks

PHNs were established in 2015 to improve the efficiency and effectiveness of health services. During the pandemic, PHNs initially assisted in PPE distribution to primary care providers. More than 34.5 million units of PPE were provided via PHNs.

The role of PHNs evolved throughout the pandemic, with PHNs bringing together their local knowledge and ability to bridge elements of the health care system provided by the Commonwealth and state and territory governments. The PHNs developed regional community pathways for

COVID-19 positive people, while ensuring plans were in place for management and escalation through the community health system.

Between October 2021 and June 2023, PHNs were funded to commission home visits to avoid unnecessary escalation of patients to hospital. PHNs commissioned medical services, GPs, Aboriginal Health Workers, nurse practitioners and practice nurses to undertake home visits for treatment of COVID-19 symptoms, or for other medical needs that could not be delivered by telehealth.

In the first half of 2023, PHNs contacted over 1,400 disability accommodation settings to ensure residents had appropriate access to primary care providers. PHNs support disability accommodation to arrange vaccinations, on or off-site, with local primary care providers and further support the development of relationships between the accommodation and primary care providers.

Other Health Supports

Healthdirect Australia (Healthdirect)

Healthdirect is a national health information and advisory service. The pandemic brought about a systemic change as to how all States and Territories use Healthdirect.

Healthdirect operated the National Coronavirus Helpline (NCH) from March 2020 to December 2023. The NCH handled almost five million calls and operated 24 hours a day, seven days a week. The NCH also included a free interpreting service and had several dedicated priority lines providing support to:

- COVID-19 positive patients,

- aged and disability care workers,

- First Nations peoples, and

- people with disability, their carers, family and friends.

Healthdirect also operated the Living with COVID (LwC) program from January 2022 to October 2023. The LwC included a helpline connect COVID-19 positive consumers to the right level of care. The LwC helpline handled more than 560,000. The CSIRO's digital health and research program conducted an independent evaluation of the LwC program[16]. It found that the LwC helpline adapted well to changing circumstances such as snap lockdowns and 'spikes' in case numbers, increased health literacy and enabled members of the public to make informed decisions about their care. The evaluation found the LwC helpline successfully connected consumers to primary care enabling early intervention and was deployed as a scalable model for patient triage and care access.

Both helplines were transitioned to sustainable business as usual arrangements within the Healthdirect suite of services.

Healthdirect provided other services to support Australians during the pandemic. For example, the Easy Vaccine Access (EVA) concierge call back service addressed access barriers. The EVA supported more than 17,000 vaccine bookings. In addition, the COVID-19 symptom and antiviral eligibility checker was created and is available in 11 languages. This tool was accessed by more than 16.2 million uses.

COVID-19 Practice Incentives Program (PIP)

The Practice Incentive Program encourages general practices to continue providing quality care, enhance capacity, and improve access and health outcomes for patients. The COVID-19 PIP was

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[16] https://media.healthdirect.org.au/publications/CSIRO_Living-with-COVID-program-evaluation.pdf

established to encourage continuity of care and follow-ups for patients receiving the COVID-19 vaccine.

General practices needed to be accredited under the Royal Australian College of General Practitioners (RACGP) Standards and follow the National Vaccine Storage Guidelines to be eligible participants. This provided assurance that selected practices had cold chain management processes in place and effective procedures to maintain the shelf life and potency of the COVID-19 vaccines. General practices could claim $10 per eligible patient that received both first dose and second dose of a COVID-19 vaccine at the same practice.

A total of 8,217 practice payments were made to general practices under this program.

Later in 2021, the COVID-19 In-reach Vaccination Incentive was introduced to support general practices undertake in-reach COVID-19 vaccination services for aged care and disability support workers in their workplace. Once the minimum threshold for workers had been met, it was expanded to allow payments for in-reach services to residents in aged care homes or disability residential facilities.

General practices could claim $1,000 for a minimum of 50 COVID-19 assessment services through an in-reach vaccination clinic, with additional payments of $20 per service to a worker or resident thereafter. A total of 74 practice payments were made to general practices who undertook in-reach vaccination services.

Strengthening Medicare – General Practice Grants Program

The Government provided funding from April 2023 for the Strengthening Medicare – General Practice Grants Program. General Practices and eligible ACCHOs can access the program to expand patient access and improve their services across Australia.

The program provides a one-off grant (between $25,000 to $50,000 based on practice size and accreditation status) to each general practice and eligible ACCHO to make investments in innovation, training, equipment, and minor capital works in one or more of three investments streams:

- enhance digital health capability,

- upgrade infection prevention and control arrangements to increase capacity to treat COVID-19 positive and other respiratory patients in a general practice setting, and

- maintain and/or achieve accreditation.

Key Learnings

The Australian health system was largely able to adapt to COVID-19-related movement restrictions through substituting face to face care modalities with virtual care modalities. While this was successful for many interventions, it did not suit all types of care. The full impact of the emergency phase of the pandemic on the long-term health of people who many have missed health care due to lock downs and restrictions is likely unknown.

The role of primary care is critical in every Australian health emergency response. Throughout the pandemic, primary care providers have demonstrated their value, quickly adapting their services and dealing with challenges for patients and health professionals. Detailed consideration of the role of primary care in emergency response preparedness is vital to ensure Australia can move quickly in future possible pandemics.

Defined roles and responsibilities of primary care providers would benefit future preparedness, while maintaining flexibility to respond appropriately depending on the emergency health situation. Considering the role of PHNs in future emergency responses should also occur. PHNs potential contribution should be clearly defined, and they should participate in pre-pandemic planning exercises.

For the GPRC program, lessons were recognised and applied through the development of an emergency response capability via the GPRC Panel. Other key lessons from the original GPRC program include:

- Reliance on temporary infrastructure was not sustainable from a financial or health perspective, and

- Engaging general practices through contracts reduces data integrity as consultations are not centrally recorded and fees are not linked to an individual practitioner's provider number.

4.2. Aged Care Support

Support for older Australians was central to the Department's response planning. From the beginning of the pandemic, the Department supported aged care providers to implement measures to prevent or reduce the risk COVID-19 from entering RACHs. This included providing:

- o on-site vaccinations,
- o guidance around IPC protocols and managing visitations to aged care homes,
- o daily monitoring and case management,
- o regular on-site PCR testing, and
- o provision of surge workforce, PPE and RATs when outbreaks occurred.

The Department published the first overarching plan for management of COVID-19 for Australia through the AHPPC on 31 January 2020. This was followed by a specific National COVID-19 Aged Care Plan that National Cabinet endorsed in August 2020. The plan outlined the national approach for supporting the aged care sector to prevent, prepare, respond and recover from COVID-19.

This plan was further updated in late 2020 to consolidate learnings from the initial phases of the pandemic and included specific guidance, information and tools to support aged care recipients, their families, the aged workforce and providers of aged care services. As the pandemic evolved, more targeted guidance was developed to support the sector, including winter and summer preparedness plans.

The aged care sector's initial response to COVID-19 took a strong risk averse approach. At times, this meant implementing stringent restrictions on visitations and movement within and between RACHs. The Department supported providers to increase their IPC and emergency planning capabilities. This included providing regular guidance around furloughing staff and visitation to

RACHs based on AHPPC advice. As preparedness capabilities increased the sector moved towards a risk-based approach that balanced the need for strong IPC protocols with the physical, social and emotional needs of older people. This change was supported by high vaccination rates among residents of aged care homes and oral antivirals treatments becoming available.

Outbreaks impacted the health and well-being of residents through the direct impact of COVID-19 infections and beyond with broader health issues linked to isolation and quarantining requirements. Repeated COVID-19 waves also impacted aged care staff, with COVID-19 related furloughing and isolation requirements exacerbating existing workforce shortages across the sector.

Key aged care support

Most RACHs experienced at least one COVID-19 outbreak. The Department provided additional supports for RACHs to deal with these outbreaks, such as directly reimbursing facilities for the costs incurred of dealing with an outbreak and additional funding to ensure the viability of homes. A range of workforce supports including supplementary workforce through agency staff and deploying ADF personnel and upskilling existing workforce through IPC training were also provided.

Further details on additional supports provided to the aged care sector and older people during COVID-19 can be found at **Attachment 5**.

Key learnings

Throughout the pandemic there was tension between restrictions applied to and by aged care services and the settings that were applicable to the broader community. This created a challenge for the sector in balancing the human rights of aged care residents to interact with family, friends, loved ones and carers, with the real risks to health and lifespan of residents.

Noting these tensions, the impact of COVID-19 on residential aged care has been significant, with over 6,000 COVID-19 related resident deaths in aged care over the course of the pandemic.

Since 2020, there has been a significant reduction in COVID-19 case mortality in aged care from 33% of cases in 2020 to 1.6% of cases in 2024. This reduction is due to a range of factors including greater preparedness of the sector and the availability of effective vaccines and treatments.

The pandemic occurred concurrently with the Royal Commission into Aged Care Quality and Safety, which highlighted deficiencies in the aged care system and recognised the system was already under strain. The Royal Commission also noted the aged care system was not adequately prepared to respond to a significant outbreak, such as the COVID-19 virus. Some of the key challenges in the sector's response included:

- turnover in leadership positions or low staffing levels due to worker fatigue and burnout,
- limited IPC expertise and significant gaps in IPC practice, and
- complacency in stocking or correctly using PPE.

The absence of robust screening procedures to identify cases early increased the risk and challenges of managing an outbreak.

In addition to the Royal Commission and other external reviews, the Department continued to adapt its approach guided by advice from the sector, AHPPC and ACAG, and State and Territory officials. Two of the key measures implemented in response to this advice and feedback was the introduction of IPC leads and access to additional aged care surge workforce.

In December 2020 all RACHs were required to have a dedicated IPC Lead. The fourth COVID-19 wave saw smaller spikes in cases, less severe outbreaks, and fewer resident deaths per cases, compared with earlier waves. This suggests improved preparedness in aged care homes.

As of 9 February 2024, the Surge Workforce Support Program has covered 188,069 shifts in aged care services impacted by COVID-19. It includes GPs, nurses, care workers, allied health workers, executive and ancillary staff.

The surge workforce support program provided more than 200 deployable resources nationally to support RACHs experiencing critical staff shortages.

Access to time limited surge workforce ensures aged care homes are adequately supported. The program creates a stabilising and protective effect providing quality care and service to older Australians.

In response to the COVID-19 pandemic, the Aged Care Quality Standards were strengthened to include specific outcomes on emergency and disaster management (Outcome 2.10) and infection prevention and control (Outcome 4.2). Note, the final draft of the strengthened Quality Standards is not yet in operation but will be incorporated into and implemented as part of the new Aged Care Act (see Section 6).

4.3.   Mental health and suicide prevention supports

Public health and social measures were highly successful at preventing the spread of COVID-19 at the beginning of the pandemic. However, these measures (such as lock downs and density limits) came at a significant social and economic cost and had, in some cases, serious mental health impacts. Psychological distress remained elevated throughout 2023, underlining the importance of continued support in this area.

The legacy of COVID-19 and its associated lockdowns continues to impact the mental wellbeing of the Australian community, with two in five Australians reporting their mental health has been affected by the pandemic. Digital service provider data confirms that service demand is higher than pre-pandemic levels. Other data and research indicates the mental health impacts of the pandemic, including grief, economic hardship and social isolation, will continue for some time. There is emerging evidence of the long-term psychological and cognitive impacts of long-COVID, estimated to affect about 5% of Australians. This is likely to contribute to ongoing demand for mental health support.

Whole of Population Supports

An early component of the Government's mental health response was the *National Mental Health and Wellbeing Pandemic Response Plan (*Response Plan). The Response Plan's core objective was for Australians to prioritise their mental health in line with physical health, and set out advice to help navigate this.

Beyond the initial funding committed under the Response Plan, the Government subsequently implemented a range of mental health supports, including:

- Temporarily increasing the number of psychological therapy sessions available to an individual under the Better Access to Psychiatrists, Psychologists and General Practitioners program, from 10 to 20 sessions. Medicare-subsidised telehealth services were also available,
- Increased funding to a range of digital mental health services, and
- Support for PHNs to commission mental health nurses to provide in-reach mental health services for older Australians experiencing social isolation or loneliness.

For more information on whole of population mental health support, please see **Attachment 6.**

Support for Target Populations

The pandemic caused changes to the way Australian's lived, worked, learned and engaged in every aspect of society, contributing to stress and anxiety. Different supports were needed for different cohorts and the Department addressed this through implementation of a range of measures for different cohorts, including:

- Supporting the mental health of people in mandatory quarantine through a range of specifically designed digital, telephone and telehealth mental health services,
- Support for people in isolation by promoting geo-location-relevant COVID-19 alerts and information, encouraging help seeking behaviour and prompts for early intervention,
- Support for residents of RACHs, by funding a range of measures to address isolation. The eligibility of the Better Access program was expanded to allow RACH residents access treatment via GP referral in line with referral pathways in the broader community,
- Additional funding for Healthdirect to collate and disseminate mental health information,
- Support for children and young people, through funding programs in schools and other programs, and
- Support for First Nation's social and emotional wellbeing by developing a suite of culturally appropriate COVID-19 resources.

For more information targeted mental health support, please see **Attachment 6.**

Suicide Prevention

The Department worked closely with jurisdictions to monitor deaths by suicide, including through investment in the AIHW Suicide and Self-Harm Monitoring System (SSHMS). National suicide data, published annually in the ABS Causes of Death publication, does not show an increase in deaths by suicide in either 2020 or 2021.

In 2021, 81 of the people who died by suicide had the COVID-19 pandemic identified as a risk factor, which represents 2.6% of all suicides. This is a reduction from 3.2% in 2020.

Key Learnings

Throughout the pandemic the Department assembled a detailed knowledge base of the impacts of the pandemic on the mental health and wellbeing of the broad population. This included understanding how it impacted different population groups and locations at different points in time. Other recent events such as the 2019-20 bushfires, flooding events, and other disasters and isolation added to this knowledge.

Learnings from the more vulnerable or those at-risk of experiencing mental health difficulties, will be considered in future mental health response measures. This will include lessons from aged care recipients, older people, children and youth, as well as consideration of workforce requirements to support surges in demand, particularly over a long period of time.

Central to the rapid implementation of many of the COVID-19 mental health initiatives was leveraging existing relationships with the States and PHNs. For example, the Head to Health initiative was able to be stood up in 4 weeks as it used existing infrastructure within established primary care settings.

4.4. Impacts to screening programs and services

Screening and preventative health access

Medical screening and preventative health were impacted by the pandemic. As outlined in Cancer Australia's paper on COVID-19 Recovery[17], the pandemic disrupted the three national population cancer screening programs for breast, cervical and bowel cancers.

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[17] Cancer Australia 2021. The impact of COVID-19 on cancer-related medical services and procedures in Australia in 2020

In 2020 and 2022 there were 163,595 and 158,211 fewer cancer-related diagnostic procedures, based on 2017 - 2019 trends. This may result in more cancers being diagnosed at a later stage.

Breast cancer screening

AIHW's BreastScreen Australia Monitoring Reports showed that participation in the BreastScreen Program dropped from 55% in 2018-2019 to 48% in 2020-21.

Suspension of some BreastScreen services occurred between 2020 and 2022 in response to public health requirements and flooding. Modelling suggests a short delay between regular screening mammograms is unlikely to change the long-term outcomes of any detected cancers. During these suspensions some BreastScreen Australia staff were redeployed for COVID-19 related care.

BreastScreen Australia received funding from 2022 to 2024 to boost the capacity to re-engage women and catch up on delayed screening.

Cervical cancer screening

The National Cervical Screening Program (NCSP) continued to operate during COVID-19. The NCSP changed from 2-yearly Pap tests to 5-yearly Cervical Screening Tests in December 2017[18]. With this change, the number of Cervical Screening Tests conducted was expected to be lower in 2020 compared to 2019. In 2020 843,971 fewer tests were conducted than in 2019. There were fewer cervical screening tests in April 2020, and to a lesser extent in May 2020[19] than expected. However, there was an ongoing trend towards increased participation over the 2018-2022 period, with participation reaching 68%.

Bowel cancer screening

The National Bowel Cancer Screening Program (NBCSP) continued to invite eligible Australians to screen throughout the COVID-19 pandemic. Screening participation rates dropped from 43.8% in 2019-2020 to 40.9% in 2020-2021, however subsequent research undertaken by Cancer Council in 2023 indicated that natural disasters had more of an impact than the pandemic. While high COVID-19 case numbers led to a relative decrease of 5% in kit return rates, the research also found 15+ day lockdowns within a month led to a 10% increase in bowel screening kit returns[20].

The median time between the positive screen and a follow-up diagnostic assessment increased from 49 days (for the period 1 January 2019 and 31 December 2020) to 58 days (for the period 1 January 2020 and 31 December 2021).

The NBCSP received additional funding in March 2022 to support access to colonoscopy and grow capacity to process those procedures delayed due to the pandemic.

In support for screening activities, the Cancer Council Australia ran a campaign between September and November 2020 and between March and April 2021, to encourage Australians who had delayed cancer screening to 'Put Cancer Screening Back on Your To-Do List'.

Travel restrictions to support vulnerable populations

Responding to calls from the First Nations community, on 20 March 2020, the National Cabinet provided in-principal agreement to restrict travel in and out of specified remote communities. This was done in partnership with the community, under the *Biosecurity Act 2015* (Biosecurity Act) with the aim of preventing the spread of COVID-19 to vulnerable populations, including First Nations people.

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[18] National Cervical Screening Program monitoring report 2021 (aihw.gov.au)
[19] Cancer screening - Australian Institute of Health and Welfare (aihw.gov.au)
[20] Durkin et all. Centre for Behavioural Research in Cancer, Cancer Council Victoria. National Bowel Screening Campaign 2022: FOBT Kit Return Results by Region. 15 May 2023.

Other Health Supports

Palliative care: caring@home COVID-19 supplement packs

To assist people within home palliative care, the Department commissioned the development of a COVID-19 Supplement Pack as an adjunct to the standard palliative care caring@home pack. The supplement pack reduced the reliance on the telehealth and palliative care clinical workforces and alleviated the pressure of equipment shortages during the height of the COVID-19 outbreak. The supplement pack contained clinical equipment and provided and information and educational video illustrating how to use the clinical equipment. Over 10,000 caring@home supplement packs were provided across Australia.

Hearing Services Program (HSP)

The HSP supports hearing services for almost one million eligible Australians. During COVID-19, fewer people were able to attend appointments, temporary providers closed and there was general reduced service availability for an immediate period.

A range of HSP program services can be delivered by teleaudiology (telehealth). In 2020, the Government funded development of national teleaudiology guidelines to support best practice delivery of teleaudiology services.

The Department adapted HSP processes, temporarily removing some documentation requirements in response to barriers presented by COVID-19 public health restrictions. This allowed client consent and agreement for services to be given electronically or verbally over the phone. Post-pandemic, the program continues to allow electronic or verbal client consent for some program services.

Program data showed these measures were effective in ensuring access to hearing services. By April 2020, the rate of new clients accessing the program had fallen by 80%, and service delivery levels fell by approximately 20% between March to June 2020.By July 2020, new client rates and service delivery had returned to pre-pandemic levels.

With the temporary removal of the requirement for written client agreement for maintenance from March 2020 through to 30 June 2021, there was a $34 million increase to device maintenance expenditure. With the reintroduction of client agreement to maintenance, maintenance related expenditure has reduced to pre-pandemic levels.

There was also an increase in the reported number and claims for replacement devices. Providers advised that there were increased rates of lost devices due to challenges with mask wearing. Since the reintroduction of evidence requirements and reduced COVID-19 prevalence, replacements rates have commenced returning to pre-pandemic levels.

Consumer protections

To protect Australian consumers, the Government implemented several determinations made by the Health Minister throughout the pandemic to prevent price gouging and exportation of critical sanitary and medical products, essential goods, and RATs.

Disruptions to the health system

Following a decision by the National Cabinet restrictions were applied to selected elective surgeries from 26 March 2020. This decision was made to preserve PPE stocks in Australia and ensure there were adequate staff and beds in case Australia experienced a surge in COVID-19 related hospitalisations.

Under these restrictions, only Category 1 and exceptional Category 2 procedures could be undertaken. These restrictions were eased (but not fully lifted) from 29 April 2020, allowing all Category 2 and some important Category 3 procedures to be performed. Suspensions then occurred on a jurisdiction-by-jurisdiction basis to create additional hospital capacity and ensure those who needed acute COVID-19 hospital care were able to receive it.

Elective surgery restrictions had a significant impact on the private sector, which ordinarily make up over half of all elective surgeries.

Private Hospital Viability Guarantee

To ensure private hospital beds and the private hospital workforce were available to supplement public hospitals during COVID-19 outbreaks, the Government provided financial assistance through COVID-19 Partnership. This also ensured the viability of the private hospital sector and the ability to resume normal operations at the end of the COVID-19 pandemic. The Government's contribution covered the gap between each private hospital's minimum viability costs and any revenue received by that private hospital. This resulted in a cost to the Government of $1.5 billion over the period that it was in place, from 3 April 2020 to 30 September 2022.

Private hospitals were successfully used during the Victorian COVID-19 wave in late 2020, with more than 500 patients accommodated in response to outbreaks in RACHs. In other jurisdictions there was less success with this approach. Some private hospitals considered that they did not have the right capability to care for this cohort. It was also observed that often private hospital staff were already working across the public hospital or aged care sectors.

Private hospital capacity was also used to supplement the public hospital system. For example, transferring surgical cases to a private hospital to allow a nearby public hospital to dedicate additional capacity for patients with COVID-19.

Pathology Sector Viability

The Government provided funding to private pathology providers to ensure they were able to remain operating and provide essential testing services. This was also in recognition that major pathology providers were ineligible for JobKeeper due to their size of their businesses. One of the three major private pathology providers applied for and received grant funding to provide a revenue guarantee from April-September 2020 to ensure that essential pathology testing was maintained.

Private health insurers commitment to support sector recovery

Private health insurers committed to not profit from the COVID-19 pandemic given the restrictions on members' access to hospital and services and treatments, and subsequent reduction in claims. The Department, in consultation with the Australian Competition and Consumer Commission, the Australian Prudential Regulation Authority and the private health insurance sector, developed a framework to monitor private health insurers against their commitments[1].

Health insurers provided premium relief and expanded the benefits available to Australians who hold private health insurance. Some of these initiatives have included:

- deferral of 2020, 2021 and 2022 premium changes,

- extending their products to cover all COVID-19 related claims,

- allowing policy holders to suspend their policy and reactivate it without re-serving waiting periods,

- waiving premiums for policy holders experiencing financial hardship while honoring benefit claims, and

- supporting members via rebates, short term premium reductions, extension of benefits, and roll-over of benefits into the next calendar year.

As of 30 June 2023[2], insurers had returned 84.7% of estimated permanent claims savings to policy holders ($3.5 billion). Givebacks by insurers will continue to be announced and made after this date.

5. International Policies

Relevant Term(s) of Reference: International policies to support Australians at home and abroad (including with regard to international border closures and securing vaccine supply deals with international partners for domestic use in Australia).

In this section:

- 5.1 - Restrictions on travel to and from Australia

- 5.2 - Travel requirements – masks, screening pre-departure testing, vaccination and declarations

- 5.3 - Response to Outbreaks: Australian Medical Assistance Teams deployment

- 5.4 - International engagement with partners on vaccine supply

- 5.5 - International engagement and assistance including on surveillance

Refer to the relevant section for:

- 3.1 - National Medical Stockpile including PPE provision

- 3.4 and 3.5 - COVID-19 vaccine and treatment rollouts

- 3.5 - Quarantine / Repatriation arrangements

5.1. Restrictions on travel to and from Australia

Australia's COVID-19 suppression strategy sought to reduce the risk of COVID-19 at its international border. The then Health Minister implemented international travel restrictions via Determinations under the Biosecurity Act. These decisions were supported by medical advice that considered the perceived severe and immediate threat to human health. Australia was one of the first countries in the world to implement international travel restrictions in response to COVID-19.

The Biosecurity Act enabled the Government to make the necessary human health requirements at the international border. Under section 42 of the Biosecurity Act, the "Human coronavirus with

pandemic potential" (which included SARS-CoV-2[21]/COVID-19) was included as a Listed Human Disease on 21 January 2020.

Initial response

Travel restrictions were progressively implemented over the course of the pandemic. Starting on 1 February 2020, foreign nationals that had been to mainland China were required to quarantine for 14 days prior to entering Australia. On 20 March 2020, Australia's international borders were closed to all non-citizens and non-residents. From this date, all Australians and permanent residents were required to undertake managed quarantine for 14 days in a hotel or other accommodation upon arrival in Australia.

On 18 March 2020 an Emergency Determination banned all cruise ships entering Australian waters and required those in Australian waters to leave. The ban ended when the Human Biosecurity Emergency Period relating to COVID-19 in Australia lapsed on 17 April 2022.

By 25 March 2020, the Government implemented a 'travel ban' on all Australians departing Australia to travel overseas (unless an exemption applied), through an Emergency Determination under the Biosecurity Act. Many of these measures were conceptualised, discussed by Ministers and implemented on the same day.

Ongoing response

By mid to late 2020, National Cabinet began considering steps to enable reopening of Australia's borders. This included the staged increases in international arrival caps and the creation of safe travel zones.

A one-way safe travel zone with New Zealand commenced on 16 October 2020, enabling passengers who had been in New Zealand to travel to Australia without needing to quarantine on arrival. The safe travel zone was suspended several times in 2021 in response to outbreak clusters.

On 22 March 2021, a determination was made to allow Australian citizens and permanent residents to travel to New Zealand from Australia without needing to seek an exemption from the ABF. Two-way quarantine-free travel between Australia and New Zealand subsequently commenced from 19 April 2021

The Government continued to monitor the international situation to enable timely country risk assessments. From 3 to 15 May 2021, the Government implemented a high-risk country travel pause on passengers (including Australian citizens and permanent residents) from India. This was due to a sharp increase in COVID-19 cases in India, with over 3 million each day for several days in a row. There was a significant increase in the number of COVID-19 cases detected in international travelers in quarantine within Australia who had returned from India, threatening to overwhelm local health resources.

Reopening of Australian borders

Australia's staged international border reopening commenced on 1 November 2021. This allowed fully vaccinated Australians to travel overseas without an individual exemption. This aligned with the Australian population having higher (at or near 80%) vaccination rates nationally.

The emergence of new variants prevented the full reopening of Australia's international borders. On 28 November 2021, the Government introduced a high-risk country travel pause for select countries in Africa because of the new Omicron variant. Those who had been in a country of concern in the 14 days prior to their travel were either denied entry (for non-citizens/permanent residents of

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[21] COVID-19 is an infectious disease caused by the SARS-CoV-2 virus: https://www.who.int/health-topics/coronavirus#tab=tab_1 https://www.health.gov.au/committees-and-groups/phln#publications

Australia) or required to quarantine on arrival. Those already in Australia at the commencement of the measures were required to immediately self-isolate and be tested for COVID-19.

The Government reopened borders to fully vaccinated eligible visa holders (primarily skilled, student, family, and humanitarian visas) from 1 December 2021, enabling these cohorts to come to Australia without a travel exemption. This was extended to all fully vaccinated visa holders from 21 February 2022.

Communication for travel restrictions

The Department provided a range of communication materials to support the community understanding travel requirements. For example, the Department provided social media updates regarding travel requirements, including links to the relevant jurisdictional webpages.

Communication was tailored to meet the varying needs across the community including advice for people returning to Australia from overseas. Materials were available online, provided to airlines to adapt for use at overseas departure points and available at Australian entry points. A mix of targeted advertising, public relations, media engagement and briefing were used as well as tailored and accessible information for diverse audiences.

Key Learnings

In 2021 an audit was conducted by the ANAO on the Management of International Travel Restrictions during COVID-19[22]. The ANAO report noted that the Department's arrangements for implementing and managing travel restrictions were largely effective and well informed by robust planning and policy advice. Restricting international travel had proven effective in reducing the risk of widespread disease transmission through uncontrolled importation of cases.

Considerations in border closures and messaging

The rapid closure of Australia's borders was a crucial early decision in the pandemic response. This decision helped prevent the significant spread of COVID-19 and Australia's health system becoming overwhelmed. Maximising vaccination coverage prior to reopening the borders enabled the health system to prepare and reduced the rates of severe illness from outbreaks.

There were significant social and economic impacts from the border closures. These included the separation of families, financial burden on those who were still required to travel and quarantine, and the economic impact on businesses (such as supply chain and workforce challenges).

Biosecurity considerations in the maritime environment

The Ruby Princess cruise ship incident highlighted several gaps in Australia's human biosecurity framework in the maritime environment. These were explored through several external reviews, namely the Inspector-General of Biosecurity review of the Ruby Princess cruise ship incident[23], and the NSW Special Commission of Inquiry into the Ruby Princess[24]. Work is ongoing within both the Department and the Department of Agriculture, Fisheries and Forestry (DAFF), to implement the recommendations from these reviews. Some legislative changes to the Biosecurity Act's subordinate legislation were made in 2023.

These changes include requiring all cruise ships arriving in Australia to arrive in negative pratique (requiring manual permission to disembark passengers) and clarifying the pre-arrival reporting process and timeframes for all incoming vessels to Australia.

Any changes to future mechanisms need to be workable during uncertain and dynamic times. Some elements of the Biosecurity Act, such as the Human Biosecurity Control Orders

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[22] https://www.anao.gov.au/work/performance-audit/management-international-travel-restrictions-during-covid-19
[23] https://www.igb.gov.au/sites/default/files/documents/igb-confidence-testing-report_1.pdf
[24] https://www.nsw.gov.au/sites/default/files/2023-07/Report-of-the-Special-Commission-of-Inquiry-into-the-Ruby-Princess.pdf

(HBCO), were not used because they were administratively impractical compared to other available measures in federal and state/territory legislation.

The HBCO could be reviewed to make them more deployable in situations such as with very high numbers of cases as seen in the Ruby Princess scenario. Other changes such as cruise ships now being in negative pratique combined with other existing federal and jurisdiction-level powers, have to some extent mitigated these concerns. On balance, reforms to the HBCO framework is not priority for legislative change at this time.

5.2.   Travel requirements – masks, screening pre-departure testing, vaccination and declarations

Travel restrictions

In conjunction with measures and travel restrictions to respond to the spread of COVID-19 globally, several other actions were taken by the Government and Department to protect Australia. Including:

- Enhanced border measures and communications to keep travellers aware of changes to travel requirements,
- Enhanced health screening,
- Mask wearing and predeparture testing, and
- Travel declarations.

Further detail is at **Attachment 7.**

Key Learnings

The substantive provisions of the Biosecurity Act commenced in June 2016, meaning this was the first time many of its human health powers had been utilised. While several preparedness exercises had been conducted prior to 2020, the breadth of possibilities were not covered in those exercises. In particular, the emergency powers had a broader application, and were used to implement a greater range of public health and social measures, than foreseen during the pre-pandemic considerations and exercises.

As noted in *Section 5.1 - Key Learnings,* ensuring the Biosecurity Act is appropriately designed and includes powers to respond to a wide range of scenarios could assist in responding to future pandemics. Central to any consideration regarding changes to the Biosecurity Act is ensuring response mechanisms are proportional to perceived heath threats and the need to balance personal liberties.

Speed of response

One major strength of Australia's response was the ability to use emergency determinations under s477 of the Biosecurity Act to respond swiftly and effectively to evolving situations. Strong legal and policy support in the Department enabled s477 determinations to be signed and registered quickly to respond to changing and rapidly emerging events.

Variability in measures and messaging

A key challenge during the pandemic response was the variability in the measures and messaging across States and Territories. For example, jurisdictions had varying isolation, quarantine, and travel requirements during different phases. Similarly, the resumption of cruising was challenged by vastly different reporting and outbreak management requirements across jurisdictions.

While this was often necessary to manage individual jurisdictional contexts and risks, it resulted in challenges providing consistent public health messaging, causing confusion and eroding trust. It is anticipated the Australian CDC's establishment will help to address some of these challenges by strengthening relationships between the Commonwealth and States and Territories.

5.3. International partner engagement on vaccines and treatments

Timely access to COVID-19 vaccines was crucial to Australia achieving high immunisation rates during the early stages of the pandemic.

Australia's COVID-19 vaccine purchases

As outlined in *Section 3.4*, Australia's investments in vaccines included both sovereign and international options. This provided the Government with choice and flexibility during vaccine development uncertainty. This section focuses on our international vaccine efforts.

Supply flexibility due to strong partnerships

Throughout 2021 when the vaccination program was experiencing vaccine shortages, the Department secured additional vaccines through dose swap arrangements and vaccine purchases from other countries experiencing a surplus. For example:

Dose swap

- 500,000 doses of Pfizer were provided by Singapore on 31 August 2021 with Australia then providing 500,000 doses to Singapore in November 2021, and

- Four million doses of Pfizer were provided by the United Kingdom (UK) on 3 September 2021 with Australia then providing four million doses to the UK in November and December 2021.

Surplus purchases

- One million doses of Pfizer were purchased from the Republic of Poland on 15 August 2021, and

- One million doses of Moderna were purchased from European Union member states on 3 September 2021.

International donations

Australia donated more than 52 million doses to countries in the Indo Pacific and Southeast Asia, including:

- 23.6 million doses as part of our commitment to share 40 million doses through the Department's procured supply, and

- 28.5 million doses as part of the commitment to share 20 million doses through DFAT's agreement with UNICEF.

Following the establishment of a separate donation framework with the COVAX Facility, Australia offered a further 16.8 million doses for distribution to participating developed and developing countries. Included in this, 16,000 doses to Belize, Saint Vincent and the Grenadines.

Indemnity for vaccine manufacturers

Indemnities were provided to COVID-19 vaccine manufacturers covering certain liabilities that could result from the use of their vaccine[25]. This was not unique in a global context, with indemnities a common element of agreements with vaccine manufacturers internationally.

If the Government did not provide certain indemnities to vaccine manufacturers, there would have been significant delays in securing commitments to supply or even a refusal from manufacturers to supply vaccines in Australia.

The COVID-19 Vaccine Claims Scheme was established to maintain public confidence and provides support where a person suffered moderate to significant harm following the administration of a COVID-19 vaccine. The Scheme is scheduled to end on 30 September 2024.

5.4. COVID-19 Deployments

The National Critical Care and Trauma Response Centre (NCCTRC) is a key component of the Government's disaster and emergency medical preparedness and response capability to incidents of local, national and international significance. The NT Government receives funding from the Government to ensure the NCCTRC's has 24/7 health disaster response capabilities.

The NCCTRC provides trauma response services and surge workforce capacity to the Royal Darwin Hospital and national training and coordination of personnel registered to deploy with AUSMAT. AUSMAT team members are drawn from all State and Territories.

Between February 2020 and April 2022, the AUSMAT undertook 22 COVID-19 related missions; 10 domestic missions and 12 international missions (see **Attachment 8**). In addition to deployments, the NCCTRC supported the Tokyo Olympic Games and Paralympic Games in 2021, the Beijing Winter Olympics and Winter Paralympic Games in 2022 and supported quarantine services at the Centre for National Resilience (see *Section 3*.6).

Key Learnings

During the Omicron outbreak in late 2021 and early 2022, Australia's domestic public health response constrained the availability of AUSMAT personnel. AUSMAT was able to respond to every requested mission over the course of the COVID-19 pandemic, however personnel constraint impacts on AUSMAT capacity should be considered for the future.

An independent review of Australian Emergency Medical Teams (EMT) capabilities commissioned by the Minister for Health and Aged Care in 2023 provided several findings on how to support current and future EMT capability (nationally and internationally). These findings are being used to support the further development and refinement of Australia's existing EMT capabilities including strengthening the domestic deployment capabilities of AUSMAT.

5.5. International engagement

The Department engaged with other countries facing similar experiences with COVID-19 vaccine programs such as New Zealand and the United Kingdom. This provided an opportunity to share learnings about the implementation of the COVID-19 vaccine programs and other activities

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[25] Public Governance, Performance and Accountability Amendment (Vaccine Indemnity) Bill 2023 -
Submission from the Department of Health and Aged Care to the Senate Finance and the Public Administration Legislation Committee – Inquiry into Public Governance, Performance and Accountability Amendment (Vaccine Indemnity) Bill 2023

occurring internationally. The Department also participated in regular forums initiated by the COVAX Facility.

The TGA collaborated with international regulators leveraging information received from the:

- Australia-Canada-Singapore-Switzerland-United Kingdom (Access) Consortium,
- European Medicines Agency OPEN initiative,
- United States Food and Drug Administration,
- Medsafe, (New Zealand), and
- International Coalition of Medicines Regulatory Authorities.

The TGA was one of four regulators invited by the European Union to take part in their vaccine evaluation meetings. This enabled detailed discussions on the safety, efficacy and quality of vaccines with one of the world's major regulators.

To support surveillance efforts, the CMO held regular, informal discussions with counterparts from Canada, New Zealand, United Kingdom, and the United States. These discussions allowed sharing of technical and policy details to improve the understanding of challenges. The group continues to meet to discuss public health approaches to COVID-19 and emerging threats including approaches to seasonal flu.

Key Learnings

Engagement through strong international connections can facilitate early access of information on emerging infectious health threats. Working closely with global partners to manage threats helps enable early and informed decision making on domestic responses. It also guides global and regional responses and informs targeted support Australia can offer its neighbours.

Further, Australia is actively engaged in two separate but linked negotiations. The development of a new international instrument on pandemic prevention, preparedness and response (pandemic treaty) and amend the *International Health Regulations 2005* (IHR). A strong global health system is critical for improving the detection and prevention of infectious disease outbreaks.

The new Health Security Unit in the Interim Australian CDC will look to harness these opportunities and strengthen Australia's health protection framework.

Relevant Term(s) of Reference: Mechanisms to better target future responses to the needs of particular populations (including across genders, age groups, socio-economic status, geographic location, people with disability, First Nations peoples and communities and people from culturally and linguistically diverse communities).

6. Preparation and readiness for future responses

This section will cover:

Details of mechanisms implemented or planned to improve future emergency responses, not otherwise noted in prior sections, including:

- 6.1 - Evidence based decision making
- 6.2 - Key data assets, systems and capability
- 6.3 - Aged Care
- 6.4 - First Nations, Disability and CALD

6.1. Evidence based decision making

The COVID-19 pandemic required a rapid and adaptable response from the Government. It was important to have as much research, data and information available to enable evidence-based decisions.

The Department required additional capabilities and capacity to meet the speed and scale of the pandemic. For example, the Department commissioned several modelling pieces from the University of Melbourne (UoM), including the Doherty Institute, to inform policy on public health and social measures. The UoM's *Situational Assessment of COVID-19 in Australia* reports[26] used epidemiological data to model health service presentations and the impact of interventions.

Establishing a better understanding of COVID-19 was an immediate priority given it was a novel disease. The Department acted quickly to announce the Medical Research Future Fund (MRFF) Coronavirus Research Response on 11 March 2020. Three priority areas for investment were identified:

- vaccine development,
- treatment development, and
- other COVID-19 specific respiratory medicines research.

The MRFF has supported 85 projects across 29 grant opportunities. The National Health and Medical Research Council (NHMRC) has supported 44 research projects. Several projects supported through the MRFF have contributed to evidence-based decision making and provided insights into future emergency pandemic responses including capacity development. Key projects are described in **Attachment 9.**

Decision-making processes of expert committees, such as the AHPPC and its sub-committees also made significant contributions, providing decision makers with the most accurate and timely clinical advice available at the time.

A research prioritisation framework will be developed as part of the establishment of the Australian CDC to facilitate rapid public health research in response to emerging infectious diseases. This framework will leverage existing funding mechanisms, including the MRFF and NHMRC, to explore ways to reduce red tape and improve the timeliness of approval and disbursement processes.

6.2. Key data assets, systems and capability

The value of data linkage work extends beyond COVID-19 into many other settings, including other infectious diseases and chronic conditions. A clear learning from the pandemic is the need for a national interoperable surveillance system with inputs from other data sources. This will allow improved monitoring capability, understanding of disease trends, and inform how government investments can be targeted most effectively.

The Government, in partnership with States and Territories, made significant improvements to Australia's data capabilities during the pandemic. This included:

- establishing track and trace capability for COVID-19 vaccines,

- weekly linking of AIR, MBS, and PBS data into the Person Linked Integrated Data Asset. In addition, there was the rapid linkage of population level data by creating a national single COVID-19 database, the COVID-19 Register. A national dashboard of ICU activity, the Critical Health Resources Information System was also developed,

- establishing strong data sharing relationships with jurisdictions, other departments and providers underpinned the timely integration of data, and

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[26] https://mspgh.unimelb.edu.au/research-groups/centre-for-epidemiology-and-biostatistics-research/infectious-disease-dynamics/covid-19-national-situational-assessment

- developing internal capability and relationships to produce robust research and evidence which uses complex linked datasets.

Bolstering data capabilities and maintaining investments in data systems will remain a key part of Australia's pandemic preparedness. In particular there are opportunities to incorporate national hospitalisations and case data to provide a quantitative indicator of case severity in addition to mortality data.

There are further opportunities in relation to national disease surveillance. The National Notifiable Disease Surveillance System (NINDSS) is the core data system used for national COVID-19 surveillance. The NINDSS coordinates national surveillance of communicable diseases through daily reports from jurisdictions. The NINDSS is case-based, not person-based, and it is not possible to link case information to personal information in other health and social datasets to further analyse at-risk populations.

System deficiencies further reduced the Department's ability to coordinate national response activities. Ad-hoc data systems were developed to address these deficiencies however these interim solutions often result in policies and products being developed based on data sourced from a range of different systems.

6.3.   Workforce

The pandemic exacerbated existing challenges faced by the health and aged care workforce. The Department worked with other agencies and governments to facilitate movement of health and aged care workers. This included support for short term exemptions to work restrictions for international medical and nursing students and introducing additional flexibilities to workforce programs. Despite these efforts, challenges remained.

Domestic and international travel restrictions and the associated costs with quarantine compounded challenges in attracting overseas trained workforce, and movement of other essential health and aged care workforces such as AUSMAT.

As a result, the Visas for GPs Program saw a 30% reduction in the number of Health Workforce Certificates issued for overseas doctors in 2020-21 compared to 2019-20.

In 2020, changes to the AHPRA sub-register made up to 26,000 practitioners eligible to practice once again. However, surveys indicated only 8% of these practitioners returned to the workforce.

To provide greater flexibility to health professionals, the locum tenens period was extended from two weeks to twelve weeks. The extension was a temporary change to support the COVID-19 response, reducing the number of Medicare provider number applications and allowing faster processing of applications for health professionals.

As discussed in *Section 4.4*, as part of the Private Hospital Viability Guarantee, the Government and jurisdictions partnered with the private hospital sector to utilise the 30,000 hospital beds, and the sector's 105,000 skilled workforce across 657 private and not-for-profit hospitals.

While the private hospital capacity was useful as part of the Victorian aged care response in 2020, it quickly became apparent that the workforce serving private hospitals was not a dedicated workforce. Much of the 105,000 headcount was also engaged in aged care and public hospital settings, meaning it was not able to be redeployed in the public hospital and aged care sectors.

The vaccination rollout was a substantial effort and required a redistribution of resources and workforce to ensure the timely and effective delivery of COVID-19 vaccines to Australians. This redistribution may have impacted capacity in other parts of the health system.

6.4.   Aged care future state preparedness and response

Since the delivery of the Royal Commission into Aged Care Quality and Safety Final Report, the Government has invested more than $30 billion in additional funding into the aged care system.

The Government's reform agenda for aged care also aims to ensure that older people in Australia are prioritised and there are continued improvements in quality, safety and choice. This is being achieved through a suite of reforms, including:

- Workforce support for upskilling and furloughing of staff,
- support for facilities to address the direct additional costs,
- introducing star ratings to make informed choices,
- funding a 15% wage rise for more than 250,000 aged care workers,
- face-to-face support in Services Australia service centers, and
- expanding the National Aged Care Mandatory Quality Indicator Program.

These reforms complement the continued focus on recovery and maintenance of the aged care sector's response capability and preparedness for any future pandemics. The Department continues to support aged care providers to build their capability and capacity by:

- providing on-going financial assistance that supports the planning for and management of outbreaks, including COVID-19 and other infectious diseases,
- Supporting continued surge workforce for RACHs impacted by an outbreak and experiencing staff shortages, and
- On-going access to IPC resources and online training material, surveillance and monitoring activities and research into existing IPC processes.

6.5. Supporting people from First Nations communities

Early in the pandemic the Government acknowledged that First Nations peoples were likely to be disproportionately impacted by COVID-19. This led the Department implementing measures to support First Nations communities that complemented and aligned with the priority reforms of the National Agreement on Closing the Gap, in close partnership with First Nations stakeholders.

First Nations emergency responses measures were developed through partnership and planning at the local level. A COVID-19 Advisory Group, jointly chaired by the Department and the NACCHO, brought together expert medical and First Nations representatives to strengthen First Nations voices on COVID-19 issues. The Advisory Group formally transitioned in 2023 to the National Aboriginal Torres Strait Islander Health Protection sub-committee (NATSIHP), a sub-committee of the AHPPC.

ACCHOs were essential in the COVID-19 response. Funding was provided to the ACCHO sector to implement COVID-19 responses that were bespoke and tailored to the local community. The Government worked with the sector to provide flexible funding to ensure suitability for local communities with diverse needs. This ensured fit for purpose communication, support and advice for First Nations people.

Since 1 January 2023, the Government has been transitioning the COVID-19 response to normal health service delivery arrangements. The Department is continuing to work in partnership with the NACCHO, NATSIHP, ACCHOs and communities to implement measures to increase vaccination uptake and promote community-led, targeted and local COVID-19 responses for First Nations people.

6.6. People with Disability

People with disability experienced profound challenges throughout the COVID-19 pandemic. These included difficulties accessing disability supports, health services and information to help them navigate the health emergency. Some people with disability continue to isolate themselves from the community to avoid risk of exposing themselves to COVID-19.

Australian data indicates people with disability, as a population, are at higher risk of severe disease and death due to COVID-19 than the general population. This is likely due in part to the increased

prevalence of complex underlying health conditions amongst this group. Other factors may also contribute to this risk, including inequitable access to health services.

The Government and State and Territory Governments encountered several challenges in responding to the COVID-19 health emergency for people with disability, including:

- communicating effectively and efficiently with people with disability (with diverse communication needs), their families and the disability support workforce,

- delivering appropriate adjustments to ensure people with disability can access testing and vaccination services,

- preventing and supporting the management of outbreaks in disability residential services operating with a casualised workforce with no or limited clinical staff, and

- overcoming data limitations to obtain information on vaccination rates and the impact of the pandemic on people with disability (e.g. data on COVID-19 mortality rates among people with disability).

Some key learnings[27] observed throughout the pandemic include:

- The impacts of COVID-19 on people with disability have been profound but varied reflecting the diversity of health and support needs among this population,

- Systemic efforts to engage people with lived experience early in the design of the emergency responses will help to ensure responses are appropriately informed from the beginning,

- Community-informed responses to engaging and communicating with people with disability will help enable more effective engagement and better dissemination of information,

- Communication of health advice to people with disability must be tailored, directed through the right channels to help it reach target groups quickly, and in an appropriate format to be accessed and understood,

- Addressing data gaps and better data capture will support more informed health responses, and

- Clear governance arrangements between Government health and disability agencies at the federal and jurisdictional levels will enable better future health emergency responses.

Collaboration between relevant areas of the Department, Government agencies, State and Territory health and disability agencies and the disability community were pivotal in shaping emergency response measures for people with disability. This collaboration improved throughout the pandemic. Groups like the Advisory Committee on the Health Emergency Response to COVID-19 for People with Disability established in April 2020 and the Disability and Health Sector Consultation Committee in April 2021 were central to the improved collaboration.

6.7. Supporting people from Culturally and Linguistically Diverse communities

Experience of the COVID-19 pandemic showed diverse and tailored responses are required to effectively engage with everyone in Australia. According to the ABS 2021 Census, over half of the Australian population were born overseas or have one parent born overseas. Over 350 different languages are spoken in homes in Australia and almost a quarter of households use a language other than English.

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[27] These reflect learnings from the Advisory Committee captured in the 'Lessons Learned During the COVID-19 Pandemic' report, accessible via: https://www.healfh.gov.au/resources/pubiications/iessons-learned-during-the-covid-19-pandemic-advisory-committee-on-the-health-emergency-response-to-covid-19-for-people-with-disability.

Prior to 2020, the Department's communication with people from CALD backgrounds was limited. It was done by translating existing assets and engaging media outlets such as SBS and large-scale ethnic press. Lack of specialised skills and limited capacity meant the most populous groups were targeted more frequently. COVID-19 revealed health system weaknesses, and barriers these groups faced accessing information and health care.

While translated materials were important to ensure CALD communities had access to information, 79% of Australian CALD populations surveyed in 2023 prefer to receive their health information in plain English and 84% prefer audio-visual resources. Opportunities for people to have in-language and culturally safe conversations with people they trust, where they feel confident to ask questions, are also very effective in helping people overcome barriers to access. Intermediaries (community leaders/trusted messengers) are gateways to genuine engagement and communication within CALD communities.

From December 2022, the Department established a dedicated Multicultural Health Section to lead a coordinated approach and ensure policies and programs across the portfolio consider are culturally safe and responsive to the needs of multicultural communities in their design and implementation.

6.8. Communication with diverse groups

Three key groups – the CALD Communities COVID-19 Health Advisory Group, the First Nations Health Advisory Group, and the Disability Working Group – played essential roles in the Government's communication response to COVID-19. They provided pathways to build trust with diverse communities and their lived experience helped to improve processes, enhancing community access and understanding of issues.

Their advice has led to lasting improvements.

The ongoing advice and scrutiny provided by these groups has led the Department to reflect on its engagement with diverse groups and explore ways to improve this capability.

7. Glossary

ABF	Australian Border Force
ABS	Australian Bureau of Statistics
ADF	Australian Defence Force
ACCHO	Aboriginal Community Controlled Health Organisations
AHPPC	Australian Health Protection Principal Committee
ANAO	Australian National Audit Office
APA	Advance Purchase Agreements
AUSMAT	Australian Medical Assistance Team
CALD	Culturally and Linguistically Diverse
CDNA	Communicable Diseases Network Australia
CET	National COVID-19 Clinical Evidence Taskforce
CRTCA	COVID-19 Rapid Test Concessional Access
CVAS	COVID-19 Vaccine Administrative System
Defence	Department of Defence
DFAT	Department of Foreign Affairs and Trade
DHA	Department of Home Affairs
DSS	Department of Social Services
EMT	Emergency Medical Team
GPRC	General Practice-led Respiratory Clinics
HSP	Hearing Services Program
IHR	*International Health Regulations 2005*
LwC	Living with COVID program
MBS	Medicare Benefits Scheme
MRAC	MBS Review Advisory Committee
MRFF	Medical Research Future Fund
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSIHP	National Aboriginal Torres Strait Islander Health Protection sub-committee
NBCSP	National Bowel Cancer Screening Program
NCSP	National Cervical Screening Program
NCCTRC	National Critical Care and Trauma Response Centre
NDIA	National Disability Insurance Agency
NMS	National Medical Stockpile
NINDSS	National Notifiable Disease Surveillance System
OCS	Operation COVID Shield
OPAN	Older Person Advocacy Network
PBAC	Pharmaceutical Benefits Advisory Committee
PBS	Pharmaceutical Benefits Scheme
PCR	Polymerase chain reaction
PHN	Primary Health Network
PHLN	Public Health Laboratory Network
PIP	Practice Incentives Program
PM&C	Department of the Prime Minister and Cabinet
POCT	COVID-19 Remote Point of Care Testing
RACH	Residential Aged care homes
RAT	Rapid Antigen Test
rHTA	rapid Health Technology Assessment
RACGP	Royal Australian College of General Practitioners
SAHQ app	South Australian Home Quarantine Application
SIL	supported independent living disability settings
SSHMS	Suicide and Self-Harm Monitoring System
TGA	Therapeutic Goods Administration
TTS	thrombosis with thrombocytopenia
UoM	University of Melbourne
VACRC	Victoria Aged Care Response Centre
WHO	World Health Organization