Senate Select Committee on COVID-19

Submission

28 May 2020

australian healthcare & hospitals association

the voice of public healthcare®

OUR VISION

A healthy Australia, supported by the best possible healthcare system.

OUR MISSION

To conduct research, educate and influence the healthcare system to achieve better health outcomes, improved patient and provider experience, greater equity and sustainability.

OUR GUIDING PRINCIPLES

Healthcare in Australia should be:

Effective

Accessible

Equitable

Sustainable

Outcomes-focused.

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INTRODUCTION

The Australian Healthcare and Hospitals Association (AHHA) welcomes this opportunity to provide feedback to the Senate Select Committee on COVID-19 inquiry into the Australian Government's response to the COVID-19 pandemic.

AHHA is Australia's national peak body for public hospitals and healthcare providers. Our membership includes state and territory health departments, Local Hospital Networks and public hospitals, community health services, Primary Health Networks and primary healthcare providers, aged care providers, universities, individual health professionals, and medical colleges and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

Infectious diseases have been identified as one of the greatest risks to public health over the next 10 years (WHO 2020). Globalisation, urbanisation and climate change are fuelling the increased incidence of epidemics such as COVID-19 (WEF 2020). It is therefore essential that governments seek to prepare and implement strategies that ensure systems are appropriately resourced and prepared for such events. AHHA has made detailed recommendations for a stronger health system in '*Healthy people, healthy systems'* (AHHA 2017), a blueprint for health reform in which governments are called upon to create a healthy Australia supported by the best possible health system. The value in these health system reforms have also been highlighted with the recent bushfire season. Experiences through the COVID-19 pandemic, as well as the recent bushfire season, floods and drought, demonstrate the commonalities in reforms needed for our health system to be able to respond in times of natural disasters, national emergencies and national public health emergencies that affect all aspects of the Australian health system.

This submission builds on AHHA's blueprint vision, offering recommendations for coordination and resilience building activities within the domains of:

- Governance and decision-making
- National coordination, regional responsiveness
- Health impacts and models of care
- Coordinated research and data investment.

GOVERNANCE AND DECISION-MAKING

- The rapid establishment of the National Cabinet enabled a strong multi-level coordinated national response to the COVID-19 pandemic.
- There must be commitment to transparency in the scientific evidence shaping decision-making. The release by the Australian Government of modelling underpinning COVID-19 decision making was too slow.
- The Australian Government demonstrated a lack of investment in genuine strategic communication, at the leadership level, through the COVID-19 pandemic.
- Decisions made during a pandemic must be effectively communicated, transparently reflect the evidence, provide the rationale for any trade-offs, and recognise the rapidly changing environment in which they must be made.
- A shift to more consultative and collaborative engagement with the community is needed to inform decisions going forward and ensure community support.
- The positive and collaborative response to fund and support measures created and driven by Aboriginal and Torres Strait Islander people, organisations and communities has been recognised as a highlight of Australia's success in responding to the pandemic.

Integration of governance and decision-making across state, territory and Commonwealth areas of responsibility, ensuring consistency and coordination within and across sectors, is critical in a pandemic and other emergencies.

NATIONAL CABINET

The rapid activation of a National Cabinet, consisting of Commonwealth, state and territory representation, offered a mechanism to ensure a strong coordinated multi-level national response to emergencies, reflective of regional diversity. As evidenced in the coordinated response to the COVID-19 pandemic, the National Cabinet has allowed states, territories and the Commonwealth to share information and align action to implement a coherent strategy reactive to the emergent demands of the rapidly evolving emergency, yet has maintained mechanisms of regional decision making autonomy (Prime Minister of Australia 2020).

ADVICE TO THE NATIONAL CABINET

Critical to the success of the rapid decisions and actions that need to be taken during the COVID-19 pandemic is transparency around the factors driving decisions.

The Australian Health Protection Principal Committee (AHPPC) provides expert advice to the National Cabinet, consistent with its ongoing role to advise the Australia Health Ministers' Advisory Council. It is comprised of Chief Health Officers from each jurisdiction and is chaired by the Australian Chief Medical Officer.

While scientific evidence shapes the recommendations provided by the AHPPC, the importance of making public the scientific evidence informing decisions is critical for building public confidence and trust. It supports full use of leading scientists' transdisciplinary expertise to deepen

understanding and sharpen the response. While calls for data underpinning COVID-19 decisions (AAS 2020) were responded to with the release of Government modelling data (Doherty Institute 2020), Governments should commit to greater transparency and more timely provision of information informing policy decisions.

The strong reliance on scientific evidence to inform action through the COVID-19 pandemic is perceived positively, particularly in contrast to the apparently limited manner by which the Australian Government has relied on scientific evidence in preparing for and responding to bushfires and climate change.

COMMUNICATION OF DECISIONS

Through the COVID-19 pandemic, communication has been needed that ensures the entire population understands what is happening and are able to follow crucial instructions. This strategic communication necessary at the leadership level is quite different to typical political messaging It requires strong relationships with people at senior levels across all areas of government and the public service; access to the most trusted subject matter experts; and inclusion of leadership teams engaged at the highest level of decision-making.

While acknowledging there have been some improvements over time, communication is an area the Australian Government has managed less than optimally. An early example was the announcement in mid-March of the need for mass events to be cancelled to achieve social distancing, but the Prime Minister still stating that he would attend a live football game in the days before the rules were introduced. Another occurred at a press conference in late March when hairdressing was deemed an essential service and acceptable for 30 minute periods, despite the 1.5m social distancing clearly unable to be practised and inconsistencies with beauty salons being deemed non-essential.

The way experts are supported to speak directly and frankly with the population also influences public confidence in decision-making. Suggestions have been made that Dr Norman Swan, a medically qualified journalist, had become a ‘single source of truth … for many people’ on COVID-19 despite his expertise being related to paediatrics (Henderson 2020). It has also been reported that there has been criticism that official advice from the Chief Medical Officer (CMO) was ‘slow and badly communicated’ (Chrysanthos & Koziol 2020). However, peak medical and public health associations publicly backed the CMO, calling on colleagues to reinforce his advice amid misinformation and alternative sources claiming authority on the issue (Chrysanthos & Koziol 2020).

The use of experts to communicate decisions through the COVID-19 pandemic has not been successful, particularly in contrast, e.g., to the unwavering public support for the way the NSW Rural Fire Service Commissioner provided advice through the 2019-20 bushfire season (Thomson 2020).

CONSULTATION AND COLLABORATION

In the emergency phase of the COVID-19 pandemic, the community has trusted governments to act in its best interests with little consultation. This is understandable given the necessary focus on the epidemiology and upscaling of testing, contact tracing, treatment capacity and personal

protective equipment (PPE). However, as Australia moves out of the emergency phase, government decisions will significantly impact the 'new way of life' and investment, consultation and collaboration is critical to foster trust and a sense of common ownership.

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Aboriginal and Torres Strait Islander health experts and Aboriginal Community Controlled Health Organisations recognised early the impact the COVID-19 pandemic could have on communities. Swift action was taken to prepare and disseminate awareness campaigns for Aboriginal and Torres Strait Islander communities along with planning for prevention and primary healthcare responses (Turner 2020; McQuire 2020).

Reducing the risks of the pandemic took a public health approach, with a strong focus on the social determinants of health. In particular, the pre-existing housing inadequacy in many communities was exacerbated by the pandemic. Furthermore, vulnerable communities in regional areas, close to centres of infection, were identified for targeted preventive activity (NACCHO 2020a). Successful advocacy by the Aboriginal and Torres Strait Islander health leaders also resulted in restrictions to visitors to remote communities and the roll out of rapid testing in remote communities (NACCHO 2020b).

The outcome of the focus across the sector has meant that, as of 3 May 2020, only 55 (0.8% of all cases tested) have been people identifying as Aboriginal and/or Torres Strait Islander, and no cases in remote or very remote communities (Turner 2020). The Australian Government and National Cabinet's positive and collaborative response to fund and support measures created and driven by Aboriginal and Torres Strait Islander people, organisations and communities have been recognised as crucial to the successful response to the pandemic (Turner 2020).

NATIONAL COORDINATION, REGIONAL RESPONSIVENESS

SUPPORTING THE PRIMARY CARE RESPONSE

- Action is necessary to ensure Australia's primary healthcare providers rapidly respond in times of pandemics and other emergencies as part of national and regional plans.
- The Australian Government must ensure telehealth is effectively established and embedded in primary healthcare so that it can be scaled as required in times of pandemics and other emergencies.
- Continued investment in *healthdirect* as a shared cross-government provider of health information and advice by phone and online is important for ensuring a rapid response to future pandemics and emergencies. A nationally-coordinated review of the support provided via hotlines and online during the COVID-19 pandemic (including *healthdirect*, hotlines established by individual states and territories, and other services established through government funding) will provide insight to the effectiveness of this response, particularly in terms of a national mechanism for meeting the diverse needs of Australians and reflecting local health care contexts. This will inform planning for future pandemics and other emergencies.

The Australian Government support for the primary healthcare response appeared to have the following main areas of focus (Australian Government Department of Health 2020a):

1. Establishment of dedicated primary care respiratory clinics in general practices. This approach was intended to ensure there was the appropriate infrastructure, capability and infection control training and support for the general practices, while also complementing the respiratory clinics established by state and territory health services.
2. Reducing exposure to COVID-19 in health care settings, through the establishment of the COVID-19 national hotline to support the flow of cases; a broad community campaign to safely direct people to appropriate care; and the provision of Personal Protective Equipment (PPE) from the National Medical Stockpile through Primary Health Networks.
3. Enabling the provision of health care via telehealth.

MOBILISING A GP-LED PRIMARY HEALTH RESPONSE

The ability to mobilise a GP-led primary health response when a health system is reliant on individual practices determining alignment with their own strategic priorities has been questioned over time and across the world (e.g. Harris & Harris 2006; Tarrant et al 2014). It was questioned again in relation to the COVID-19 pandemic in Australia, where it was noted that the rapid response to establish respiratory clinics was only achieved through action by state and territory governments and hospital services, despite funding available through the Australian Government for general practices (COPHE 2020). However there are also examples where general practices worked effectively to rapidly respond as part of a collaborative effort at the local level, such as the Emerald GP clinic in rural Queensland opening the first rural COVID-19 respiratory clinic on 1 April (ACCRM 2020).

The establishment of PHNs recognised that a strong, accessible primary health care system keeps people well and out of hospital by supporting them to manage their health issues in the community and at home. They provide the infrastructure to support, adjust and reform the primary health care system within their regions, through planning, designing and commissioning evidence-based health services to support specific needs of local communities (Australian Government Department of Health 2018).

However, for rapid mobilisation to be achieved and at scale to meet health system goals, alignment of payment and performance measures in coordination with other sectors is required (Takach 2016). In Australia, funding to general practice is provided primarily through fee-for-service payments, supplemented by nationally-determined practice and service incentive payments intended to focus on aspects of general practice that contribute to quality care (Australian Government Services Australia 2019). Standards for quality and safety of general practice services have been developed by the Royal Australian College of General Practitioners (RACGP 2020), with formal accreditation against these Standards a requirement to be eligible for practice and service incentive payments (Australian Government Services Australia 2019). PHNs provide support to practices for these initiatives and can commission specific services to meet local need. However, they cannot require general practices to participate in any particular program, to provide specific services, or to achieve defined outcomes to address local needs.

Through both the 2019-20 bushfire season and COVID-19 pandemic, PHNs have held a key role leading regional health responses and recovery, on behalf of the Commonwealth, and sometimes in partnership with state health authorities. Examples of activity have included: the distribution of Personal Protective Equipment (PPE) from the National Medical Stockpile; the commissioning of respiratory clinics and mental health services; and the distribution of community grants during the bushfires. They have also supported the workforce by providing telehealth implementation support, developing localised response pathways and supporting locum placements.

In times of crises, health care providers across Australia's health system must be committed to responding as part of a national or regional plan. The Australian Government must invest in systems that will enable general practices to rapidly respond in times of pandemics and other emergencies as part of the broader healthcare system. PHNs should be engaged in the development of regional pandemic planning, which feeds upwards into state and national plans. An example of where this worked effectively during the bushfires was in the Nepean Blue Mountains region. Here the PHN had developed a suite of localised response pathways to prepare for the bushfire season, from both a clinical and logistical perspective (Hendrie 2019). These systems must be developed and tested in advance of emergencies, at the regional level, so they can be enacted quickly when needed.

HEALTH CONTACT CENTRES ENABLE ACCESS TO QUALITY INFORMATION

To assist in reducing exposure to COVID-19 in health care settings, the National Coronavirus Hotline was expanded to triage people with respiratory symptoms and those who are concerned about contact with a possible COVID-19 case. The Australian Government did this by leveraging the existing *healthdirect* information and advice services, increasing this to a 24/7 triaging service staffed by health professionals (Australian Government Department of Health 2020b). An online symptom checker was also established (*healthdirect* 2020).

Health contact centres provide an important mechanism for access to quality healthcare and health information. To achieve their full potential, these centres must be properly integrated with national and state-based healthcare systems. The information and advice offered must meet the diverse needs of local populations within local health care contexts. The existing cross-government support for *healthdirect* enabled a rapid response in establishing phone and online support for quality up-to-date information in a rapidly changing environment. However, states and territories also established additional helplines. While some specifically provided non-health advice, others included health advice (DHHS 2020), and it is unclear whether there was a duplication of services, conflicting services, or a perceived or actual gap in services being addressed.

A coordinated review of both the national and state and territory health contact centres established during the COVID-19 pandemic will provide insight into the breadth of concerns raised by the public. It should also examine the extent to which these concerns were being addressed, how diverse needs and local contexts were managed, and improvements to ensure best practice management in the future.

ENABLING TELEHEALTH

The provision of health care consultations by telephone or videoconference was enabled for health care providers nationally, for a limited time period, with new MBS telehealth items. Private health insurers also introduced reimbursements for telehealth consultations for some allied health and mental health services (PHA 2020a; PHA 2020b). While telehealth is much broader than just consultations by telephone on videoconferencing, the wide-scale adoption of any telehealth has not previously been achievable in primary healthcare. In contrast, to ensure patient safety during the pandemic, state and territory health departments have been implementing innovative telehealth care models such as virtual hospitals, remote monitoring of patients and outpatient telehealth consultations.

The list of MBS telehealth services initially required all patients to be bulk billed. After five weeks, the requirement for specialist and allied health service providers to bulk bill was removed. GPs and other medical practitioners were required to continue to bulk bill for Commonwealth concession card holders, children under 16 years old and patients who are more vulnerable to COVID-19. However a temporary doubling of the bulk-billing incentive was introduced for consultations, diagnostic imaging and pathology services, and for services provided to more vulnerable patients (Australian Government Department of Health 2020c). While bulk billing arrangements have been incentivised for GPs, for all other health care providers, allowing the charging of co-payments does not assist with equity of access in circumstances where patients cannot afford the co-payment. While the business model for providers needs to be sustainable, consideration also needs to be given to equity and affordability issues for patients accessing telehealth services.

The implementation of telephone and video consultations during the COVID-19 pandemic has been provider-dependent, which in the primary healthcare environment in Australia means many small businesses individually determining the business and care model that suits their practice. While there are guidelines and advice from various entities, individual providers must ultimately determine and implement the appropriate architecture for these consultations to align with their practice's strategic priorities and perceived patient needs. This includes physical and digital infrastructure, business

processes, information management, care models, workforce structures, and culture and relationships with external entities as required (Nous 2015).

Unfortunately, there are reports that upwards of 80% of general practitioners are only utilising the telephone, not videoconferencing (Hansra 2020; O'Rourke 2020). It must be acknowledged that the presence or absence of visual cues creates a much greater functional change to consultations provided face-to-face. The MBS telehealth items introduced also do not support opportunities to augment care through text and email, nurse triage, integration and coordination with the broader care team, or integration with remote diagnostic and monitoring technology.

An assurance of quality services has been limited to the Australian Government Department of Health stating that telehealth services may only be provided where it is safe and clinically appropriate to do so. It has also been reported that use will be monitored, with it expected that practitioners have in place arrangements to ensure that patients can access a face to face consultation where it is clinically required (AMA 2020a). Reports of Medicare statistics suggest however that claims for health assessments and minor procedures, which require patients to attend in person, have seen the greatest reduction in claims. Falls in GP chronic disease management items and GP mental health items have also seen reductions, despite the creation of telehealth equivalents (O'Rourke 2020).

The inclusion of mental health consultations within the Australian Government's $680 million telehealth package for health and allied health workers has been vital for promoting the mental health of Australians while ensuring adherence to social distancing protocols (National Mental Health Commission 2020). One million mental health telehealth consultations were recorded between mid-March and early April at a cost of $35million with 50% of mental health consultations delivered through digital platforms (Morgan & Morrison 2020). Health professionals have reported growth in the number of patients seeking mental health treatment in response to economic and social disruptions created by the pandemic (Bartone, Hickie & McGorry 2020). However, privacy concerns surrounding telehealth, and confusion as to whether mental health treatment was classified as essential, has led some patients with chronic or paranoid mental health conditions to disengage with regular services which will likely have negative consequences for patient outcomes (Hayne 2020; Sarcevic 2020).

Telehealth will be an important mechanism for care delivery through this and future pandemics, as well as in other national disasters and emergencies. Embedding telehealth will need to be driven by more than individual general practices operating to meet their own practice priorities and desired incentive payments. Care models must be patient-centred, outcomes-focused, coordinated and integrated with the broader health sector to target and respond to local community needs. Accountability and responsibility for implementing telehealth effectively in general practices and primary healthcare requires agreed and supported leadership and governance arrangements. Equity and affordability must also be assured. Future national health funding agreements should continue to support the innovative telehealth care models pursued by state health departments. The Australian Government should not be trying to establish these systems and arrangements in a crisis, but ensure they are established and embedded as part of normal/standard health service arrangements.

MANAGING HEALTH RESOURCES

Personal protective equipment (PPE)

- National leadership in clearly communicating the evidence and approach to prioritising the supply and distribution of PPE was needed. Government communication surrounding PPE distribution did not sufficiently acknowledge the personal risk to health practitioners confronted with PPE shortages.

Testing

- National reporting of cumulative testing data should be supplemented with daily data. Data reflecting the most recent two weeks, and in relation to population size, should also be reported as this provides transparency in the rationale for the public health controls required.
- The Australian Government must collaborate with state and territory governments to ensure that the public receives consistent and accurate information about when they need to be tested and how they should approach testing. Inconsistencies between state and federal testing criteria should be clearly acknowledged and communicated with primary healthcare workers to prevent system inefficiency and to avoid confusion with the public.
- Recognising the limitations on domestic testing supplies, AHHA supports that the Australian Government continues to periodically re-assess the testing criteria for COVID-19 to ensure that community transmission is monitored and public health interventions are suitably targeted toward high-risk populations.
- AHHA supports the conclusions of the Rapid Research Information Forum and does not support the Australian Government implementing mass screening measures which use invalidated serological testing methods.

Surge capacity of ICU

- The Australian Government has been proactive in supporting state and territory governments and hospitals to adequately respond to an anticipated surge in demand for intensive care unit (ICU) beds during the COVID-19 pandemic.
- In the partnership with the private sector, transparency will be critical to providing public confidence in the arrangements.
- With the easing of restrictions to elective surgery, the level of activity may vary between states and regions. The Australia Government must support development of a plan to ensure consistent prioritisation of procedures, with reassessment of patients according to evidence based criteria. Equity of access should be monitored and reviewed on an ongoing basis.

Health workforce

- National data on the health workforce requires investment.

Medicines

- The Australian Government Therapeutic Goods Administration and Department of Health are commended for keeping a focus on this ongoing issue by closely tracking current or anticipated medicines shortages.

Contact tracing and the COVIDSafe app

- Given the significant investment, clarity is required about the place of the app in the Australian response to COVID-19.

PERSONAL PROTECTIVE EQUIPMENT

PPE supply

COVID-19 has seen a significant disruption to global Personal Protective Equipment (PPE) supply chains, with The World Health Organization (WHO) estimating that a 40 percent increase in global manufacturing was required to meet demand (WHO 2020a). Australia has not been immune to this trend with many health services and professionals reporting PPE shortages during the COVID-19 response (Macintyre 2020). There were less than 3 million masks in the national stockpile when the bushfire crisis hit, with many then distributed and used to protect against bushfire smoke throughout Australia's black summer (Macintyre 2020). This has contributed to significant PPE shortages throughout the pandemic, inhibiting health professional safety and exposing an unsustainable Australian reliance on global supply chains and international PPE manufacturers (Ryan & Florance 2020; Sas 2020).

Border closures and travel restrictions have inhibited essential PPE imports from international manufacturers and prevented the ability to perform important quality and safety inspection and regulation processes (TGA 2020a). In the midst of the pandemic, ensuring PPE quality and safety also became problematic with Australian Border Force intercepting $1.2million in counterfeit faulty PPE, primarily from China (Greene 2020). However, despite these quality and safety concerns, shortages necessitated a continued reliance on overseas manufacturing with the government sourcing 2 million Chinese made masks certified by Chinese authorities (Clarke 2020).

With scientists predicting an increased frequency of pandemic events as a result of the globalisation and climate change (Ensia 2020), COVID-19 has demonstrated that sourcing large quantities of PPE from international manufacturers is no longer a reliable and sustainable option for Australia. AHHA urges governments to take the lessons from the COVID- 19 pandemic and rigorously examine Australian PPE manufacturing and supply chain processes, including how to most effectively support capacity for substitute manufacturing at times of emergency. It is an opportunity to implement new manufacturing models that are responsive, cost effective, environmentally sustainable (e.g. smaller production carbon footprint), create local jobs and advance the Australian economy. At times of significant disruption to the economy, the workforce and public health, governments also need to be adaptive and flexible in supporting the deployment of alternative approaches to meeting surge demand for essential products and services.

Governments and industry took initial steps in this direction with the Department of Industry, Science Energy and Resources initiating a request for information to map Australian manufacturing production capabilities of medical PPE and the rapid response of 640 businesses indicating their capacity to pivot to PPE production (DISER 2020; Andrews 2020). While some burdensome regulatory process have been removed to expedite PPE provision such as the Medical Technology Association of Australian securing an exemption from competition law to enable data and design sharing between medical technology companies to accelerate the development of PPE supply solutions, essential quality and safety approvals mean Australian manufacturing is not the most responsive short term solution (Rubensztein-Dunlop et al 2020).

Governance and regulatory process must continue to be examined and reformed to ensure streamlined process and information sharing in the development of new PPE production and supply processes. New and innovative manufacturing solutions must be built on data and evidence and

incorporate strategies that embed equity and value. Consultation with relevant stakeholders, health professionals, health and professional peak bodies and consumer representatives is vital to ensure PPE supply chains are flexible and responsive to health system and community needs.

PPE distribution, coordination and communication

A clear government strategy of decision making relating to the allocation of PPE from the National Medical Stockpile was absent from public discourse throughout the COVID-19 response. The $1.1 million investment to increase PPE purchasing and distribution from the National Medical Stockpile was welcome (Australian Government Department of Health 2020d). However, a lack of transparency and inconsistent messaging led to confusion and access difficulties for health, aged care and disability services, creating anxiety and uncertainty, and inhibiting patient care (Mahase 2020).

Clear and consistent governance structures and communication were missing from PPE distribution processes throughout the COVID-19 response. Responsibility for the distribution of the National Medical Stockpile PPE was divided with Primary Health Networks (PHNs) delegated primary healthcare PPE provision, and state and territory governments assigned responsibility for public hospital distribution. Guidance was provided to PHNs on managing this distribution, to manage the rationing of these scarce resources. However, this was not well received by those who could not access supplies (e.g. dentists, nurse practitioners, allied health practitioners, aged care workers and specialists) when masks were only being supplied to GPs and community pharmacists directly providing clinical services. Alternatively, the goal of the rationing was not well understood and should have been better communicated to healthcare services, professionals and the public (e.g. when the number of masks that could be supplied even to GPs was limited, sometimes down to two per practice). This led to confusion, limited timely and equitable distribution, and created PPE shortages in some areas (Woodley 2020a; Murphy 2020; Knaus 2020a). While local decision making and control is supported in these circumstances, national leadership in clearly communicating the evidence and approach to prioritising distribution was needed. Without it, PPE distribution processes created confusion and undermined health professionals' confidence (Woodley 2020a).

Government communication surrounding PPE distribution also did not sufficiently acknowledge the personal risk to health practitioners confronted with PPE shortages. The personal burden of rationing decisions was not fully recognised leaving health professionals feeling unprotected and undervalued. This negatively impacted their health, welfare, willingness and ability to provide care at a time when a healthy productive health workforce was most needed (Woodley 2020b).

Frontline staff in public hospitals, general practice, Aboriginal Controlled Community Health Organisations, pharmacies, aged care workers and institutions where an outbreak was confirmed received PPE prioritisation in line with expert scientific and clinical advice (Australian Government Department of Health Ministers 2020a). However, there was a considerable lack of guidance for other members of the healthcare providers community with allied health and community health workers reporting confusion on appropriate PPE use and supply access channels. Private hospitals were also left without timely guidance. Despite many private providers engaging in partnerships with public providers to assist in the provision of care to COVID-19 patients (Australian Government Department of Health Ministers 2020b), they reported encountering considerable difficulty sourcing additional PPE distribution information.

Training and communication on appropriate infection control procedures and how to effectively use PPE was progressively provided by governments throughout the pandemic response. A 30-minute online training model on the fundamentals of infection and prevention control when responding to COVID-19 was launched quickly (Australian Government Department of Health 2020e). This was later supplemented by instructional videos on protocols for use, and demonstration of how to effectively dress in PPE (McMillan 2020), intended to reduce confusion and assist health professions for whom use of PPE use is not a common practice.

In preparation for future pandemics and other emergencies, transparency, communication and training on PPE use and supply must be enhanced across the entire health system incorporating public, private, community, social providers and the community as a whole to enhance planning and response capabilities. This will also give confidence to healthcare providers and the public on how priorities are being set on the use of limited supplies in times of a surge in demand.

TESTING

Testing response

The level of testing is critical to understanding how the pandemic is progressing and whether responses are adequate and effective. AHHA commends all Australian governments on their rapid upscaling of Australia's national testing capabilities since 22 January 2020. The Australian Government reports over 1 million tests for COVID-19 were conducted nationally in those first four months, with 0.6% of these tests returning a positive result (Australian Government Department of Health 2020f). The World Health Organization (WHO) recommends that in considering adjustments to public health and social measures, the number of tests conducted should be reported daily. Further, it identifies one indicator of the epidemic being controlled is when <5% of samples are positive for at least two weeks, provided surveillance continues in the order of 1/1000 population/week (WHO 2020b). As such, AHHA recommends that the Australian Government supplement the reporting of cumulative testing data with daily data. Data reflecting the most recent two weeks, and in relation to population size, should also be reported as this provides transparency in the rationale for the public health controls required.

Testing kits

The Australian Government must ensure that Australia has access to high quality, evidence-based diagnostic testing measures to appropriately manage the COVID-19 pandemic. There are two main types of tests: nucleic acid/PCR tests, considered more clinically sensitive for detecting early infections and are an indicator for viral shedding, and point of care (POC) serology antibody tests which generally provide historic information about viral exposure (TGA 2020b).

The Australian Government Therapeutic Goods Administration (TGA) played a significant role in supporting COVID-19 testing in Australia. It is acknowledged that, as an emerging infectious disease, there is limited evidence available to assess the accuracy and clinical utility of available tests. However, due to the urgent nature of the pandemic, the TGA developed two emergency exemption pathways to legally supply COVID-19 testing kits in Australia. Some COVID-19 tests have undergone an expedited assessment by the TGA to enable their legal supply in Australia (TGA 2020c). A pathway for the supply of unapproved tests has also been developed, with supply limited to accredited pathology laboratories to ensure appropriate application and interpretation of results (TGA 2020c).

Post-market assessment of all tests approved was implemented to verify performance and continue to inform their use in Australia (TGA 2020b). Early results from this post-market review have determined that some manufacturers have claimed a significantly better sensitivity compared to that observed since TGA approval (Bond et al 2020). In particular, these results support global evidence for the poor sensitivity of some point of care (POC) serological tests during the early stages of infection and highlight that care must be taken with their application (Rapid Research Information Forum 2020).

The Australian Government has reportedly acquired 97,000 nucleic acid/PCR detection testing kits and 1.5 million POC serological testing kits to supplement diminishing national supplies (Woodley 2020c; Zillman 2020). With the arrival of these additional testing kits, the Prime Minister has indicated that the Australian health system is sufficiently resourced to meet immediate national requirements (Woodley 2020c).

AHHA acknowledges the need for the Australian Government to rapidly acquire COVID-19 diagnostic kits during the early stages of the pandemic, with the main value of POC serological tests being that they are affordable, provide rapid results and do not require specialist training to use (Rapid Research Information Forum 2020). However, subsequent evaluations have shown that POC serological testing measures alone are not sufficient for acute diagnostic testing or population health screening measures. At this time, AHHA supports that POC serological testing kits should be used only to supplement results from nucleic acid detection tests.

Testing criteria

The current Australian Government criteria for COVID-19 testing are based on advice from the Australian Health Principal Protection Committee (AHPPC 2020a). As the pandemic evolves, this advice has needed to be responsive to such things as emerging evidence, the observed incidence and transmission in Australia, changing public health measures and availability of pathology test kits, reagents and swabs. Recommendations and their rationale have been publicly reported in statements from the AHPPC (AHPPC 2020a), with AHHA pleased to see prioritisation in testing of those working in areas or vocations with an elevated risk of transmission and to address vulnerable groups (e.g. those in aged or residential care, rural and remote Aboriginal and Torres Strait Islander communities and correctional facilities (AMA 2020b). The Chief Medical Officer seeking assistance from GPs to strictly apply guidelines in referring patients for testing was also supported (Murphy 2020).

In addition to the testing criteria endorsed by the National Cabinet, some state and territory governments have expanded their testing criteria beyond the national recommendations (AMA 2020b). Reports then followed of confusion about testing challenging coronavirus containment efforts in ACT and NSW (Woodley 2020d), and patients who met NSW Health requirements for testing being refused at testing centres which were following the National Cabinet guidelines (Woodley 2020d). Although the Australian Government is not responsible for the states and territories testing response, the need for consistent communication between governments and the primary care sector has been highlighted (AMA 2020c). Inconsistent or unclear communication on the appropriate testing criteria has impacted the efficiency of the primary care response. Across all levels, the Australian Government must seek to collaborate with state and territory governments to ensure that the public receives consistent and accurate information about when they need to be tested and how they should approach testing. Inconsistencies between state and federal testing

criteria should be clearly acknowledged and communicated with primary healthcare workers to prevent system inefficiency and to avoid confusion with the public.

Recognising the limitations on domestic testing supplies, AHHA supports that the Australian Government continues to periodically re-assess the testing criteria for COVID-19 to ensure that community transmission is monitored and public health interventions are suitably targeted toward high-risk populations.

Mass screening

Some commentators have argued that mass screening methods are necessary to ascertain the true distribution of COVID-19 (Padula 2020). To this end, Australia has been exploring the potential use of POC testing kits for disease surveillance and control, including the testing of asymptomatic citizens. While AHHA acknowledges the need for broader screening methods to inform public health interventions, the poor accuracy of available POC testing kits must be considered by the Australian Government before implementing large-scale national screening strategies.

Global evidence supports a cautious approach to wide-scale testing using POC serological testing kits. The United Kingdom's National COVID Testing Scientific Advisory Panel recently released the results of their evaluation into nine commercial POC serological tests. Researchers concluded that the performance of these POC tests was inadequate for both individual patient applications and population prevalence studies (National COVID Testing Scientific Advisory Panel 2020). The results of similar tests conducted by the University of Oxford are yet to be published, though researchers have indicated that none of the antibody test kits they have validated would meet the criteria for a good test under the United Kingdom's Medicines and Healthcare products Regulatory Agency (Bell 2020).

Furthermore, Australia's Rapid Research Information Forum has highlighted that the predictive value of serological testing is inversely proportional to disease prevalence (Rapid Research Information Forum 2020). So long as the prevalence of COVID-19 is low in Australia and the available serological tests are not appropriately specific, there is a substantial risk that wide-scale serological testing measures (including POC kits) would produce inaccurate results (Rapid Research Information Forum 2020). Consequently, AHHA supports the conclusions of the Rapid Research Information Forum and does not support the Australian Government implementing mass screening measures which use invalidated serological testing methods.

SURGE CAPACITY OF INTENSIVE CARE UNITS

The Australian Government has been proactive in supporting state and territory governments and hospitals to adequately respond to an anticipated surge in demand for intensive care unit (ICU) beds during the COVID-19 pandemic.

Modelling showed that impending demand for ICU beds could overwhelm the capacity of Australian hospitals, and that action was necessary to rapidly decrease the rate of new cases and radically increase the number of ICU beds (Meares & Jones 2020). The importance of public health measures (e.g. social distancing) lacked commitment from the Prime Minister early in the pandemic, but were eventually strongly implemented. An assessment of the capacity of ICUs to respond to the expected increase in demand demonstrated bed capacity could be near tripled in response, but a shortfall in invasive ventilators would be likely and a large increase in the clinician and nursing staff numbers would be required (Litton et al 2020).

Ventilator capacity and distribution

The Australian Government established a taskforce that has identified minimum technical requirements for invasive ventilators that would suitable for supply to and use in Australian hospitals when approved devices are not available during the pandemic (TGA 2020b). Rapid federal and state and territory government action has enabled some Australian manufacturers to pivot to ventilator production e.g. the introduction of time-limited ministerial power to exempt ventilators from the usual safety and performance requirements of the Therapeutic Goods Act (Knaus 2020b) and the Australian Government $31 million agreement with a consortium of companies to produce ventilators (ABC News 2020). Ventilators are expected to be available at the end of July (Knaus 2020b).

Partnership with the private sector

The Australian Government partnered with the private health sector, guaranteeing viability of the private hospital sector in return for ICU capacity during the COVID-19 response. The agreement not only provides over 30,000 hospital beds, but also the sector's 105,000 skilled workforce to support a response (Australian Government Department of Health Ministers 2020c).

This ground-breaking agreement ensures the best use of all resources available in the health system to support the strongest possible approach to managing the COVID-19 pandemic. The public funding commitment being subject to the provision of these services to operate as not-for-profit, as well as being subject to audit requirements, is important. Transparency will be critical to providing public confidence in the arrangements.

The agreement between the Australian Government and private hospitals is anticipated to end once Australia is confident that public and private hospitals can resume normal activities while sufficient capacity is retained to respond to the COVID-19 pandemic. A review should be undertaken of the agreement to evaluate the impact of the arrangements, with consideration to be given to the agreement being reactivated in the event of future crises that require a rapid response. They could then be incorporated into frameworks for crisis management planning and preparedness at national, state/territory and regional levels.

Suspension of elective surgery

The suspension of non-urgent elective surgeries in both the public and private health systems was an important action agreed by the National cabinet to preserve resources and help the health system prepare for any surge in ICU demand due to a coronavirus outbreak. As well as ensuring the accessibility of beds and health workers, scarce PPE would be reserved to ensure supplies were prioritised for the COVID-19 response (Mills 2020).

The National Cabinet's gradual easing of restrictions had enabled elective surgery to now become available while ensuring surge capacity in the hospital system is maintained. With an estimated 400,000 people added to the hospital waiting lists during the shutdown (McCauley & Dow 2020), a plan is needed to clear the backlog. National principles for introducing elective surgery have been devised to be applied by the states and territories, with private hospitals encouraged to mirror their own state's approach to surgical activity (AHPPC 2020b). However it is acknowledged that the level of elective surgery activity may vary between states and regions. The Australia Government must support development of a plan to ensure consistent prioritisation of procedures, with reassessment

of patients according to evidence-based criteria. Equity of access should be monitored and reviewed on an ongoing basis.

Monitoring capacity

A valuable response by the Australian Government has been establishing the Critical Health Resource Information System (CHRIS), in conjunction with the Australian and New Zealand Intensive Care Society (ANZICS), Ambulance Victoria and Telstra Purple (Australian Government Department of Health 2020g). Operational nationally in all public and private hospitals with ICUs, the CHRIS allows information to be shared about the location of available ICU beds and equipment (adult and paediatric) to support the system to respond in times of surge and peak patient demand. The CHRIS national live data set should be maintained.

MEDICINES

Great variability in medicines supply security has been reported between states and territories, between different sized hospitals and between metropolitan and regional sites during the COVID-19 pandemic (SHPA 2020). The Australian Government Therapeutic Goods Administration and Department of Health are commended for keeping a focus on this ongoing issue by closely tracking current or anticipated medicines shortages.

HEALTH WORKFORCE

In preparation for adequately responding to a surge in demand for hospital care through the COVID-19 pandemic, the Australian Government targeted increasing the nursing workforce that could be redeployed through:

- online education for registered nurses to develop skills and knowledge in the delivery of care in intensive care and high dependency units across Australia; and
- online refresher courses to enable registered nurses who have recently left the profession to return (Australian Government Department of Health 2020h).

Ahpra and the National Boards also established the pandemic response sub-register to help with fast tracking the return of experienced and qualified health practitioners if a rapid response to the pandemic was needed (Ahpra 2020). The mobilisation of medical students in supportive roles was also enabled within appropriate frameworks (AMSA 2020).

National data on the health workforce, however, requires investment. Live national data to inform the workforce that might be redeployed to other areas could be useful in pandemics, but also in responding to national disasters (e.g. bushfires) and national emergencies. For example, the oral health workforce is highly experienced in managing infection control. With significant restrictions on dental practice, there were missed opportunities to redeploy the oral health workforce in areas with increased demand in infection control.

CONTACT TRACING AND THE COVIDSAFE APPLICATION

Contact tracing is an important public health measure for controlling COVID-19. By promptly identifying and managing contacts of confirmed COVID-19 cases, secondary cases can be identified earlier to interrupt further transmission (ECDC 2020). State and territory governments have implemented traditional contact tracing approaches. The Australian Government has since

developed and deployed a mobile contact tracing application ('app'), COVIDSafe, that can supplement traditional approaches to contract tracing by being able to more quickly identify and contact people that have been at risk of exposure.

AHHA supports a secure and well-designed app, where its single purpose is to speed up contacting people exposed to COVID-19 to minimise the spread of the virus, as both a key part of an efficient public health effort and to build trust with the Australian people. As published in joint principles with the Australasian Institute of Digital Health (AIDH & AHHA 2020), introduction of the app must first satisfy 10 principles to increase the likelihood of widespread adoption. These were: communication transparency; safe user-friendly design; minimum data collection and specific scope; data security; opt-in and end date; user control; anonymity assurance; usage rights; legal protection; and independent evaluation. It is also vital for the Australian Government to clearly communicate to the public the safeguards that are in place to protect individual's data to ensure community trust in the app.

Success of the app is reliant on the proportion of Australians downloading it, with varying communication about the minimum target and how it relates to the public health measures being implemented (Leins et al 2020). Further confusion about the role of the app was created when the Defence Minister confirmed that downloads will have no impact on the decision of national cabinet or state governments to ease restrictions (Wahlquist 2020). The operation of the app has also been limited by reports of issues integrating it into the existing state and territory contact tracing methods (Taylor 2020). Given the significant investment, clarity is required about the place of the app in the Australian response to COVID-19.

HEALTH IMPACTS OF THE COVID-19 PANDEMIC AND MODELS OF CARE

- With the health impact on those infected varying substantially, the coordination required across the entire health sector to quickly diagnose, provide supportive care, monitor for deterioration and refer as required, while minimising transmission cannot be overstated.
- The health impacts are more wide-ranging than just the impact on those infected. The physical and mental health needs of those who are quarantined, in isolation and practising social distancing, as well as the needs of front line health care workers, will need to be addressed now and into the future.
- As the population re-engages with the health system, the Australian Government needs to be proactive in supporting initiatives that will see this backlog in care addressed effectively and efficiently. These include remote patient monitoring, medical hotels, hospital in the home and telehealth outpatient services. Funding models and integration between the primary and hospital sectors will be critical.
- AHHA supports the continuation of mental health support as a health priority post COVID-19. clarification of the roles and responsibilities of the Deputy Chief Medical Officer for Mental Health vis-a-vis those of the National Mental Health Commissioner to ensure effective leadership.
- Acknowledgement of the need and response in the provision of mental health services has been strong, but mental health outcomes are fundamentally linked to factors such as personal safety, employment, income and housing security. The Australian Government needs to ensure that people continue to have an adequate living income and somewhere safe to live, and not revert to the former Newstart payment rate. There must also be greater levels of investment in drug and alcohol and family violence support.
- The Australian Government's gradual restoration of elective surgery presents an opportunity to dramatically reduce the number of low- or no-value care procedures by prioritising the introduction of care that is supported by evidence of its relative value.

AN EVOLVING UNDERSTANDING

An understanding of the health impacts of the COVID-19 pandemic is still evolving for this emerging pathogen, noting treatment of the first cases in Wuhan, China of the virus now identified as SARS-CoV-2 was only confirmed on 31 December 2019. As the virus has rapidly spread across the world, a clinical and epidemiological understanding of the disease has grown, helping to inform the preparations and response for the Australian health system.

RECOGNISING VARYING NEEDS

The health impact on those infected varies substantially, and health care services needs to be flexible and coordinated to respond to the varying needs. The majority of infected people will develop mild to moderate symptoms. As symptoms are typical of many respiratory syndromes (most commonly fever and cough), screening and referral processes for testing need to be clearly communicated both

for the health workforce and the broader population to quickly identify those at risk of infection and contain transmission (Theravajan et al 2020).

People with mild to moderate symptoms can be managed in the community, although those with moderate symptoms or with risk factors for progressive disease require careful monitoring. With requirements for those who have suspected and confirmed coronavirus to isolate, monitoring for clinical deterioration is important with early referral to hospitals when detected. It is currently estimated that around 15% of those infected will require hospital care, and 5% will require more intensive care support (Theravajan et al 2020).

However, the health impacts are now recognised as more wide-ranging than just the impact on those infected, with the physical and mental health needs of those who are quarantined, in isolation and practising social distancing also needing to be identified and addressed. Economic dislocations associated with pandemics responses also contribute to this burden.

HEALTH NEEDS IN QUARANTINE

The adequacy of nursing and medical support available to people being quarantined has been questioned (Davey 2020; Moodie 2020; Bucci & Blucher 2020). There have also been reports of mental health needs, in particular, not being met (Bucci & Blucher 2020). While the management of people in quarantine is identified as a state responsibility, the Australian Government could have shown national leadership to ensure physical and mental health needs were met.

ONGOING CHRONIC DISEASE MANAGEMENT

Maintaining chronic disease management during the COVID-19 pandemic has been raised across the world as a serious issue, with concern for the impact of interrupted care. There have been many reports of reductions in the presentations for screening and follow up appointments (e.g. for cancers), presentations to ambulances and emergency departments for heart attacks, consultations with GPs for chronic conditions and pathology tests are down by 30-50% (Hendrie 2020), despite funding changes to support the provision of remote consultations with health practitioners being introduced quickly (i.e. through telehealth MBS items).

The Australian Government responded by promoting messages for people with chronic health conditions to not neglect their regular health care. Temporary changes to medicines regulation were also introduced to support continued supply of medicines (e.g. Continued Dispensing arrangements and medicine substitution arrangements), as well as funding a 'COVID-19 Home Medicines Service' to deliver PBS medicines to people in their home at no cost (Australian Government Department of Health Ministers 2020d; Australian Government Department of Health Ministers 2020e).

As the population re-engages with the health system, the Australian Government needs to be proactive in supporting initiatives that will see this backlog in care addressed effectively and efficiently. Initiatives introduced prior to and during COVID-19 should be considered for continued support, and applied to chronic care, including:

- Remote monitoring of patients, using wearables and patient reported measures (e.g. as established in Sydney (Sydney LHD 2020));
- The use of medical hotels (e.g. as established in Tasmania (McCauley 2020));

- Hospital in the home programs (e.g. as established in Brisbane (Metro South Health 2020)); and
- Telehealth outpatient services (e.g. as established in Canberra (Giannini 2020) and recommended in the Western Australian Sustainable Health Review (Western Australia Department of Health 2019).

Ensuring funding arrangements are in place to make these services viable (and not just trials or only for those who can pay) will be critical to the ongoing development of these models of care. Support for integration with and leadership by general practice and primary healthcare will be critical.

MENTAL HEALTH IMPACT

The 2019 draft Productivity Commission Mental Health Report identified that population mental health needs are currently vastly underserved by the Australian mental health system, with service provision highly fragmented, disconnected, and siloed (Productivity Commission 2019). Modelling is predicting a rise in suicide rates by 25-30% in the wake of COVID-19 (Bartone, Hickie & McGorry 2020), and evidence from past pandemics suggests that 25-33% of the community will experience high levels of worry and anxiety during pandemic periods (Black Dog Institute 2020; Bults 2015).

Preliminary data and anecdotal evidence from service providers reinforces these predictions with crisis organisations and suicide prevention services reporting higher demand. States and territories have reported increases in negative public behaviours such as speeding and violence associated with anger and frustration. Early survey data has also reported the number of people experiencing anxiety, stress, boredom and poor mental health spiked significantly between March and April (Australian Government 2020; Liddy et al 2020). With mental health presentations likely to increase substantially in the wake of COVID-19, it is essential Governments take immediate action and invest to reform and strengthen Australia's fragmented mental health system to ensure services are agile, responsive and available to meet the evolving mental health needs of the Australian community. AHHA's recommendations for a stronger mental health system can be found in our submission to the Productivity Commission Inquiry into Mental Health.

AHHA commends the Government on the recognition of the importance of mental health support during COVID-19 through the allocation of $74 billion to support the mental health sector initial adaptation and response, followed by an additional $48 million for implementation of a *National Mental Health and Wellbeing Pandemic Response Plan* (Australian Government Department of Health 2020i Hunt 2020). Considerations of vulnerable population and the broader social and economic factors exacerbating anxiety were also acted on in a timely manner. Targeted funding was directed to organisations supporting vulnerable populations, and bipartisan political support enabled interventions targeting economic stressors to be rapidly enacted e.g. job keeper payments, and nationally consistent financial hardship supports for energy, water, and rates (Australian Government Department of Industry, Science, Energy and Resources 2020; Black Dog Institute 2020).

Health professionals were identified early as a population facing increased mental health risk from the pressures of COVID-19 (Australian Government Department of Health 2020i; Black Dog Institute 2020; Chua 2004). However, Government capacity and bureaucratic structures slowed the provision of targeted resources leaving healthcare workers potentially exposed. Many professional colleges and services self-organised to establish their own supports, such as the Royal Australian and New

Zealand College of Psychiatrists (RANZCP) emergency response register to assist frontline health workers (RANZCP 2020).

AHHA supports Government efforts to include all stakeholders and existing resources in the development of dedicated resources for healthcare workers such as The Essential Network (TEN) (the mental health support application developed for frontline workers). We also commend the Government on engaging external expertise through the development of collaborative partnerships e.g. Smiling Minds new dedicated health professional program (Koh 2020). We, however, remain mindful that confused messaging and delays in the launch of these resources risked duplicated effort as many organisations and professionals embarked on the development of similar support platforms and resources to meet immediate needs (Mindspot 2020; RACGP 2020; Phoenix Australia 2020).

There have also been reports that non-clinical health care workers have even higher anxiety than clinical health care workers. This is possibly a result of reduced accessibility to formal psychological support, less first-hand medical information on the outbreak, and less intensive training on PPE and infection control measures (Tan et al 2020).

AHHA supports the continuation of mental health support as a health priority post COVID-19. The rapid development, and National Cabinet acceptance, of the *National Mental Health and Wellbeing Pandemic Response Plan* is to be commended (Australian Government 2020; Morgan & Morrison 2020). It would be useful to have clarification of the roles and responsibilities of the Deputy Chief Medical Officer for Mental Health vis-a-vis those of the National Mental Health Commissioner to ensure effective leadership.

The Government must continue to build on these initial steps and strengthen the mental health support system prioritising diverse community consultation, evidence based practice and value driven investment. Ongoing action is needed to create a joined up, nationally coordinated mental health system to support Australia's ongoing mental health needs post-pandemic (SBS News 2020). Any mental health response that does not take into account the social determinants, including personal safety, income, employment and housing, will be limited. There must also be greater levels of investment in drug and alcohol and family violence support. AHHA has previously made a submission to the Australian Government on the need for comprehensive reform of the alcohol and other drugs treatment sector (AHHA et al 2019).

CRITICAL NEED TO ADDRESS THE DETERMINANTS OF HEALTH

The health of Australians during and in the recovery from the COVID-19 pandemic is fundamentally linked to the social and economic impacts. Acknowledgement of the need and response in the provision of mental health services has been strong, but mental health outcomes are fundamentally linked to factors such as personal safety, employment, income and housing security. Modelling by the Brain and Mind Centre at the University of Sydney identified that investment in mental health programs and services are vital, but supplementary to the efforts to increase community connectedness and the social and economic supports required (The University of Sydney 2020).

The Australian Government's action to introduce the JobKeeper payment has been critical in supporting employers to keep staff employed, minimising the rise in the unemployment rate (ACOSS 2020). Still, 2.7 million people became unemployed or had their hours reduced as a result of the COVID-19 pandemic, and the new JobSeeker payment (doubling the rate formerly provided as

Newstart) provides security during a time where employment prospects are low (ACOSS 2020). More than 474,000 people also left the labour force in April (ABS 2020).

The Australian Government needs to ensure that people continue to have an adequate living income and somewhere safe to live, and not revert to the former Newstart payment rate which has not been increased in real terms since 1994, as this will be critical for preventing poor mental health outcomes during a time where there is heightened suicide risk. Such an increase has widespread support within the community, business and industry, and would provide an immediate and ongoing boost to aggregate demand within the economy.

OPPORTUNITY TO REDUCE LOW VALUE CARE

The suspension of non-urgent elective surgeries in both the public and private health systems was an important action to ensure adequate capacity to prepare for an anticipated surge in hospital demand. The Australian Government's gradual restoration of elective surgery (AHPPC 2020c) now presents an opportunity to dramatically reduce the number of low- or no-value care procedures by prioritising the introduction of care that is supported by evidence of its relative value. State and territory governments have the insights and data to start reporting the rates of low-value care, and should introduce strategies to review clinical decision-making around key low- and no- value areas. The Australian Government should legislate to empower private health insurance funds to reduce such care in the private system (Elshaug & Duckett 2020) and in a manner that does not disadvantage policy holders.

The reduction in other care during the COVID-19 pandemic (e.g. GP consultations and pathology testing) also presents an opportunity to reduce low value care. The Australian Government should support a review to determine the extent to which the reduction in care was a reduction in low value care. Strategies should be implemented to ensure high value care is supported while low value care can be identified and minimised.

COORDINATED RESEARCH AND DATA INVESTMENT

- The Australian Government must commit to and resource research that focuses on health policy, health economics and more directly on the structure and function of the health system. This will be critical in ensuring that the evidence base needed to respond appropriately to the current health crisis, as well as future and ongoing challenges, is strong, nationally consistent, and suitable both for service planning and future research efforts.

The impact of the COVID-19 pandemic on both public health and the economy demonstrates the immense reliance on the capacity of our health system to respond effectively.

For health services to meet people's needs into the future, the stronger the evidence base, the better equipped the system will be. To date, investment in COVID-19 research through the Medical Research Future Fund and direct grants from government have largely focused on clinical and epidemiological research. However, research that focuses on health policy, health economics and more directly on the structure and function of the health system is urgently needed.

Such research will allow Australian Governments to identify patterns within the health system and its policies, structures and effectiveness for better management of systems shock (COVID-19 pandemic), natural disasters (2019-2020 bushfires), and slow burning longitudinal challenges (chronic diseases, increasing health system costs) in an economic, rigorous manner that incorporates the complexity of the problems we face.

Health systems research is the enabler of a resilient, efficient and effective health system. We strongly emphasise the pressing need to support health systems research that will advance a resilient health system in the context of the current COVID-19 pandemic and future shocks.

Investment is crucial in the development and implementation of a health systems evaluation and resilience framework that can be used to:

- identify the direct and indirect effects of COVID on health service delivery and health governance, including specific implications for health service providers and healthcare workers (for example ventilator capability planning);
- evaluate the cost-effectiveness and impact of various health system and service measures, innovations and strategies introduced during the COVID pandemic (including for example, telehealth funding mechanisms, national real-time data on ICU capacity, enhanced regional leadership roles of PHNs and use of private hospital capacity to supplement public hospital capacity);
- evaluate the preparedness of the health system and communities to respond swiftly and appropriately to adverse health related events; and
- plan for post-event recovery and health system resilience to situation-related crises, including mental health.

The support of the Australian Government, and appropriate commitment and resourcing to progress this work will be critical in ensuring that the evidence base needed to respond appropriately to the current health crisis, as well as future and ongoing challenges, is strong, nationally consistent, and suitable both for service planning and future research efforts.

CONCLUSION

It is the responsibility of all levels of government and policy makers to ensure that Australia's health system is appropriately prepared to respond to pandemics or other emergencies. The COVID-19 pandemic and recent bushfire disasters have highlighted the significant impact globalisation and climate change are having on human health and the nature of responses required by our health system and other parts of the economy.

Policy makers have a window of opportunity to learn from these events and act to strengthen system and service capabilities through the development of a coordinated health approach to the preparedness for, response to, resilience to and recovery from pandemics and other emergencies.

This needs to be done in cooperation across all levels of government, working with the professions and the community for flexible and coordinated responses, and where appropriate engaging with industry to provide innovative supply side solutions. It is critical that this is done in a manner that ensures the public's trust in the set of responses to these threats.

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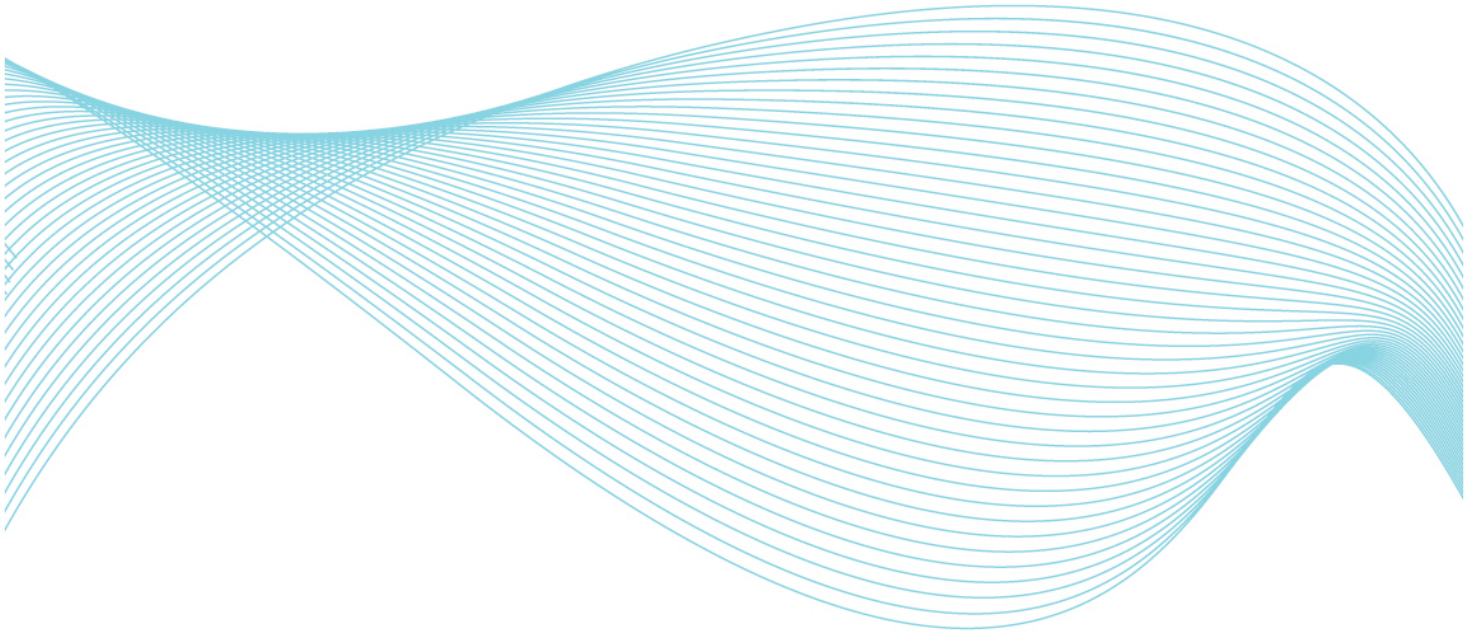

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