Submission to Commonwealth Government COVID-19 Response Inquiry

The need for an Australian standing pandemic communication capability

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Overview

This submission focuses primarily on TOR 2 (key health response measures), TOR 3 (broader health supports), TOR 7 (community supports) and TOR 8 (mechanisms for future responses).

Who we are: A/Prof Claire Hooker is co-Director Academic Education in the Sydney School of Public Health. Prof Julie Leask is recognised as the global leader in health risk communication and has advised WHO, UNICEF, and National and State governments. We collaborate in risk communication.

Key proposition: **Pandemics change the communication ask of governments**[1] and require best practice risk communication to respond effectively. Crucially, this requires listening and responding to communities. Yet most COVID-19 communication was focused on public health messaging, informed by assumptions (more than evidence) about public views.

Our Recommendations:

1. Establish channels for multi-directional communication. Most importantly, ensure dedicated channels for communities, particularly priority populations, to represent their concerns to Government. Examples include Aboriginal and Torres Strait Islander communities; cultural and linguistically diverse communities; people with Disability; children/ youth and those 65 or older; people with significant illness; and those who face extensive social disadvantage. These channels should be in place prior to a pandemic and rehearsed in simulations.
2. Expand risk communication capacity in public health and pandemic response workforce through education and training.
3. Embed research-based risk communication expertise in key decision-making bodies in the Australian Centre for Disease Control.

Definitions

The WHO defines **risk communication** as "the real-time **exchange** of information, advice and opinions between experts or officials and people who face a hazard or threat to their survival, health, or economic or social wellbeing."[2] Risk communication requires **community engagement,** which WHO defines as "engaging communities **as equal partners** in the creation of emergency response solutions that are acceptable and workable for those they impact." The goal of community engagement is communities that "confidently **share** the leadership, planning and implementation of initiatives throughout the health emergency response cycle."

Risk communication involves governments listening to communities as well as relaying information and advice to them.[3] Multidirectional communication and community engagement need to be operationalised through **new formal structures**, to achieve the principles for public communication set out in the Australian Health Management Plan for Pandemic Influenza.

The Australian Covid-19 response lacked expertise in, and prioritisation of, risk communication.

The Australian Health Management Plan for Pandemic Influenza sets out principles for communicating with the public in a pandemic. In certain aspects of the pandemic, **these were rarely achieved.** This was the result of lack of risk communication capacity at the highest levels, insufficient planning and rehearsal of plans; and the absence of structures and processes to operationalise these principles in practice. There were limited mechanisms for governments to hear from communities particularly during more urgent phases of decision making[4] and risk communication and social

science expertise were not embedded in pandemic management decision making bodies such as the Australian Health Protection Principle Committee. **Risk communication is not 'downsteam' from policymaking** and is not message development and deployment. It is a distinct field of expertise that studies effectiveness of emergency communication strategies and messages; studies successes and failures to learn from the past; undertakes messaging experiments; and uses specialised methods to engage with communities and involve them in decision making. **The low priority accorded to communication in practice** was revealed by disparities such as between the MRFF allocation of over **$95 200 000** allocated for trials and treatments in 2020 while only $600 000 was allocated for research in communication.[5]

Communication failures during COVID-19 were immensely costly. **Misinformation** and **social polarisation** (particularly expressed as 'COVID denial' and lockdown protest) are closely linked phenomena that pose the most significant threat to successful pandemic management globally.[6] Best practice risk communication prevents and minimises these expressions of 'public outrage'. Risk communication expertise is urgently needed to respond to pandemics in the future. For example, the Australian Health Management Plan for Pandemic Influenza **does not contain principles and guidelines for communication within organisations**, yet many workplaces struggled to communicate effectively with their frightened, disempowered and increasingly outraged staff. **This has contributed to the crisis now facing the education and healthcare workforces**. Risk communication capacity needs to be greatly expanded to address these issues in the future.

Recommendations #1: Create structures for multi-directional communication.
Rationale: There was often a lack of data and consultation with communities about COVID-19 control measures. Particularly during times of rapid policy change, government actors would make assumptions about the public capacity and response to certain measures. When engagement did occur, it was successful, such as the early establishment of the Aboriginal and Torres Strait Islander COVID-19 Taskforce. Hearing from communities during the making of public policy may have enhanced decision-making about e.g., the vaccine rollout, contract tracing App, implementation of public health orders, and how vaccines and masks mandates were implemented.

What multidirectional communication involves:

- Involving communities in planning and communicating about COVID-19 control measures. Where this occurred, uptake of measures was more effective, and minimised need for costly and inefficient law enforcement. Listening to communities can be achieved by structures such as standing community panels or a public Taskforce. Structures should be established prior to an emergency so they can be mobilised in times of rapid decision making.
- Supporting community leaders to play critical communication roles within their communities. This includes providing access to expert information. Where leaders were supported during the vaccine rollout, communities were successfully promoted and supported vaccination.[7]
- Working with journalists. Our interviews with leading health reporters found they were important allies in conveying information and played key quality improvement role in their own organisations, yet had compromised access to information. Governments should provide specialist health reporters with priority access to data.
- Provide forums for sharing information and asking questions. We commend the regular updates from government chaired by NHMRC aimed at informing expert commentators.

Recommendation # 2: Expand capacity in risk communication
Rationale: Although the principles of risk communication have been established for decades, they are rarely put into practice by companies, Governments or organisations. Often staff in these organisations comment on the lack of enactment of these principles at all levels. For example, 'communicate early and often' and 'increase perceptions of control by recommending actions the public can take' are two cardinal principles of best practice risk communication. Yet in January and

February 2020 Governments prepared for the pandemic behind closed doors, leaving Australians exposed to, and frightened by, media reports of pandemic crisis overseas. Anti-Asian racism, widespread supermarket stockouts and unnecessary and harmful school closures[8] could all have been minimised or averted.

What increasing capacity in risk communication involves:

- Expanding opportunities for education and training in risk communication at multiple levels;
- Ensuring training in risk communication is prioritised for leaders and managers;
- Ensuring training that distinguishes risk communication from regular communications; activities such as campaigns, public health messaging and media management.

Recommendation #3: Embed communication science expertise in pandemic decision making.
Rationale: Communication is not separate from decision making. **Actions speak louder than words.** Even high-quality community engagement can *reduce* trust where there are no means for community perspectives to be taken into account in pandemic management decisions. Positively, more accurate forecasts of public behaviour, made possible by community engagement and research insights, **can and should affect pandemic modelling and decision making.** Best practice pandemic management means including risk communication and social science expertise in the central decision-making structure (e.g., AHPPC). Examples include the Netherlands where social science support provided advice and recommendations to government and linked via a chair to a group of behavioural experts, sociologists, health psychologists and health promotion experts.[9] Where risk expertise was missing and 'business as usual' public health messaging was utilised, mistakes were made. This was the case with early vaccination campaigns. For example, 'Arm Yourself' was an inappropriate message for young Muslim men after years of peace-related communication. Risk communication expertise is also needed given the uncertainties of pandemic management and the importance of balancing health, resourcing and economic considerations, which the public interpreted as confusing and inconsistent messaging.

What embedding risk communication expertise in decision making involves:

- Ensuring that an external-to-government, research-based risk communication expert is a member of any key pandemic decision making Committee;
- Providing resources for risk communication expertise to interface with social and behavioural science and ethics expertise, to inform pandemic management;
- Providing priority resourcing for rapid risk communication research, particularly in community-based forms, to be sustained throughout a pandemic to inform decision making, given the high rate of success of outcomes of pandemic social and behavioural research[10];
- Providing a structure for risk communication expertise to interface with Government marketing, communications and campaign teams

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