Preamble

The following represents my personal impressions of the areas of the Australian Government pandemic response that require attention for the improvement of a future pandemic response. This submission remains agnostic to the question of "success" or otherwise of the response. However it can be assumed that the points made imply that policy settings in the given areas could be optimised. In the interests of brevity this discussion is not exhaustive and I am available at the request of the inquiry panel to provide further discourse on the pandemic response.

Overall Decision Making

The Australian Health Protection Principal Committee (AHPPC) was successful in bringing together the most experienced public health officials in Australia to make policy for the Australian pandemic response. The formal and informal processes established over several decades facilitated a unified and cohesive decision-making unit, chaired by the Chief Medical Officer of Australia. Trust and interpersonal relationships were key enablers. It is my view that **the overall structure and function of the Australian Health Protection Principal Committee should be retained**.

Nonetheless the decision-making suffered from a series of pathologies in need of attention for future response.

The aspects of the decision-making structure that were successful were:

- Use of a structure (the AHPPC) that had been deployed many times for smaller scale public health emergencies, ensuring that systems and processes could be stood up quickly at the start of the pandemic
- A strong set of relationships between Chief Health Officers, the Chief Medical Officer of Australia and the Office of Health Protection that meant that interpersonal conflict seldom became an issue

- Adopting a general principle of not creating new structures to manage the pandemic response eg. using the existing structure with co-opting of experienced subject matter experts ([redacted]) to the AHPPC[1][2]

The aspects of decision-making that require attention are:

- **Decision making was not recursive or iterative.** There was no dedicated forward planning group that could adopt a non-operational, horizon-scanning position to anticipate the 'next questions' generated by pandemic policy. The absence of this capability, used commonly in military operations, meant that senior officials had no time to anticipate the consequences of their decisions, discuss the evolution of the pandemic and change policy accordingly. There are innumerable examples of how this could be improved, but the most notable was the persistence of 2020-era isolation and testing policies into the Omicron-era which effectively led to nationwide workforce and testing shortages and could have been addressed through a relaxation of isolation requirements and a shift from PCR to rapid-antigen testing.
- **Decisions were not evaluated against agreed ethical frameworks.** Whilst decisions were made with the best intent, there was a notable absence of agreed ethical framework to discuss and evaluate decisions. This allowed the creation of a 'disease-control at all costs' policy path dependence, which, whilst suited to the first wave, was poorly suited to the vaccine-era. The ethical framework created in August 2021 should be adopted and made widely known across the Whole Of Government.[3]
- **Poor transition to an emergency footing of committees other than AHPPC.** Daughter committees of the AHPPC (eg. Communicable Diseases Network of Australia and

[1] The UK had a different model with several larger committees, potentially compromising the ability to achieve rapid consensus amongst experts were it to be applied to the Australian context.
[2] Evidence provided to the Australian Government Senate inquiry suggested that an insufficient range of expertise was present on the Government advisory committees. I do not believe this to be the case and robust debate prior to consensus on a range of issues was the norm rather than a 'group think' effect
[3] The NHMRC *Decision-Making for Pandemics: An ethics framework* is a useful starting point, but this should be a living document and is less concise than previous examples including Upshur and colleagues *"Stand on Guard For Thee"*. It is questionable whether such a document should sit with the NHMRC, and consideration should be given to involving the Australian Human Rights Commission in co-owning and reviewing such a document

Infection Control Expert Group) did not have the same institutionalised capacity as AHPPC to engage in emergency decision making, leading to delays in some instances[4]

- **No ability to commission policy-relevant research.** The AHPPC had no direct ability to drive a research agenda to answer the key public health and clinical questions that were required to iterate pandemic policy. The Department of Health also failed to provide direction or leadership in this regard. Papers that were published from within the Office of Health Protection were not designed to answer policy-relevant, immediate questions.
- **Individual and institutional fatigue.** Early fatigue amongst decision makers led to exhaustion and potential for poor decision making. Fatigue occurs very early in disaster response (within days to weeks rather than months). It is likely that fatigue contributed to the deterioration in decision-making quality over the course of the pandemic, particularly a tendency toward group-think, path-dependence and a failure to assess and consider alternative courses of action. Examples include, but are not limited to, vaccine procurement and distribution decision-making; persistence of PCR-based testing regimens; persistence of 2020-era isolation and quarantine recommendations.

Potential remedies include:[5]

- Reflection on whether the Department of Health is the optimal agency to coordinate a pandemic response or whether such responsibility should rest with the National Emergency Management Agency and Home Affairs
- Ensuring that emergency management principles are known and adopted by the Departments of Health across all jurisdictions, including the rotation of senior officials during a crisis to allow key individuals sufficient rest and to build capacity and capability amongst 2ICs and 3ICs
- A regular program of pandemic exercising including minor (annual) and major (3 – 5 yearly) whole of government exercises

[4] From the CDNA perspective this was mitigated by **appointing** [redacted] Two key examples include – failure of CDNA to ratify enhanced data collection for Health Care Worker infection for at least six months post-pandemic onset and the failure of ICEG to effectively manage the controversies around transmission dynamics and route of infection

[5] See section below on Research for a detailed discussion on improvements to research

- More detailed operational guidelines on how Government departments should structure their response to the pandemic ie. Guidance that would specify the immediate formation of a planning group of individuals familiar with our Health Protection architecture (ie. Former or current officials) tasked with testing policy against ethical frameworks

Federal and State Roles in a Pandemic

Although the notable discordance between State and Federal governments was clear to the public in the second half of 2020, the issue arose almost immediately with divergent policy on quarantining of school and university students returning from China in January of 2020.

Policy discord within the Federation has notable disadvantages that cannot be excused by framing each jurisdiction as having individual or specific needs during the pandemic that vary substantially from those as a nation. These include

- Confusing the Australian public at a time when clarity in essential
- Diminution of the rights conferred by Australian citizenship including the ability for a jurisdictional government to discriminate based on place of residence in Australia
- Impairing co-operation in the event of maldistribution of disease impact

As a hypothetical example, whilst a ventilator sharing policy was formulated by myself and endorsed by Directors-General of Health in the first half of 2020, it is almost impossible to conceive that such a strategy could have been effectively implemented in the political climate that rapidly took hold. In the event of a pandemic where the mortality is increased and the age distribution skewed to working-age adults or younger Australians, the resultant of federal-state tensions will be loss of life.

After lengthy personal reflection on this issue, I believe only one solution is possible to avoid this situation in the future. I strongly encourage the Inquiry to recommend **amendment of the Biosecurity Act to ensure that all disease control powers are vested in the federal government during a national Biosecurity Emergency**. In such a scenario, the decision-making capacity of the AHPPC will be optimised by allowing Chief Health Officers freedom to

consider optimal nationwide disease-control policies. To take state border closures as the most contentious example, it is possible to imagine that state border controls could still be a policy recommendation of the Federal Government via the AHPPC, however state governments would be tasked with implementation only and not be able to exercise their own powers nor independently implement their own policy.

Research

In comparison to other similar nations, particularly the United Kingdom, the research output of Australian academic institutions during COVID-19 was poorly coordinated, delayed, and generally failed to provide timely, policy relevant research data.

The UK, by contrast, was able to provide ground-breaking research including, but not limited to, the RECOVERY trial. The paper by three leading Australian researchers, [redacted] outline the limitations and potential future model in their paper and I endorse their reflections.[6]

The APPRISE project which was dedicated to forming networks that would answer the key questions during the first 100 days of a pandemic could not then be considered a success against that measure. However, the central issue is not with the APPRISE project itself, but with the Department of Health and the National Health and Medical Research Council, which failed to adapt to the emergency. The use of existing grant application and funding models, albeit expedited, was poorly suited to answering pandemic policy questions and those institutions going forward must be considerably more directive in setting and driving a rapid research agenda.

Notable successes and models to follow include the research outputs from the Australian and New Zealand Intensive Care Society, which was able to provide data on intensive care resource availability within the first two months of the pandemic that considerably influenced the

[6] Bowen AC, Tong SY, Davis JS. Australia needs a prioritised national research strategy for clinical trials in a pandemic: lessons learned from COVID-19. Med J Aust. 2021 Jul;215(2):56-58

trajectory of policy, including arguably the decision to close the international borders. Another example included the rapid serosurvey of surgery patients to enable the re-commencement of elective surgery after its pause during the first wave.[7]

Australia must have a direct link between the questions of policy makers and the answers derived from real time research. This role should be the function of the Centres for Disease Control (see final section for further discussion).

Vaccine Mandates

Vaccine mandates should be broadly defined as any policy that discriminates between a vaccinated and unvaccinated individual during a pandemic.

The imposition of vaccine mandates had two main drivers:

1. The early evidence that vaccination decreased transmissibility of the virus following infection with wild-type and alpha variants.
2. The need to reduce demand of health services created if large proportions of the population remained unvaccinated.

It is not clear the extent to which mandates drove vaccine uptake. The highest vaccination rates occurred during the Delta outbreak in Victoria and New South Wales, strongly suggesting a correlation between an individual's perception of their own vulnerability to disease and being vaccinated. During the same period and despite availability of the vaccine in other states rate of uptake was significantly lower, suggesting that personal vulnerability is a stronger driver than mandates.

It is probable that mandates enabled less affected states to achieve higher vaccination rates by the time they had their Omicron waves. On the other hand the personal cost to individuals who did not receive the COVID-19 vaccination was substantial and not limited to the pandemic

[7] Notably, this project was directed at the request of and funded by the Office of Health Protection, driven by a Deputy Chief Medical Officer and institutions were directly co-opted to participate without a grants process.

period. Australians who chose not to be vaccinated suffered life changing events including job loss, for which there was limited or no recourse to typical statutory authorities such as Fair Work Australia. Where cases were brought to Fair Work or Industrial Relations and Courts, Commissioners and Judges generally avoided considering the justification for termination and deferred entirely to the medical advice of the time[8]. Cases brought by individuals against their employer were ongoing into late 2022 and included dismissal due to non-adherence with 4th vaccine mandates.[9]

The political discussion around mandates falsely conflated Australians who were "anti-mandate" with "anti-vaccination". If not yet proven, it is at least highly plausible that this led to more Australians than would otherwise have been the case being pushed to the margins of public health discourse and into the arms of true conspiracy theorists and anti-vax influencers.

The Federal Government position that individual employers would manage mandates and that it was not a role of Government was an incorrect decision. This allowed employers discretion to impose mandates beyond the first two doses of COVID-19 vaccine, with some agencies including State Government emergency services imposing up to fourth dose mandates in the absence of any evidence and indeed ignoring evidence that any benefit in transmission reduction was overcome by the increased transmissibility of the Delta and subsequent variants.

The mandate decision was one of the clearest examples of a failure to use the principles of verifiability, responsiveness and proportionality in assessment of pandemic policy.

On balance, mandating of vaccination during a pandemic should be subject to the following considerations:

1. It must only ever be used as a 'last resort' policy where vaccination uptake remains low despite education and the persistence of low vaccination rates is likely to cause

[8] Personal Communication. Panel discussion. Australian Bar Association Annual Conference 2022
[9] Davis, Allan and Ors v State of Queensland

significant harm to the community, where that harm has been reliably quantified and communicated to the community.

2. Vaccine mandates can only be initiated or ceased by the Federal Government under the Biosecurity Act. No other legislative instrument can be used to discriminate against an individual based on their vaccine status.
3. The duration of mandates must be time limited and justification for their continued imposition subject to publication of the research upon which the decision is based.[10]

Cross-border Access to Healthcare

Federal Government funding of state health systems should be made contingent on the ability for any Australian to access healthcare anywhere in Australia under any circumstances, including during a pandemic. In particular, **State Governments must never be permitted to deny access to healthcare to any Australian citizen for the purposes of communicable disease control**. The definition of denial of access includes inability to access care at the most proximate or most familiar healthcare facility, even if that facility is across state borders. This must apply in particular, but not limited to, the communities of the Northern Rivers of NSW, Albury-Wodonga and the Murray River communities in the Riverina region of Victoria and New South Wales.

Future Decision-making Structures - Australian Centres for Disease Control (ACDC)

An ACDC represents both an opportunity and a risk to pandemic policy in Australia.

The major risk is the distancing of sound policy advice from disease control capability by "hollowing out" the Department of Health. The advantage of the current structure is that the senior officials and their staff have the knowledge of the working of government, the

[10] Note this policy can and should be applied to any disease control policy that involves imposition of individual rights in favour of disease control and should be used in concert with the Australian Pandemic Ethics Framework

relationships with officials from other agencies and a working ability to be able to balance competing policy imperatives that have shown to occur during a pandemic.

The creation of a separate institution risks creating an isolated, non-engaged and poorly integrated QUANGO subject to institutional group think and single-minded pursuit of disease-control over all other priorities in a pandemic. In short, **many of the faults of the Australian pandemic response as outlined above could be magnified** if the terms of reference and role of the CDC extend into the roles traditionally held by the Chief Medical Officer of Australia, the AHPPC and its daughter committees.

The marked departure from scientific evidence and pragmatism exhibited within the United States Centres for Disease Control during COVID-19 is a cautionary tale in the how a CDC can become divorced from the society it is designed to serve. There is no evidence at all to suggest that nation's with CDC's performed any better during the pandemic or that a CDC *ipso facto* produces better pandemic policy. The structure and function of the ACDC will define how it contributes to a future pandemic response.

That said, a CDC that is purely operational, designed to establish and maintain a cutting-edge epidemiology capability that can be exported to the region as a soft-power tool of diplomacy would be the ideal function for an ACDC. The ACDC should be modelled on the National Critical and Trauma Response Centre, with a highly operational, research focussed and limited policy-making role, and one that is dedicated to building response capacity and capability as well as relationships within the federation and the region. Moreover, the NCCTRC is subservient to the Department of Health and Department of Foreign Affairs and Trade for its activity, reporting through the Office of Health Protection and

The difficulty with an expanded policy making role for a CDC is that it will become another "partner agency" of the Department of Health in a similar way to multiple other partner agencies (ranging from the Commission of Safety and Quality in Healthcare through to [redacted] and everything in between) with limited oversight from the Secretary of Health and an unclear division of responsibility between agencies during both year on year business and likely even more so during an emergency. This distance would place it further away from other

key agencies involved in emergency response, namely Home Affairs and its own National Emergency Management Agency.

In terms of practical recommendations, it is critical that the **formation of the ACDC does not involve any functional or legislative change** to the role of Chief Health Officers, the AHPPC or the Chief Medical Officer of Australia. Public Health policy and decision making during a pandemic must rest with officials who operate within the structure of government, can be held accountable by their Minister and are subject to the same operating environment as any other government official.

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15 December 2023