January 10, 2024

Key stakeholders were largely ignored by government during the COVID-19 pandemic.

Please find 2 communications which were directed to decision makers during early 2021 (early roll out) and in 2022 to provide evidence. None of this was written in hindsight. Decisions makers continually reminded us that decisions were made with the best evidence at the time. I question this.

Yours sincerely

Dr Bob Kass MBBS MRCP MScMCH DCH FAFPHM
Public Health Physician
[redacted]

March 2021

I am a public health physician who has worked at community level for over 30 years.

The current strategy behind the 1B vaccine roll out undermines the delivery of primary care services in Australia.

There is much to be proud of in Australia's response to the COVID 19 pandemic. The opposite has to be said for the start of the vaccine roll out. Surely a rethink is necessary! Australia has had a publicly funded influenza program for more than 20 years. It has performed very well over many years. Much of the 1B target population would be accounted for within the annual flu program so why has the Commonwealth Department of Health departed from this long-trusted model of the past. This needs to be explained to the public.

The target group for influenza is also the "at risk" group for serious complications of COVID-19. It would have made sense for general practice to lead the 1B response entirely using the existing State vaccine distribution outlets. General practitioners know their vulnerable people, particularly those who are elderly or with major pre-existing medical issues. They see these people on a regular basis, they hold their records, and they can prioritise their own individual roll out. They would have a good understanding of their community, their degree of compliance, the level of IT literacy and whether there are pockets of vaccine hesitant individuals within their area. This is good primary care and what we should expect in Australia.

I believe this is what we have seen with the COVID-19 pandemic response in NSW - the gold standard community public health response. Public health in NSW is very much decentralized with public health units across the state. These public health units know their communities. We observed this with the Northern Beaches outbreak where 180,000 people were severely affected rather than 8.5 million people. This is targeted public health and should also apply to the vaccine roll-out with General Practice taking the lead role.

I have had discussions with a number of medical practices who elected not to participate in the original "Expression of Interest" in January. Many of these practices would be seen as "traditional general practice". Highly respected, always fully booked, know their community. So why did they not put up their hands in the first place and why are they now locked out of playing a role when the goal posts have been moved so dramatically! I believe attempts to belatedly join have been met with complete rejection by the Adelaide PHN who have sited Commonwealth DOH instructions.

These are intriguing questions which need to be addressed by both the State and Commonwealth Health Departments. I believe the strategy must be revisited as soon as possible. I would strongly recommend we move to the model used for our annual influenza program. The "laggards are setting the pace" is also relevant here in Australia.

Dr Bob Kass
MBBS MRCP MSc MCH DCH FAFPHM
Public Health Physician
[redacted]

2022

Dear Minister,

There is currently a good deal of discussion over Australia's response to the COVID-19 pandemic, particularly the vaccine rollout.

In March 2021 I communicated with the Commonwealth Chief Medical Officer, Paul Kelly and also with South Australia's Chief Medical Officer on the design of the vaccine roll out (letter provided).

It was very evident by as early as mid to late 2020 older people were more likely to die from COVID-19. **(Figure 1).**

I was very concerned that the proposed structure did not cater for the most vulnerable members of the community. We already had a well-tested program for the delivery of annual influenza vaccine and I was arguing that this model should be adopted for COVID-19.

Unfortunately, this was not the case and it appeared both the Commonwealth and State Governments had very different agendas. There was an undersupply of vaccines to general practice by the Commonwealth and a focus by the State Government on vaccine hubs. Older Australians (those most vulnerable) did not identify with the hubs, preferring to use their general practices which were starved of vaccines. Nursing staff was also hard to recruit with the State Government paying higher hourly rates.

From April 2021 I had the privilege of working with a southern suburbs general practice to deliver COVID vaccines to their clientele. The practice did not take up the first Expression of Interest (EOI) as they rightly believed they would be given very little vaccine. They did, however, take up the second offer in late May.

The timing of the influenza program starting in March 2021 gave us an opportunity to compare uptake rates for both influenza and COVID over the same period. We monitored the Australian Immunisation Record at the same time. We followed over 800 people over 80 years. It was very evident that the coverage for COVID-19 dramatically improved once the general practice commenced their vaccine program. We were also pleased to note a more than 90% coverage for influenza for both males and females in just over 2 months. **(Figure 2).** It took quite a lot longer to achieve the same with COVID program, but it was still achieved within 4 months.

I believe the rollout was driven more by politics than good public health policy. This was very frustrating from the perspective of a public health physician **NOT** employed within the public health system.

If we had been able to provide the ASTRAZENECA vaccine to those most vulnerable (>65 years) we would have circumvented the social media scare campaign in the middle of the year. We would have been able to achieve high rates of coverage within a 2-3 month period in an age group which was very unlikely to have a problem. Unfortunately, there was a great deal of hesitancy as a result of the delay, and I would have counselled a few hundred people. I can only remember 1 person who preferred to wait for the Pfizer and much of the practice's success was due to the individual's trust in the practice.

In 2022 we sampled 1 in 6 females and 1 in 3 males from our original cohort to determine uptakes for Dose 3 and 4. At no stage did we refer to dose 3 as a booster, preferring to use the phrase "3 dose course". I feel this helped a great deal in us achieving an uptake of over 85%. The dose 4 uptake is also encouraging at over 70%.

I believe primary care, including pharmacy remains the key to any successful pandemic response in the future. Hopefully we may see a more common-sense approach in the future. Primary care medicine is struggling, and we need the Commonwealth and States to fully investigate the funding issues currently. A properly funded primary care system may also help with issues of ambulance ramping.

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[redacted]

Figure 1

THE AFFECT OF AGE ON MORTALITY WITH COVID-19

A META ANALYSIS WITH 611,583
Clara Bonanad et al
JAMDA 21 (2020) 915-1918

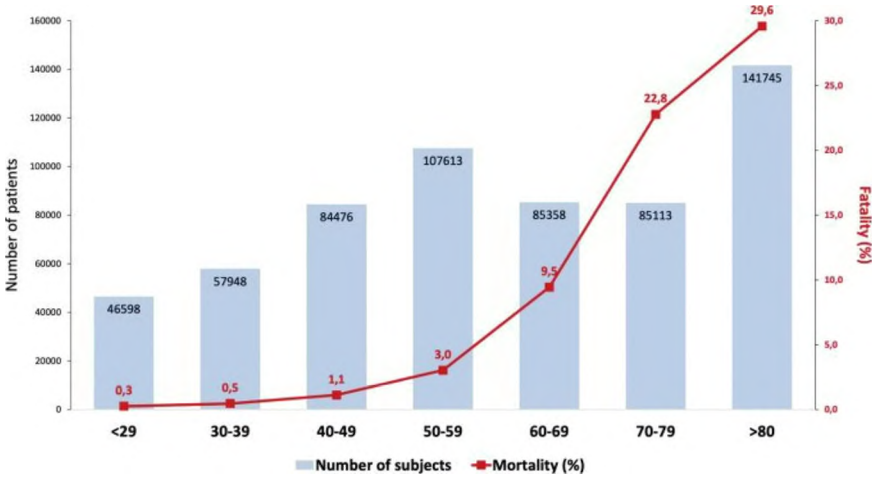
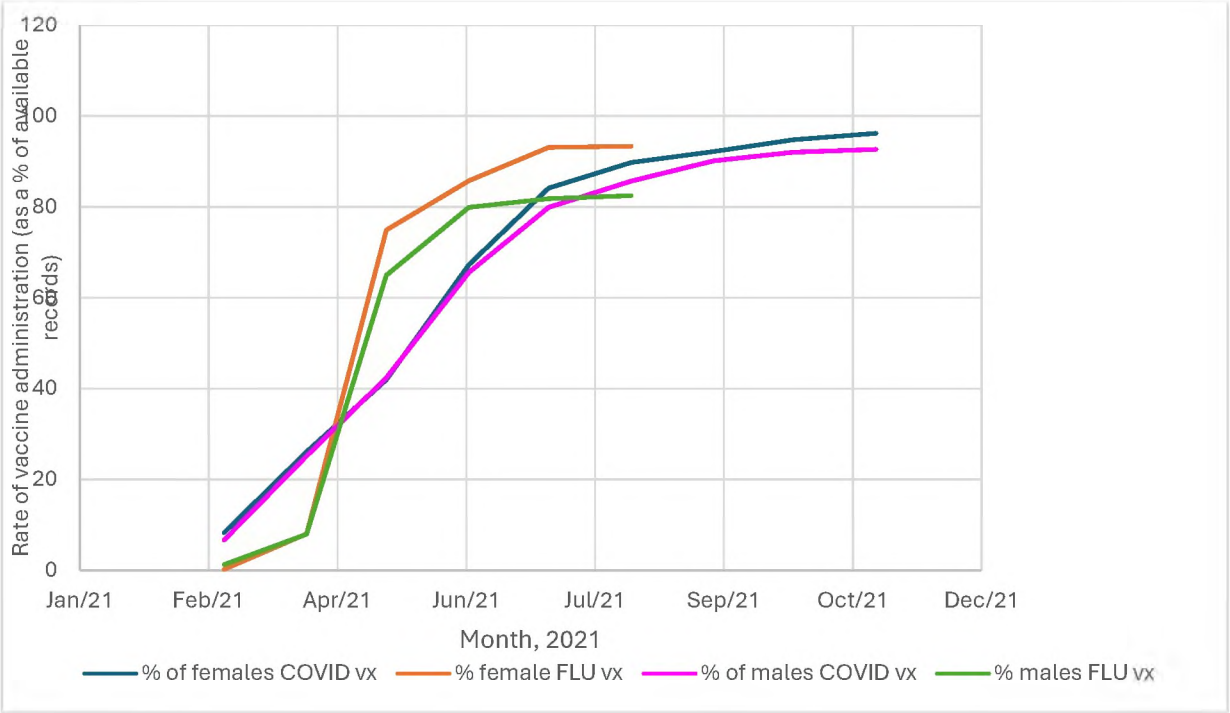


Figure 2

COVID AND INFLUENZA VACCINATIONS

MARCH TO OCTOBER 2021 (MALES AND FEMALES AGED 80 +)



COVID DOSE 3

	31 March 2022		
	DOSE 3	SAMPLE	PERCENTAGE
FEMALE	59	69	85.5
MALE	64	71	90.1