Covid Inquiry – Submission by Patrick Tobin

I welcome the opportunity to provide a submission to this Inquiry in my capacity as a private individual.

Personal Relevant Experience

I was the Executive General Manager, Policy and Advocacy at the Royal Australasian College of Physicians (RACP) from January 2017 until February 2021. In this capacity I had frequent contact on a wide range of health related issues, including the response to Covid-19, with the Office of the Health Minister, Hon Greg Hunt; as well as officials within various parts of the Department of Health.

I was previously the Director of Health Policy at Catholic Health Australia from 2003-2016 and in that capacity was a member of, and Chair for several years (201-2016), of the Health Sector Group of the Commonwealth Attorney General's Department Trusted Information Sharing Network (TISN), which brought together Federal Health Department and key private sector health providers, including hospitals, pathology laboratories, pharmaceutical suppliers and medical device companies to ensure the continued operation of critical infrastructure during periods of crisis.

I currently work part-time as a Policy Advisor with the Australian Medical Association.

My comments below are based on my experiences above but are made in my own personal capacity and do not necessarily reflect the views of any the above organisations.

General comment

Firstly I would like to pay tribute to the incredible hard work, under enormous pressure and during a period of rapidly changing scientific advice, of all the clinicians and other frontline workers who put the health of themselves and their families on the line to serve and save others.

I would also like to acknowledge the incredible efforts of all those working across Government, from the Minister, his staff and Departmental staff to develop and rollout a response to this pandemic. Notwithstanding the tragic loss of life and continuing morbidity of those suffering ongoing long Covid, it is clear that the effectiveness of the response saved many tens of thousands of lives that would otherwise have been lost.

Particular successes I had close knowledge of included the extremely rapid rollout of MBS telehealth items, working with Indigenous health organisations in the early stages of the pandemic to minimise Covid-19 exposure and deaths in Indigenous communities, the decision to close the international border as well as the regular, structured update meetings with the Department of Health for medical practitioners, allied health providers and their peak bodies, which enabled rapid two-way flow of information from the government to health providers as well as information on the impact of the response measures back to government.

Nevertheless, in order to save lives in future pandemics, it is important that lessons are learnt and measures put in place to anticipate and respond to the next pandemic.

Clearly defined Responsibilities – Private and Public Sectors – Need for regular rehearsals

It is clear that one of the areas of particular frustration was the blurred understanding of roles, responsibilities and expectations across different parts of the health sector. Confusion of understanding particular roles and responsibilities clearly led to delayed decision-making in areas such as vaccine rollout in aged and disability care and more broadly. This Inquiry will undoubtedly hear many, well-informed submissions about the impact of having different public health measures and restrictions implemented by different jurisdictions and what role the Commonwealth should and can play in their support or co-ordination.

From my personal perspective, as a Chair of the TISN Health Sector Group, I was fortunate to witness the very positive lessons learned from bringing in key players from across all critical industries as well as the different tiers and jurisdictions of government to role play potentially catastrophic scenarios. Such role plays rapidly brought into sharp focus the linkages and dependencies of all industries and tiers of government on each other in the face of a significant challenge to one sector and how rapidly the effective operation of society could be brought to a standstill.

Exercise Cumston in 2006 rehearsed the impact of a global outbreak of an influenza pandemic in Australia. Many valuable lessons were learned which were put to use during the Covid response (unfortunately many recommendations will still likely be applicable today). It is also clear that Operation Cumston vastly underestimated the scale of societal disruption that was ultimately going to be caused by a pandemic such as Covid turned out to be – future exercises need to be more robust in developing scenarios to be tested. In my view, given rapidly changing technologies, travel patterns, media and social media use, pandemic training exercises of at least the scale of Operation Cusmston should be conducted every 5 years with the results used to update Commonwealth and Jurisdiction pandemic plans.

- **Conduct large scale pandemic rehearsals involving all jurisdictions and key industry sectors every five years**
- **Future pandemic rehearsals need to be robust and challenging – noting the deep impact of the Covid pandemic on societal functioning**

<u>Access to the National Medical Stockpile (NMS) – which health services were eligible?</u>

One area of particular frustration was access to the National Medical Stockpile – in particular for medical specialists working in the community.

Access to personal protective equipment (PPE) was an issue early in the pandemic resulting from global supply chain shortages. PPE was made available from the NMS to health workers in public hospitals – although there was variability across both jurisdictions and particular hospitals and hospital departments as to access and the particular PPE made available (ie surgical v's P2/N95 masks). Nevertheless this was a clear responsibility of hospitals.

Similarly the Commonwealth took responsibility for ensuring and enabling GPs to access PPE from the NMS.

For medical specialists, including respiratory physicians, working in non-hospital settings, it was not clear whether they could or could not access PPE from the NMS. Inquiries to the Commonwealth at the height of the initial wave of the pandemic took over 3 months to resolve – with the ultimate answer being that they could not access PPE from the NMS.

Given respiratory physicians and other specialists were seeing complex cases of respiratory disease in non-hospital settings, it seemed strange that they were not able to access PPE from the NMS when GPs could. This situation was made worse by the delay in receiving definitive advice from the Commonwealth at a time when there were global shortages of PPE - leading specialists to try to sort PPE from their own devices and in the meantime risking their own and their patients' health. Early timely advice to medical specialists working in the community would have helped them source their own PPE or at least have provided the clarity to make decisions about how they would be able to provide their services going forward.

- **Policies such as who has access to the NMS and in what circumstances should be clear for all health service providers at the outset of a pandemic**

<u>Inconsistent publicly available technical clinical advice</u>

Another area of frustration at times was the inconsistent provision of technical clinical advice. A particular example related to the use of masks in different clinical circumstances. Prior to the declaration by the WHO that significant spread of Covid 19 was could occur by aerosols, there was significant debate about whether surgical or P2/N95 masks were appropriate in different clinical settings and patient circumstances. The publicly available technical advice provided on the Health Department website, including the advice from committees such as ATAGI and CDNA as well as different jurisdictions was at times inconsistent on this point. Often this resulted from delays in the committee meeting cycle – with those committees with more recent meetings benefitting from the most recent new and emerging evidence and updating their advice accordingly.

Whilst it was clear that scientific understanding of the mechanisms of transmission of Covid-19 was rapidly evolving, again it was concerning that the inconsistency of advice could lead to health workers being unnecessarily exposed to risk – especially if health services adopted the least stringent of the ranges of advice on offer for reasons such as budget or access to stocks.

Whilst acknowledging the challenges of ensuring consistency of technical advice during a period of rapid change in scientific understanding, more future effort needs to be put into ensuring consistent and up to date advice is provided in all government public communications (including across jurisdictions).

- **More future effort needs to be put into ensuring consistent and up to date advice is provided in all government public communications (including across jurisdictions) – with responsibly preferably being given to a medical adviser for ensuring technical consistency across platforms.**

<u>Provision of adequate notice to clinicians of changes to Covid-19 policy settings</u>

A further frustration for clinicians as the pandemic continued were announcements of changes to, for example, vaccine eligibility being publicly announced (sometimes even by the Prime Minister) prior to advice being provided to clinicians. Clinicians were then confronted by patients who were more up to date in the latest policy settings than the clinicians.

Recognising the challenges of the political system and the need to confidentiality leading to announcements, nevertheless every effort should be made to providing clinicians with advanced notice (even if only 24 hours) of pandemic policy changes so they are in a position to provide accurate advice and up to date treatment options to their patients.

- **Clinicians to be provided of advance notice of pandemic related policy changes relevant to clinical practice**

<u>Pathology POC testing – jurisdictional inconsistency</u>

Whilst the management of the Covid response in Indigenous communities by governments working in partnership with Indigenous health organisations was generally very successful in the early stages of the pandemic, a particular example of frustration with inconsistencies across jurisdictions emerged with the ability to deploy point of care pathology testing for Covid-19 in remote Indigenous communities. This was important as point of care testing (albeit not as accurate as laboratory testing) would allow a rapid real-time local response to an outbreak in a local community compared to the delay of several days potentially incurred where a test had to be transported to a facility thousands of kilometres away - with a likely rapid local spread of Covid-19 in the meantime. For a period of time POC testing was allowable in remote communities in the NT but not Queensland (despite the Commonwealth's best endeavours). Whilst out of scope for this Inquiry, future responses should seek to minimise such inter-jurisdictional variations.