AMSANT Submission to the Senate Inquiry into the Australian Government's response to the COVID-19 pandemic

1 June 2020

About AMSANT

The Aboriginal Medical Services Alliance NT (AMSANT) is the peak body for Aboriginal Community Controlled Health Services (ACCHSs) in the Northern Territory (NT). AMSANT has been established for over 25 years and has a major policy and advocacy role at the NT and national levels. Our 26 members are located right across the NT, from Darwin to the most remote areas. The ACCHSs sector is the largest provider of primary health care to Aboriginal people in the Northern Territory. ACCHSs deliver comprehensive primary health care in an integrated, holistic, culturally secure framework which combines a population health approach with primary health care service delivery; in addition, ACCHSs are also involved in diverse health research activities.

AMSANT provides guidance and advocacy on a wide range of research, public health issues, education, workforce, continual quality improvement programs, social and emotional wellbeing, housing and other determinants of health that affect NT Aboriginal people. AMSANT has high level collaborations with the NT and Australian Governments on these issues.

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Recommendations

Biosecurity issues

1. That the Aboriginal Community Controlled Health Service (ACCHS) sector must be included at all levels of decision-making when border control and biosecurity measures are implemented.
2. That ACCHSs are funded to provide services to people in quarantine.

Food security issues

3. That the Australian Government works with remote community stores to achieve greater equity in supply and pricing of essential health products and healthy food.
4. That the Australian Government ensures public health nutrition experts are involved in food security responses and working groups.
5. That additional funding is provided to Aboriginal organisation to address underlying food security issues to reduce the reliance on emergency food relief and food programs and provide a pathway for Aboriginal people to become food secure.
6. Maintain increased social security payments and ensure greater equity through increasing the remote area allowance to reflect the higher cost of living in remote Australia.

Public health issues

7. That the Australian Government releases vaccinations to the NT and other jurisdictions with remote populations one to two weeks earlier than other jurisdictions on the understanding that vaccinations will be prioritised to remote and Aboriginal populations.
8. That the NT and Australian governments work together to address the storage and staffing issues causing slow distribution of influenza and other vaccinations (including potentially a COVID-19 vaccine).
9. That the PHNs report on performance indicators about how they engage with the ACCHS sector and an independent complaint mechanism is instituted for ACCHSs to use if they believe that they have been treated unfairly by the PHNs.
10. That the Australian Government mandates that Aboriginal and Torres Strait Islander people are included in the governance of each PHN including at the Board level.
11. That the current telehealth items created for COVID-19 remain permanent.
12. That there is reimbursement of the resources required to support the patient in telehealth, either in additional items for Aboriginal Health Practitioners/Registered Nurses in supporting the patient, or a loading for the existing telehealth items.
13. That the requirement for far-end specialist in a telehealth consultation to claim Medicare is abolished so that the primary health care service can claim patient-end support services if the far-end specialist does not make a claim.

Coordination of government responses

14. That the Aboriginal community controlled sector be included at all levels of governance and decision making as matter of priority.

15. That the Australian Government funds and develops a national CDC which has a key priority of working with the community controlled health sector and other Aboriginal organisations on communicable disease challenges in Aboriginal populations.

16. That the Australian Government continues the Commonwealth-convened Aboriginal and Torres Strait Islander COVID-19 Advisory Group to consider a range of communicable disease challenges.

17. That jurisdictions should review governance structures for management of emergencies to ensure that the ACCHS sector is included as a key partner.

18. That a general Aboriginal and Torres Strait Islander pandemic plan is developed and finalised, with oversight by the Commonwealth-convened advisory group, and a more thorough consultation process than occurred with the previous plan.

19. That the Commonwealth Department of Health urgently completes modelling to ascertain the most effective approach to containing an outbreak in a remote community and the resources required to implement the approach, and shares this information widely with NACCHO and affiliates, other Aboriginal organisations, jurisdictional public health authorities and communities. The Australian Government and jurisdictions should then work together with the community controlled health sector and other relevant Aboriginal organisations to ensure coordinated and fully-resourced implementation of the most effective and acceptable approach to outbreak management in remote communities.

Workforce/staffing issues

20. That plans be developed and implemented to create surge capacity for ACCHSs during emergencies to avoid clinical closures in Aboriginal communities, including access to emergency funds.

21. That development of a surge capacity for COVID-19 includes the creation of a cohort of remote-ready nursing and medical staff, oriented to primary health care, for the following purposes:
    - While no cases in a remote community but there is an increased population due to the biosecurity measures: boost existing workforce by ensuring all existing positions are filled to assist with the increased workload with 8 to 12 week placements; and backfill positions when current staff become sick, take remote or other leave or need relief
    - Initial COVID-19 cases or an outbreak in a remote community: rapid deployment to affected communities to implement 'contain and test' or other emergency strategies.

22. That the Australian Government pays for the cost of quarantine for ACCHS workforce.

23. That increased funding and support for training and development of local workforce is provided to ensure cultural safety and reduce reliance on interstate staff, including expanding tertiary-level nurse training in the NT to enable Aboriginal people who want to study nursing and stay close to family within the NT, and funding additional Aboriginal Health Practitioner trainee positions.

24. That key strategic actions for immediate action should be carried out to improve the capacity of remote health services to respond while COVID-19 remains a threat, and to ensure greater preparedness for future public health emergencies, including:

- sustainable solutions to the employment, support and remuneration of local Aboriginal staff in remote health services
- funding for at least 50 Aboriginal Health Practitioner (AHP) trainee positions for the Northern Territory
- training and support for remote administrative and support staff
- ensuring all nursing staff working in rural and remote centres are employed under contracts which include training and support to provide short periods of cover in very remote (RAMA 7) Aboriginal communities
- providing graduate nursing programs to encourage supported learning and experience in Aboriginal and remote health
- recognition of GPs working in remote Aboriginal health as rural/remote generalists with advanced training in Aboriginal Health
- addressing remote health staff accommodation, including for local Aboriginal staff.

Social and emotional wellbeing issues

25. That locally-led approaches to strengthening and maintaining MH and SEWB, incorporating appropriate cultural recovery and healing practices are adopted.

26. That rapid response funding is provided to the Aboriginal community-controlled health sector for responding to prevalent and incident alcohol and other drug use, and domestic and family violence.

27. That there should be clear priority of continued culturally-safe healthcare provision and management of existing illness, and responsiveness to new or acute mental illness and suicidality.

28. To ensure compliance with COVID-19 restrictions, targeted funding should be provided for telehealth expansion: hardware, infrastructure and future incurred costs (including training).

29. That equitable, needs-based funding is provided for the Aboriginal community-controlled health sector to address historical shortfalls and current and emerging MH and SEWB needs.

CDP participation requirements

30. That the Community Development Program (CDP) remains voluntary with mutual obligation requirements suspended for the duration of the pandemic threat.

31. That the Australian Government moves to reform CDP to incorporate a core jobs component pool of subsidised part-time jobs in Aboriginal community controlled organisations, supplemented with training and meaningful activities directed by local communities on projects which address community objectives, as proposed by Aboriginal Peak Organisations NT (APO NT).

Increased Jobseeker payments

32. That the Australian Government extends the current doubled rate of Newstart for the duration of the pandemic and that the rate be significantly increased from the pre-existing level once the pandemic has passed.

Introduction

Thank you for the opportunity to provide a submission to the Senate Inquiry into the Australian Government's response to the COVID-19 pandemic.

Like much of Australia, and indeed the world, AMSANT has spent the most part of 2020 consumed by the COVID-19 pandemic. AMSANT's role has been twofold: firstly, providing support for our member services as they prepare and respond to the unfolding pandemic and secondly, advocating on behalf of our members and Aboriginal people and communities across the Northern Territory.

The Aboriginal community controlled health sector in the Northern Territory responded quickly in the early stages of the coronavirus epidemic as it rapidly evolved into a pandemic.

Now, more than ever, the COVID-19 pandemic has brought to the fore many issues on which AMSANT has spent years advocating. The pandemic has highlighted deep inequities in housing, environmental health infrastructure, food security, employment and wealth distribution that have placed many Aboriginal people and communities at significantly greater risk during this pandemic.

At present, there are no active cases of COVID-19 in the Northern Territory, no deaths attributable to COVID-19 in the NT, and no confirmed cases in Aboriginal people. However, we must not allow these favourable circumstances achieved through prompt, evidence-based action to create complacency. As the country moves towards the 'new normal', this must be inclusive of our most vulnerable populations. Experience overseas demonstrates that COVID-19 is much more deadly in populations that have high levels of poverty, chronic disease and poor housing, and that being from an ethnic minority independently increases the risk of death (Williamson et al, 2020). These factors place our population at the highest levels of risk. The new normal must recognise that investing in measures that address these inequities will create a stronger society and one that can protect those most at risk as this pandemic continues, and into the future.

In the Northern Territory, the Aboriginal community controlled sector – inclusive of health and other Aboriginal community controlled organisations – has been responsive, adaptive, resourceful, collaborative, strategic and wholly focussed on the best outcomes for our people.

Background

The Aboriginal community controlled health services (ACCHS) sector in the Northern Territory (and elsewhere around Australia) responded quickly in the early stages of the novel coronavirus epidemic. Recent history and the lessons learnt from the 'swine flu', or pandemic (H1N1) influenza in 2009, were front of mind. The impact of the H1N1 on Aboriginal people and communities was such that AMSANT recognised that the ACCHS sector must be prepared, well in advance, to keep the virus out of Aboriginal communities, particularly remote communities and town camps. National data from the H1N1 outbreak demonstrated hospitalisation rates for Aboriginal people that were eight times higher, and ICU admissions also eight times higher, than the rest of the population. H1N1 also drew attention to the impact of seasonal influenza on Aboriginal populations throughout the NT, with NT health services commenting that H1N1 was just 'a really bad flu year'.

Social determinants of health

It is well known that population health outcomes are the result of underlying structural and social determinants. The COVID-19 pandemic has highlighted that overcrowded housing, poverty and

other social determinants have placed Aboriginal people at disproportionate risk from pandemics and other communicable diseases such as rheumatic heart disease.

Aboriginal people in the NT were disproportionately affected by pandemic (H1N1) 2009 influenza. A study (Flint et al, 2010) showed that among Aboriginal people in the top end of northern Australia, hospital admissions were 12 times higher and ICU admissions were five times higher than the non-Indigenous population. Overcrowded and inadequate housing was noted as a contributing factor to the impact of the pandemic on Aboriginal people in the NT.

Experience from the United States demonstrates that Indian reservations have COVID-19 infection rates that are four times higher than rates in the rest of the community, and that communities with low English literacy and poor housing infrastructure are the most at risk (Akee et al, 2020). US Centre for Disease Control (CDC) data demonstrates that death rates in Arizona in First Nations people occurred at rates 11 times higher than would have been expected if the death rate was the same as the rest of the State after adjusting for the younger age distribution of the population (CDC United States, 2020).

The risk profile of Aboriginal people is such that an outbreak of COVID-19 in a very remote community with overcrowded housing is going to be very difficult to contain. Recommendations for physical distancing, self-isolation and quarantine are extremely challenging for Aboriginal communities, where overcrowded housing and inadequate environmental health hardware (plumbing, cooling/heating, cooking facilities, stable power supply) is commonplace. Despite Aboriginal people's genuine attempts to comply with public health recommendations, these environmental conditions mean that stay-at-home orders are extremely arduous. The poor environmental conditions experienced by Aboriginal people widely across the NT are an outcome of numerous polices over many years that have contributed to insufficient numbers of homes to adequately house the population, ineffective maintenance and repair programs, and poor investment in community infrastructure that enables good public health. The present situation is a breach of fundamental human rights.

It is also apparent that the Australian Government's response in doubling the rate of unemployment benefits, relaxing mutual obligation requirements and providing additional supplements has had a significant short-term benefit in alleviating poverty levels and improving capacity to cope with the immediate restrictions and challenges.

The long-term solution, however, is to address the underlying determinants of poor health including housing, poverty, racism and unemployment.

Biosecurity issues

AMSANT joined with prominent Aboriginal coalitions to call for a special control area to be established to prevent the threat of COVID-19 in the Northern Territory and its remote regions.

On 19 March 2020, the Combined Aboriginal Organisations of Alice Springs held a press conference calling for restrictions on visitors to the Northern Territory. This was in response to the Governor-General's declaration of a human biosecurity area on 18 March 2020, giving the Minister for Health the power to issue directives under the Biosecurity Act. Spokesperson for the Combined Aboriginal Organisation and CEO of the Central Australian Aboriginal Congress, Donna Ah Chee had this to say:

> *All organisations were really clear that we need to make the entire NT and the tristate region a Special Control Area for COVID-19. This means that we want to apply the same travel restrictions that apply to international visitors nationally to visitors to the Northern Territory from any Australian jurisdiction.*

This is really our only hope of preventing the NT from experiencing the type of exponential spread that is now being seen in Sydney, Melbourne and other Australian cities.

…

We have to stop pretending that the health system will cope no matter how well prepared we try to make it. We don't have the workforce or the infrastructure in intensive care to cope with the surge that will come if we let this pandemic unleash its full force on the NT.

The Aboriginal Peak Organisations of the NT (APO NT) joined the call to urgently establish quarantine zones, noting the in-principle agreement of National Cabinet to restrict travel into remote Aboriginal communities. AMSANT CEO, John Paterson, had this to say in a media release issued on 20 March 2020:

If this virus gets into our communities it will wipe out an entire generation of elders and many, many younger people as well.

The only way to prevent this from happening is to accept the reality that it is simply not possible to stop remote community residents from travelling between communities and regional centres and that here in the Territory we are all in this together.

National Cabinet agreed on 20 March 2020 that under the Commonwealth Biosecurity Act 2015, states and territories would nominate areas in consultation with Indigenous communities and restrictions would be applied on persons entering or leaving these nominated areas (Prime Minister of Australia media release, 20 March 2020). The Chief Minister of the Northern Territory confirmed on 20 March 2020 that 'all 76 remote communities in the NT which asked to be protected should have the Act applied to them, as requested by the Land Councils and the National Aboriginal and Community Controlled Health Organisations' (Chief Minister media statement, 20 March 2020).

AMSANT acknowledges that the swift establishment of biosecurity zones for remote communities, along with the closure of the NT's territory borders, were actions that were instrumental in preventing COVID-19 from spreading to remote communities. These were extreme and unprecedented measures, but necessary.

Whilst the public health benefit of closing NT borders and restricting movement in and out of remote communities is undeniable, the implementation and practical application of the biosecurity measures has been complicated and confusing. This was particularly so for the process for controlling movement into remote community 'designated areas', which was managed by the Northern Territory Government.

The determination to protect remote Aboriginal communities passed into law in late March. Under this legislation, only essential workers could enter designated areas without a 14-day quarantine. Essential workers which included personnel from all sectors including health, education, police, and others as well as tradespersons, were required to apply for an Approved Remote Essential Worker (AREW) permit. Residents of remote communities were strongly encouraged to return to and remain in their home communities and those who visited regional towns were largely not permitted to return to their communities unless they had completed a 14-day quarantine.

It very quickly became evident that the scale of the task and complexity of the process adopted completely overwhelmed the capacity of the Northern Territory Government to implement the necessary measures in a timely manner. So much so that at the present time the Government has still not been able to complete processing of applications, with more than 8,800 processed to date. Ironically, this has had the effect of significantly reducing the number of people travelling to remote communities as so many "essential workers" have been unable to travel while they are waiting for permits. However, it is has also been the case that government departments and many Aboriginal

and non-government organisations voluntarily held back on making visits to communities and explored options for providing services and support by phone, videoconferencing and online.

However, a more serious unintended consequence of permit delays was that many Aboriginal community controlled organisations and service providers, including ACCHSs, found themselves unable to move essential frontline staff who were waiting for permits, with the added burden that their corporate staff were swamped with the complex and confusing process of applying for AREW and Land Council permits for all their operational staff.

Long delays in processing AREW permits have been particularly difficult for ACCHSs, resulting in some instances, in the severe restriction of health services' capacity to continue delivery of essential primary health care services in remote communities.

By way of summary, key issues experienced by AMSANT's member services and communities in the implementation of the Commonwealth Biosecurity Act include:

- Long delays in processing permits
- Short duration of permits
- Confusing, complex frequently changing process
- Potential for criminalisation due to lack of understanding of Biosecurity Act
- Inconsistent and sometimes arbitrary actions by police in some regions allowing or denying access to designated areas
- Aboriginal people not able to return home to communities because the quarantine process is difficult, with a lack of support for those required to isolate
- Confusion around the process for patients on discharge from hospital or following outpatient appointments.

Anecdotal reports received by AMSANT throughout this time have revealed a range of unintended consequences arising from biosecurity control measures. Many of these can be attributed to the reluctance of authorities to involve the Aboriginal community controlled health sector in the planning and management relating to these measures.

AMSANT member services have experienced many instances where instructions from police have been technically in line with biosecurity controls, but at odds with health service delivery; for example, a dialysis bus transporting patients not being allowed to return into a community, or a remote community health service ambulance not being allowed out of community to attend to a patient call-out. Other examples include remote health service workers not able to transport a body from community to morgue facilities in town; and patients being discharged from hospital and cleared to return to community but health workers not provided with clearance required to drive to town and bring the patient back to community.

AMSANT has also held concerns that the Biosecurity Act has had unintended consequences as some Aboriginal people have begun, but have not been able to complete the 14-day quarantine due to lack of welfare, cultural and other supports, and culturally inappropriate quarantine facilities. Aboriginal organisations have done their best to assist where they can, however, this has been unfunded and has required organisations to divert personnel and resources from other programs. There is also evidence that quarantining can have significant psychological effects and that these can be long lasting (Brooks et al 2020). Aboriginal people are likely to be more vulnerable because of past experiences with punitive government policies (past and ongoing) and higher levels of trauma due to the ongoing effects of colonisation. There have been some anecdotal reports of severe psychological reactions to quarantine and also inappropriate lack of support (e.g. young women being left alone in hotel quarantine after having just given birth, with no support). People were much more likely to complete quarantine if they were regularly visited by social support teams (ideally twice a day). ACCHSs are the most appropriate organisations to provide the holistic care required but needed to be funded to do so. It has also been difficult for Aboriginal people who have

not been able to access regional towns for needed supplies such as winter clothes and cheaper food supplies.

On balance, whilst the biosecurity measures have achieved the original purpose of limiting the threat of COVID-19 to remote communities and thus protecting vulnerable Aboriginal people in remote Northern Territory communities, the application of these measures have been difficult and inconsistent and have caused health risk by disrupting essential services. AMSANT has advocated considerably on behalf of our members for a more simplified process for accessing designated areas.

Recommendations

1. *That the ACCHS sector must be included at all levels of decision-making when border control and biosecurity measures are implemented.*
2. *That ACCHSs are funded to provide services to people in quarantine.*

Food security issues

The COVID-19 pandemic has highlighted serious ongoing concerns with food security which must be addressed. The Northern Territory Aboriginal communities are heavily impacted by the double burden of disease, with high rates of malnutrition and chronic disease, which are linked to food insecurity, poverty and inequality. Restrictions to supplies, increases in cost and a lack of involvement of the public health workforces in critical goods issues have impacted food supply and food security in Northern Territory Aboriginal communities, many of which were already facing serious food security stress.

In the Northern Territory, up to 34 per cent of Aboriginal people live in a household that had run out of food in the previous 12 months. This is compared to just four per cent in the non-Aboriginal population prior to this pandemic (ABS, 2015). This can only be expected to increase in the coming months, however there have been no attempts by government to truly understand the level of this during the lock down.

Many residents in remote communities across the Northern Territory rely on a range of services and programs, including schools, childcare centres, aged care facilities, youth services and emergency food relief services, for the provision of at least one meal each week as up to 20% of household don’t have facilities to prepare food (AIHW, 2017). One of the earliest impacts of the pandemic was the panic buying of grocery staples across the nation, which prompted the major supermarket chains (Coles and Woolworths) to implement restrictions in purchasing quantities and pause online ordering services. The flow on from this meant that service providers in remote and urban areas of the Northern Territory experienced immediate difficulties in providing food to clients. This served to exacerbate already serious food security issues for vulnerable people who were usually reliant on these services for food and lead to a reliance on food donations and emergency food relief. However, there is little access to emergency food relief in most remote communities.

Despite Minister Wyatt ensuring remote community stores would ‘continue as normal’ on the 8th April, AMSANT became aware that some remote stores, which are an essential service, were forced to move to higher cost suppliers and received less than 50% of stock orders into May. This has led to higher prices and reduced choice for community members – where there are already historically high prices and lower availability – which has meant that many remote community residents have been unable to cover food costs and gain access to basic, essential products. This may lead to greater rates of people going without meals and becoming food insecure, which has long term health impacts.

AMSANT received reports from a number of remote childcare services that were concerned with the major supermarkets capping supply quantities and no longer offering delivery to services. Services

had to weigh up the need to provide meals, with 'chewing through funding' by purchasing groceries through remote stores which typically have much higher prices and were also experiencing increased demand. Childcare services are critical to ensuring children receive regular meals in remote communities, where rates of stunting are as high as 23 per cent (NT Department of Health, 2018).

Essential non-food grocery items have also been in limited supply during the COVID-19 pandemic, such as warm clothing, blankets, nappies, sanitary products and baby formula. In Central Australia, communities have had to rely on donated warm clothes, transported when it can be arranged with organisations that have exemptions to travel, or on the Bush Bus.

Recommendations

3. *That the Australian Government works with remote community stores to achieve greater equity in supply and pricing of essential health products and healthy food.*
4. *That the Australian Government ensures public health nutrition experts are involved in food security responses and working groups.*
5. *That additional funding is provided to Aboriginal organisation to address underlying food security issues to reduce the reliance on emergency food relief and food programs and provide a pathway for Aboriginal people to become food secure.*
6. *Maintain increased social security payments and ensure greater equity through increasing the remote area allowance to reflect the higher cost of living in remote Australia.*

Public health issues

Difficulties in securing adequate supply of personal protective equipment (PPE) were experienced by AMSANT member services across the Northern Territory, and PPE shortages remained in some locations well into May. Whilst AMSANT understands that this was in the context of more widespread issues with PPE supply, of greater concern to us was the inequitable distribution of PPE that disadvantaged ACCHS services in preference to mainstream general practices, some of whom were declining to test suspect COVID-19 cases. AMSANT notes that the National Aboriginal Community Controlled Health Organisation (NACCHO) has addressed the role of PHNs in the distribution of PPE in their submission. The NT PHN was reasonably equitable in how it distributed PPE in the NT, although more weight could have been given to the fact that remote ACCHS cannot easily send community members to the hospital or a pandemic clinic for testing and that some GP practices refused to undertake COVID tests prior to pandemic clinics being established. It is critical to protect remote health staff, not only for their own safety but also because if infected, staff could easily spread COVID-19 into the community very quickly.

This inequitable distribution was reflected in the Minister for Health's doorstop interview on 8 April 2020 (Hunt, 2020), where it was announced that 11 million masks were being distributed across Australia, with only 75,000 (0.7 per cent) allocated to Aboriginal community controlled health organisations.

AMSANT has also held concern about the inequitable distribution of influenza vaccines into, and within, the Northern Territory. Despite the assurances of the president of the Australian Medical Association, Dr Tony Bartone, in the Health Minister's doorstop interview on 8 April 2020 that the influenza vaccination program would progressively roll out over April, it is our experience that in the Northern Territory, ACCHS have continued to experience shortages of influenza vaccines. It was concerning to receive anecdotal reports from low risk, health individuals 'down south' in Sydney and Melbourne who were able to access influenza vaccines easily whilst knowing that some of Australia's most vulnerable people with greater susceptibility to influenza would not have the opportunity to

get an influenza vaccination until well into the influenza season. This may well to be late to protect them.

Issues that caused the delays include release of the vaccination from the Commonwealth to jurisdictions with substantial remote populations at the same time as southern states. This is fundamentally inequitable given the very high health burden in the NT. Other factors include an NT distribution system that was based on chronological ordering rather than a priority-based system based on the needs of the population. There is also a lack of funding for storage and surge staffing in the NT. As a result of these factors, services that were keen to provide vaccinations to their communities quickly as a priority this year were unable to do so because only small quantities of vaccination were distributed at a time. At the time of writing, vaccine undersupply and distribution remains an issue. This is not a new problem; in 2019, the influenza season came early in Central Australia and was quite severe. ACCHSs were frustrated at the very slow distribution of vaccines and this likely led to avoidable morbidity and mortality.

AMSANT understands that there have been negotiations between the Commonwealth and the NT government to provide some short-term funding to assist with storage capacity but that these discussions have not resulted in any firm funding commitment. We believe that these issues must be resolved; not just for the influenza vaccination distribution, but also for the potential roll-out of a COVID-19 vaccine in an equitable way.

Recommendations

7. *That the Australian Government releases vaccinations to the NT and other jurisdictions with remote populations one to two weeks earlier than other jurisdictions on the understanding that vaccinations will be prioritised to remote and Aboriginal populations.*
8. *That the NT and Australian governments work together to address the storage and staffing issues causing slow distribution of influenza and other vaccinations (including potentially a COVID-19 vaccine).*
9. *That the PHNs report on performance indicators about how they engage with the ACCHS sector and an independent complaint mechanism is instituted for ACCHSs to use if they believe that they have been treated unfairly by the PHNs.*
10. *That the Australian Government mandates that Aboriginal and Torres Strait Islander people are included in the governance of each PHN including at the Board level.*

AMSANT acknowledges that there has been an increased focus on telehealth, including the introduction of new Medicare Benefits Schedule (MBS) items targeting telehealth consults. These have been very beneficial and we recommend that they should be made permanent. However, AMSANT held concerns that these MBS items do not provide the same benefit to ACCHSs as to mainstream primary care providers. The patient profile of ACCHSs in the Northern Territory is generally one that requires more intensive support from their health service in order to access telehealth. Barriers related to internet connectivity also impact on the ability of patients to access telehealth, as does the requirement in a specialist telehealth consult of the far-end specialist claiming a benefit in order for the patient-end primary health care service to also claim. Given that the majority of specialist consults for ACCHS patients are with NT hospitals, which operate under an Activity Based Funding model and do not claim the specialist-end telehealth MBS item, this means that Medicare rejects the patient-end support services MBS item claim by the primary health care service.

AMSANT wrote to the Principal Medical Officer of the Department of Health to advocate for COVID-10 telehealth MBS items to include items for Aboriginal Health Practitioner/nurse supported consults. The response was that new items for services not currently funded under the MBS were not considered as part of the current processes for telehealth expansion. AMSANT was disappointed

in this response and believes that it further entrenches the barriers for our people to access the continuity of care they require, especially in the current circumstances of the pandemic.

Recommendations

11. *That the current telehealth items created for COVID-19 remain permanent.*
12. *That there is reimbursement of the resources required to support the patient in telehealth, either in additional items for Aboriginal Health Practitioners/Registered Nurses in supporting the patient, or a loading for the existing telehealth items.*
13. *That the requirement for far-end specialist in a telehealth consultation to claim Medicare is abolished so that the primary health care service can claim patient-end support services if the far-end specialist does not make a claim.*

Coordination of government responses

Australia does not have an Australian Centre for Disease Control to coordinate complex infectious disease challenges that are either national or affect multiple jurisdictions. AMSANT along with the Public Health Association of Australia (PHAA) have long called for such a structure. Australia will face an increasing threat from communicable disease as the climate changes, with spread of communicable diseases such as mosquito borne disease to new areas and an increasing threat of new pandemics. The Aboriginal community in Northern Australia is affected by communicable disease challenges that have largely been defeated elsewhere, including rheumatic heart disease, trachoma, bronchiectasis and tuberculosis. There needs to be a coordinated national effort, in partnership with the ACCHS sector, to tackle these devastating illnesses.

The Australian Government convened an Aboriginal and Torres Strait Advisory group that included representation from all NACCHO affiliates and most state governments, as well as leading Aboriginal clinicians. The group was co-chaired by the Indigenous Health Division and NACCHO. It has proved to be a very useful group and has provided timely advice that has been endorsed by the Australian Government. The group should have been convened earlier; it was convened in early March resulting in a somewhat rushed approach to input at a very busy time for the sector. The group has provided oversight and guidance to the development of a management plan for Aboriginal and Torres Strait islander populations that was developed very quickly and is useful, but could have been improved if there had been a foundational plan for management of pandemics in Aboriginal and Torres Strait Islander populations upon which a COVID-19 plan could have been built. The development of such a plan should have been prioritised after the disproportionately high mortality and morbidity from H1N1. The group also oversaw the development of a document outlining guidance for the management of the first case and an outbreak in remote communities.

It is AMSANT's experience that throughout this period, coordination of government responses has been somewhat convoluted. Complicated governance structures have been difficult to navigate and the inclusion of the Aboriginal community controlled sector has been ad hoc and inconsistent. One of the key reasons for this in the NT is that the pandemic has been managed through invoking the NT Emergency Management Structure, which is legislated to be police-led and has a structure that is almost entirely intra-governmental. This is appropriate for cyclones but less so for a complex and evolving pandemic, which should be health-led and needs to include external stakeholders, such as the ACCHSs sector and peak Aboriginal organisations, in high-level planning and decision-making. The NT's Emergency Management Structure has resulted in decision-making without essential external input and complicated and confusing processes as external stakeholders have attempted to have their concerns and expertise responded to.

Remote communities are highly at risk of high rates of mortality and morbidity from COVID 19 and other severe pandemics. From international experience, it is now becoming clear that traditional public health measures such as ensuring timely case detection and isolating cases and contacts from

unexposed people as well as appropriate social distancing measures are not likely to be enough to control an outbreak in a remote community where spread is likely to be very rapid. Central Australian Aboriginal Congress (Congress) has developed a model based on the approach taken by the town of Vo (population approximately 3000) after the first Italian COVID death occurred there. The model (called 'contain and test') is based on requiring people to stay in place in their houses whilst voluntary community wide testing is undertaken to detect both symptomatic and asymptomatic cases who were then isolated. Over 40% of cases detected by two rounds of testing in Vo (undertaken 12 days apart) were asymptomatic, with 79 cases being detected on the first round and 29 on the second. Cases were then placed in social isolation. Notably, there were no further deaths in Vo and few cases over the following months whilst the outbreak continued to spread in the rest of Northern Italy.

The approach of isolating a community, requiring everyone to quarantine, and asking all people to undertake at least two rounds of testing (which would be voluntary) will be challenging to implement. However, a more traditional approach risks people leaving for other communities or regional towns and spreading the infection further, and a very high proportion of people who stay in community developing COVID 19 over a period of a few months. AMSANT has reviewed and endorsed the Congress approach. The 'contain and test' model is provided as an appendix to this submission. The approach needs to be supported by modelling to compare outcomes of the 'contain and test' approach to less assertive approaches and to ascertain what resources are required to effectively implement the most effective approach – which we believe is likely to be the 'contain and test' approach. The decision about the best approach needs to also be based on Aboriginal leaders' judgement that people are likely to leave a community if a COVID case is confirmed – which risks a regional rather than a community outbreak. This work needs to be undertaken urgently and then shared widely with all jurisdictional public health authorities, NACCHO and affiliates, relevant Aboriginal organisations and Aboriginal communities.

Recommendations

14. *That the Aboriginal community controlled sector be included at all levels of governance and decision making as matter of priority.*
15. *That the Australian Government funds and develops a national CDC which has a key priority of working with the community controlled health sector and other Aboriginal organisations on communicable disease challenges in Aboriginal populations.*
16. *That the Australian Government continues the Commonwealth-convened Aboriginal and Torres Strait Islander COVID-19 Advisory Group to consider a range of communicable disease challenges.*
17. *That jurisdictions should review governance structures for management of emergencies to ensure that the ACCHS sector is included as a key partner.*
18. *That a general Aboriginal and Torres Strait Islander pandemic plan is developed and finalised, with oversight by the Commonwealth-convened advisory group, and a more thorough consultation process than occurred with the previous plan.*
19. *That the Commonwealth Department of Health urgently completes modelling to ascertain the most effective approach to containing an outbreak in a remote community and the resources required to implement the approach, and shares this information widely with NACCHO and affiliates, other Aboriginal organisations, jurisdictional public health authorities and communities. The Australian Government and jurisdictions should then work together with the community controlled health sector and other relevant Aboriginal organisations to ensure coordinated and fully-resourced implementation of the most effective and acceptable approach to outbreak management in remote communities.*

Workforce/staffing issues

In the Northern Territory, the ACCHS sector is the largest provider of primary health care services to Aboriginal people, delivering more than 60 per cent of all episodes of care and contact with Aboriginal patients. It is widely acknowledged that Aboriginal people in remote and very remote areas of the Northern Territory represent some of Australia's most vulnerable populations, who carry a disproportionate burden of chronic disease, comorbidities and multi-morbidities compared with the general Australian population. ACCHSs already operate in remote communities where essential infrastructure is often inadequate or lacking, with an overloaded health workforce providing care to communities with high health care needs, and a lack of local training options. Therefore, it is even more critical to consider the issues impacting on ACCHS health workforce in the context of the COVID-19 pandemic.

Measures to restrict travel into and within the Northern Territory placed immediate strain on the health workforce relied upon by remote ACCHSs and in at least one instance resulted in the temporary closure of a remote community clinic, thus posing a serious risk to the health of the community given that the clinic is the only access to emergency care. Many remote health services rely on fly-in, fly-out locum health professionals, such as general practitioners (GPs) and remote area nurses (RANs) to supplement their locally-based workforce. Services were faced with logistical and financial challenges arising from the requirement for staff to complete mandatory 14-day quarantine before they could travel out to community. Staff already located on community faced the challenge of not being able to leave, either to travel to town on their days off to purchase food and other essentials, or for respite. ACCHSs have also had to bear the financial burden of the costs of enforced quarantine for locum staff, placing additional strain on already stretched services.

AMSANT notes the inequitable application of biosecurity exemptions to government and ACCHS personnel. In our observation, government employees received exemptions to quarantine and expedited remote area permission passes, whilst ACCHS workforce did not. AMSANT also notes that there is no agreed plan or commitment to share a pool of staff to ACCHSs that are critically short because of quarantine requirements and other issues related to the pandemic (including reduced transport options for locums) within the NT. Government health services have sufficient capacity to have access to a pool of staff who could be redeployed quickly if needed for short periods to cover an emergency, whereas even moderately large ACCHSs in remote regions do not have sufficient staff in hub or support roles who could staff remote clinics at short notice. Also missing is collaborative planning regarding the development and implementation of a surge workforce response with adequate availability, skills and expertise to be deployed if there was an outbreak. AMSANT and NACCHO have asked for a surge workforce to be deployed in regional centres and remote communities that are short staffed, with these surge staff ready to support an outbreak in a remote community at very short notice. At present, Remote Area Health Corps and other locum agencies draw on interstate staff who are not work ready as they are required to quarantine for two weeks, due to border closures. Despite being two months in to a pandemic, there is still no agreed and workable plan that will be able to deploy staff within 12-24 hours for what is likely to be a severe and ongoing health emergency in the event of an outbreak.

AMSANT acknowledges that our ACCHSs' workforce have been unwavering, working tirelessly through this period. In particular, special mention must be made of the Aboriginal staff in the health workforce during this time of crisis, as they play a critical role in our services for our people.

Concerted effort must now be made to boost capacity of the remote ACCHS workforce to ensure it can meet the health needs of the communities they serve, and to effectively plan their response in the event of an outbreak. Immediate steps could include ensuring all existing positions are filled to assist with the increased workload; backfilling positions when current staff become sick, take remote or other leave or need relief; and pooling staff with the NT. However, more strategic actions are required to improve the sustainable capacity of the ACCHS workforce. Unfortunately, in the NT, we

are losing capacity to train local staff, with Charles Darwin University downgrading nursing including reducing training opportunities outside of Darwin and relocating most of their nursing academics to Brisbane.

There also needs to be funding for the ACCHS sector to compensate services for quarantining staff whilst borders remain closed. This has been a substantial expense in an underfunded sector. Services should be able to recoup this cost and the Australian Government should pay for it ongoing.

Recommendations

20. *That plans be developed and implemented to create surge capacity for ACCHSs during emergencies to avoid clinical closures in Aboriginal communities, including access to emergency funds.*
21. *That development of a surge capacity for COVID-19 includes the creation of a cohort of remote-ready nursing and medical staff, oriented to primary health care, for the following purposes:*
    - *While no cases in a remote community but there is an increased population due to the biosecurity measures: boost existing workforce by ensuring all existing positions are filled to assist with the increased workload with 8 to 12 week placements; and backfill positions when current staff become sick, take remote or other leave or need relief*
    - *Initial COVID-19 cases or an outbreak in a remote community: rapid deployment to affected communities to implement 'contain and test' or other emergency strategies.*
22. *That the Australian Government pays for the cost of quarantine for ACCHS workforce.*
23. *That increased funding and support for training and development of local workforce is provided to ensure cultural safety and reduce reliance on interstate staff, including expanding tertiary-level nurse training in the NT to enable Aboriginal people who want to study nursing and stay close to family within the NT, and funding additional Aboriginal Health Practitioner trainee positions.*
24. *That key strategic actions for immediate action should be carried out to improve the capacity of remote health services to respond while COVID-19 remains a threat, and to ensure greater preparedness for future public health emergencies, including:*
    - *sustainable solutions to the employment, support and remuneration of local Aboriginal staff in remote health services*
    - *funding for at least 50 Aboriginal Health Practitioner (AHP) trainee positions for the Northern Territory*
    - *training and support for remote administrative and support staff*
    - *ensuring all nursing staff working in rural and remote centres are employed under contracts which include training and support to provide short periods of cover in very remote (RAMA 7) Aboriginal communities*
    - *providing graduate nursing programs to encourage supported learning and experience in Aboriginal and remote health*
    - *recognition of GPs working in remote Aboriginal health as rural/remote generalists with advanced training in Aboriginal Health*
    - *addressing remote health staff accommodation, including for local Aboriginal staff.*

Social and emotional wellbeing issues

AMSANT holds concerns for how the COVID-19 pandemic may impact on the social and emotional wellbeing of Aboriginal people in the Northern Territory. Aboriginal communities already experience an overwhelming burden of mental health and suicidality and the COVID-19 pandemic will potentially lead to an increase in acute community trauma and stressors, including alcohol and other

drugs (AOD) misuse, gambling, family violence and neglect. Increased stress as a result of social isolation is likely to increase during this pandemic period and contributes to suicide risk (Gunnell et al, 2020).

Whilst there have been efforts to increase telehealth service delivery, AMSANT notes the difficulties for many Aboriginal people in taking advantage of telehealth due to connectivity issues and low digital literacy.

AMSANT is also concerned about the disruption of the pandemic on service delivery, including outreach and remote social and emotional wellbeing (SEWB) and mental health service delivery, at a point in time where continuity of access is critical.

The Australian Government Department of Health 'Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19): Management Plan for Aboriginal and Torres Strait Islander populations/Operational Plan for Aboriginal and Torres Strait Islander populations' (March 2020) largely overlooks mental health impacts and responses. The plan also makes no mention of the potential for increased suicidality. AMSANT considers that this is a significant oversight, given the risk factors already presented in Aboriginal communities.

AMSANT advocates for policy responses that take into account the proximal and distal effects of the pandemic on MH and SEWB among Aboriginal communities within the NT. We know that Aboriginal communities are best positioned to identify both the causes of mental illness and the best ways to strengthen and promote good MH and SEWB. Responding effectively to anticipated significant risks will require that services and communities prepare for increased and expanded demand for MH and SEWB support, to BOTH minimise vulnerabilities and maximise strengths and resilience factors.

Recommendations

25. *That locally-led approaches to strengthening and maintaining MH and SEWB, incorporating appropriate cultural recovery and healing practices are adopted.*
26. *That rapid response funding is provided to the Aboriginal community-controlled health sector for responding to prevalent and incident alcohol and other drug use, and domestic and family violence.*
27. *That there should be clear priority of continued culturally-safe healthcare provision and management of existing illness, and responsiveness to new or acute mental illness and suicidality.*
28. *To ensure compliance with COVID-19 restrictions, targeted funding should be provided for telehealth expansion: hardware, infrastructure and future incurred costs (including training).*
29. *That equitable, needs-based funding is provided for the Aboriginal community-controlled health sector to address historical shortfalls and current and emerging MH and SEWB needs.*

CDP participation requirements

AMSANT wrote to the Minister for Indigenous Australians on 12 March 2020 to raise our concerns that participants of the Community Development Programme (CDP) were still required to attend activities, despite the declaration of COVID-19 as a global pandemic. AMSANT called for the Minister to suspend attendance requirement for CDP participants on public health grounds and to reduce the risk of COVID-19 transmission in vulnerable remote communities. AMSANT CEO John Paterson wrote:

> *It is our view that as an overarching principle, people should not have to risk their health to fulfil participation requirements, or be worried about losing their payments because of contingencies faced through unprecedented circumstances.*

The Minister for Indigenous Australians provided advice in a media release on 22 March 2020 (Wyatt, 2020) that requirements for CDP participants to attend group activities would be suspended and, with it, mutual obligation requirements.

The NT biosecurity restrictions will be lifted on 5 June 2020. However, remote communities remain highly at risk of potential COVID-19 infections and will continue to experience economic and social disruptions and challenges into the foreseeable future. Where it is safe to restart CDP activities supported by the community this should be considered, however, the suspension of mutual obligation requirements should remain, particularly for the duration of the pandemic threat, which is likely to be until a vaccine is available. This is also necessary as foreshadowed reform of CDP has not occurred and it would be inappropriate to resubject CDP participants to the discriminatory and harmful breaching regime of the existing scheme. In addition, the prospect of a lengthy period of rebuilding local economies and job markets means that focus should shift to job creation.

Indeed, the current hiatus provided by the COVID-19 pandemic offers an opportunity for the Australian Government to work towards reform of CDP that would see it shift from a compliance-driven work-for-the-dole scheme to one based on the provision of a core of subsidised jobs in Aboriginal community controlled organisations, supplemented with training and meaningful activities directed by local communities on projects which address community objectives. This reform has been proposed by Aboriginal Peak Organisations NT (APO NT) and a coalition of Aboriginal and peak organisations including current Aboriginal CDP providers.

Recommendations

30. *That the Community Development Program (CDP) remains voluntary with mutual obligation requirements suspended for the duration of the pandemic threat.*
31. *That the Australian Government moves to reform CDP to incorporate a core jobs component pool of subsidised part-time jobs in Aboriginal community controlled organisations, supplemented with training and meaningful activities directed by local communities on projects which address community objectives, as proposed by Aboriginal Peak Organisations NT (APO NT).*

Increased Jobseeker payments

AMSANT congratulates the Australian Government on its prompt action in doubling the Newstart benefit rate and thereby boosting the income of some of the neediest households within Indigenous communities across Australia at a time of health and economic crisis. The increased payments have been crucial to improving food security and the health and wellbeing of those who are unemployed, particularly in remote communities. It has been suggested by early estimates that these measures will increase the total income flowing to Aboriginal people in very remote areas by 26 per cent (Markham, 2020).

In that regard, we believe that the prospect of the return of the Newstart payments to the pre-existing level after six months would be a disastrous outcome for remote communities, with income levels plunging at a time of greatest uncertainty and risk with the ongoing pandemic. It has been well-established that the previous Newstart rate was seriously inadequate given the high cost of living in remote areas and that a significant increase was urgently required.

AMSANT believes that the Australian Government should extend the current doubled rate of Newstart for the duration of the pandemic and that the rate be significantly increased from the pre-existing level once the pandemic has passed.

Recommendation

32. *That the Australian Government extends the current doubled rate of Newstart for the duration of the pandemic and that the rate be significantly increased from the pre-existing level once the pandemic has passed.*

Appendix

A COVID-19 'contain and test' strategy for remote Aboriginal communities. A joint proposal by Central Australian Aboriginal Congress and the Aboriginal Medical Services Alliance Northern Territory. 18 May 2020.

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