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Commonwealth Government COVID-19 Response Inquiry

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Introduction

Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) is the peak body for Aboriginal Community Controlled Health Services (ACCHS) in the Northern Territory. ACCHSs are valued for the provision of culturally appropriate, holistic primary health care and are well positioned to address barriers to accessing health care (such as racism, transport and cultural needs).

The maintenance of public health restrictions until the availability of COVID-19 vaccines and antivirals is likely to have been an important contributing factor to the lower-than-expected mortality rates among Aboriginal and Torres Strait Islander people at the time that many restrictions were lifted in early 2022. In contrast, the national 2020 COVID-19 mortality rate for Native Americans in the United States was almost three times that for the Caucasian population - the rate being highest on “reserves”, which is their equivalent of Australian Aboriginal remote communities (Leggat-Barr et al., 2021).

However, the current mortality rate from COVID-19 in Aboriginal and Torres Strait Islander people is 1.6 times that of non-Indigenous people; in remote and very remote areas, this increases to 3.7 times (data up to 31 March 2023; ABS, 2023). Higher rates of socioeconomic disadvantage (ABS, 2023) and some of the highest rates of chronic disease in the world (Hare et al, 2022) drive this disproportionate impact. However, features of the Australian Government’s pandemic response could have been delivered more effectively to better protect this population. This submission outlines identified strengths and deficiencies of the pandemic response below, as well as recommendations for improving systems to avert a disproportionate impact on Aboriginal people in the NT in the next public health emergency.

Governance and Aboriginal leadership

The Aboriginal and Torres Strait Islander Advisory Group on COVID-19 (the ‘Taskforce’) was established in March 2020, co-chaired by the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Australian Government Department of Health. Key reasons for the effectiveness of the Taskforce include:

- Co-chairing by people with relevant expertise (e.g. in this case Dr Dawn Casey and a senior public servant with experience in the ACCHS sector).
- Aboriginal representation from the outset.
- High level input into Communicable Diseases Network Australia (CDNA).
- Adequate resourcing, including secretariat support.
- Knowledgeable membership including key affiliate representation.

The ACCHS sector also demonstrated its role of leadership, expertise, and adaptability during health emergencies. The sector delivered an immediate and effective response despite existing resource limitations in the primary care sector.

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Recommendations:

1. Advisory and/or decision-making bodies that would direct any public health emergency response for Aboriginal and Torres Strait Islander communities must be formed early and include leadership from the ACCHS sector.

Funding and resources

ACCHSs played a significant role across all essential pandemic activities, including raising awareness of COVID-19, promoting and delivering vaccines, and supporting those who contracted COVID-19. Rapid provision of funding to ACCHSs and affiliates, to support these activities, was relatively flexible with reasonable reporting processes. Deployment of rapid and flexible funding to the ACCHS sector is essential in any future response.

However, there was a lack of Australian Government support for vulnerable Aboriginal communities during the first severe Omicron wave of COVID-19 in the NT. The NT Government was overwhelmed and avenues to obtain Federal support in a timely manner were not clear.

In early 2022, three ACCHSs s requested assistance during the Omicron outbreaks. One was being impacted by floods and internet/phone outages and another two were having severe COVID outbreaks to manage with already existing severe staffing shortages. The NT government was not able to support their COVID response in a timely manner and the avenues to request Federal assistance was not clear, despite Darwin being the base for the National Critical Care and Trauma Response Centre. By the time Federal assistance was made available, the emergencies in each of the communities had already peaked and for one remote community – the response provided (‘mapping of need’) was not a priority (when practical support on the ground was required). There must be clear and timely avenues for support for very remote communities in a public health emergency given the limited resources available and heightened vulnerabilities of remote communities.

There was also insufficient support for homeless people or people living in very overcrowded houses who could not safely isolate when they had COVID 19. This lack of support contributed to rapid spread of COVID 19 within Aboriginal communities.

Recommendations:

2. Rapid and flexible funding must be provided to the ACCHS sector to carry out essential public health emergency activities and to support additional costs - e.g. the cost of quarantining staff.
3. Reporting and administrative requirements of public health emergency funding must not be overly burdensome on health services.
4. Federal government support in a public health emergency must be timely and accessible in response to urgent health service and community needs particularly in remote and very remote communities or high risk urban communities – e.g. town camps.

Biosecurity zones

In February 2022, the Commonwealth Minister for Health, at the request of the NT Government and with the support of the Northern Land Council established a series of biosecurity zones to slow the movement of people, and the spread of COVID-19. It is difficult to assess the impact these

biosecurity zones had on reducing the spread of COVID-19 because there was no reported community spread in NT towns. The challenges to implement the zones included:

- Significant added stress on an already strained primary care workforce.
- Anecdotal suggestion that the biosecurity zones were "leaky", people could get around them (e.g. leaving a car at the outskirts of the zone and then walking across the border). To stop this would require massive police resourcing which is unlikely to be sustained.
- Biosecurity measures included limiting visitation access to "'essential workers' only", with governments and agencies such as the NT PHN unilaterally deciding which services were non-essential and often diverting these workers to other areas. This included nearly all allied health workforce and the mental health, alcohol and other drug, domestic and family violence and social and emotional wellbeing (SEWB) outreach workforce. The decision about what workforce is essential should be made with local ACCHSs and communities with advice from public health and the decision should be commensurate with the public health threat. Given the high rate of SEWB problems and chronic disease, the decision to cease these services for months at a time caused significant harm.
- The biosecurity measures required Aboriginal people who needed hospitalisation or to undergo other medical treatment to quarantine in locations that could be minimally supported and, in some cases, distressing and even dangerous (e.g. young Aboriginal mothers being discharged from hospital with their first baby having to isolate in a culturally unsafe and unsupported quarantine and patients discharged from psychiatric care quarantining on their own).
- Feedback from clinicians also included that some patients at quarantine facilities had difficulties accessing their regular medications.

Recommendations:

5. Where public health emergency responses may have a significant social impact (e.g. biosecurity zones) there must be rapid funding of measures to provide support for those affected (e.g. appropriate quarantine facilities).
6. ACCHSs and local communities should be central to the decision making about which services should continue and how they should continue in a public health emergency with the decision being guided by the severity of the public health threat. Services that should be considered high priority include allied health and responses to, and management of, mental health, domestic and family violence, alcohol and other drug use, and social and emotional wellbeing.

Access to vaccination and treatment

COVID-19 vaccination was rolled out too slowly to the NT ACCHS sector, with vaccines being freely available to low-risk people in Darwin at the same time they were inaccessible to very remote people. It appeared that the Federal Government felt that remoteness was sufficient to protect these communities along with the biosecurity measures. However, if there had been community transmission in towns such as Alice Springs or Broome, biosecurity measures (with their deficiencies as listed above) would not have been sufficient to protect remote communities.

One factor of the slow rollout was ineffective messaging (discussed further below), which caused a lack of trust (e.g. about safety of the AstraZeneca vaccine) that could not be recovered in some communities. There should have been a more rapid pivot to Pfizer vaccine availability for all Aboriginal community members to hasten uptake of vaccines.

A positive feature of the response was the lower thresholds for Aboriginal people in very remote communities to access antivirals – this was essential in communities known to be at higher risk of poor health outcomes from COVID-19.

Recommendations:

7. Vaccinations and treatments must be prioritised and effectively distributed to high-risk groups including Aboriginal communities.

Public health messaging

Australian Government messaging for COVID-19 broadly, and COVID-19 vaccination specifically, was relatively ineffective for Aboriginal people in the NT. Local organisations produced high quality resources that were responsive to local community information needs and preferences (see Trudgen, 2020 as one example). These organisations (including ACCHSs) should be resourced to undertake public health messaging.

There remain ongoing issues with a lack of clear messaging to the public, including Aboriginal communities about the ongoing risk of COVID-19 risk, the long-term impacts of COVID-19 on chronic disease risk and Long COVID.

Aboriginal and Torres Strait Islander communities were targets for disinformation regarding the COVID-19 vaccine, which may have contributed to vaccination rates under 90% in Aboriginal communities when COVID-19 arrived in the NT (Roussos, 2021). Disinformation compounds hesitancy and distrust of government activities, stemming from the events of colonisation. Culturally sensitive public health messaging, led by local Aboriginal communities, should be initiated as early as possible in a health emergency, to combat disinformation campaigns and to promote informed choice for Aboriginal people.

Recommendations:

8. Aboriginal organisations including ACCHSs should be resourced to create and disseminate health promotional resources in a public health emergency.

Data

Stratified data, specific to Aboriginal mortality and morbidity, was slow to be collected, analysed and accessed. This data was initially restricted to Australian Government committees. Health services, including ACCHSs, needed to have accurate information about the potential risks for their communities and should have been provided with timely data. The new Australian Centre for Disease Control should prioritise improving Aboriginal and Torres strait islander communicable disease data and ensure that this data can be shared with ACCHSs and local communities.

Recommendations:

9. Public health emergency data, including mortality and morbidity data, specific to Aboriginal communities must be provided in a timely manner to ACCHSs.

Broader health system impacts

Redirection of resources to address COVID-19 led to reduced healthcare provision (e.g. routine medical or chronic diseases checks, or specialist medical services). This was exacerbated by health

workforce shortages, (in the NT, particularly fly-in-fly-out staff impacted by lockdowns), and jurisdictional border restrictions.

This pandemic highlights a need to explore what is required in ACCHSs to provide effective primary healthcare during public health emergencies.

Telehealth: Temporary Medicare Benefits Schedule (MBS) Telehealth items assisted in improving access to primary care. Telehealth for Aboriginal and Torres Strait Islander people needs to be culturally safe, well-resourced, and in addition to (not replacing) face-to-face care. Effective use of Telehealth in the ACCHS setting is resource-intensive, as a clinician usually supports the patient in-person during the consultation. Given the ongoing remote workforce crisis, Telehealth items should be expanded again in remote and very remote areas to include suitable items such as care plans and review of care plans.

Recovery phase: The recovery phase will be protracted in remote and very remote areas. Prior to the pandemic, workforce trends included very high turnover and locum use rates. This was exacerbated by the pandemic such that in 2020, one third of the vacancies in Aboriginal primary health care were in the NT (where the majority of Aboriginal people live in remote or very remote areas). This is very disproportionate relative to population share (the NT comprises only 10% of the total Aboriginal population). Most clinical indicators have declined since 2020, with little sign of recovery, revealing the strain on primary care (AIHW, 2023). This is very concerning given that the life expectancy gap in the NT is the widest of any jurisdiction.

There needs to be sustained workforce support for the recovery phase, particularly in remote and very remote areas. AMSANT is working with the Department of Health and Aged Care on an urgent response to the workforce crisis based on a policy paper with short, medium and long term actions (attached). Any identified actions must be resourced. There must also be policy action to support more equitable distribution of the health workforce.

Investment in building the resilience and capacity of the ACCHS sector is not just about service provision – it is also about investing in the employment of Aboriginal and Torres Strait Islander people. This potential area for growth has not been thoroughly considered in the pandemic response. Aboriginal and Torres Strait islander staff were invaluable in the acute phase of the pandemic with key skills including providing culturally safe communication, addressing vaccine hesitancy and supporting contact tracing. Enhanced public health training could support a larger Aboriginal workforce working across a range of communicable diseases within Aboriginal primary health care who could then easily pivot to a central role in a pandemic response or other public health emergency. There is also a need for increased Aboriginal and Torres Strait Islander participation in the government public health workforce to ensure a culturally safe and more effective response.

There also needs to be consideration of a public health loading for ACCHSs particularly in Northern Australia where the rates of communicable diseases such as trachoma and rheumatic heart disease are particularly high. ACCHSs also often undertake much of the work normally done by public health staff in other populations-e.g. contact tracing. Funding could also be used to support local workforce and ensure ongoing pandemic preparedness. AMSANT suggests this loading be set at 10%.

Recommendations:

10. ACCHSs need to be adequately resourced for ongoing maintenance of primary healthcare provision during a public health emergency, in addition to supplementary emergency activities.
11. MBS rebates for Telehealth should be expanded in remote and very remote areas to improve access to primary healthcare where face-to-face care may have limited availability.
12. There must be long term resourcing and policy attention to the workforce crisis in remote and very remote areas that was exacerbated by the pandemic.
13. Invest in capacity building for the ACCHS sector with a focus on Aboriginal and Torres Strait Islander workforce including training and support for an Aboriginal and Torres Strait Islander public health workforce.
14. Leadership from the ACCHS sector must continue throughout the recovery phase.
15. ACCHS should be provided with a 10 % communicable disease loading to support clinical and public health approaches to communicable disease control.

Community supports and social determinants of health

How social determinants affected Aboriginal and Torres Strait Islander people was not adequately considered in the pandemic response. Extreme measures were undertaken (such as isolating whole communities), it was still not possible to slow the spread of COVID 19 in remote communities and in town where overcrowding in social housing existed. Funding should be increased to improve remote housing conditions in the NT, where widespread poor quality and overcrowded housing infrastructure exacerbated the spread of COVID-19 infection. Whilst overcrowding and homelessness remains at high levels, regional quarantine centres will need to be stood up quickly in the event of another public health emergency that requires Aboriginal people to quarantine and isolate.

During periods of lockdowns, biosecurity zones and quarantine, many Aboriginal people and communities became isolated with limited social supports or access to services. Resources such as additional welfare payments must be considered to offset the financial hardship associated with a public health emergency.

Recommendations:

16. Social determinants of health, community infrastructure and financial support must be addressed to ensure community preparedness for future public health emergencies.

References

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