Commonwealth Government

COVID-19 Response Inquiry Report

ISBN 978-1-925365-55-9 (online)

The Hon Anthony Albanese MP
Prime Minister
Parliament House
Canberra ACT 2600

Dear Prime Minister

Report – COVID-19 Response Inquiry

On 21 September 2023 you announced an independent inquiry into Australia's response to the COVID-19 pandemic with an Inquiry panel consisting of myself as chair, Professor Catherine Bennett, and Dr Angela Jackson.

On behalf of the Panel, I am pleased to present to you the report of our Inquiry.

Consistent with our terms of reference, we considered health and non-health responses to the pandemic which were the responsibility of the Commonwealth Government or undertaken jointly with the states and territories. We examined the roles and responsibilities of governments in managing pandemic responses, the interaction between tiers of government, and the overall cohesiveness of the national response.

The report includes nine guiding recommendations and 26 actions for change to enhance Australia's preparedness and response systems to manage future public health emergencies.

The panel wishes to thank the large number of people who voluntarily participated in our Inquiry, providing input and feedback through submissions, interviews, focus groups and roundtables. This has included individual and community groups, industry and business, unions, experts across a range of fields, and decision makers and officials from all levels of government. These engagements were invaluable in giving us insights into the government response and its impacts and providing a mechanism for testing our thinking.

We would also like to thank the taskforce established within your department that has provided support in conducting our Inquiry.

Yours sincerely

Robyn Kruk AO
Chair
COVID 19 Response Inquiry Panel
25 October 2024

On behalf of Prof. Catherine Bennett and Dr Angela Jackson

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Preface

Acknowledgement of Country

We acknowledge the Traditional Owners and Custodians of Country throughout Australia on whose lands we all work, play and live. We acknowledge their continuous connection to lands, waters, skies, culture and community.

We pay our respects to their Elders past and present and acknowledge the Aboriginal and Torres Strait Islander people who contributed to the development of this report. We extend that respect to all Aboriginal and Torres Strait Islander people, who continue to pave the way for change, leading from a place of strength, resilience and courage.

We recognise Aboriginal and Torres Strait Islander people's significant contribution to society, and celebrate the unique place and role they have in shaping a just and fairer Australia. We thank them for their shared wisdom.

Acknowledgement of lived experience

We acknowledge that COVID-19 touched every person, every organisation and each sector in different ways. We recognise that for some people in our communities the health, social, and economic impacts are still being felt.

We respect and value each person's unique journey, and appreciate the willingness of the many people who shared their own lived experience with the Inquiry. Hearing these experiences helped shape our report and recommendations to improve Australia's preparedness for future pandemics.

Content warning

This report contains material that may be distressing for some readers. If you need to talk to someone, support is available.

The following confidential support services are available 24 hours a day, seven days a week to anyone affected by issues raised while reading this report:

Beyond Blue – www.beyondblue.org.au

- 1300 224 636
- 24-hour counselling service, available via telephone, web chat or email

1800RESPECT – www.1800respect.org.au

- 1800 737 732
- 24-hour counselling service for sexual assault, family and domestic violence

Lifeline Australia – www.lifeline.org.au

- 13 11 14 or text 0477 13 11 14
- 24-hour crisis support service, available via telephone, online and text chat

Suicide Call Back Service – www.suicidecallbackservice.org.au

- 1300 659 467
- 24-hour counselling service for suicide prevention and mental health, available via telephone, online and by video chat

13YARN – www.13yarn.org.au

- 13 92 76
- 24-hour national support line for Aboriginal and Torres Strait Islander people in crisis

Aboriginal and Torres Strait Islander people should be aware that some information in this report may have been provided by deceased persons.

A note on language

Technical terms

We have tried not to use jargon and technical terms unless they are well known or help clarify a point. Where we consider a definition is useful, these are provided at Appendix A: Terminology. This covers:

- a list of acronyms that are widely used in the report, noting we also spell out most acronyms on their first use in any chapter
- a glossary of defined technical words that are widely used in the report.

References are also provided throughout the report to direct readers to further evidence and information on key initiatives discussed.

Priority populations

Throughout this report we refer to 'priority populations'. We define these as populations who may be at greater risk in a pandemic. These populations may experience inequitable burden of disease and disparities in health and economic outcomes.[1] This may stem from inequities in social determinants of health, including education, employment, socio-economic status and access to health care and other government services.[2] People may also experience intersecting layers of inequality and social disadvantage.[3] In the context of a pandemic, priority populations may face increased health risks or disproportionate impacts from pandemic response measures.

The panel acknowledges the significance of language for these groups. We recognise that the preferred use of language varies between individuals and communities. For the purposes of this inquiry, we respectfully use the following terms.

- *People with disability:* We use the term 'disability' in the context of the internationally recognised social model of disability. This describes disability as a social construct. In this model, intersecting societal barriers are the obstacles to equal participation, not individual impairment.[4] We use person-first language – 'person/people with disability' – in this report. We recognise the diversity of people with disability and that language preferences vary.
- *Culturally and linguistically diverse (CALD) communities:* People in CALD communities are born overseas or have a parent born overseas, have migrated to Australia as a refugee or asylum seeker, may be in Australia temporarily for work, study or long-term visit and/or speak languages other than English. The panel acknowledges there is diversity between and within CALD communities in Australia that the term 'CALD communities' cannot fully capture. It notes that some groups prefer alternative terms. The term 'CALD communities' is used respectfully in acknowledgment of the thousands of cultural, religious, language and ethnic identities that exist.[5] The terms 'multicultural communities' and 'migrant communities' are also used.

Foreword

Pandemics are predicted to occur on average every 20 years – and the likelihood of us seeing another significant event is growing.[6] While the type and timing of the next pandemic remains uncertain, we can be assured that it is likely to occur within our lifetime. And when it does there is all likelihood that we will be facing concurrent crises, with the ongoing rise in geopolitical tensions, cybersecurity threats and natural disasters.

This makes it the right time to consider what we have learnt from the COVID-19 pandemic, especially as we now have more detailed analysis, reflection and feedback on the efficacy of Australia's response.

This inquiry aims to use the benefit of hindsight to guide future actions: not to 'fix' the actions taken during the last pandemic, or deride the decisions that were made, but rather to harness the innovations that helped us and identify ways to maximise the success of our response whilst ensuring it is proportional to the threat. We recognise that decision-makers were guided by the expert advice available at the time, and we also consider what additional evidence would help inform responses in future.

We have built a picture of what Australia can do better next time by gathering information from people across government, the health sector, community groups and industry who were involved in Australia's COVID-19 pandemic response. We have listened to the views of the Australian public to capture how the pandemic response impacted their lives, and what they would like to see done differently in a future pandemic.

For most, it was not easy to meet with us and relive their pandemic experiences. Speaking with us brought back the trauma of the pandemic: the fear of the virus, the exhaustion associated with seemingly never-ending days; the frustration and anger regarding restrictions on liberty and not being able to be with loved ones; the moral distress of making unbelievably difficult decisions that impacted heavily on people's lives; and the uncertainty of not knowing when and if things would return to normal.

Nevertheless, very few people turned down our request to meet. Many approached us, despite having retired or having moved into new roles. All who met with the panel demonstrated a strong belief in the importance of what needed to be learned by honestly reflecting on the COVID-19 pandemic so we are in a stronger position to handle what is next.

What we heard was a recognition that Australia was one of the most successful countries in its pandemic response and yet, like other countries, was not adequately prepared for a pandemic. There were existing plans, but these were limited. There was no playbook on what actions to take in a pandemic, no regular testing of systems and processes to make clear who would lead parts of the response, and no arrangements on sharing resources and data. Critically, there was also no discussion on who was best placed to communicate information to Australians in a situation where we did not have all the answers and each community had different backgrounds, health risks and fears.

Few people we heard from disagreed that preparedness is the key to facing the next pandemic. Australia needs structured systems which are flexible enough to deal with whatever risks the next pandemic raises. This includes having playbooks based on lessons learnt that are regularly stress-tested to identify gaps, that prioritise the most at risk in our community, and that have the foundations in place to make evidence-based decisions whose effectiveness can be monitored in real time. The goal is to combine a balanced, proportionate and adaptable response to the threat with an approach that protects health and the health system and minimises the risk of harm to Australians and the widening of existing health, social and economic inequities.

Achieving a successful, efficient pandemic response cannot rely on government alone. No one layer of government has the power needed to achieve what is required. Instead, governments, community groups, experts and industry need to work together to bring their knowledge, capabilities and resources to the table. This work needs to begin prior to the next pandemic, and should focus on embedding agreements and building the relationships which will be needed in a crisis.

We cannot be complacent and assume that we are as yet better positioned to deal with the next health based emergency with many raising concerns that lessons are not being translated and capability falling in some key areas below the level relied upon during the COVID-19 pandemic.

Many key stakeholders have indicated that the most effective structures established during the pandemic no longer exist. Many offer key benefits to building better understanding and ongoing policy within government across areas like manufacturing, supply resilience and community supports. Key people who lived through the pandemic and learnt the lessons have moved on and a reticence to engage has re-emerged.

The key partner in preparing our pandemic response is the public. A pandemic response is only effective if people are prepared to change their behaviour to control the disease and trust advice even when significant restraints are called for. We have heard that the trust in governments and science required to do this has waned as a result of the COVID-19 pandemic and the response. Rebuilding trust and maintaining it must be an immediate and ongoing priority and key to preparing effective response plans that mitigate the risk of harm and support broad health objectives.

Overall, we believe that people should be proud of what we achieved during the pandemic. Despite the relative immaturity of our plans and supporting governance structures, Australia had lesser health and economic impacts in the pandemic than most other countries around the world. We achieved this because we had people who worked unbelievably hard and made difficult decisions, and communities that accepted strict restrictions – all in the country's best interests. These people included the public, community organisations, businesses, essential workers, government officials and a host of volunteers. We hope they see their voices and experiences reflected in this report, and we trust that the insights provided will be useful for Australians as they prepare to respond to the next pandemic.

The Inquiry would not have been possible without the support of community groups, not-for-profit organisations, industry bodies, Commonwealth, state and territory officials, and the contributors of the over 2,201 submissions received by the Inquiry. Our special thanks go to the Secretariat established with the Department of the Prime Minister and Cabinet, led with skill and focus by Ms Pauline Sullivan, and comprising professionals from across the Australian Public Service.

Ms Robyn Kruk AO, Chair

Professor Catherine Bennett

Dr Angela Jackson

Recommendations and Actions

Priorities for Australia's preparedness

Minimising harm

Guiding recommendation

Ensure decision-making processes in a pandemic fully account for the broader health, economic and social impacts of decisions, and the changing level and nature of risk to inform escalation and de-escalation of the response to minimise harm.

Immediate actions – Do in the next 12-18 months

1. Address critical gaps in health recovery from the COVID-19 pandemic, including prioritising greater investment in mental health support for children and young people and a COVID catch-up strategy in response to a decline in the delivery of key health prevention measures.
2. Review the COVID-19 Vaccine Claims Scheme, with a view to informing the future use of similar indemnity schemes in a national health emergency for a wider profile of vaccines and treatments.
3. Conduct post-action reviews of outstanding key COVID-19 response measures to ensure lessons are captured, including a review of the *Biosecurity Act 2015* (Cth) and key economic measures.
4. Establish structures to ensure young people and their advocates are genuinely engaged, and impacts on children are considered in pandemic preparedness activities and responses to future emergencies. This should include establishing the role of Chief Paediatrician and including the Chief Paediatrician and National Children's Commissioner on the Australian Health Protection Committee.

Medium-term actions – Do prior to the next national health emergency

20. The Australian Government work with the states and territories to improve capability to shift to remote learning if required in a national health emergency. This should include:
    - incorporating competency in developing and delivering remote learning into initial teacher training and the Australian Professional Standards for Teachers
    - investing in the development of a suite of remote learning modules consistent with the Australian Curriculum, made available to all schools, teachers and students to improve preparedness for future emergencies that may require school closures.

Planning and preparedness

Guiding recommendation

Develop and regularly stress-test preparedness and a national response to a pandemic that covers the broader health, economic and social response and fully harnesses capability and resources across governments, academia, industry and the community sector.

Immediate actions – Do in the next 12-18 months

5. Develop updated health emergency planning and response arrangements in conjunction with states and territories, and key partners, including consideration of escalation and de-escalation points, real-time review and a focus on post-emergency recovery. This should include:
    - An enhanced National Health Emergency Plan (updated National Health Emergency Response Arrangements) and updated National Communicable Disease Plan. These updated plans should align with the Australian Government Crisis Management Framework.
    - Management plans under the National Communicable Disease Plan for priority populations.
    - Modular operational plans for specific sectors, including high-risk settings, which can be deployed in response to a variety of hazards.
6. Develop legislative and policy frameworks to support responses in a public health emergency, including for:
    - international border management
    - identifying essential services and essential workers
    - quarantine
    - the National Medical Stockpile
    - an Economic Toolkit.
7. Finalise establishment of the Australian Centre for Disease Control (CDC) and give priority to the following functions for systemic preparedness to become trusted and authoritative on risk assessment and communication, and a national repository of communicable disease data, evidence and advice:
    - Build foundations for a national communicable disease data integration system, enabled for equity and high-priority population identification and data interrogation, with pre-agreements on data sharing.
    - Commence upgrade to a next-generation world-leading public health surveillance system, incorporating wastewater surveillance and early warning capability.

- Work with the Department of Health and Aged Care and jurisdictions on updated communicable disease plans.
- Conduct biennial reviews of Australia's overall pandemic preparedness in partnership with the National Emergency Management Agency.
- Establish an evidence synthesis and national public communications function.
- Build foundations of in-house behavioural insights capability.
- Establish structures including technical advisory committees to engage with academic experts and community partners.

Medium-term actions – Do prior to the next national health emergency

21. Build emergency management and response capability including through:
    - regular health emergency exercises with all levels of government, interfacing with community representatives, key sectors and a broad range of departments
    - regular economic scenario testing, to determine what measures would be best suited in different forms of economic shocks and keep an Economic Toolkit up to date
    - training for a pandemic response.
22. Develop a whole-of-government plan to improve domestic and international supply chain resilience.
23. Progress development of the Australian Centre for Disease Control in line with its initial progress review and to include additional functions to map and enhance national pandemic detection and response capability.

Leadership

Guiding recommendation

Ensure the rapid mobilisation of a national governance structure for leaders to collaborate and support a national response that reflects health, social, economic and equity priorities.

Immediate actions – Do in the next 12-18 months

8. Establish mechanisms for National Cabinet to receive additional integrated expert advice for a whole-of-society emergency, including advice on social, human rights, economic and broader health impacts (including mental health considerations), as well as specific impacts on priority populations.

9. Agree and document the responsibilities of the Commonwealth Government, state and territory governments and key partners in a national health emergency. This should include escalation (and de-escalation) triggers for National Cabinet's activation and operating principles to enhance national coordination and maintain public confidence and trust.

10. Agree and test a national Australian Government governance structure to support future health crisis responses, including an appropriate emergency Cabinet Committee and a 'Secretaries Response Group' chaired by the Department of the Prime Minister and Cabinet that brings together the lead Secretaries and heads of relevant operational agencies, to coordinate the Australian Government response.

Medium-term actions – Do prior to the next national health emergency

24. Maintain regularly tested and reviewed agreements between relevant national and state agencies on shared responsibilities for human health under the *Biosecurity Act 2015* (Cth) with a focus on facilitating a 'One Health' approach that considers the intersection between plant, animal and human biosecurity.

Evidence and evaluation

Guiding recommendation

Ensure systems are in place for rapid and transparent evidence collection, synthesis and evaluation.

Immediate actions – Do in the next 12-18 months

11. Improve data collection, sharing, linkage, and analytic capability to enable an effective, targeted and proportionate response in a national health emergency, including:
    - improvements to timeliness and consistency of data collection and pre-established data linkage platforms across jurisdictions, including for priority populations
    - expanded capability in Australian Government departments to gather, analyse and synthesise integrated economic, health and social data to inform decisions
    - finalising work underway to establish clear guardrails for managing data security and privacy and enabling routine access to linked and granular health data, and establishing pre-agreements and processes for the sharing of health, economic, social and other critical data for a public health emergency.

Medium-term actions – Do prior to the next national health emergency

25. Continue to invest in monitoring and evaluating the long-term impacts of COVID-19, including for long COVID and vaccination adverse events, mental health, particularly in children and young people, and educational outcomes.

Agility

Guiding recommendation

Build, value and maintain capability, capacity and readiness across people, structures and systems.

Immediate actions – Do in the next 12-18 months

12. Develop a plan to build, value and maintain emergency management capability within the Australian Public Service, including planning and management of a surge workforce.
13. Agree nationally consistent reforms to allow health professionals to work to their full training and experience.
14. Embed flexibility in Australian Government grant and procurement arrangements to support the rapid delivery of funding and services in a national health emergency, including to meet urgent community needs and support populations most at risk.

Medium-term actions – Do prior to the next national health emergency

26. Include a focus as part of ongoing systems upgrades on modernising and improving data, systems and process capabilities to enable more tailored and effective program delivery in a crisis.

Relationships

Guiding recommendation

Maintain formal structures that include a wide range of community and business representatives, and leverage these in a pandemic response alongside the use of temporary structures.

Immediate actions – Do in the next 12-18 months

15. Ensure there are appropriate coordination and communication pathways in place with industry, unions, primary care stakeholders, local government, the community sector, priority populations and community representatives on issues related to public health emergencies. Structures should be maintained outside of an emergency, and be used to provide effective feedback loops on the shaping and delivery of response measures in a national health emergency.

Trust

Guiding recommendation

Rebuild and maintain trust between government and the community including by considering impacts on human rights.

Immediate actions – Do in the next 12-18 months

16. Develop and agree transparency principles for the release of advice that informs decision-making in a public health emergency.
17. Develop a national strategy to rebuild community trust in vaccines and improve vaccination rates.

Equity

Guiding recommendation

Ensure pandemic support measures include all residents, regardless of visa status, prioritise cohorts at greater risk, and include them in the design and delivery of targeted supports.

Immediate actions – Do in the next 12-18 months

18. Proactively address populations most at risk and consider existing inequities in access to services (health and non-health) and other social determinants of health in pandemic management plans and responses, identifying where additional support or alternative approaches are required to support an emergency response with consideration for health, social and economic factors.

Communications

Guiding recommendation

Build and maintain coordinated national public health emergency communication mechanisms to deliver timely, tailored and effective communications, utilising strong regional, local and community connections.

Immediate actions – Do in the next 12-18 months

19. Develop a communication strategy for use in national health emergencies that ensures Australians, including those in priority populations, families and industries, have the information they need to manage their social, work and family lives.

Recommendations and actions

The Inquiry has identified nine guiding recommendations and 26 actions, including 19 immediate actions for implementation in the next 12 to 18 months. These are key foundations for pandemic preparedness and community resilience.

Actions should be implemented with Commonwealth and state and territory governments and key partners where relevant. National Cabinet should have broad oversight of these actions, with support from relevant ministerial councils and First Secretaries. This chapter outlines key principles to guide implementation.

Minimising harm

Ensure decision-making processes in a pandemic fully account for the broader health, economic and social impacts of decisions, and the changing level and nature of risk to inform escalation and de-escalation of the response to minimise harm.

Immediate actions – Do in the next 12-18 months

Action 1: Address critical gaps in health recovery from the COVID-19 pandemic, including prioritising greater investment in mental health support for children and young people and a COVID catch-up strategy in response to a decline in the delivery of key health prevention measures.

Timing: in the next 12–18 months

Lead: relevant department or entity/s with Health Ministers

Prioritise additional mental health funding and investment in services for children and young people, to help manage the ongoing mental health impacts of the pandemic on this cohort.

Health Ministers should coordinate a 'COVID Catch-up' strategy in response to a decline in the delivery of elective surgery and cancer screenings, including:

- a national plan to reduce the elective surgery backlog, in consultation with the private and public hospital sectors
- additional funding and an implementation strategy to re-engage regional, rural and remote and other high-risk populations in preventive care to help address undiagnosed cases of cancer, diabetes and other illnesses.

Action 2: Review the COVID-19 Vaccine Claims Scheme, with a view to informing the future use of similar indemnity schemes in a national health emergency for a wider profile of vaccines and treatments.

Timing: in the next 12–18 months

Lead: relevant department or entity/s

The COVID-19 Vaccine Claims Scheme review should:

- examine barriers to access for the vaccine scheme based on feedback from the public, users and primary care providers, and links between the scheme and vaccine hesitancy
- consider international research on vaccines claims schemes and their relation to public health and confidence in vaccination
- include findings of how future processes could be improved.

Action 3: Conduct post-action reviews of outstanding key COVID-19 response measures to ensure lessons are captured, including a review of the *Biosecurity Act 2015* (Cth) and key economic measures.

Timing: in the next 12–18 months

Lead: relevant department or entity/s

Review the human biosecurity provisions of the *Biosecurity Act 2015* (Cth), including to:

- examine whether further amendments are needed to ensure it can be deployed proportionately to the level of risk in human health emergencies
- explore ways to ensure any decisions on extensions of determinations include consideration of broader advice on the health, economic, educational, social, equity and human rights impacts
- consider inclusion of provisions for tabling or publishing relevant advice and rationale for the extension of determinations that implement restrictive measures under the *Biosecurity Act 2015* (Cth).

Review the effectiveness of the remaining key economic support measures deployed during the pandemic, to draw lessons for the development of the Economic Toolkit.

- The following significant economic measures that have not been subject to a comprehensive review should be prioritised: Boosting Cash Flow for Employers, the Coronavirus Supplement, HomeBuilder, the Pandemic Leave Disaster Payment, the COVID-19 Disaster Payment, and the Early Release of Super.

Review the aged care retention payment program.

Action 4: Establish structures to ensure young people and their advocates are genuinely engaged, and impacts on children are considered in pandemic preparedness activities and responses to future emergencies.

Timing: in the next 12–18 months

Lead: relevant department or entity/s

This should include:

- Establishing the role of Chief Paediatrician.
- Including the Chief Paediatrician and National Children's Commissioner on the Australian Health Protection Committee.
- Ensuring consultation mechanisms facilitate genuine engagement with children and young people and advocates charged with representing their interests in pandemic preparedness activities and responses to future emergencies.

Medium-term actions – Do prior to the next national health emergency

Action 20: The Australian Government to work with the states and territories to improve capability to shift to remote learning if required in a national health emergency.

Led by the Department of Education, this should include:

- incorporating competency in developing and delivering remote learning into initial teacher training and the Australian Professional Standards for Teachers
- investing in the development of a suite of remote learning modules consistent with the Australian Curriculum, made available to all schools, teachers and students to improve preparedness for future emergencies that may require school closures.

Planning and preparedness

Develop and regularly stress-test preparedness and a national response to a pandemic that covers the broader health, economic and social response and fully harnesses capability and resources across governments, academia, industry and the community sector.

Immediate actions – Do in the next 12-18 months

Action 5: Develop updated health emergency planning and response arrangements in conjunction with states and territories, and key partners, including consideration of escalation and de-escalation points, real-time review and a focus on post-emergency recovery.

As part of this, develop:

- An enhanced National Health Emergency Plan (updated National Health Emergency Response Arrangements) and updated National Communicable Disease Plan. These updated plans should align with the Australian Government Crisis Management Framework
- Management plans under the National Communicable Disease Plan for priority populations
- Modular operational plans for specific sectors, including high-risk settings, which can be deployed in response to a variety of hazards.

Timing: in the next 12–18 months

Leads:

- National Health Emergency Plan – Department of Health and Aged Care and the Minister for Health with input from relevant departments and agencies including the National Emergency Management Agency and the Australian Centre for Disease Control (CDC)
- National Communicable Disease Plan – Department of Health and Aged Care with input from relevant departments and agencies including the CDC, and agreed at the Health Ministers Meeting
- Management plans – Department of Health and Aged Care with input from the CDC, relevant departments and agencies, and state and territory governments
- Modular operational plans – relevant lead department or entity/s, with state and territory governments

The series of plans should:

- have clearly defined scope, ownership and accountability, including a clear legal basis and defined roles for Commonwealth bodies (including the CDC), states and territories, and industry partners such as aged care providers

- work in symphony with the Australian Government Crisis Management Framework; interface with emergency management plans at state and regional levels; and reference sub-plans including priority population management plans, workforce plans and the communications strategy
- draw on technical expertise and be updated in light of risk assessments, and scientific and technological developments
- embed pre-planned review mechanisms to support the real-time, rapid review of consequences as they arise, including quick assessments and corrections to emergency response measures without a protracted inquiry process
- incorporate feedback from community, industry and academia into plans and response measure adjustments
- be flexible enough to be used in response to a range of communicable disease or pandemic scenarios, while covering more likely events (such as an influenza pandemic)
- include mitigations to address impacts of the planned response – for example, compassionate exemptions to public health orders (minimising harm)
- consider transition and recovery
- include arrangements that support workforce preparedness (such as surge models)
- require post-action reviews, including on a whole-of-government basis
- include external oversight and complaints handling and embed privacy principles.

Develop management plans for priority populations under the National Communicable Disease Plan, including:

- Aboriginal and Torres Strait Islander people
- people with disability
- culturally and linguistically diverse communities
- older Australians
- children and young people
- regional, rural and remote communities.

Management plans should:

- take into account the unique needs of priority populations and co-design with communities and experts from the relevant sectors including primary care and relevant service providers (such as aged care and disability providers) and Public Health Networks
- consider the transition out of pandemic settings and take into account potential risks for priority populations as protective health measures are reduced

- establish infrastructure and pre-agreements to support data sharing, and enable rapid research for real-time pandemic detection, risk assessment, and response evaluation
- utilise the latest data and evidence and regularly test through health emergency scenario exercises that involve all partners identified in the plan (also see Action 21)
- address recommendations arising from scenario testing in a timely way.

The Management Plan for Aboriginal and Torres Strait Islander people should include co-designing strategies to mitigate the risk of a virus spreading to remote Aboriginal and Torres Strait Islander communities, limiting the impact of pandemic response measures on cultural practices, and ensuring culturally appropriate delivery of vaccination and healthcare services. This plan should be aligned with the Closing the Gap Priority Reform Areas and make explicit the central role of the community-controlled sector in responding to a pandemic.

The Management Plan for people with disability should include co-designing strategies for in-reach vaccination services in residential settings, ensuring continued access to supported decision-making and oversight of closed settings, ensuring support workers and carers can access health settings, and expanding virtual and telehealth services. This plan should consider the interface between the disability and health systems and link to other related agreements and strategies, including the National Health Reform Agreement.

The Management Plan for culturally and linguistically diverse communities should include co-designing strategies to ensure culturally appropriate delivery of vaccination and healthcare services that acknowledge the specific language and cultural barriers different communities may face. This plan should consider the role of community organisations, leaders and intermediaries.

The Management Plan for older Australians should account for older Australians both in residential aged care facilities and their own homes. This should include co-designed strategies which embed a human rights approach to mitigate isolation and loneliness, prioritisation for vaccination and other treatments, and surge workforce requirements. Compassionate exemptions should be made to ensure people at the end of their lives are not denied visitation by family and friends.

The Management Plan for children and young people should consider the differential health and indirect impacts children and young people may face and specific interventions that may be required. The plan should be aligned with the operational plan for early childhood education and care and schools.

Develop modular operational plans for specific sectors to be deployed in response to a variety of hazards. Plans should be developed by relevant agencies in conjunction with the states and territories, and relevant service providers:

- Early childhood education and care and schools – led by Department of Education
- Managing the international border – led by Department of Home Affairs

- Repatriation of Australian citizens – led by Department of Foreign Affairs and Trade, with the Department of Home Affairs and National Emergency Management Agency
- Quarantine – coordinated by Department of the Prime Minister and Cabinet, with the Department of Home Affairs and Department of Health and Aged Care
- Supply chains – led by Department of Industry, Science and Resources
- Aged Care – led by Department of Health and Aged Care
- Housing – led by Department of Social Services

The Early Childhood Education and Care and Schools plan should:

- recognise access to education as an essential service for children and young people and consider strategies to maintain early childhood education and care (ECEC) attendance and keep schools open during public health emergencies, where consistent with health advice
- document triggers and criteria for the closure of ECEC and schools where recommended by health advice, and criteria for reopening
- be developed in consultation with states and territories, education providers, peak bodies, education and public health experts, and children and young people
- commit governments to shared principles, triggers and criteria, while allowing flexibility to respond to local risks and circumstances
- recognise that ECEC and school educators are essential workers if health advice recommends children and young people continue attending ECEC or school, and should receive priority access to vaccination; PPE and infection, prevention and control training
- include development of a more responsive ECEC emergency funding model that can be deployed rapidly, respond to different needs, support consistency in children's access to services, be predictable for parents and sustainable for providers, and account for a transition out of emergency settings.

The Managing the International Border plan should:

- document and stress-test pre-agreed roles and responsibilities across decision-making powers (Commonwealth) and implementation powers (states and territories), to ensure that the interface between the Australian Government agencies (such as the Department of Foreign Affairs and Trade, the Department of Home Affairs and the Australian Border Force) and state and territory agencies (such as state police, health and hotel quarantine providers) is seamless – operationally and legally
- recognise the interdependencies between any quarantine arrangements and international border controls (arrival caps, entry approvals and the movement of goods), the aviation and maritime sectors, and diplomatic relations.

The Repatriation plan should:

- clearly define how repatriation systems will be scaled up in a future pandemic and pay due consideration to humanitarian and domestic border intersections
- include processes to review the exemption decision-making process and its underpinning rules during a future public health emergency to ensure exemptions are timely and equitable, align with the key health objectives they are intended to support, and seek to better balance health risks with personal circumstances and human rights.

The Quarantine plan should:

- draw on recommendations from the 2021 National Review of Quarantine
- establish and regularly update best-practice guidance, informing practical implementation for quarantine facilities (including on infection prevention and control standards and changing technologies), which is informed by CDC advice.

The Supply Chains plan should:

- be developed in consultation with state and territory governments and industry
- consider agreed protocols between Commonwealth and state and territory governments, should state border travel be restricted, to ensure ongoing operation of critical supply chains
- include provision for scenario exercises with industry to simulate responses to supply chain disruptions.

The Aged Care plan should:

- document an agreed escalation response model for a sector-wide crisis
- include clearly defined triggers and criteria for escalation and de-escalation
- cover the clinical response, surge workforce capacity, infection prevention and control strategies, personal protective equipment, outbreak management strategies (such as compassionate quarantine, self-isolation and cohorting)
- identify data required to inform the response
- consider the interface between aged care and health services.

The Housing plan should:

- be aligned with the National Agreement on Social Housing and Homelessness
- include development of potential emergency measures in advance of a future pandemic to ensure access to secure and affordable housing is maintained.

Action 6: Develop legislative and policy frameworks to support responses in a public health emergency.

This should include frameworks for:

- international border management
- identifying essential services and essential workers
- quarantine
- the National Medical Stockpile
- an Economic Toolkit.

Timing: in the next 12–18 months

Leads:

- Essential services and essential workers – Department of the Prime Minister and Cabinet
- International border management – Department of Home Affairs
- National Quarantine Strategy – Department of the Prime Minister and Cabinet with the Department of Home Affairs and the Department of Health and Aged Care
- National Medical Stockpile – Department of Health and Aged Care
- Economic Toolkit – Treasury

Essential services and essential workers frameworks should include:

- definitions of essential workers and essential services in a national health emergency
- mechanisms to support rapid harmonisation between the Australian Government and state and territory governments where practicable
- a set of agreed principles to guide decision-making, with respect to the movement of essential workers and the continued operation of essential services in a crisis
- a commitment to clear and consistent communication of the definitions and how they will apply
- clearly communicated rationale for localised approaches where required
- arrangements for priority access to vaccination, PPE, and infection, prevention and control training in a national health emergency.

The international border management framework should:

- formalise a targeted legislative framework to give clear legal power to 'close the border' in an emergency that minimises any legal risks.

The National Quarantine Strategy should:

- formalise governance arrangements around the activation of quarantine, with a focus on triggers for de-escalation and recovery

- clarify the roles and responsibilities of Commonwealth and state and territory governments, as well as industry bodies, formalising principles for cost-arrangements and workforce requirements
- identify a full set of quarantine options, including home quarantine, to limit the use of hotel quarantine and ensure that purpose-built quarantine facilities can be quickly re-engaged
- be designed closely with the Department of Health and Aged Care, the Department of Home Affairs and the Australian Centre for Disease Control, and states and territory agencies with experience operationalising quarantine arrangements during the pandemic
- account for the complex pathways and many different cohorts which the COVID-19 experience has shown us will be processed through the system
- establish culturally appropriate options for people in remote Aboriginal and Torres Strait Islander communities to quarantine on country in a national health emergency, and culturally appropriate options for culturally and linguistically diverse communities.

The National Medical Stockpile plan should:

- address the recommendations from both the 2021 Australian National Audit Office audit and the 2022 Halton Review on National Medical Stockpile preparedness.

The Economic Toolkit should:

- be developed by Treasury and the Reserve Bank of Australia, in consultation with relevant departments and the states and territories
- include measures that can be tailored to respond to different forms of economic crisis, including a public health emergency, with an appropriate gender lens applied.
- cover the division of responsibilities of the Australian Government and state and territory governments for the development and implementation of economic response measures
- draw on lessons from reviews of significant aspects of Australia's COVID-19 response, including ensuring all residents, regardless of visa status, are supported during the response
- be updated over time to reflect research and reviews of economic settings (see Actions 8 and 22)
- consider the mechanisms for the implementation of measures, and whether these could be enhanced to better support delivery – such as upgrades to existing systems or data-sharing arrangements
- consider the role of transparency mechanisms in promoting public trust.

Action 7: Finalise establishment of the Australian Centre for Disease Control (CDC) and give priority to the following functions for systemic preparedness to become trusted and authoritative on risk assessment and communication, and a national repository of communicable disease intelligence capability and advice.

Timing: in the next 12–18 months

Lead: Australian Centre for Disease Control

- Work to finalise the Australian Centre for Disease Control in cooperation with the Department of Health and Aged Care, state and territory governments and key non-government organisations. It needs to complement and enhance existing emergency and health governance architecture.

Build foundations for a national communicable disease data integration system, enabled for equity and high-priority population identification and data interrogation, with pre-agreements on data sharing, including:

- Finalising an evidence strategy and key priorities to drive optimal collection, synthesis and use of data and evidence, address data gaps and develop linkages to public health workforce capability data. This would include:
    - identifying inconsistencies and gaps in shared data with the states and territories to prioritise for national surveillance data linkage, and upgrading existing datasets by improving data consistency and enabling data linkage readiness (see Action 11)
    - establishing technical advisory groups that bring together technical expertise as required to contribute to preparation of pandemic guidelines and rapid research-gap advice; advise on developments in their fields that should be incorporated in future pandemic detection and response strategies; assist in designing and reviewing pandemic exercises; and advise on national technical capacity and training needs. This can rapidly contribute additional expertise in a crisis
    - finalising work underway to establish clear guardrails for managing privacy and enabling routine real-time access to linked, granular data.
- Publishing a report on progress against key priorities identified in this data strategy.

Commence upgrade to a next-generation world-leading public health surveillance system, including:

- commencing establishment of new comprehensive surveillance infrastructure that incorporates wastewater surveillance to facilitate disease detection and monitoring, risk assessment, national data sharing, and operating with state and territory systems to provide national updates on notifiable diseases
- developing a plan to improve at-risk cohort data collection and linkages to ensure cohorts are visible in an emergency and responses can be appropriately tailored
- ensuring captured surveillance data meet the analytical needs of public health responders and support rapid research and real-time evaluation
- drafting enhanced surveillance protocols for potential use in pandemic settings, including for proactive community screening and for the cohort of first cases to monitor for persistent symptoms resulting from infection
- enhancing early warning surveillance capability and related modelling to inform procurement planning for the National Medical Stockpile (to be undertaken by the Department of Health and Aged Care)
- confirming linkages with New Zealand health authorities and other regional partners, and agreeing to near real-time data and intelligence sharing with them and other regional partners.

Work jointly on updated communicable disease plans, including:

- working with the Department of Health and Aged Care on finalising the:
    - National Health Emergency Plan, aligned to the Australian Government Crisis Management Framework (see Action 1)
    - National Communicable Disease Plan, which would be agreed by the Health Ministers Meeting (see Action 1)
- jointly holding a major pandemic drill with NEMA to assess national, whole-of-government preparedness, involving the Prime Minister, First Ministers and senior officials from the Commonwealth, state and territory governments and the Australian Local Government Association
- determining responsibility and accountability for implementing actions arising from these scenarios, enabling continual updating and quality improvement, with support from the Department of the Prime Minister and Cabinet and NEMA. These should also be reported to the Secretaries Board.

Conduct biennial reviews of Australia's overall pandemic preparedness in partnership with NEMA, including:

- summaries of new pandemic exercises held to date
- detailed reporting on local and national incidents with advice on system strengths and weaknesses
- recommendations for system improvement
- a preliminary view of how many public and private health workers might need to be deployed in response to different pandemic scenarios, as informed by an assessment of national capacity
- mapping of national technical public health pandemic response and research capability to identify skills gaps and coordinate and resource training programs in partnership with the Department of Health and Aged Care and states and territories
- reporting to the Health Minister and National Cabinet prior to tabling in the Australian Parliament.

Establish an evidence synthesis and public communications function, including:

- support for both business-as-usual communication activity and crisis communications in a public health emergency
- working with the Department of Health and Aged Care, NEMA and the Department of the Prime Minister and Cabinet to develop a national communication strategy for use in national health emergencies (see Action 19)
- making communication a focus for technical advisory group input, drawing from public and private channels to provide risk communication data synthesis and behavioural and social science expertise
- in-house expertise in evidence synthesis and communication.

Build foundations of in-house behavioural insights capability, including:

- mapping existing behavioural insights functions across the Australian Government with the Behavioural Economics Team of the Australia Government
- working with experts to develop a fully scoped and costed business case for an in-house behavioural insights capability.

Establish structures including technical advisory committees to engage with academic experts and community partners, including:

- public reporting on work to support research and intelligence exchange with research institutes in Australia and abroad, including behavioural research, private scientists, and peak health industry bodies.

Medium-term actions – Do prior to the next national health emergency

Action 21: Build emergency management and response capability.

This should include:

- Regular health emergency exercises with all levels of government, interfacing with community representatives, key sectors and a broad range of departments (led by the Department of Health and Aged Care), including:
    - large-scale exercises that bring in all levels of government, a broad range of departments/agencies, including the Australian Centre for Disease Control (CDC), as well as broader Australian academia, industry and civil society groups
    - exercises and stress tests for testing and contact tracing, including the utilisation of genomic surveillance across jurisdictions and analytic epidemiology capability
    - a primary coordination role for the National Emergency Management Agency (NEMA) and the Department of the Prime Minister and Cabinet to test the cooperation between the health system and broader emergency management arrangements, and apply relevant learnings to other crises
    - timing balanced against resourcing for other capability-building activities, including staff training and readiness reviews.
- Regular economic scenario testing to determine what measures would be best suited in different forms of economic shocks and keep an Economic Toolkit up to date (led by Treasury), including:
    - a primary coordination role for Treasury and inclusion of state and territory treasuries
    - testing a system-wide response, including Treasury, the Reserve Bank of Australia and key economic and financial regulators at the Australian Government level
    - drawing on the Economic Toolkit to test the suitability of those measures to respond to different types of economic shocks
    - reflecting any learnings from scenario testing exercises in updates to the Economic Toolkit.
- Training for a pandemic response (led by NEMA), including:
    - arrangements to train agency staff in emergency management to better equip them to surge to contribute to whole-of-government crisis responses
    - establishment of training programs to address technical expertise gaps identified through emergency exercises and add to response capacity at jurisdictional level when a crisis occurs during an active training period

    - a primary coordination role for the CDC/NEMA with input from technical advisory committees and states and territories, and embedded within jurisdictions.

Action 22: Develop a whole-of-government plan to improve domestic and international supply chain resilience.

This should include:

- consideration for how resilience can be built across all critical supply chains
- arrangements to collect supply chain data to support decision-making
- engagement structures that encourage ongoing and regular communication between government and industry on the development and implementation of the whole-of-government plan and emerging supply chain issues.

Action 23: Progress development of the Australian Centre for Disease Control in line with its initial progress review and to include additional functions to map and enhance national pandemic detection and response capability.

This should include:

- agreeing standardised case definitions and reporting requirements across jurisdictions
- linking datasets prioritising residential aged care, the National Disability Insurance Scheme (NDIS), the Australian Bureau of Statistics, the Australian Taxation Office and the Department of Social Services
- undertaking pandemic response capability mapping and coordinating national training programs with jurisdictions to address capacity gaps
- acting on recommendations arising from scenario testing and post-incident reviews it has facilitated following health emergencies and through this Inquiry
- establishing a library of living guidelines for high-risk clinical, residential and occupational settings and health professions that can be readily adapted for a new health emergency. This should include nationally agreed testing and tracing principles. These guidelines should be developed in partnership with:
    - the Department of Health and Aged Care, states and territories and relevant professional bodies
    - the NDIS Quality and Safeguards Commission in relation to disability settings
- embedding behavioural insights capability to assess, refine and enhance the effectiveness of pandemic responses

- drawing on national health workforce trend data to inform advice on pandemic readiness of the health system. This would include oversight of national surge workforce capabilities and gaps to be mapped and ready to be operationalised in a future emergency response
- developing dedicated ethical guidelines and processes for national health emergencies to enable rapid review in a changed risk context and enable real-time crisis-related research, overseen by the National Health and Medical Research Council.

Leadership

Ensure the rapid mobilisation of a national governance structure for leaders to collaborate and support a national response that reflects health, social, economic and equity priorities.

Immediate actions – Do in the next 12-18 months

Action 8: Establish mechanisms for National Cabinet to receive additional integrated expert advice for a whole-of-society emergency, including advice on social, human rights, economic and broader health impacts (including mental health considerations), as well as specific impacts on priority populations.

Timing: in the next 12–18 months

Lead: Department of the Prime Minister and Cabinet

- In parallel with making decisions based on key public health advice, National Cabinet should consider the differential impacts of a pandemic across the population and economy. This must include considering and mitigating unintended consequences, and seek to minimise negative impacts on broader health, mental health, educational, equity, economic and social outcomes.
- Human rights considerations should be embedded into National Cabinet's decision-making processes, particularly where measures are intended to significantly restrict rights and freedoms.
- This might include mechanisms for a national health emergency that allow:
    - Health Ministers' expertise to be utilised as a key source for whole-of-system health advice for National Cabinet
    - Heads of Treasuries to be expanded in a crisis to include the Reserve Bank of Australia Governor (and other key economic regulators as required) to bring together national economic expertise to support National Cabinet
    - expert advice to be sought from the Australian Human Rights Commissioner and other commissioners (e.g. National Children's Commissioner) to support better understanding of the broader impacts of their decisions on human rights and priority populations.

Action 9: Agree and document the responsibilities of the Commonwealth Government, state and territory government and key partners in a national health emergency. This should include escalation (and de-escalation) triggers for National Cabinet's activation and operating principles to enhance national coordination and maintain public confidence and trust.

Timing: in the next 12–18 months

Lead: Department of the Prime Minister and Cabinet

This should include:

- National Cabinet providing opportunities for more structured engagement and active consultation with local government to enhance the coordination and communication of a national response
- agreeing escalation (and de-escalation) triggers for activation and operating principles to enhance national coordination and maintain public confidence and trust, including in relation to state border closures
- greater clarification of roles and responsibilities, including around key areas of shared or intersecting responsibility such as vaccine distribution, health and social care of people with disability, older Australians and the provision of economic support in a national health emergency.

Action 10: Agree and test a national Australian Government governance structure to support future health crisis responses, including an appropriate emergency Cabinet Committee and a 'Secretaries Response Group' chaired by the Department of the Prime Minister and Cabinet that brings together the lead Secretaries and heads of relevant operational agencies, to coordinate the Australian Government response.

Timing: in the next 12–18 months

Lead: Department of the Prime Minister and Cabinet

A purpose-specific governance structure, aligned with the revised Australian Government Crisis Management Framework, should be rapidly mobilised and tested in future pandemic incidents requiring a multi-sectoral response.

Plans should be tested to ensure they are ready to be mobilised ahead of a crisis.

The governance structure should include:

- an Emergency Management Cabinet Committee to manage the Australian Government's response, with appropriate membership and operating principles to reflect the nature of the risk, the role of statutory decision-makers and the importance of having the right people, with the right knowledge, at the right table, at the right time
- a 'Secretaries Response Group' with a similar role to the Secretaries Committee on National Security, to support the Prime Minister and Cabinet to lead the coordination, development and implementation of the Australian Government response.

- The Secretaries Response Group should be chaired by the Department of the Prime Minister and Cabinet and include lead Secretaries and heads of operational agencies that reflect the specific circumstances of the emergency and response.
- There should be formal reporting lines between the Secretaries Response Group and other senior officials' bodies, including supporting clusters of officials across relevant departments to progress work and enhance coordination with the states and territories.

Medium-term actions – Do prior to the next national health emergency

Action 24: Maintain regularly tested and reviewed agreements between relevant national and state agencies on shared responsibilities for human health under the *Biosecurity Act 2015* (Cth) with a focus on facilitating a 'One Health' approach that considers the intersection between plant, animal and human biosecurity.

- Agreements should ensure clarity and agreement on roles and responsibilities between governments and government agencies under the *Biosecurity Act 2015* prior to the next crisis.

Evidence and evaluation

Ensure systems are in place for rapid and transparent evidence collection, synthesis and evaluation.

Immediate actions – Do in the next 12-18 months

Action 11: Improve data collection, sharing, linkage, and analytic capability to enable an effective, targeted and proportionate response in a national health emergency.

Timing: in the next 12–18 months

Lead: relevant department or entity/s

Improvements to data collection and pre-established data linkage platforms, including:

- Delivering actionable insights regarding optimal emergency response design to ensure emergency responses can be appropriately designed, tailored and adjusted through real-time evaluation of both intended outcomes and broader impacts.
- For priority populations, this should include:
    - Aboriginal and Torres Strait Islander people – enhanced data collection in line with Indigenous Data Sovereignty and Indigenous Data Governance principles
    - Children and young people – investment in improved longitudinal data to monitor educational outcomes and wellbeing
    - Culturally and linguistically diverse communities – prioritising collection of key metrics in primary and acute healthcare settings, including country of birth, language spoken, interpreter requirements, ethnic/cultural background and year of arrival
    - People with disability – ongoing investment in and stewardship of the National Disability Data Asset, including enhanced data transparency such as facilitating access and analysis by researchers and relevant non-government organisations
    - People experiencing homelessness and housing insecurity – enhanced data collection on different types of homelessness and on ages, cultural backgrounds, hospitalisation and mortality rates of people experiencing homelessness.

Expanded capability in Australian Government departments to collate and synthesise economic and health data to inform decision-making, including:

- bolstering health departments at all levels of government with public health data analytic expertise to better inform policy decisions
- translating health statistics and information for the wider health community and general public, helping to build health data literacy particularly in pandemic settings

- leveraging research across academia and research institutions through the Australian Centre for Disease Control (CDC) technical advisory groups in key methods areas
- coordinating and resourcing training programs in partnership with states and territories and research institutions to address gaps in applied public health analytic and evidence synthesis expertise identified within and across jurisdictions
- planning for how Treasury and the CDC will work together to integrate health and economic data and analysis.

Finalising work underway to establish clear guardrails for managing data security and privacy and enabling routine access to linked and granular health data, and establishing pre-agreements and processes for the sharing of health, economic, social and other critical data for a public health emergency, including:

- ensuring rapid mobilisation of real-time evidence gathering and evaluation
- sharing within the Australian Government, between the Commonwealth and states and territories and with relevant sectors
- finalising agreements by the CDC on the sharing of health data between the Commonwealth and the states and territories (also see Action 7)
- prioritising key health data on Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities and people with disability
- prioritising key health and education data on children and young people
- establishing appropriate arrangements for the sharing of data related to the delivery of economic support measures, as described in the Economic Toolkit. This could encompass data sharing within the Australian Government, and with the state and territories.

Medium-term actions – Do prior to the next national health emergency

Action 25: Continue to invest in monitoring and evaluating the long-term impacts of COVID-19, including long COVID and vaccination adverse events, mental health, particularly in children and young people, and educational outcomes.

- Where evidence from ongoing monitoring and evaluation shows long-term impacts of the COVID-19 pandemic continue to be seen, governments must ensure policies and programs in place are tailored to actively address the impacts.
- Evidence collected from ongoing monitoring and evaluation should inform plans and responses to future public health emergencies in order to mitigate similar long-term impacts.

Agility

Build, value and maintain capability, capacity and readiness across people, structures and systems.

Immediate actions – Do in the next 12-18 months

Action 12: Develop a plan to build, value and maintain emergency management capability within the Australian Public Service, including planning and management of a surge workforce.

Timing: in the next 12–18 months

Lead: relevant department or entity/s

This should:

- prioritise investment in emergency management capability uplift across the public sector, especially within the Department of Health and the Department of the Prime Minister and Cabinet, to ensure there is a sufficiently large pool of people who have knowledge and understanding of crisis management and delivery principles and approaches
- establish arrangements to ensure agencies are able to appropriately fulfil their emergency management obligations and agreed roles and responsibilities under the Australian Government Crisis Management Framework.
- establish arrangements to train agency staff to better equip them to surge to contribute to whole-of-government crisis responses
- ensure the Secretaries Board maintains a role in stewarding these priority emergency management capabilities
- be aligned with the work done under Action 21 to improve capability and readiness, including through exercises and readiness reviews.

Action 13: Agree nationally consistent reforms to allow health professionals to work to their full training and experience.

Timing: in the next 12–18 months

Lead: relevant department or entity/s

Options outlined in the independent Scope of Practice Review should be prioritised, including harmonising existing legislation and regulation which govern what services pharmacists can provide.

In addition, these reforms should include:

- simplifying and streamlining the legal basis under which Aboriginal and Torres Strait Islander Health Practitioners are able to administer medications
- supporting nurse-led clinics to work independently and be remunerated equitably for services provided that are commensurate with those of a GP, such as for vaccination
- streamlining legislative changes made during the pandemic to engage the broadest possible range of health professionals in ongoing immunisation efforts.

Action 14: Embed flexibility in Australian Government grant and procurement arrangements to support the rapid delivery of funding and services in a national health emergency, for instance to meet urgent community needs and support populations most at risk.

Timing: in the next 12–18 months

Lead: relevant department or entity/s

This should include:

- funding arrangements for community organisations and industry, and procurement processes
- funding mechanisms that allow organisations to rapidly develop and deliver solutions tailored to their communities
- funding to Aboriginal and Torres Strait Islander community service providers and the community-controlled health sector, culturally and linguistically diverse community organisations and Disability Representative Organisations during a national health emergency
- flexible funding to Primary Health Networks to support innovations in primary care delivery
- guidance and random audits embedded in program delivery.

Medium-term actions – Do prior to the next national health emergency

Action 26: Include a focus as part of ongoing systems upgrades on modernising and improving data, systems and process capabilities to enable more tailored and effective program delivery in a crisis.

Consider preparedness for future crisis as part of ongoing investment in key data, system and process capabilities, including:

- Prioritising the modernisation of Department of Foreign Affairs and Trade repatriation systems, which must be:
    - ready to make better use of existing data capture processes and to assist in mobilising the core consular structures to be scaled up in a global crisis

    - scalable in a future crisis to ensure those who want to come home can be regularly communicated with and supported.

- Building on the successful use of the Australian Taxation Office's Single Touch Payroll to deliver the JobKeeper payment, future IT system upgrades should consider potential 'emergency capability' that could support greater flexibility in program delivery in a crisis.
- Working to address known data gaps, which could enhance the effectiveness of policy measures, while being cognisant of the burden on the business and community sector.

Relationships

Maintain formal structures that include a wide range of community and business representatives, and leverage these in a pandemic response alongside the use of temporary structures.

Immediate actions – Do in the next 12-18 months

Action 15: Ensure there are appropriate coordination and communication pathways in place with industry, unions, primary care stakeholders, local government, the community sector, priority populations and community representatives on issues related to public health emergencies. Structures should be maintained outside of an emergency, and be used to provide effective feedback loops on the shaping and delivery of response measures in a national health emergency.

Timing: in the next 12–18 months

Lead: relevant department or entity/s

- Build and maintain engagement mechanisms outside of an emergency with the community sector and industry (including businesses and entities across the supply chain).
- Maintain and build on effective structures that were established before or during the COVID-19 pandemic, including those with priority populations such as Aboriginal and Torres Strait Islander people, people with disability, culturally and linguistically diverse communities and older Australians.
- Consult these groups on the development and updating of pandemic plans, and ensure they participate in stress-testing exercises.
- Ensure there are clear mechanisms to feed into decision-making processes in an emergency, and genuinely engage relevant bodies in pandemic preparedness activities and responses to future emergencies.
- Utilise these structures in national health emergencies to provide effective feedback loops on the delivery of response measures.

As part of this:

- make the Culturally and Linguistically Diverse Communities Health Advisory Group, or similar advisory body, a permanent subcommittee of the Australian Health Protection Committee
- make the Advisory Committee for the COVID 19 Response for People with Disability, or a similar advisory body, a permanent subcommittee of the Australian Health Protection Committee. The advisory body should also have clear mechanisms to feed into the Disability and Health Sector Consultation Committee

- ensure permanent advisory structures for culturally and linguistically diverse communities and people with disability have roles consistent with the National Aboriginal and Torres Strait Islander Health Protection subcommittee and the Aged Care Advisory Group, including reporting to the Australian Health Protection Committee
- engage Primary Health Networks in emergency planning and fund them in a flexible way to ensure they can leverage community connections.

Trust

Rebuild and maintain trust between government and the community including by considering impacts on human rights.

Immediate actions – Do in the next 12-18 months

Action 16: Develop and agree principles for the transparent release of advice that informs decision-making in a public health emergency.

Timing: in the next 12–18 months

Lead: relevant department or entity/s

- National Cabinet (and other key decision-making bodies) should be more transparent in disclosing the expert advice that underpins their decisions, and the other multi-sectoral factors that must necessarily influence policy decisions.
- This should include the rationale for why decisions are being made that result in significant reduction of freedoms.
- Principles should be developed in partnership with science communication experts to ensure consideration is given to how evidence and advice can be easily interpreted given the inherent complexities and nuances.

Action 17: Develop a national strategy to rebuild community trust in vaccines and improve vaccination rates.

Timing: in the next 12–18 months

Lead: relevant department or entity/s with Health Ministers

As part of this:

- Health Ministers should urgently agree a strategy for addressing the broad decline in COVID-19 vaccination, especially among priority cohorts, with a view to formalising policy responsibility to improve these vaccination rates by target dates.
- There should be an emphasis on lifting early childhood vaccination rates for other communicable diseases to pre-pandemic levels.

Equity

Ensure pandemic support measures include all residents, regardless of visa status, prioritise cohorts at greater risk, and include them in the design and delivery of targeted supports.

Immediate actions – Do in the next 12-18 months

Action 18: Proactively address populations most at risk and consider existing inequities in access to services (health and non-health) and other social determinants of health in pandemic management plans and responses, identifying where additional support or alternative approaches are required to support an emergency response with consideration for health, social and economic factors.

Timing: in the next 12–18 months

Lead: relevant department or entity/s

- All plans and response measures should have an equity lens applied, including for health, social, human rights and economic factors (see Action 1).

Communications

Build and maintain coordinated national public health emergency communication mechanisms to deliver timely, tailored and effective communications, utilising strong regional, local and community connections.

Immediate actions – Do in the next 12-18 months

Action 19: Develop a communication strategy for use in national health emergencies that ensures Australians, including those in priority populations, families and industries, have the information they need to manage their social, work and family lives.

Timing: in the next 12–18 months

Lead: relevant department or entity/s with the Australian Centre for Disease Control

The strategy should:

- create a central public health emergency communications hub that serves as a single source where the Australian public can find integrated information about the emergency response around the country
- be informed by behavioural science and risk communication expertise
- proactively seek to ensure consistency of messaging between levels of government, providing supporting rationale and evidence for different approaches
- leverage existing communication channels through professional bodies, unions, local government and advocacy groups
- meet the diverse needs of communities across Australia, including through co-design
- include mechanisms to coordinate and consolidate communications, considering the timing and frequency of announcements
- include a strategy for addressing the harms arising from misinformation and disinformation, which incorporates:
    - information environment and ongoing narrative monitoring to combat misinformation
    - transparent engagement with social media companies
    - promotion and coordination of policies to increase the resilience of the information environment
    - partnership between government and trusted organisations, experts, media, and other influencers to pre-bunk and debunk misinformation
- build on the principles of crisis and risk communications and have clear communication goals, including:

    - being timely, transparent, empathetic and consistent, promoting action and effectively communicating risk to foster trust
    - being inclusive, addressing inequities in accessing information, and supporting two-way communication
    - reflecting an evidence-based approach relevant for the contemporary information and media environment
    - embedding ongoing evaluation practices to ensure communication activities are effective, are appropriate, and are meeting the diverse needs of the Australian public
- account for the distinct communications preferences and requirements of priority populations – including:
    - reflecting the key role of community and representative organisations in communicating with priority populations, including Aboriginal and Torres Strait Islander community organisations; peak bodies for children, young people and education providers; culturally and linguistically diverse community organisations; Disability Representative Organisations; peak bodies for older Australians; and community service providers
    - funding community and representative organisations to tailor and disseminate communications through appropriate channels and trusted voices
    - providing plain English messaging to community organisations for tailoring in a timely manner.

Context

Chapter 1 – The Inquiry

On 21 September 2023 the Prime Minister the Hon Anthony Albanese MP announced the independent Commonwealth Government COVID-19 Response Inquiry. The panel was asked to deliver a final report to government by 30 September 2024. Following this, the Department of the Prime Minister and Cabinet established a taskforce to support our work.

1. Scope

Our terms of reference are at Appendix B: Background on the Inquiry. On 3 November 2023 we provided further detail on the areas being examined. Recognising their breadth, we have considered health and non-health responses to the pandemic which were the Commonwealth Government's sole responsibility or its joint responsibility with the states and territories. Actions undertaken unilaterally by states and territories were not in scope.

We have considered the roles and responsibilities of all levels of government in managing pandemic responses, the interaction between these tiers of government, and the overall cohesiveness of the response. This includes national governance mechanisms such as National Cabinet and the Australian Health Protection Principal Committee.

2. Our approach

We are not the first to consider Australia's pandemic preparedness, and we are unlikely to be the last. It was important to us to conduct an inquiry that was rigorous and grounded in the experiences of people involved in the pandemic response and those impacted. We drew heavily on relevant research and previous reviews.

In considering the task before us, seven principles emerged that have guided our Inquiry. We have worked to embody these principles in inviting and receiving written information, hosting and attending meetings and forums, and preparing this report to government. They are:

- Draw on evidence. We welcomed published independent research and evidence-based findings relevant to our terms of reference. We have not duplicated work already undertaken. Instead, we build upon it by identifying gaps and emerging best practice. We focus on opportunities to develop a national perspective. Where we have found the evidence base wanting, we have highlighted these areas for further development and examination.
- Reflect the diversity of experiences of Australians during the pandemic. We engaged broadly and openly to ensure lived experiences and perspectives – including from individuals, community groups, unions, businesses, peak bodies, and experts across a range of fields – informed this report.
- Be forward-looking and aspirational about how to improve the government's response to any future health emergency. Bringing together stakeholder views, the recommendations of past reviews and the latest research helped us make

recommendations about the best possible approach to proportionate and effective pandemic management.

- Focus on what the Commonwealth can change – unilaterally or jointly with the states and territories. A key driver of Australia's national response was its status as a federation of states and self-governing territories. The Inquiry actively engaged with state and territory and local governments as well as Australian Government agencies in reviewing the roles and responsibilities of each tier of government. We considered how they worked together and how decisions were implemented during the pandemic.
- Focus on the issues that will have the most significant impact. We identified priority areas of investigation early in our consultation process and in considering past reviews. We tested what we heard with sector and community roundtables and refined our thinking through targeted engagement to focus on the areas of greatest impact.
- Propose actionable recommendations, with clear lines of responsibility. We wanted to ensure the recommendations in this report could be quickly adopted and implemented by the Australian Government, and have continuously consulted with government decision-makers and officials. Ultimately they will be responsible for implementing our recommendations, both now and when the next health emergency occurs.
- Confidentiality and non-attribution. We committed to handle information provided by our stakeholders confidentially and according to the Australian Privacy Principles. We consulted stakeholders on a 'no attribution' basis, which allowed frank and fearless discussions on a wide range of sensitive topics. Accordingly, except where stakeholders provided explicit permission, our final report will not attribute views to individuals.

2.1. Your voice

Trust and inclusion were central themes of our Inquiry. We wanted as many people as possible to be able to share their lived experience of the pandemic. We wanted those people to see their experience reflected in our report, in their words. This was a challenging task given the number and uniqueness of experiences. We also wanted to hear from experts and international counterparts and to learn from and challenge their ideas. With this in mind, we provided different ways for people to be involved:

- Inviting public submissions. We received 2,201 submissions from organisations and individuals.
- Hosting stakeholder consultations. We held more than 250 consultation sessions with stakeholders from across governments, community groups, industry, business and unions, and with experts from a range of fields.
- Convening focus groups and interviews. A total of 176 participants attended focus groups and interviews targeted to elicit views and experiences of individuals from different priority populations.

- Commissioning a community input survey. The survey received 2,126 individual responses, reflecting the diversity of Australian society.
- Holding roundtables. We held 27 roundtable discussions with more than 300 participants, including experts – recognising the vital role of experts as trusted sources of information during the pandemic – and representatives from industry and community organisations and those with lived experience.

Further information is available at Appendix C: Stakeholder engagement.

2.2.Report structure

The Inquiry has adopted a whole-of-government view in recognition of the wide-ranging impacts of COVID-19 across portfolios and the community. As a result, our challenge has been to present a concise and representative account of the considerable evidence available to us.

In the chapter that follows, we provide an overview of the national experience of the COVID-19 pandemic in Australia, both in terms of our preparedness and across the four 'phases' – alert; suppression; vaccine rollout; and transition/recovery, which includes the long-tail impacts – that we use to frame discussions in the other parts of this report.

The scale of the pandemic response meant that it touched on a wide range of interconnected policy issues. While each report section is divided into standalone chapters, significant themes and issues are often discussed in more than one chapter or section.

Preparedness, Governance and Leadership reviews governance arrangements, coordination and decision-making across all levels of government, and the roles of political leaders and the Australian Public Service (APS). It considers the importance of trust in any emergency response and the interplay between health restrictions and fundamental rights and freedoms.

International Border Closures and Quarantine examines the Australian Government's implementation of international travel restrictions, including travel bans and efforts to bring overseas Australians home. It considers the impact of border closures on individuals, as well as on Australia's health outcomes and economic performance.

Health Response evaluates Australia's health response during the pandemic, considering the long-term consequences of COVID-19 for individual health and the broader health system. It discusses the availability, use and communication of evidence; attempts to suppress the virus; the rollout of vaccines and treatments; and our future pandemic preparedness.

Equity acknowledges the diversity of experiences and challenges between and within different population groups. It explores the enablers, challenges and lessons learnt from the COVID-19 pandemic response for:

- Aboriginal and Torres Strait Islander people
- children and young people
- culturally and linguistically diverse communities

- people with disability
- people experiencing homelessness or housing insecurity
- older Australians
- women.

Economic and Industry Response considers the economic impacts of the pandemic and the pandemic response in Australia, including on households, industry and businesses, the workforce and supply chains. It evaluates the measures taken to manage the economy, with a view to informing responses to future public health emergencies. The panel acknowledges the services of Chris Murphy, Visiting Fellow at the Australian National University, who, based on his recent research into the macroeconomic effects of the pandemic and Australia's policy responses, was engaged to provide an expert peer review of chapters 20 and 21 in this section.

Chapter 2 – COVID-19 in Australia

The COVID-19 pandemic will be remembered as a period of significant change that altered every aspect of life in Australia and around the world. As the virus evolved, government responses, community attitudes and behaviours also changed.[7]

By 2022 COVID-19 was the third leading cause of death in Australia. However, in 2020 it was difficult to predict the impact it would have on Australians, or on the health system. Our understanding of COVID-19 has continued to evolve as new waves and virus variants emerged.

We acknowledge the diversity of experiences during COVID-19. For most Australians, the story of the pandemic is not one of policy announcements but of time away from loved ones, changes to work or study, health or financial challenges, and personal tragedies. We are particularly conscious of the tail of this pandemic – chronic health burden from infection, vaccination or disruption to health care access, mental health impacts, workforce recovery and ongoing financial impacts.

This report divides the period between the arrival of COVID-19 in January 2020 and today into four 'phases': alert, suppression, vaccine rollout and transition/recovery. The markers of each phase, including the changes in the virus, key government initiatives and aspects of the community experience, are described below.

1. Phases of the pandemic

1.1. Alert phase: January to April 2020

Health experts in China confirmed human-to-human transmission of SARS-CoV-2, the virus that causes COVID-19, on 20 January 2020.[8] On 25 January 2020 the first case of COVID-19 onshore in Australia was detected. By 22 March 2020, 1,765 confirmed cases, including seven deaths, had been reported in Australia.

By mid-March the supply of test kits struggled to meet demand and, in some states and territories, only a subset of people were being tested – returned travellers, contacts of known cases, and people hospitalised with community-onset pneumonia with no known cause. We will never know the full extent of spread in the community during this period.

From this point, Australia's crisis response rapidly escalated. All governments took a 'precautionary' approach to prevent COVID-19 entering and spreading in the community, protecting at-risk populations and preparing the health system. There was global uncertainty about when or if a vaccine or treatment for COVID-19 would be developed. Governments introduced wide-ranging public health orders, including a national lockdown from 29 March 2020 to ensure Australia's health system had the capacity to treat people who would become seriously ill. This 'first wave' lockdown ended when state and territory governments started progressively easing restrictions after six to eight weeks.

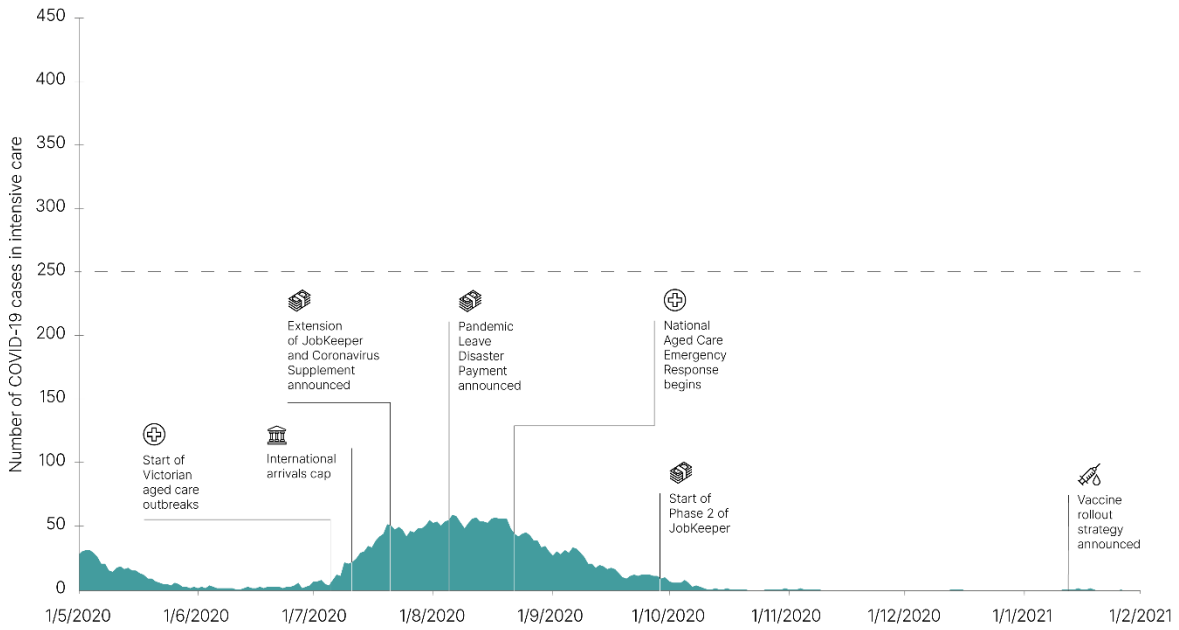
Travel into and around Australia was restricted, with international borders closed, access to remote communities limited, and interstate travel restrictions imposed by states that, at the time, had fewer COVID-19 cases: Tasmania, the Northern Territory, South Australia, Western Australia and Queensland.

Throughout this period, the Prime Minister, premiers and chief ministers met regularly through the newly established National Cabinet. Policy responses focused on the short-term public health implications, but the pandemic soon transformed into a whole-of-society crisis. In response to the emerging economic crisis, in March 2020, three economic packages were introduced to provide vital support for households and businesses. These supports included the JobKeeper Payment, a wage subsidy, and the Coronavirus Supplement – an additional payment for people receiving income support payments.

The public health restrictions governments imposed made significant changes in all our lives. Public gatherings were limited, supply chains were stretched and businesses closed. Many people transitioned to working or studying from home. Others continued attending work in frontline roles in a much changed environment. This period was marked by uncertainty about the virus, fear based on devastating reports of COVID-19 experiences overseas, and dire predictions about the impact on the Australian economy and the health system.

1.2. Suppression phase: May 2020 to January 2021

Figure 1: A timeline of COVID-19 in Australia during the suppression phase[9]



In May 2020 Australia moved into an extended period of trying to keep the virus out, curtailing transmission when border breaches did occur, and keeping case numbers low enough that optimal care and access to intensive care units (ICUs) and ventilators would be available to all COVID-19 cases, without minimising impacts on the access to usual healthcare for the general population. Meanwhile, experts around the world worked to develop and trial vaccines for

effectiveness in reducing severe disease and death. International evidence was emerging that COVID-19 was more than a respiratory infection – it affected multiple organs, and in some cases caused prolonged symptoms.

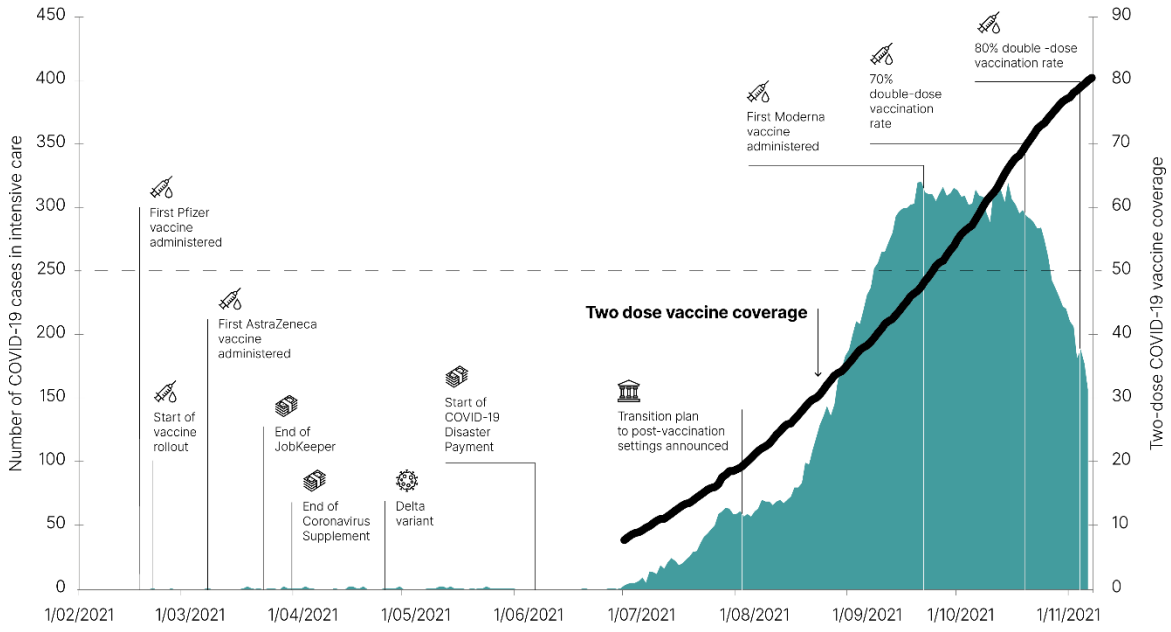
During this period, pandemic responses and experiences began to diverge across the country. After national lockdown restrictions were eased from May 2020, some states and local government areas were able to maintain low case numbers. These places largely returned to life as normal, though there were still international border restrictions and state border closures that separated people from loved ones and hindered movement of supplies. In Victoria, by contrast, the pandemic became more severe. New introductions of the virus into the community via hotel quarantine led to high case numbers that stretched the health system, and triggered devastating outbreaks in aged care facilities that resulted in tragic loss of life. Significant restrictions were reintroduced, including lengthy lockdowns state-wide and, for greater Melbourne, for much of the second half of 2020. At that time, Melbourne held the global record for the longest COVID-19 lockdown.

As it became clear that the pandemic would not be short lived, many Australians adapted to working and studying remotely. Others dealt with significant challenges in juggling the demands of work and caring responsibilities. School-aged children struggled to adjust to remote learning and time away from friends and peers. Essential workers in sectors such as health, aged care and early childhood education and care were overworked and concerned about risks to their own physical and mental health.

Significant effects beyond the health system became apparent during this period. Many people were negatively affected by lockdowns and business closures, with significant implications for their financial security. The financial supports that the government had introduced in the alert phase continued throughout the suppression phase, even after restrictions were lifted across much of the country. This allowed a substantial proportion of households and businesses to build up significant savings. Some of these supports were adjusted as understanding of the pandemic and its effects and expected duration grew. The government progressively introduced other support packages for sectors that experienced ongoing disruptions or had not benefited from the earlier supports – for example, media, tourism, arts, and early childhood education and care.

1.3. Vaccine rollout phase: February to November 2021

Figure 2: A timeline of COVID-19 in Australia during the vaccine rollout phase[10]



By October 2020 vaccines had been trialled and shown to be effective in reducing the severity of COVID-19. They were soon being rolled out overseas under emergency authorisation.

Australia was slower than some countries to approve vaccines and secure supply, continuing to rely on the success of the suppression strategies and international border restrictions to manage the virus in the community until the Australian vaccine rollout began on 22 February 2021. The rollout took a phased approach that prioritised groups considered most at risk of exposure to the virus or of severe illness or death if infected. Aggressive suppression strategies in response to local outbreaks had to be maintained until vaccination rates reached a level where enough Australians were protected from severe disease for the health system to cope with widespread infection, without affecting access to critical non-COVID related health services.

The vaccine rollout was slow to start, hampered by logistical challenges, a lack of vaccine supply, and concerns about rare but serious side effects. However, it picked up pace by mid-2021 as the eastern states experienced a growing wave of infections caused by the Delta variant. Mandatory vaccination was introduced in a range of workplaces in the second half of 2021. These included high-risk settings such as health services and residential aged care, and sectors with high mobility such as aviation, distribution hubs and freight. By November 2021, 80 per cent of the adult population had received two vaccine doses. Children were not prioritised for vaccine uptake because they were less likely to be infected with the original variants or develop severe COVID-19.

During this phase, real-time evaluations of international vaccine rollouts found that vaccines were also proving successful in reducing infection risk and onward transmission, but never to a

point that would support eradication of the disease. An increasing number of animal reservoirs for SARS-CoV-2 were found, making it clear that global eradication was not going to be possible. This meant we could only delay, not prevent, the transition to COVID-19 being endemic – lockdowns and test, trace and isolate at scale were not sustainable disease control measures and, along with vaccines, were progressively becoming less effective.

In Australia, some states largely remained free from community transmission throughout the vaccine rollout, but several experienced rising case numbers following the significant community spread of the Delta variant from June 2021, initially in New South Wales. Localised lockdown restrictions were progressively introduced in 3 eastern states, and many schools and businesses were closed. The rapid spread of the virus extended to areas that had previously remained free from COVID-19, including some remote Aboriginal and Torres Strait Islander communities.

During this phase, the government's approach to economic supports began to change. Both the JobKeeper Payment and the Coronavirus Supplement ended in March 2021. The Delta wave and the return of lockdowns in some states meant that new financial support measures were needed for both households and businesses.

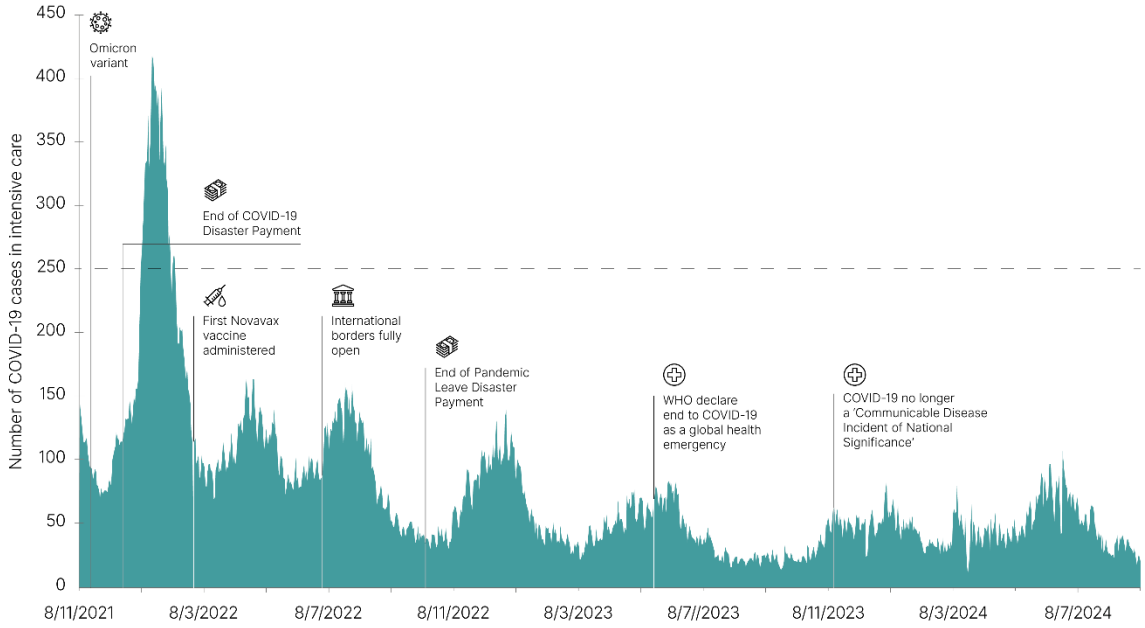
Debate on the best path to easing restrictions began with the release of the National Plan to Transition Australia's National COVID-19 Response on 6 August 2021 (the National Plan). The National Plan involved a four-step transition tied to vaccination rates to shift from a focus on suppressing transmission to preventing as much as possible severe illness and death as the virus became endemic in Australia.

The initial plan was based on previous COVID-19 variants circulating at the time of the vaccine trials. With the arrival of Delta in mid-2021, the modelling that informed the National Plan had to be redone to account for the increased transmission potential and disease severity of this new variant. This pushed the adult vaccination target from 70 to 80 per cent. The Delta variant was more infectious and had a shorter incubation period. Close contacts were more often infectious before the original case even knew that they themselves were unwell. Even with the population partially vaccinated, these changes in the virus, together with higher cases numbers, meant that previously successful 'test, trace and isolate' measures began to fail.

Vaccination was still protecting people from severe disease and death and had also been found to be protective against long COVID. However, evidence from overseas showed that vaccines had become less effective in preventing infection or transmission with Delta. Those who remained unvaccinated were excluded from some of the early social and work-related easing of restrictions. Throughout this period, many people felt uncertain about when they would be able to return to normal life. Others were fearful about the lifting of restrictions.

1.4. Transition/recovery phase: November 2021 to present

Figure 3: A timeline of COVID-19 in Australia during the transition/recovery phase[11]



By the time the Australian Government announced a 'transition to living with COVID-19' once vaccination targets were reached, all Australian states and territories had experienced COVID-19 outbreaks. During this period we saw strong economic recovery, the reopening of state and international borders, and the easing of restrictions.

Unfortunately Australia's reopening coincided with the arrival of the even more transmissible Omicron variant in December 2021. In New South Wales and Victoria, 'test, trace and isolate' measures were pulled back because they could not sufficiently control the spread of this new variant. COVID-19 vaccines continued to protect from more severe disease, but a booster dose became more important with the initial two-dose course no longer as effective against this new variant. With the arrival of Omicron, it was even clearer that there could be no choice about whether we transitioned to COVID-19 as an endemic disease – it was just a question of how and when we made this transition and how we would cope with the inevitable sharp rise in infections.

Despite a lower case fatality rate with Omicron infections, especially in a population with high vaccination coverage, there were many more deaths during the period when we experienced our first true community-wide exposure and infection. The overall crude case fatality rate from the start of the Omicron waves until March 2024 was 0.19 per cent, compared with 0.71 per cent for Delta and a peak case fatality rate of 3.3 per cent in October 2020.[12] Had Australia not been successful in suppressing the spread of the virus and preventing community-wide transmission before Australia reached its target of 80 per cent double dose vaccination status for the eligible population, and experienced a similar death rate to Canada, we would have seen eight times[13] the number of COVID-19 associated deaths.[14]

Many Australians returned to a life not too dissimilar from the one they knew before the pandemic. However, some people felt unsafe as restrictions eased, and others continue to grapple with the 'long tail' of physical and mental health impacts of the virus and the response. Many people are experiencing vaccine fatigue and there has been a decline in COVID-19 booster and general vaccination uptake, including among priority cohorts who remain more at risk of severe disease.

The risk of developing long COVID reduced with the latest variants. However, it remains unclear how many Australians were or are affected. Despite substantial research efforts, there is continued uncertainty about the best treatments to improve outcomes.

On 20 October 2023 Australia declared that COVID-19 was no longer a Communicable Disease Incident of National Significance. SARS-CoV-2 variants continue to circulate in our community today, and COVID-19 is monitored and managed as one of Australia's notifiable communicable diseases.

Preparedness, Governance and Leadership

Overview

Large-scale public health emergencies such as pandemics are one of the world's most pervasive risks. As demonstrated by COVID-19, their impacts can be significant and far reaching. Australia needed to deploy a whole-of-society response led by the highest levels of government on a scale that covered health, economic and social measures. National leadership and governance structures, pandemic preparedness and planning, and the community's level of trust in government were critical.

Australia's early pandemic response was characterised by decisive leadership, agile implementation and public trust that government and fellow citizens would do the right thing. There was a common sense of purpose, from the Prime Minister and state and territory leaders through to the health system, industry and the public. However, there are significant lessons to be learnt for future public health emergencies that require nationally driven responses. We must act on the lessons learnt from this pandemic so that we are prepared for any future crisis of this magnitude and show national leadership, particularly given the public's confidence in the response frayed as the pandemic wore on.

Australia has strong emergency management credentials that are now more frequently tested in the face of extreme weather events and other natural disasters. As the COVID-19 pandemic was emerging, Australia was just coming out of an extended catastrophic fire season. Emergency teams were fatigued, but relationships were strong and systems could be repurposed quickly. Australia was considered well equipped to respond to public health emergencies – it ranked highly on global rankings of pandemic preparedness and global health security.[15] We heard that pandemics had been identified in government and private sector risk assessments, but there were issues and gaps in these assessments, and no-one planned for an event as long, complex and severe as the acute phase of COVID-19 or for its lengthy recovery period.[16]

Being prepared for a crisis of the magnitude of COVID-19 is a challenge. Health security capacities were tested by the unprecedented scale, duration and impact of the pandemic. Australia's health system, which was under pressure before COVID-19, was placed under further stress. Medical and protective equipment stockpiles, surveillance systems, testing and tracing, rapid research and data integration all needed to be significantly improved or expanded in the midst of crisis to meet the demands of COVID-19.

Chapter 3: Planning and preparedness examines the Australian Government's planning and preparedness for a pandemic. It evaluates familiarity with and application of pandemic plans and emphasises the need to plan and build capacity and capability for future crises.

As countries around the world grappled with the severe impacts of COVID-19, the Australian public looked to the nation's leaders to work with a unified sense of purpose in the face of

uncertainty and fear. Strong and decisive political will and action was needed to avoid the grave consequences seen elsewhere. Leaders made a series of courageous decisions early on to protect Australian lives. The Prime Minister's initiative to establish National Cabinet, centralising decision-making with state and territory leaders, resulted in a forum that had the membership and authority to rapidly consider and determine a national direction. Australia was recognised globally as successful in taking these early decisive steps – during the first 18 months of the pandemic, they resulted in some of the world's lowest case numbers, and lowest numbers of hospitalisations and deaths from COVID-19. It also delayed the inevitable arrival of community-wide transmission until a vaccine could reduce the infection fatality rate and incidence of long COVID and save the health system from collapse.[17]

However, over time, the unified direction and national leadership began to deteriorate and cracks in the system started to emerge. Decisions became less cohesive and coordinated as the pandemic continued. Differences in levels of local risk and response capacity led to different responses across the country. Politics also played a role in response stances, with rhetoric and directions becoming more politicised. There was a lack of public transparency about the evidence that was used to support decision-making at National Cabinet and by the Australian Government. There was a view that decision-making was prioritising the immediate health impacts rather than broader health impacts and economic, social and human rights issues.

Chapter 4: Leading the response examines the leadership required during the national response to the pandemic. This includes an analysis of decision-making, governance arrangements and coordination.

The nation's leaders were making difficult and unprecedented decisions, which were being implemented rapidly and effectively across almost every department and portfolio agency in the Australian Public Service. Many key responsibilities are shared with states and territories and required coordination across governments. Australian Government departments and agencies demonstrated leadership, agility, unified commitment and capacity to pivot rapidly to support the Australian Government in designing and delivering the COVID-19 response.[18] However, there are lessons to be learned to ensure the Australian Public Service is ready to respond to future crises. In particular, the response relied heavily on existing relationships rather than on clearly defined emergency governance arrangements for protracted multi-sectoral responses that involve complex interfaces with jurisdictions and non-government stakeholders.

Chapter 6: The Australian Public Service: responding to a multi-sectoral crisis examines how Australian Government departments and agencies activated structures to coordinate and implement the pandemic response. Key elements of the response are examined and the Australian Public Service workforce and service delivery is analysed.

People were required to drastically change their behaviour so that public health measures designed to protect Australian lives from a deadly virus would be successful. There were

impacts on freedoms and human rights. There was a need for public trust in the government's competency to make decisions in their best interest, using evidence from trusted experts and institutions, and trust that others would also follow the government's directions.

Australians' trust in government, public services, institutions, scientists, health professionals and each other evolved over the course of the crisis. In 2020 trust rose across the board, including in government, public institutions, media, non-government organisations and businesses.[19] This trust was amplified by the effectiveness of early measures and showed the confidence Australians had in the collective approach their leaders had taken. As the unity of Australia's response dissipated, so too did Australians' trust. A backlash against stringent measures began, supercharged by the length of the pandemic, the disproportionate impacts of the virus and response measures across the community, and the broader social and economic impacts on people.

Chapter 5: Trust and human rights considers trust in government and the impact the response had on people's freedoms and human rights. It identifies the issues that impacted on trust in government and institutions and which responses were perceived as most detrimental to individual freedoms and rights throughout the pandemic. It also outlines specific issues regarding digital technology and privacy in the pandemic.

Timeline

- 2006: National Pandemic Influenza Exercise (Exercise Cumpston) is held.
- 2008: Exercise Sustain 08 is held.
- 2011: National Health Emergency Response Arrangements are developed.
- 2014: National Framework for Communicable Disease Control is developed.
- September 2016: Emergency Response Plan for Communicable Disease Incidents of National Significance is developed.
- May 2018: Emergency Response Plan for Communicable Disease Incidents of National Significance: National Arrangements is developed.
- 2019: Department of Health runs a series of emergency management exercises.
- December 2018: National Action Plan for Health Security 2019–2023 is developed.
- August 2019: Australian Health Management Plan for Pandemic Influenza is updated.
- 21 January 2020: 'Human coronavirus with pandemic potential' is added to the Biosecurity (Listed Human Diseases) Determination 2016.
- 7 February 2020: Australian Health Sector Emergency Response Plan for Novel Coronavirus is finalised.
- 27 February 2020: Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19 Plan) is activated.
- 5 March 2020: Prime Minister commissions the National Coordination Mechanism.
- 13 March 2020: Council of Australian Governments agrees to establish National Cabinet.
- 13 March 2020: National Cabinet establishes the National Partnership on COVID-19 Response.
- 17 March 2020: Australian Health Protection Principal Committee is appointed a subcommittee of National Cabinet.[20]
- 18 March 2020: A 'human biosecurity emergency' period is declared under the *Biosecurity Act 2015* (Cth).
- 18 March 2020: National Cabinet agrees to measures for indoor gatherings of fewer than 100 people.
- 20 March 2020: Non-Australian citizens and non-residents are no longer allowed to enter Australia.
- 25 March 2020: National COVID-19 Coordination Commission is established.

- 25 March 2020: Australian citizens are banned from leaving Australia, with limited exemptions.
- 29 March 2020: Tighter public gathering restrictions are introduced: no more than two people.
- 29 March 2020: Hotel quarantine begins.
- 26 April 2020: The voluntary coronavirus app COVIDSafe is launched.
- 4 September 2020: National Cabinet agrees to develop a plan to 'reopen' Australia by Christmas.
- 30 April 2021: The India Travel Pause begins.
- 28 June 2021: National Cabinet endorses mandatory COVID-19 vaccinations for workers in residential aged care facilities.
- 6 August 2021: National Cabinet agrees the National Plan to Transition Australia's COVID-19 Response.
- 17 April 2022: Human Biosecurity Emergency Declaration relating to COVID-19 lapses.
- 30 September 2022: National Cabinet agrees to end mandatory isolation requirements for COVID-19.

Chapter 3 – Planning and preparedness

1. Context

Pandemic threats are inevitable and increasing. COVID-19 was the most impactful pandemic in 100 years. However, we are likely to have less time to prepare for the next one. New viral outbreaks are occurring at an increasing rate. On average, two new viruses are occurring in humans per year and are turning into larger outbreaks more often.[21]

Many health emergencies are incident based, are short in duration, and can be managed effectively by the health sector. However, no one agency or level of government can independently respond to the nation-wide impacts of a pandemic like COVID-19. Before COVID-19, government and private sector risk assessments had identified pandemics as a significant risk. However, no-one had prepared sufficiently for the length, complexity and severity of the acute phase of COVID-19, or its lengthy recovery period. A fundamentally different approach must be taken to a pandemic of COVID-19's scale. There is a need for substantial preparation of an integrated suite of plans that can be rapidly mobilised, adjusted to reflect the specific nature of the disease, and sustained over long periods.

COVID-19 had enormous consequences for the world in terms of lives lost, people's long-term health, social cohesion, and financial situation. These justify the required investment, commensurate with risk, in pandemic prevention and preparation. It has been estimated that every dollar spent on pandemic prevention saves $20 in pandemic harm.[22]

At the start of the pandemic, Australian society did not have a good understanding of the threat posed by a pandemic. Many did not fully understand that it was probably not going to be possible to prevent all infections or deaths in a pandemic and that hard decisions had to be made. We continue to see downstream impacts on our people, health, and economy.

Australia has strong emergency management credentials. We have a significant volunteer workforce, resource sharing, expertise, capability between national and state levels, and constructive international engagement. However, emergency management structures are now more frequently tested by extreme weather events and other natural disasters and they remain reliant on Australia's strong commitment to the collective good.

As the COVID-19 pandemic was emerging, Australia was responding and recovering from the 2019–20 Black Summer bushfires. Emergency teams were fatigued, but Australia's crisis plans and arrangements were well tested. During the alert phase, Australia benefited from being able to slow incursion and buy time to prepare the health sector and other response systems, gather information about the new disease threat, and work out what needed to be done to address it.

Strong foundational structures and relationships between health authorities and the broader emergency management ecosystem will be needed in any national response to a future protracted, health-driven, whole-of-society crisis with severe economic and social impacts. For a response to be effective and sustainable, there is a need for far greater coherence and pre-planning in the development and use of key workforce, data, and supporting systems. Also,

governance (who does what, and why) should be agreed on ahead of time, communication and information flows (who needs to know what and when) should be improved, and sophisticated risk assessment and real-time evaluation should inform escalation and de-escalation points across the nation.

We continue to see a lack of preparedness for other complex and concurrent crises that Australia faces.[23] To ensure we are prepared for future threats of this kind, our whole-of-society resilience to these crises must be improved so it is more imaginative, resourced, and flexible.

Preparedness and planning

Preparedness aims to identify and refine the plans, arrangements, resources and capacities that will be needed to efficiently manage an emergency and effectively move from response to recovery. Pandemic preparedness aims to reduce the negative impacts of a pandemic by improving the strength and resilience of systems so as to maximise the effectiveness of interventions to stop or slow the outbreak, and reduce the population's vulnerability. Preparedness activities can include strengthening the resilience of the healthcare system, establishing early warning systems, building trusted relationships, and reducing inequality.

Planning is a subset of preparedness. Planning establishes arrangements in advance so that timely, effective, and appropriate responses can be made to a hazardous event or disaster.

2. Response

Governments in Australia have a shared responsibility for responding to public health emergencies. The Australian Government is primarily responsible for national coordination, can be engaged by jurisdictions to support their emergency responses, and manages Australia's exposure to imported infectious diseases and pandemic risks.[24] State and territory governments are responsible for managing emergencies and operational responses in their respective jurisdictions. Each level of government has its own health and broader emergency plans and structures.

At the Australian Government level, responsibility for managing exposure and response to pandemics is shared across numerous agencies, in differing capacities (see Chapter 6: The Australian Public Service: responding to a multi-sectoral crisis). At the time of the pandemic, the Australian Government Department of Health and Aged Care (Department of Health) had a lead role in planning for, coordinating, and delivering the COVID-19 response. Its activities were informed by a series of health emergency management plans that covered everything from high-level governance and coordination arrangements, down to practical specific actions.[25] These plans included:

- the National Health Emergency Response Arrangements – 2011
- two 'hazard agnostic' communicable disease plans: the Emergency Response Plan for Communicable Disease Incidents of National Significance – 2016; and the Emergency Response Plan for Communicable Disease Incidents of National Significance: National Arrangements (National Communicable Disease Plan) – 2018

- the Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19 Plan) – 2020. The COVID-19 plan was heavily based on the Australian Health Management Plan for Pandemic Influenza (Influenza Plan) (2019) – another disease-specific operational plan.

Australia did not have a national technical advisory body like the European Centre for Disease Prevention and Control. Instead, the National Framework for Communicable Disease Control (2014) was intended to deliver an integrated communicable disease response.[26] The framework, developed in partnership with states and territories, included a commitment to work collaboratively to coordinate public health functions and improve Australia's ability to respond to communicable disease outbreaks. In 2015 the Australian Health Protection Principal Committee recommended three priority areas for implementation from the framework:[27]

- surveillance and laboratories
- information systems and research
- leadership and governance.

In 2018 the Department of Health was in the process of creating an implementation plan for the National Framework for Communicable Disease Control, but this was never published.[28] However, some gaps that were identified in the framework were addressed before COVID-19. For example, a Centre for Research Excellence in Infectious Disease Emergency Response Research was established in 2016, and work to integrate specialised genomics started in 2017.[29]

Leading up to COVID-19, the Department of Health had undertaken a series of exercises and scenarios to test and build familiarity with its emergency management arrangements. Most of these exercises were done internally. They included, for example, tests of processes (such as communications, national medical stockpile, and medical assistance team deployment), and disease familiarisation exercises.

Generally only one or two of the Department of Health's exercises per year involved state and territory representatives or other federal agencies (see Appendix D: Master chronology). Most were focused on non-communicable disease emergencies, such as terrorism threats and radiological or mass casualty incidents. The most recent pre-COVID-19 external exercise (2019) was a test of biosecurity arrangements. The focus of that exercise was roles and responsibilities for cruise ships. Over the same period, the Department of Health participated in several exercises led by other federal agencies, which focused on incidents with health consequences.[30]

During COVID-19 the Australian Government rapidly recalibrated existing plans and mobilised resources to respond. A Communicable Disease Incident of National Significance was declared early (18 February 2020).[31] As a result, the health response and national health coordination arrangements were fully mobilised (as outlined by the National Health Emergency Response Arrangements and the health sector-specific communicable disease plan).[32]

The Influenza Plan, with operational detail and a 'menu of actions', was available and had been updated mere months before the COVID-19 pandemic.[33] However, it was quickly realised it

would be better to have a plan specific to the new coronavirus to account for its particular disease characteristics. The early COVID-19 Plan was developed by 7 February 2020, published on 18 February 2020 and activated on 27 February 2020.[34] It was heavily based on the Influenza Plan. The Influenza Plan and the COVID-19 Plan set out Australia's approach to communicable disease emergency management in four phases: prevention, preparedness, response, and recovery.

Figure 1: 2019 Australian Health Management Plan for Pandemic Influenza – Approach to managing an influenza pandemic[35]

As part of this Inquiry, we identified four phases of the COVID-19 pandemic (see Chapter 2: COVID-19 in Australia). The 'standby' period within this figure corresponds to the earliest part of our 'alert' phase – while governments were preparing to activate plans. Our suppression and vaccine rollout phases align to the 'Action' phase in the figure, and our recovery phase aligns to stand-down and recovery.

Moves were quickly made to introduce whole-of-government coordination, including the establishment of National Cabinet as detailed in Chapter 4: Leading the response. The Australian and state and territory governments decided to trigger a nationally coordinated response based on their observation of international developments. On 25 February 2020, before the World Health Organization declared COVID-19 a pandemic, the National Communicable Disease Plan was activated, allowing for whole-of-government coordination to respond to health and non-health consequences of the pandemic.[36]

The Department of the Prime Minister and Cabinet managed the Australian Government Crisis Management Framework, which designated a lead minister as well as agency responsibilities and accountabilities during nationally significant crises.[37] However, at the time, coordination responsibilities (particularly for whole-of-government crisis coordination) were unclear.[38] During COVID-19 the Department of Home Affairs undertook elements of whole-of-government coordination to fill this gap. At the time, the Department of Home Affairs had an operational crisis role in relation to hazards that sat within the portfolio's responsibilities (such as natural disasters or terrorism), and maintained all-hazard crisis coordination tools and arrangements through its Emergency Management Australia Division.[39] In 2018 the Department of Home

Affairs had also undertaken a pandemic stress test with other federal agencies participating to test pandemic crisis arrangements and clarify roles.[40]
In the crisis, other plans were created, including consequence management plans such as the National Mental Health and Wellbeing Pandemic Response Plan (May 2020). Operational and management plans for priority populations were also developed, expanding substantially upon plans for at-risk groups in the pre-existing health plans.[41] These included the Management Plan for Aboriginal and Torres Strait Islander Populations (March 2020), the Management and Operational Plan for People with Disability (September 2020), and several plans for Aged Care, including managing COVID-19 outbreaks in residential aged care (March 2020 to September 2022).[42] There has been some work done since the pandemic to better consider and integrate the needs of people with disability and their families, carers and representatives in planning processes (for example, the Emergency Management Targeted Action Plan under Australia's Disability Strategy – 2021).[43]

To enable a whole-of-government national approach, governments, community and businesses used existing systems or created new systems that would facilitate workforce support and data-sharing. For example, in 2021 a cross-government data-sharing agreement was established and the COVID-19 Register was developed as a linked dataset for research use.[44]

For society to continue to function, parliaments, government bodies, courts, service providers and businesses all needed to continue to operate. However, their continuing operation rested on their individual preparedness. There was a large variance in preparedness across government. For example, the Department of Parliamentary Services was able to activate and rely heavily upon its pandemic plan to enable Parliament and executive government functions to continue, including through virtual Cabinet and Senate committee meetings).[45] The Department of Foreign Affairs and Trade needed to adapt its crisis management arrangements to account for its outdated pandemic contingency plan.[46] Some economic agencies had scenario-tested measures following the Global Financial Crisis, but these had not considered pandemics and measures that may be needed to respond (see the Economic and Industry Response section). Some other agencies completely abandoned plans they deemed inappropriate or had no plans to fulfil their roles or support business continuity.[47]

3. Impact

Between 2004 and 2017, after a series of reviews and updates, Australia's health system preparedness was judged to have evolved from 'critical but stable' to 'a comprehensive system of capabilities and functions to prepare, detect and respond to health security threats'.[48] In 2017, a World Health Organization-led international team of experts evaluated Australia's health security core capabilities. The team found Australia had made outstanding progress in implementing the International Health Regulations and gave it top scores for preparedness and emergency response operations. To date, 20 recommendations to improve Australia's health security identified in this review have been fully completed, and most of the 66 remaining are actively ongoing.[49]

A combination of good health security capacity, leadership that accepted and responded to the situation and heeded expert advice, and the willingness and hard work of all Australians meant Australia could move faster to introduce tough border measures than most other countries. Although criticised at the time for overreacting, ultimately Australia was recognised globally as successful in taking these early decisive steps that resulted in some of the world's lowest incidences of cases, hospitalisations and deaths from COVID-19 during the first 18 months of the pandemic.[50]

Australia's federated system meant states and territories could pursue different approaches to respond to the crisis. These approaches were influenced by differing public health system robustness, capability, capacity and resilience across states and territories. [51] At the national level there was limited readiness or pressure on some key capabilities such as quarantine arrangements, surveillance systems, data sharing, rapid research and modelling integration, and the National Medical Stockpile.[52] System readiness, variable familiarity with plans and emergency management arrangements, gaps in the plans, and the extended nature of the crisis meant that Australia needed to plan, respond, adapt, and build infrastructure in the midst of crisis.

Previous assessments of Australia's communicable disease management arrangements had found fragmentation and duplication of efforts across government levels and departments, and challenges coordinating a complex network of advisory committees, amongst other issues.[53]

In 2018 the Department of Home Affairs ran a stress test of Australia's pandemic arrangements. It noted that, while systems were sufficient for 'ordinary crises', a very significant or near-existential crisis would push them beyond their limits. The responsible minister was not given this finding until after the COVID-19 pandemic had started.[54]

We heard that emergency response arrangements for shorter or time-limited crises were effective and could be sustained for months if needed, but government was not prepared for the pandemic to go on for years.[55]

3.1. Existing plans and scenario-testing

The Australian Government had a series of plans in place to respond to a major health emergency. However, we heard there were issues and gaps in the planning arrangements and that health plans had become more general over time. We heard the communicable disease plans had showed far less consideration of health system impacts than they previously had and did not factor in primary care, (including Primary Health Networks) or priority group-specific considerations.[56] Some noted that while multiple plans existed, they did not intersect well and there was a lack of planning for other disasters that could occur concurrently with a health emergency. Therefore, planning was required as the pandemic unfolded.[57]

> *Existing preparedness plans were found to be insufficient during the COVID-19 pandemic, and major system weaknesses were exposed, particularly in the residential aged-care sector. Regular revision and proactive simulation of*

preparedness plans should be prioritised to address future pandemics. – Royal Flying Doctor Service of Australia[58]

Plans can only be effectively used for rapid response when people are familiar with them and there are agreed roles and responsibilities, pre-established communication pathways, and well-practised arrangements. We consistently heard that plans were not nimble, tested or well known.[59] The most recent exercise pre-pandemic (cruise ships) did not lead to clarity as to roles and responsibilities, mere months later (see Chapter 8: Implementing quarantine).[60] The degree of familiarity with plans, including the Australian Government Crisis Management Framework as the capstone national crisis management policy, varied widely.[61] Through interviews and industry roundtables the panel heard relevant agencies, business and community sectors had low awareness of planning arrangements and the related coordination and communication pathways.[62]

The most recent major tests of communicable disease arrangements with multiple levels of government were Exercise Cumptson in 2006 and Exercise Sustain in 2008.[63] Both of these were comprehensive and considered 'whole of health' and 'whole of government' responses. Exercise Panda in 2014 also brought together key stakeholders to discuss strategic arrangements to manage a national response to a pandemic and directly informed the development of the 2018 National Communicable Disease Plan.[64]

Emergency arrangements were tested during disease outbreaks such as the 2009 H1N1 pandemic, Middle East respiratory syndrome coronavirus (MERS) outbreak in 2012, Ebola epidemic in 2013–2016, and Australian meningococcal cases in 2014–2016. However, these events were not as impactful, as cross-cutting, or as lengthy as COVID-19 would prove to be.

From 2014, exercises had been run within the Department of Health, but they were predominantly smaller internal exercises.[65] Resourcing had progressively been withdrawn, resulting in a narrower focus.[66] This meant that broader relationships across government and familiarity with the plans had begun to fade. In 2013, a House of Representatives standing committee recommended the Department of Health undertake a pandemic exercise with other Commonwealth and state and territory government agencies and with health consumer representatives.[67] In 2018 the Department of Health 'noted' these recommendations but did not perform a comprehensive exercise as recommended.[68]

Outside of the Department of Health, we heard that pandemic preparedness was minimal and largely perceived as a health responsibility. There was an acknowledgement that departments would have performed better if there were tried and tested plans in place.[69] With the benefit of hindsight, it is also clear there were gaps in the series of government plans for key measures relating to:

- managed quarantine
- international and domestic border closures
- economic response
- returning overseas Australians at the scale required by a global crisis

- health and safety of frontline workers, and impacts of furloughing workers
- priority settings and populations including aged care, disability and culturally and linguistically diverse communities
- school closures
- consequence management for disruptions to supply chains and essential workers and services.

> *Australia entered the pandemic without detailed prior consideration of many of the elements that were eventually implemented to reduce transmission risk. – UNSW School of Population Health*[70]

We heard pandemic characteristics are getting harder to predict, so exercises should include a range of transmissibility and lethality scenarios, including 'worst-case' scenarios.[71] We heard these exercises should be made public to build confidence and understanding of the current risk environment and Australia's level of preparedness, including a wide range of participants to reflect the complex ecosystems within which health emergencies operate.[72]

> *To ensure the plans are robust and build public confidence, the plans should be made public and exercised regularly with civil society and industry participants. – Good Ancestors Policy*[73]

The Australian public did not have good understanding of the growing health risks facing the nation. There was limited awareness and few preparation activities outside of the health system. Compared with well-known risk systems like the Australian Fire Danger Rating System and the National Terrorism Threat Level, health threats were much less prominent.[74] Australia had moved away from its previous pandemic phase system and toward a hazard-agnostic (prevention, preparation, response, recovery) model. It did not implement the Group of Eight's recommendation on creating a color-coded public health alert system to help the community see and plan for restrictions during crisis.[75]

3.2.Confusion around roles and responsibilities

We heard there was substantial confusion about roles and responsibilities across and between governments. This was particularly the case when there was no clear lead department agreed at the Australian Government level or where responsibility was shared with states and territories, or changed during the incident. For example, there were and still are major issues across shared and disputed areas of responsibility such as quarantine, returning Australians, vaccine rollout, support for at-risk groups, and supply chains. We heard that where there are joint responsibilities, there must be joint plans.[76] The panel heard about a need for stronger coordination and collaboration, rather than strict adherence to portfolio responsibilities, to deliver programs based on Australian's needs.[77]

State and territory submissions and consultation strongly affirmed the need for greater certainty and clarity on roles and responsibilities and better leveraging of existing processes, especially in the absence of existing response plans.[78] State and territory governments noted

that while they took on certain roles during the COVID-19 pandemic, it is not clear that those roles were formally their responsibility or if they would take them on in the same way again.

The Australian Capital Territory noted that 'clear roles and responsibilities between the Commonwealth and the states and territories in the management of future pandemics will need to be defined, taking account of different and legislated roles and responsibilities', and Queensland said that 'all jurisdictions would benefit from clearer delineation of roles and responsibilities' and 'greater clarity on expectations … in delivery of services that are typically considered a Commonwealth responsibility would provide better outcomes'.[79]

3.3.Unintended consequences of unplanned and untested policy measures.

During COVID-19, policies and plans were rapidly developed to respond to a quickly moving crisis and poorly tested. This increased the risk of unintended consequences and showed that engagement structures and rapid feedback loops are critical to modify responses to mitigate harm. There are several examples that span the entire COVID-19 timeline outlined across this report.

For example, during the alert phase (January to April 2020) the Australian Government made the significant decision to begin implementing international border measures to prevent COVID-19 from getting into Australia. This was a brave yet challenging decision that had been discounted in earlier plans and required the rapid development of a complex decision-making process and systems. Multiple agencies worked tirelessly to deliver a patchwork system, but the lack of a plan, linked information systems, capacity constraints linked to quarantine and clarity about roles and responsibilities led to frustration, confusion and stress for returning and travelling Australians who were trying to navigate the chaos (see Chapter 7: Managing the international border and Chapter 8: Implementing quarantine).

Before COVID-19 began there were no tailored plans for at-risk groups and considerable challenges relating to availability and comprehensiveness of key data to assist in determining risk assessment and responses. As community transmission ramped up and Australia began to move into the suppression phase (May 2020 to January 2021) governments had to develop response strategies for different groups on the run, with differing degrees of success (see the Equity section). Once plans and advisory structures were set up, these were critical to improving engagement with priority populations and sectors and had a genuine positive impact on policy development.

> *Pandemic risk is not uniform across the Australian population, differing by geography, service access, language, income level and other factors. – The Australian Partnership for Preparedness Research on Infectious Disease Emergencies*[80]

Consistent feedback was received about the benefits of key stakeholders providing advice to the government to assist in shaping response measure in meeting objectives while minimising unintended consequences and the risks of harm. The panel heard that there was sometimes no time to co-design and test solutions or leverage expertise and capacity within community and

business.[81] Where this could take place, there were demonstrable gains in the effectiveness of measures. For example, as set out Chapter 13: Aboriginal and Torres Strait Islander people, the approach of engaging with the community-controlled health sector was used to great effect. However, the panel also heard that the speed at which funding was rolled out and a lack of consultation led to inconsistency in the way businesses and community services could access support, and inflexible approaches that did not meet the needs of all providers.[82] In roundtables we heard that in several instances, industry offered to assist government with policy development or delivery of response measures, but their help was rejected.[83]

The panel heard there was a need for an ongoing rapid review and feedback mechanism for policy decisions, so that the government could better understand the impacts of its decisions (effectiveness and cost) and balance other factors with achieving health objectives. However, mechanisms for collecting evaluation data and for rapid consultation with stakeholders were sometimes limited and often ad hoc. Some mechanisms were set up during COVID-19 to help with information flow – for example, the National COVID-19 Coordination Commission, industry forums led by the Department of Industry, Science and Resources, and the National Coordination Mechanism provided an avenue to share information and resolve issues.[84]

We heard it was challenging to build relationships and understanding in government during the pandemic. This affected its ability to rapidly mobilise expertise. It also hampered the flow of information back to government from the community and industry, meaning it was difficult to use that information to shape the ongoing response to the pandemic, give feedback on unintended consequences of the measures and resolve issues.

We heard that many of the structures and relationships that were built during COVID-19 have now fallen away. We heard that, if there were a pandemic tomorrow, Australia would be back at square one.[85]

3.4. Sustainability and reliance on key people

We heard that when there is no plan in place for a crisis, relationships become key to the response.[86]

We were told Australia's pandemic achievements were largely due to massive efforts of individuals but that this should not be the case – Australia should be able to rely on clear structures and processes to bring people together and make decisions. We heard that the government, and particularly the Department of Health as the national lead, faced unprecedented demands.[87] Key technical expertise and operational expertise is limited and the department struggled to meet these and concurrent demands from within the government, industry, unions and the community about what that they needed to do to meet the public health requirements. This added to the burden on organisations and individuals.[88]

People from the Department of Health and the broader health and public service sector were relied on heavily to perform these functions without relief for years on end. This includes providing technical advice, delivering public communications and using their relationships to facilitate national coordination (see Chapter 6: The Australian Public Service: responding to a multi-sectoral crisis, and the Health Response section). Australia relied on their willingness to

innovate and invest resources into filling preparedness gaps for the public good. This was laudable, but it was not sustainable for a health crisis of the scale and length of COVID-19.[89]

The unrelenting nature and intrinsic challenges associated with their key roles have left significant impacts on many staff involved in the pandemic response effort. Many experienced leaders who were involved in the pandemic response have now moved to new roles or retired. The significant loss of expertise heightens the need to capture the lessons learnt to inform future pandemic planning, and we greatly appreciate the input from key people who have subsequently changed roles.

4. Evaluation

Australia was not prepared for a crisis like COVID-19

Australia was in many respects well prepared coming into the pandemic, with a robust health system, a healthy population, strong institutional settings and a related series of health emergency plans in place, including the National Health Emergency Response Arrangements and the National Communicable Disease Plan. The recently updated operational plan for an (influenza) pandemic was able to be quickly adapted to inform the COVID-19 Plan at the start of the crisis.

However, notwithstanding these plans and accepting that every pandemic will require agility in responding to the specific nature of the pathogen, the panel found that Australia was not prepared for a pandemic of the severity, complexity or duration of the COVID-19 pandemic.

One of the most common phrases we heard during the Inquiry was 'building the plane while it was flying'. Some of the most pivotal decisions in the pandemic were not considered in pre-existing plans, including the closure of international borders and the JobKeeper scheme. This highlights just how unprepared we were for a whole-of-society crisis that a pandemic at the scale of COVID-19 represents.

What this meant in practice was that there was little clarity as to roles and responsibilities – particularly between the Commonwealth and state and territory governments. While these issues were often settled by leaders at National Cabinet, this occurred without the benefit of detailed planning or operational input.

The panel consistently heard that this lack of clarity and disputes regarding access to information within and between governments caused significant distress, delays and increased risk of harm in key areas of the pandemic response – quarantine, international and domestic border closures, supply chains, aged care and school closures. The lack of planning and guidance was evident in their implementation. They involved complex policy and legislative arrangements. This complexity, combined with the need for rapid decision-making, meant their delivery was not as effective as possible, leading to a lack of clarity and national cohesion.

Pandemic planning specifically aims to minimise the risk of harm. When done effectively, it can reduce the negative impact of a pandemic by improving the strength and resilience of systems.

Work is needed to ensure we are better prepared in a future crisis, with the plans developed to better support the response.

In addition to the COVID-19 Plan, the panel notes that a number of plans were developed during the pandemic to address sector and cohort specific issues and challenges. Some of these were quickly released and actioned, including plans for Aboriginal and Torres Strait Islander Australians which leveraged strong existing structures, while other plans took almost the entire length of the pandemic to put in place.

The delay in implementing plans for people with disability and for culturally and linguistically diverse communities had significant implications. It contributed to delays in developing response measures that addressed the circumstances and requirements of these diverse groups and contributed to poorer outcomes, particularly earlier in the pandemic. Such cohort and sector specific operational plans are critical (see the Equity section), and our response would have better met the diverse needs of the population had these been in place before the pandemic.

Emergency management responses should be better integrated

A whole-of-society crisis must be able to mobilise a whole-of-government and whole-of-nation response. This requires better integration of emergency management responses.

Many state and territory health emergency responses are fully integrated into the broader disaster planning structures, which enables them to leverage broader government capability and supports. However this this did not occur consistently at the national level during COVID-19. The unrelenting and broad spectrum of demands on the Department of Health resulted in it becoming overwhelmed, with brutal impacts on staff, and a broader impact on public confidence.

Where the emergency management response was integrated, it worked well. This was most evident in the national response to COVID-19 outbreaks in residential aged care facilities in Victoria through the activation of the Victorian Aged Care Response Centre. The Victorian Aged Care Response Centre utilised National Emergency Management Agency emergency management processes to coordinate the response from the Australian Government, state and territory and local systems.

The panel welcomes the recently announced changes to the Australian Government Crisis Management Framework. These address important gaps that were identified during the pandemic, including by increasing accountability for and awareness of crisis planning and emergency management arrangements:

- enhancing scalability, including for the management of severe to catastrophic crises
- clarifying governance arrangements, such as the important whole-of-government coordination roles of the National Emergency Management Agency and the Department of the Prime Minister and Cabinet.

The aim in future pandemics should be to support the Department of Health and Aged Care to leverage whole-of-government capability while retaining its lead role in determining the health response. This includes by supporting specialist training to ensure there is a reserve capability of people with emergency management skills that departments can draw on to help them plug into the broader emergency management arrangements.

Regular review and stress-testing is essential

A key learning from the COVID-19 pandemic is that the existence of plans is not sufficient – these plans must be subject to regular scenario testing, exercises and ongoing risk assessments.

The COVID-19 experience highlighted that there were stronger relationships and governance structures in place where there had been exposure to and involvement in recent responses to other emergencies, such as the 2019–20 Black Summer bushfires. This highlights the importance of exercises – we cannot rely on natural disasters to bring the right people together and test our readiness for the next pandemic. Alarmingly, the last large-scale pandemic exercise with states and territories was conducted a decade before COVID-19. This cannot be repeated.

Exercises should be performed on a regular basis and bring in a broad range of participants, including all levels of government and key players from the health sector, industry, academia, and civil society as required. Revised health emergency plans must be regularly tested to ensure preparedness (see Report Summary: Australian Centre for Disease Control).

The scope of existing legal authority to support planned emergency responses and interventions should also be tested as part of scenario exercises. During the pandemic over 15 pieces of legislation were passed and 727 legislative instruments were made to support Australia's pandemic response.[90] Incorporating legal preparedness into the broader scenario exercises will enable gaps in the legal framework to be identified and remedied ahead of a crisis (such as closure of international borders) and provide an opportunity to practise previously untested powers (under the *Biosecurity Act 2015* (Cth), for example) outside of a crisis. It could also highlight any conflict that may arise between Commonwealth and state/territory laws where there are shared responsibilities or different regulatory arrangements (e.g. public health orders and work health and safety laws and essential workers), enabling these to be practically worked through ahead of a crisis. Testing of legal preparedness will also enable departments to maintain their institutional knowledge of how portfolio legislation may be deployed in an emergency, ensuring this capability is not dependant on specific individuals.

The panel considers there were significant gaps in monitoring and evaluation of our overall pandemic preparedness ahead of the COVID-19 pandemic, which have not been addressed. Ahead of our annual high-risk weather season, we assess our overall risk and level of preparedness, and our nation's leaders are routinely briefed. The panel sees value in adopting a similar approach in relation to pandemic preparedness (see Report Summary: Australian Centre for Disease Control).

We highlight the importance of multi-sectoral and transdisciplinary exercises and plans that consider a 'One Health' view. This is needed to optimise health for people, animals and our

environment and mitigate converging health threats relating to 'climate change, biodiversity collapse, stressed ecosystems, antimicrobial resistance, and ageing and increasingly comorbid population'.[91] We support the Australian Centre for Disease Control and the National Emergency Management Agency working with the Department of Agriculture, Fisheries and Forestry, the Department of Climate Change, Energy, the Environment and Water and other agencies to better consider the linkages between plant, animal and human biosecurity incidents. This includes strengthening governance arrangements for emerging infectious diseases using a One Health approach.

> *A One Health approach to emerging infections must be adopted, with legislative instruments that support information sharing and collaborative response between agencies. – Australasian Society for Infectious Diseases*[92]

Over time, potential response options for pandemics will evolve – for instance, as new technologies emerge. Enhanced and nationally coordinated investments in science and technology will widen our response options in future crises. The panel supports the recommendations of the Commonwealth Scientific and Industrial Research Organisation (CSIRO) report Strengthening Australia's Pandemic Preparedness, which describes science and technology-enabled solutions, such as investment in research, vaccine manufacturing, developing new treatments and tests, and data collection, analysis and sharing.

Investment in capability will enhance preparedness

It is accepted and readily visible that crises are becoming more frequent, intense and concurrent. Yet we are concerned that pandemic planning and associated resourcing of important capabilities are at risk of continuing to follow the same historic pattern of neglect and short-termism.

Overall, the panel is concerned that we are now less prepared to deal with future shocks, because of the toll COVID-19 has taken on our people, health and economic systems, institutions, and trust.

Action must be taken to invest in capability now – in our people, systems and structures. We must build emergency management capability across the public service and more broadly, not just through exercises but also through training, readiness reviews and stronger governance and relationships.

The establishment of a permanent Australian Centre for Disease Control would be an investment in our public health capability and demonstrate a significant commitment to pandemic preparedness.

5. Learnings

- Australia's preparedness for COVID-19 was a function of the resilience of our society, functional coordination and governance, and the agility of our people and systems to pivot as required.
- Australia relied heavily on people to adapt the response during COVID-19. This had high human, social and economic costs, some of which could have been avoided with better preparedness. These costs are too high to pay again.
- Health plans need to be more comprehensive: include primary care and mental health, better consider the needs of at-risk groups, and outline readiness indicators and escalation and de-escalation triggers.
- Long, severe or complex crises need the response to be adaptable. To enable adaptability, the government must maximise the use of expertise, plan for evaluation to inform escalation and de-escalation points for pandemic-specific measures, identify key information flows, and establish cross-cutting coordination mechanisms and feedback mechanisms that can effectively identify and deal with consequences of emergency response measures.
- Planning should include real-time evaluation strategies that can be readily mobilised to assess whether responses are achieving what they are meant to, and to be on the alert for unintended consequences, and disparities in costs and benefits across the population.
- Crisis management is a shared responsibility – it is not just the domain of one government or one department. Even where hazards have an assigned lead, all others have a responsibility to ensure readiness. There should be accountable and collective ownership of all plans and risks.
- There should be clear, well-understood and pre-agreed roles and responsibilities for leaders and senior officials, at all levels of government. These roles should be clearly outlined and enshrined in planning documents and include accountable authorities for exercises.
- Gaps in plans led to significant, potentially avoidable consequences. It is almost impossible to build response measures from scratch during a crisis in a way that minimises risk and impact on people. The government must ensure it has plans in place for priority cohorts, and plans to minimise crisis consequences and ensure resources can be mobilised to respond effectively.
- Contemporary plans should be informed by after-action reviews and lessons learnt analysis, regular whole of health system risk assessments, technology, and disease threat assessments.
- Capacity to respond cannot be built at sufficient speed during a crisis. The government must ensure its resources, capabilities, services and workforce are ready for use ahead

of a crisis. Regular audits should assess healthcare system capacity; interoperable data and surveillance systems; research and modelling integration; and workforce capability in logistics, emergency management, procurement, public health and risk communication.

- Exercises can assist identifying and resolving gaps in plans; identifying gaps in resource readiness, increasing familiarity with roles and responsibilities; and assessing and maintaining workforce knowledge and ability.

6. Actions

6.1. Immediate actions – Do in the next 12–18 months

Action 3: Conduct post-action reviews of outstanding key COVID-19 response measures to ensure lessons are captured.

Review the human biosecurity provisions of the *Biosecurity Act 2015* (Cth), including to:

- examine whether further amendments are needed to ensure it can be deployed proportionately to the level of risk in human health emergencies
- explore ways to ensure any decisions on extensions of determinations include consideration of broader advice on the health, economic, educational, social, equity and human rights impacts
- consider inclusion of provisions for tabling or publishing relevant advice and rationale for the extension of determinations that implement restrictive measures under the Biosecurity Act 2015 (Cth).

Action 5: Develop updated health emergency planning and response arrangements in conjunction with states and territories, and key partners, including consideration of escalation and de-escalation points, real-time review and a focus on post-emergency recovery.

As part of this, develop:

- An enhanced National Health Emergency Plan (updated National Health Emergency Response Arrangements) and updated National Communicable Disease Plan. These updated plans should align with the Australian Government Crisis Management Framework
- Management plans under the National Communicable Disease Plan for priority populations
- Modular operational plans for specific sectors, including high-risk settings, which can be deployed in response to a variety of hazards.

The series of plans should:

- have clearly defined scope, ownership and accountability, including a clear legal basis and defined roles for Commonwealth bodies (including the CDC), states and territories, and industry partners such as aged care providers
- work in symphony with the Australian Government Crisis Management Framework; interface with emergency management plans at state and regional levels; and reference sub-plans including priority population management plans, workforce plans and the communications strategy
- draw on technical expertise and be updated in light of risk assessments, and scientific and technological developments
- embed pre-planned review mechanisms to support the real-time, rapid review of consequences as they arise, including quick assessments and corrections to emergency response measures without a protracted inquiry process
- incorporate feedback from community, industry and academia into plans and response measure adjustments
- be flexible enough to be used in response to a range of communicable disease or pandemic scenarios, while covering more likely events (such as an influenza pandemic)
- include mitigations to address impacts of the planned response – for example, compassionate exemptions to public health orders (minimising harm)
- consider transition and recovery
- include arrangements that support workforce preparedness (such as surge models)
- require post-action reviews, including on a whole-of-government basis
- include external oversight and complaints handling and embed privacy principles.

Develop management plans for priority populations under the National Communicable Disease Plan, including:

- Aboriginal and Torres Strait Islander people
- people with disability
- culturally and linguistically diverse communities
- older Australians
- children and young people
- regional, rural and remote communities.

Management plans should:

- take into account the unique needs of priority populations and co-design with communities and experts from the relevant sectors including primary care and relevant

service providers (such as aged care and disability providers) and Public Health Networks

- consider the transition out of pandemic settings and take into account potential risks for priority populations as protective health measures are reduced
- establish infrastructure and pre-agreements to support data sharing, and enable rapid research for real-time pandemic detection, risk assessment, and response evaluation
- utilise the latest data and evidence and regularly test through health emergency scenario exercises that involve all partners identified in the plan (also see Action 21)
- address recommendations arising from scenario testing in a timely way.

Action 6: Develop legislative and policy frameworks to support responses in a public health emergency.

Frameworks should be developed for:

- international border management
- identifying essential services and essential workers
- quarantine
- the National Medical Stockpile
- an Economic Toolkit.

Action 7: Finalise establishment of the Australian Centre for Disease Control (CDC) and give priority to the following functions for systemic preparedness to become trusted and authoritative on risk assessment and communication, and a national repository of communicable disease intelligence capability and advice.

The CDC must:

- build foundations for a national communicable disease data integration system, enabled for equity and high-priority population identification and data interrogation, with pre-agreements on data sharing
- commence upgrade to a next-generation world-leading public health surveillance system, incorporating wastewater surveillance and early warning capability
- work with the Department of Health and Aged Care and jurisdictions on updated communicable disease plans
- conduct biennial reviews of Australia's overall pandemic preparedness in partnership with the National Emergency Management Agency (NEMA)
- establish an evidence synthesis and national public communications function.
- build foundations of in-house behavioural insights capability

- establish structures including technical advisory committees to engage with academic experts and community partners.

Action 12: Develop a plan to build, value and maintain emergency management capability within the Australian Public Service, including planning and management of a surge workforce.

This should:

- prioritise investment in emergency management capability uplift across the public sector, especially within the Department of Health and the Department of the Prime Minister and Cabinet, to ensure there is a sufficiently large pool of people who have knowledge and understanding of crisis management and delivery principles and approaches
- establish arrangements to ensure agencies are able to appropriately fulfil their emergency management obligations and agreed roles and responsibilities under the Australian Government Crisis Management Framework.
- establish arrangements to train agency staff to better equip them to surge to contribute to whole-of-government crisis responses
- ensure the Secretaries Board maintains a role in stewarding these priority emergency management capabilities
- be aligned with the work done under Action 21 to improve capability and readiness, including through exercises and readiness reviews.

6.2.Medium-term actions – Do prior to the next national health emergency

Action 21: Build emergency management and response capability including through regular health emergency exercises with all levels of government, interfacing with community representatives, key sectors and a broad range of departments.

Led by the Department of Health and Aged Care, this should include:

- large-scale exercises that bring in all levels of government, a broad range of departments/agencies, including the Australian Centre for Disease Control (CDC), as well as broader Australian academia, industry and civil society groups
- exercises and stress tests for testing and contact tracing, including the utilisation of genomic surveillance across jurisdictions and analytic epidemiology capability
- a primary coordination role for the National Emergency Management Agency (NEMA) and the Department of the Prime Minister and Cabinet to test the cooperation between the health system and broader emergency management arrangements, and apply relevant learnings to other crises
- timing balanced against resourcing for other capability-building activities, including staff training and readiness reviews.

Action 23: Progress development of the Australian Centre for Disease Control in line with its initial progress review and to include additional functions to map and enhance national pandemic detection and response capability.

This should include:

- acting on recommendations arising from scenario testing and post-incident reviews it has facilitated following health emergencies and through this Inquiry
- drawing on national health workforce trend data to inform advice on pandemic readiness of the health system. This would include oversight of national surge workforce capabilities and gaps to be mapped and ready to be operationalised in a future emergency response.

Chapter 4 – Leading the response

1. Context

Rapid, decisive and unified leadership at the highest level of government was needed for an effective national response to the COVID-19 pandemic. Australians had witnessed the struggles that other countries and relatives overseas were having with COVID-19, and were looking to the nation's leaders to work with a unity of purpose in the face of uncertainty and fear.[93]

The Prime Minister's early initiative in centralising decision-making with state and territory leaders, through establishing National Cabinet, formed the foundation for Australia's COVID-19 response.[94]

Under the Australian Constitution, the allocation of powers and fiscal resources is spread across the different levels of government. Certain powers are given exclusively to the Commonwealth, some are shared between the Commonwealth and the states, and others remain exclusively with the states. Under section 109 of the Australian Constitution, when a state and territory law is inconsistent with a Commonwealth law, the Commonwealth law overrides the state and territory law. While the Australian Constitution gives the Commonwealth power to make laws for the government of territories, they have been granted self-government through Commonwealth legislation.[95] Local government is not mentioned in the Australian Constitution. However, each state has a local government law that sets out rules for operation of local councils, many of which provide key community services.

Figure 2: Constitutional division of powers[96]

**These are mainly things that the Commonwealth has power over but the states and territories can also make laws on (subject to any inconsistent Commonwealth laws).*

Under the *Biosecurity Act 2015* (Cth) the Minister for Health and the Commonwealth's Chief Medical Officer[97] have extensive biosecurity powers. Before COVID-19, these powers were untested in a pandemic. State and territory Health Ministers and/or Chief Health Officers have powers under their own public health legislation. These powers also intersect with state and territory emergency management legislation and operational arrangements.

The pandemic response required the use of national powers, state policy, legislation and workforces, and collaboration with community, industry and local government.

2. Response

2.1. Commonwealth–state relations

2.1.1. National Cabinet

Commonwealth–state relations are conducted by convention – they are not set out in the Australian Constitution or other legislation. This meant the Prime Minister, with the support of state and territory leaders, was able to quickly establish National Cabinet and the supporting governance arrangements.

On 13 March 2020 the Council of Australian Governments agreed to create a smaller, streamlined 'National Cabinet' to ensure a 'coordinated response across the country to the many issues that relate to the management of the coronavirus'.[98] The new body would allow First Ministers of the nine jurisdictions to make collective decisions more quickly and share information on the evolving pandemic.

The first meeting of National Cabinet was held on 13 March 2020.[99] From 13 March 2020 to 30 September 2022 it met on 73 occasions, sometimes as often as four to five times a week.[100] National Cabinet had several unique features:

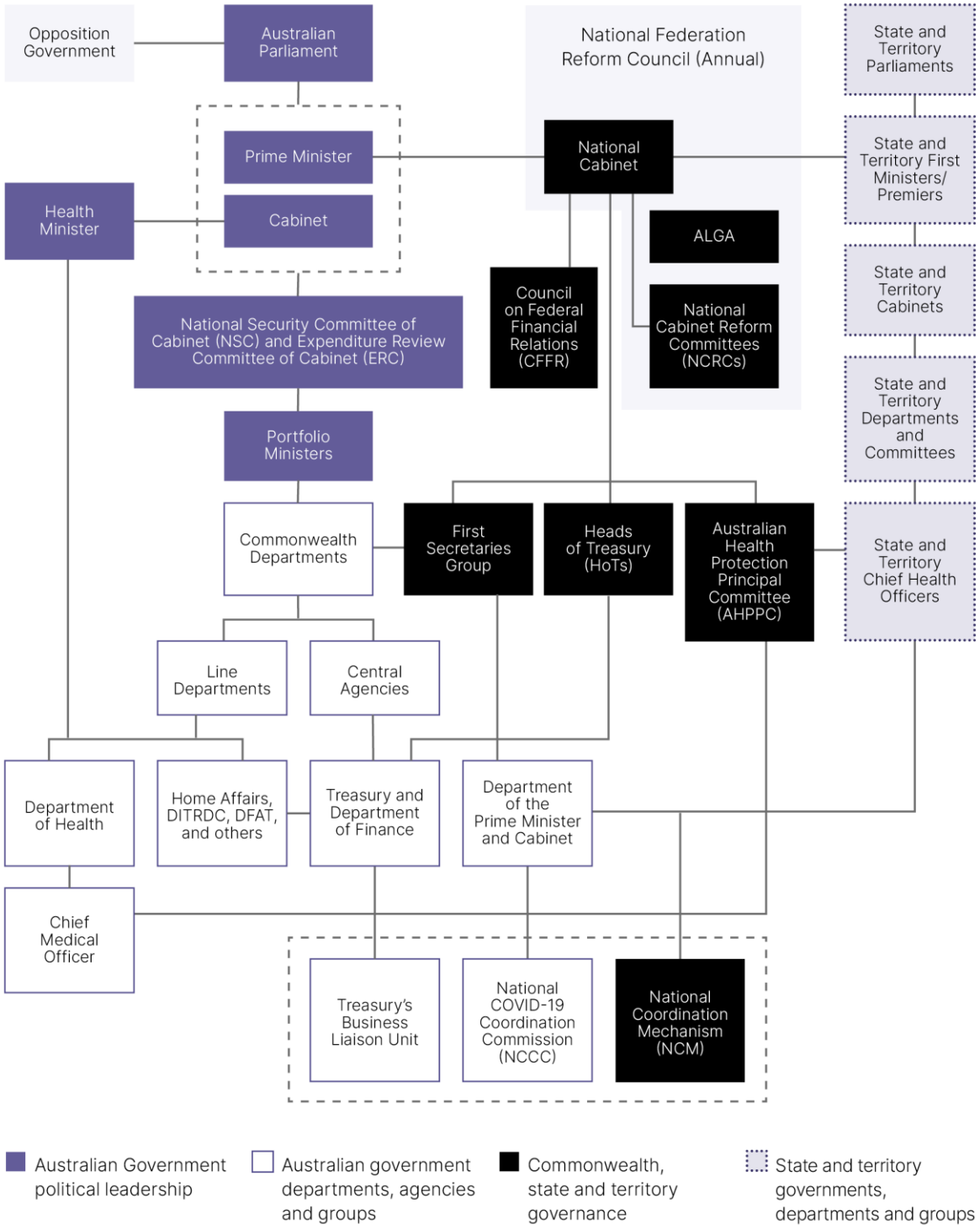
- Core attendance was limited to the Prime Minister, First Ministers and their First Secretaries – that is, there were no political advisors or additional public servants. However, experts, including public servants, were invited into the room to provide advice as needed.[101]
- The government established it as a Committee of the Commonwealth Cabinet, making it subject to Cabinet confidentiality.[102] This enabled leaders to have frank discussions.[103]
- The Prime Minister set agendas, bypassing layers of bureaucracy to quickly bring together decision-makers and public health and economic experts.[104]
- A shared singular focus on protecting people's lives led to greater information sharing and overcoming of traditional barriers between the Commonwealth and states and territories.[105]
- Secure technology was used to enable virtual meetings – this has had not previously been contemplated at scale for Commonwealth–state leaders-level meetings.[106]

Figure 3: Prime Minster holds a virtual meeting of National Cabinet[107]

National Cabinet made a number of decisions that were critical to the nation's COVID-19 response. For example, it introduced social gathering restrictions, international arrival and travel bans, hotel quarantine requirements, COVID-19 vaccination policy endorsement, the national framework for managing COVID-19 in schools and early childhood education and care, and plans to transition Australia's response out of the emergency phase and lift restrictions.[108]

During the pandemic there were no local government representatives in National Cabinet.[109] It was expected that state and territory decision-makers would consult local government on specific issues. The Australian Local Government Association was previously a member of the Council of Australian Governments.[110] As a peak body the Australian Local Government Association cannot make decisions on behalf of individual local governments.

Figure 4: Decision-making structures used during Australia's peak pandemic response[111]



2.1.2. Commonwealth–state ministers' meetings

There were also forums for Commonwealth and state and territory ministers to progress specific issues, and they reported to National Cabinet. During Australia's COVID-19 response, the two most important were the Health Ministers Meeting, comprising Commonwealth, state and territory Health Ministers; and the Council on Federal Financial Relations, comprising Commonwealth, state and territory Treasurers.[112]

The Health Ministers Meeting's role was to support decision-making and implement health policy and programs of national importance. It was a critical forum in managing the health response, including the vaccine rollout, and often met multiple times a week to work through critical cross-jurisdictional issues. However, during the pandemic First Ministers decided that the Australian Health Protection Principal Committee, usually a sub-committee of the Health Ministers Meeting, would bypass the Health Ministers Meeting and report directly to National Cabinet.[113] During the pandemic the Health Ministers Meeting met many times but did not provide direct briefings to National Cabinet. Cabinet-related confidentiality constraints limited information sharing.

This structure put the Australian Health Protection Principal Committee in the position of being the main advisory body on all health issues supporting governments in decision-making and providing operational guidance to National Cabinet.[114] It reported to National Cabinet using both regular briefings from the Chief Medical Officer as Chair of the Australian Health Protection Principal Committee and written advice.[115] The Australian Health Protection Principal Committee mainly focused on public health issues, not the broader health system or indirect health impacts of the pandemic. It was chaired by the Chief Medical Officer and comprised all state and territory Chief Health Officers. As it was an advisory committee to National Cabinet, the Australian Health Protection Principal Committee's advice was treated as Cabinet in confidence – it was only made public if National Cabinet authorised it.[116] The Australian Health Protection Principal Committee did release statements at the time, and some modelling products that informed Australian Health Protection Principal Committee and National Cabinet decisions were also released.[117] Most other Australian Health Protection Principal Committee advice from 2020 and 2021 is now public under the *Freedom of Information Act 1982* (Cth) once freedom of information and associated review processes are finalised. However, the advice was not released at the time to contextualise or support National Cabinet decisions.

The Council of Federal Financial Relations reported directly to National Cabinet on matters to do with financial relations, productivity and regulatory reforms. It was also responsible for overseeing the Commonwealth–state funding agreements. During COVID-19, the Council of Federal Financial Relations supported National Cabinet to establish the core National Partnership on COVID-19 Response,[118] under which the Australian Government was able to rapidly contribute approximately $25 billion in funding to states and territories to support the Australian health system to respond effectively to COVID-19 (see Chapter 12: Broader health impacts). Also, the Secretary of Treasury and the Reserve Bank Governor regularly attended National Cabinet, giving briefings and advice to leaders on the economic impacts of the pandemic and the types of supports they should consider.[119]

2.2.The Commonwealth

2.2.1. Australian Parliament

The Australian Parliament continued to operate throughout the pandemic, supported by the Department of Parliamentary Services pandemic plan. The plan set out methods for managing operational risks, and engagement with the Department of the House of Representatives and the Department of the Senate, so that the critical functions of the Parliament could continue and parliamentarians could discharge their representative and legislative duties throughout the pandemic.[120] Not all state and territory parliaments were able to continue to operate in this way.[121]

Parliamentary sitting periods were severely shortened, and the number of parliamentarians allowed to attend sittings in person was substantially reduced. Where parliamentarians were not able to travel, pairing arrangements (that is, if a member on one side of the House is absent for a vote, a member from the other side must also be absent for that vote) and videoconferencing were used to allow for remote participation. Electronic voting technology was developed, but parliamentarians did not vote virtually. It was decided that this technology would only be commissioned as a contingency option.[122]

During the pandemic, Parliament passed approximately 15 Bills per month – mostly significant emergency legislation to support implementation of the national response, including appropriation of funds.[123] Some parliamentary committees, such as the Parliamentary Joint Committee on Human Rights and the Senate Standing Committee for the Scrutiny of Bills, continued to meet remotely to ensure parliamentary scrutiny could continue.[124] In April 2020 the Senate Select Committee on COVID-19 was established to inquire into the Australian Government's response to COVID-19. This committee operated through the pandemic, conducted 56 public hearings and delivered its final report in April 2022.[125]

2.2.2. High Court and other federal courts

Throughout the pandemic, the High Court and other federal courts, along with state and territory courts, continued to operate by shifting to remote video connection hearings.[126] By 23 March 2020 most court buildings had been closed.[127] All personal appearances, apart from continuing jury trials, were moved online. New Zealand's courts had a similar arrangement – 'remote participation' was used for all hearings except the most serious ones.[128] Many other countries that did not have the pre-existing infrastructure for remote hearings took far longer to make the switch. For example, in the United States of America the delays in moving to remote hearings had major consequences for public health and the judiciary (for example, judges died after contracting COVID-19 and court employees were infected).[129]

2.2.3. Federal Cabinet processes

The Prime Minister was supported by Cabinet and its well-established decision-making structures. The federal Cabinet, and its committees, were adapted and expanded to suit the circumstances. The Prime Minister and Cabinet made a key decision to reallocate government

resources so they could deliver the pandemic response – National Partnership Agreements, JobKeeper Payment, infrastructure, vaccines, telehealth, mental health measures, the National Medical Stockpile and so on (see relevant chapters throughout the report).[130]

The National Security Committee of Cabinet played the role of emergency Cabinet. The National Security Committee brought together health, economic and security issues related to the pandemic and met frequently (as often as twice a day) to problem-solve and make decisions.[131] Unlike those of other Cabinet committees, National Security Committee decisions did not need to be endorsed by the full Cabinet, meaning they could be taken straight to National Cabinet or announced publicly. The National Security Committee also brought senior public servants to the same table as ministers to support rapid decision-making.[132] The core members of the National Security Committee were the Prime Minister, Deputy Prime Minister, Treasurer, Minister for Defence and Minister for Home Affairs.[133] The Minister for Health attended all National Security Committee meetings related to health.[134] The National Security Committee was supported by the Secretaries Committee on National Security, which was chaired by the Secretary of the Department of the Prime Minister and Cabinet, met regularly and mirrored the National Security Committee agenda.

2.2.4. Minister for Health and powers under the Biosecurity Act

The Minister for Health and the Chief Medical Officer roles were crucial during the pandemic because of their significant legislative powers under the *Biosecurity Act 2015* (Cth) as well as their portfolio responsibilities.

On 21 January 2020, under section 42(1) of the *Biosecurity Act 2015* (Cth), the Chief Medical Officer added 'human coronavirus with pandemic potential' to the Biosecurity (Listed Human Diseases) Determination 2016.[135] This allowed preventative biosecurity measures to be put in place, such as:

- initial designations of hotel quarantine locations as 'human health response zones'[136]
- introducing face masks for passengers and crew on incoming international flights[137]
- requirements for providing evidence of negative COVID-19 tests for passengers on incoming international flights.[138]

On 14 March 2020, after consultation with the Attorney-General, the Minister for Health and the Chief Medical Officer, the Governor-General appointed the Prime Minister to administer the Department of Health. This appointment was made out of concern that the Minister for Health could become incapacitated and a senior minister should be seen to be responsible for the exercise of the Minister for Health's extraordinary powers under the *Biosecurity Act 2015* (Cth).[139] Throughout 2020 and 2021 the Prime Minister was cross-sworn to a further five portfolios (Finance; Industry, Science, Energy and Resources; Treasury; and Home Affairs). Some of these appointments were stated to be for decision-making related to the pandemic.[140]

Once the Minister for Health was satisfied COVID-19 posed a sufficiently severe and immediate threat to human health on a scale of national significance and its entry into or spread in

Australia must be prevented or controlled, he advised the Governor-General to declare a 'human biosecurity emergency' under section 475 of the *Biosecurity Act 2015* (Cth). The Governor-General made the declaration on 18 March 2020.[141] In line with the Act, the initial declaration could not be in place for more than a three-month period. However, it could be extended, and it was extended on eight occasions (for around two years in total). The declaration remained in force until it lapsed on 17 April 2022 (when the situation no longer met the requirements of an emergency under the *Biosecurity Act 2015*).[142]

Once the human biosecurity emergency was declared, the Minister for Health was able to access extensive powers under the *Biosecurity Act 2015* (Cth) to put in place measures to prevent or control the entry or spread of COVID-19 in Australia. The Minister for Health could exercise these powers unilaterally. However, the Minister for Health's decisions took into account health advice from the Australian Health Protection Principal Committee and consultation with relevant Commonwealth ministers and were considered by the National Security Committee.[143]

There were 75 instruments for COVID-19 made under the *Biosecurity Act 2015* (Cth).[144] Determinations could be put in place for set periods during the declared emergency period, but they could also be extended if necessary, as long as the threat continued to meet the legislative requirements. In these situations, determinations were reviewed every three months. Examples of measures that were extended multiple times include:

- a ban on Australian citizens and permanent residents from travelling outside of Australia[145]
- travel restrictions into certain remote areas to protect remote Aboriginal and Torres Strait Islander Australians.[146]

Other determinations were made for short periods only. For example, the India Travel Pause (a ban on all people entering Australia who had been in India within 14 days of their flight) was in place for 14 days in 2021.[147] The determination that allowed the government to access the information provided through the COVIDSafe App was in place until it was repealed with the commencement of the *Privacy Amendment (Public Health Contact Information) Act 2020* (Cth).[148]

The declarations and determinations made were legally binding and were also exempt from disallowance by the Parliament.[149]

2.2.5. National COVID-19 Coordination Commission

On 25 March 2020 the Prime Minister established the National COVID-19 Coordination Commission to coordinate advice on actions to anticipate and mitigate the economic and social impacts of the pandemic.[150]

The National COVID-19 Coordination Commission reported to the Prime Minister and National Cabinet. National COVID-19 Coordination Commission members[151] were appointed by the Prime Minister and mainly from the business community, but former union leaders and public

servants were also included. Members were able to quickly establish important working relations using their existing relationships, including with the unions.[152]

In July 2020 the National COVID-19 Coordination Commission was renamed the National COVID-19 Commission Advisory Board. The name change reflected a change in the National COVID-19 Coordination Commission's focus away from coordination and towards advice on the long-term business-led economic recovery.[153] The board's membership was expanded[154] to assist in this new role. During the pandemic, 12 people served on either the National COVID-19 Coordination Commission or the National COVID-19 Commission Advisory Board. On 3 May 2021 the Prime Minister disbanded the National COVID-19 Commission Advisory Board.[155]

The Prime Minister had originally intended that the National Coordination Mechanism (established on 5 March 2020) and the Treasury's Coronavirus Business Liaison Unit (established on 15 March 2020) would report to the National COVID-19 Coordination Commission.[156] However, this did not become an established practice (See Chapter 6: The Australian Public Service: responding to a multi-sectoral crisis).

3. Impact

3.1. Commonwealth–state relations

3.1.1. National Cabinet

Most agree that, in the alert and early suppression phases of the pandemic, Commonwealth, state and territory leaders worked well together.[157] The panel heard the leadership the Prime Minister showed in establishing National Cabinet and the tone he set were vital to pandemic decision-making and governance.[158] National Cabinet was considered to be an improvement on the Council of Australian Governments because it was more action oriented. It also made intergovernmental relationships stronger and united all members around a common problem.[159] There was a unity of purpose shown in the face of uncertainty – this helped members to come to decisions quickly and collectively in the national interest and rise above jurisdictional issues.[160]

> *National Cabinet has proven to be a much more effective body for taking decisions in the national interest than the COAG structure. – Former Prime Minister, the Hon Scott Morrison MP*[161]

National Cabinet members all saw the National Cabinet as an important and influential forum in shaping the high-level directions of the national response.[162] It resolved problems and provided a common roadmap for federal, state and territory governments to then implement decisions, in line with the actual level of risks in the different jurisdictions.[163] As a result, the community had assurance and confidence that politicians were acting in the 'national interest' rather than political or self-interest.[164]

Feedback from roundtables and stakeholders acknowledged the impact on public confidence of national and state and territory leaders jointly seeking to protect the health and livelihood of

Australians.[165] Regular press conferences, including those following National Cabinet meetings, conveyed important updates, and many people relied on those updates as a source of trusted information.[166] The panel heard that people respected that the Prime Minister stood up first, before the state and territory leaders, to keep the public informed despite the changing circumstances. He took a considered and proportionate approach and tried to be transparent – for example, about vaccine issues. The Chief Medical Officer would often accompany the Prime Minister to press conferences. This, combined with the reliance on health advice, built trust and credibility with the public.[167]

The panel heard that, as Australia shifted into the later stages of the suppression and vaccine rollout phases, the perceived effectiveness and cohesiveness of National Cabinet began to wane as the overall levels of risk started to reduce, and situations faced by states and territories differed.[168] The 'Team Australia' spirit started to dissipate as the level of threat diminished, which many members of National Cabinet indicated was to be expected.

Relationships were visibly and publicly challenged as National Cabinet started to discuss the vaccine rollout, access to vaccines and personal protective equipment, and the lifting of a range of significant COVID-19 restrictions. This happened in part because of:

- the different approaches being taken to economic supports
- equity of access to vaccines and the broader vaccine rollout
- the lack of clarity on key roles in aged care and disability
- public commentary on the relative competency and capability of jurisdictions and the variation in jurisdictional responses
- the imposition and retention of border closures.[169]

The result was a perceived lack of coordination and consistency in communication from National Cabinet members, and it became more difficult for National Cabinet to give detailed information to assist individuals, industry and the broader community to comply with public health measures (see Chapter 11: Communicating in a crisis).

The states and territories told the panel that there needed to be greater clarity and agreement about roles and responsibilities, especially in areas of shared responsibility, and that there was a lack of coordination and appropriate implementation plans, which were not put in place early enough and were often subject to change.[170]

- It was noted that 'while vaccine procurement was appropriately a Commonwealth responsibility, the roles and responsibilities for distribution, eligibility, and administration (particularly for priority groups) were not well defined outside traditional state and territory vaccination roles and responsibilities'.[171]
- States felt greater leadership and more equitable and transparent arrangements were needed to improve the way critical goods and services, such as vaccines, were procured and distributed amongst jurisdictions. They believed vaccines should have been

distributed in line with the jurisdictional risk level (see Chapter 10: The path to opening up).

- Despite the lack of a national plan, states and territories agreed to operate, enforce and meet the costs of quarantine. Each jurisdiction adopted a distinct approach to hotel quarantine. They felt greater Commonwealth leadership was needed on hotel quarantine to provide risk-based national guidance and supporting coordination and funding structures (see Chapter 8: Implementing quarantine).
- The absence of an aged care sector plan and lack of leadership and planning between the Commonwealth and state and territory governments, healthcare systems and providers led to an inadequate and uncoordinated response and lack of control and accountability (see Chapter 18: Older Australians).

We heard that the Prime Minister often called for unity of response and focused on getting agreement on strategic directions, but he recognised it was not always possible – pragmatism was needed when the Australian Government did not control the outcomes.[172] In the early alert phase of the pandemic, this pragmatic approach was used to agree to national plans that allowed states and territories to vary their approaches depending on their own risk levels and local settings. Where there were differences in views, public messaging on specific decisions usually reflected this – for example, Western Australia did not agree with the domestic border and international arrival proposals under the Framework for National Reopening of Australia by Christmas in October 2020.[173]

However, the panel also heard that, as the pandemic continued, the Prime Minister took different approaches at different times, and it was not always clear whether he was seeking a nationally consistent one-size-fits-all approach or was comfortable with states implementing the agreed policies in line with their differences in circumstances.[174] This contributed to a growing perception in the broader community that inconsistent approaches were being adopted and led to questioning of the validity of supporting evidence.[175] Leaders and officials did not clearly communicate to the public that states and territories would need to adopt individual measures depending on their risk levels, although they made various attempts to do so. Their message was further undermined when it was observed that the states and territories were managing similar risk settings with different levels of stringency.[176]

As the situation evolved, states and territories made more unilateral decisions – for example, decisions about lockdowns, curfews, school closures, closure of outdoor play equipment and state border closures.[177] We heard from industry and other supply/logistics roundtables that, as states and territories started to make unilateral decisions, National Cabinet placed less emphasis and priority on the coordination of the response and supporting communication than was needed and outlined in their initial mandate.[178] As discussed further in Chapter 11: Communicating in a crisis, communications from leaders after National Cabinet discussions were not always well coordinated or consistent, and the evidence supporting the decisions was rarely provided. The Inquiry's community input survey results, submissions and focus groups also show that the public perception was that the Commonwealth did not appear to do enough

to ensure the response to COVID-19 was coordinated and more consistent across the states and territories.[179]

The Inquiry's focus group findings suggest there was a limited understanding of the roles and responsibilities of different levels of government in responding to the pandemic.[180] Most participants did not distinguish between the Commonwealth and state and territory government measures. They attributed the loss of unity between leaders and lack of consistency between states as a failure of Commonwealth leadership.

> *It didn't feel like the Federal Government did anything … it was like all the States were at war, 'we can do what we want, and you can do what you want' … it was divisive – Focus group participant, mental health care services user, Melbourne*[181]

> *There was no consistency between states … it tells me the government is unorganised … they all lost a little bit of credibility – Focus group participant from a CALD background, Brisbane*[182]

3.1.2. National Cabinet decision-making

The Chief Medical Officer, predominantly in their capacity as Chair of the Australian Health Protection Principal Committee, was invited to provide briefings at all National Cabinet meetings. The Commonwealth Secretary of the Treasury and the Governor of the Reserve Bank of Australia gave regular reports to National Cabinet on the economic situation.[183] National Cabinet relied on this expert advice and drew upon international experience, and Australian Government capability and expertise, which was vital in the rapidly changing risk environment. The primacy placed on public health advice set the tone for the rest of the response.[184] Direct economic briefings and moves to provide integrated health and economic data meant National Cabinet was able to quickly develop an economic response that supported the health response.[185] For example, Single Touch Payroll, JobKeeper and vaccination data were linked through the Multi-Agency Data Integration Project[186].[187] A number of states told the panel that having access to the Commonwealth experts was very useful, as was the increased preparedness to share data.[188] For additional details see Chapter 20: Managing the economy.

Although the Chief Medical Officer regularly briefed Health Ministers Meetings before National Cabinet meetings, the Australian Health Protection Principal Committee did not report to them as a group, and the Health Ministers Meeting itself was not given the opportunity to brief National Cabinet.[189] We heard that the fact that the Australian Health Protection Principal Committee reported directly to National Cabinet was a challenge for state Chief Health Officers because it potentially placed them in conflict with their own state statutory responsibilities. It also put restrictions on their briefing to their ministers. For example, Chief Health Officers' briefings to their state/territory Health Ministers were complicated by Cabinet confidentiality requirements and by differences in the roles, statutory responsibilities and communication pathways of Chief Health Officers across jurisdictions. This meant First Ministers had different levels of briefing before National Cabinet meetings.[190] With the wisdom of hindsight, leaders

saw this as having diminished the necessary focus on broader health issues, including capacity, relationships with private hospitals, elective surgery, mental health and access to health care.[191]

The panel heard the Australian Health Protection Principal Committee played an important role in supporting coordination across jurisdictions, recognising that states and territories would need to adopt individual measures based on local risks rather than a one-size-fits-all approach.[192] The second wave in the winter of 2020 was the first test of this. Victoria progressively escalated control measures after two separate incursions of the virus through hotel quarantine.[193] New South Wales managed outbreaks locally when the virus crossed the border.[194] Recently seeded outbreaks presented a different control challenge from that for an established multisite outbreak, but that disparity in response set the subsequent tone and associated dissent on interstate comparisons and public discussion on 'gold standards'.

There were differing views on whether, in times of crisis, National Cabinet should have unfettered access to the Australian Health Protection Principal Committee unless there are similar pathways in place to bring the benefits of broader health impact intelligence:

- To enable rapid decision-making, some thought it appropriate that health advice be filtered through the Chief Medical Officer, as Chair of the Australian Health Protection Principal Committee, directly to National Cabinet.[195] The political leadership found it valuable to hear advice directly from public health experts.[196]
- On the other hand, some thought the Australian Health Protection Principal Committee's direct reporting to National Cabinet made it difficult to activate existing coordination and reporting structures that were available through the Health Ministers Meeting and the Health Chief Executives Forum.[197]
- There were also concerns that public health advice was given more weight than advice on other health impacts, such as mental health, health prevention and access to health services (in the development of public health measures) because the Health Ministers Meeting did not brief National Cabinet.[198]

Both industry and community roundtables and focus groups told the panel that National Cabinet may have missed important and necessary opportunities to consult on the most effective way to achieve health objectives in the fastest way possible.[199] Public health advice was extremely important, but National Cabinet often did not give the broader health and non-health impacts an appropriate level of consideration.[200] The roundtables reaffirmed that the public health and economic responses to a pandemic are linked. It was necessary and important to prioritise public health outcomes during the early months of the pandemic. However, as the pandemic progressed, a greater balance should have been struck between broader health, economic, educational, social and other outcomes, including equity and human rights.[201] Roundtable participants suggested that the lack of consultation with a broader range of experts led to decisions that resulted in unnecessary hardship. Also, opportunities to adapt the response strategy and use targeted mitigations to protect those most affected by the pandemic were missed.

> *The response needs to be more balanced between education, health and economy, which was not present. There was a panic approach to physical health – Focus group participant, parent/carer of a school aged child, Melbourne*[202]

The panel heard that National Cabinet confidentiality requirements created an unintended disconnect between leaders, bureaucrats and the public and impeded sharing and coordination of key information, advice and planning.[203] At the time, leaders stated that the 'sharing of sensitive information and judgements in a forum that provides the ability for confidential discussions has been of great significance to effective decision making by the States, Territories, and the Commonwealth in the public interest throughout the course of the COVID-19 pandemic'.[204] It was also said that the disclosure of National Cabinet documents or discussions 'would prevent full and frank discussions'.[205]

However, the Inquiry also heard that it was counterproductive to impose such a high level of confidentiality to the advice that informed decisions, especially given many of those decisions curtailed rights and freedoms.[206] This lack of transparency came at the cost of public trust. Many non-government and industry stakeholders strongly advocated for greater transparency.[207] Focus groups indicated 'there was erosion of trust, social licence and goodwill in governments and institutions' and 'resentment towards what was lost (i.e. choice, connections, "freedoms" and autonomy) has led some mainstream audiences to become more sceptical and critical of government policies and decision-making'.[208]

> *What I was hearing was not what I was seeing. Everyone had COVID but no one was dying but Australian government was saying everyone was dying … there were a lot of conspiracy theories and I think there was a lot of information that was not shared by the Australian Government – Focus group participant who experienced quarantine, aged under 39 years, Australia-wide*[209]

3.1.3. Local government leadership

The Australian Local Government Association told the panel that local government played a larger, more active role during the pandemic than ever before. State governments could not deliver all the support that was needed, so local governments stepped in, particularly for culturally and linguistically diverse, rural and remote, and border communities.[210]

The Australian Local Government Association has criticised the lack of local government representation at National Cabinet given local government had an important role in implementing many pandemic response measures. In its submission to the Inquiry, the Australian Local Government Association noted its 'extensive community networks and established relationships and experience in supporting communities' could have been better leveraged. They are national, covering most communities in Australia with their own networks to collaborate and share information.[211]

Under the current National Cabinet Terms of Reference,[212] the Australian Local Government Association is now invited to one meeting of National Cabinet a year. However, it attends to share information and advocate rather than take part in decision-making. The Australian Local

Government Association has proposed to the panel that local government representation be extended to all meetings.[213]

3.2.The Commonwealth

3.2.1. Australian Parliament

The Australian Parliament's continued operation during the pandemic was extremely important – it enabled the Australian public to see that the Australian Parliament was resilient and their elected representatives were continuing to discharge their duties despite the emergency.[214] The Australian Parliament's question time gave senators and members, particularly the opposition, the opportunity to ask questions of the government. There was also opportunity to do this through the Senate Select Committee on COVID-19 inquiry.[215]

The early phase of the pandemic response was marked by bipartisan support for emergency measures. On 23 March 2020 the opposition leader said the opposition would act 'in a responsible and constructive manner' by voicing their views to improve the emergency legislation. He noted that 'this is not a time to prevent measures which, however imperfect, are necessary to be implemented'.[216] In 2020 the Prime Minister, the Minister for Health and the Chief Medical Officer regularly briefed the federal opposition. However, we heard that during 2021 these briefings became less frequent.[217]

The Senate Select Committee on COVID-19 and the various Senate oversight committees[218] continued to scrutinise the government's response, proposed laws and delegated legislation, including the non-disallowable instruments made under the *Biosecurity Act 2015* (Cth).[219] This was important because it maintained government accountability for decisions that were being made and made the pandemic response more transparent for the public. However, during prolonged crises it is also important to consider the burden that inquiries place upon ongoing operational responses so that the accountability does not compromise the pandemic response effort.[220] However, operational leaders said there was progressively greater transparency on the achievement of key program objectives such as the vaccine rollout, and this was important in maintaining public confidence and trust.[221]

Videoconferencing technology put in place to allow parliamentarians and witnesses to participate in committee inquiries remotely is now a permanent feature of committee hearings.[222]

3.2.2. Federal Cabinet processes

The panel heard that the federal Cabinet and subcommittee structures and processes (including the National Security Council and the Expenditure Review Committee) adapted well to the pandemic.[223] There were more meetings of Cabinet and subcommittees than in any year since the end of the Second World War. In the absence of an emergency Cabinet committee, the National Security Council was considered to be the right mechanism for decision-making on COVID-19 issues and largely worked well.[224] The Expenditure Review Committee continued to effectively integrate with the National Security Council for decisions on expenditure.[225]

3.2.3. Minister for Health and powers under the Biosecurity Act

Before the pandemic, there was little public awareness of the Minister for Health's human biosecurity emergency powers and what they entailed.[226] The panel heard that, during the pandemic, the Australian Government's intent was that *Biosecurity Act 2015* (Cth) emergency powers and other similar powers would only be triggered where measures could not be introduced under state or other Commonwealth laws.[227]

It has been suggested to the panel that the Minister for Health could be given a more graduated set of human biosecurity powers under the Act.[228] Also, it was suggested that new powers could be created that allow the Commonwealth to introduce measures to respond to a threat where there is a localised outbreak of a disease (for example, where the disease is present across state/territory borders or is present within a state or territory but has significant flow-on effects into another) before the situation escalates to a blanket national emergency-level response.[229] Others have queried whether the powers available to the Minister for Health could have been appropriately utilised to drive better coordination and minimise harmful impacts on movement of people and trade.[230]

Measures enacted under the *Biosecurity Act 2015* (Cth) were restrictive, and their broader economic, social and mental health and human rights impacts, as well as the disparities in how these impacts were experienced across communities, were not always meaningfully considered.[231] The panel heard that in the future governments should consider additional checks (such as seeking broader health and non-health advice as well as greater parliamentary scrutiny) to improve transparency, accountability and discipline.[232] We heard numerous suggestions on ways to increase transparency and protect human rights. One suggestion was that the powers be amended to ensure that any emergency determination that applies restrictive measures be published along with the reasons and accompanied by signed and published health advice.[233] It was also suggested that states and territories adopt a similar mandate.[234] For additional details see Chapter 5: Trust and human rights.

We heard that the determinations made under the *Biosecurity Act 2015* (Cth) should not be made disallowable – the Commonwealth needs a level of certainty so that it can take fast and urgent action to manage human biosecurity risks and to prevent significant consequences.[235] The then Minister for Health told the Senate Standing Committee for the Scrutiny of Bills during the pandemic that disallowance was considered unnecessary because determinations were informed by specialist advice provided by the Australian Health Protection Principal Committee and the Chief Medical Officer.[236] The current Minister for Health and Aged Care has given the same opinion to the Senate Standing Committee for the Scrutiny of Delegated Legislation.[237]

A number of Federal Court cases sought to challenge the validity of both the Governor-General's declaration that a human biosecurity emergency existed, and the Minister for Health's use of his human biosecurity emergency powers to make determinations on, for example, a high-risk travel pause and the overseas travel ban.[238] To date, each challenge has failed.

3.2.4. National COVID-19 Coordination Commission

The panel heard that one of the key strengths of the National COVID-19 Coordination Commission during the alert phase of the pandemic was its members' ability to quickly draw on their existing relationships and goodwill across sectors. For example, they were able to work with the unions to solve multi-sector problems.[239] Their networks and experience were used to establish valuable advisory working groups on manufacturing and industrial relations to help support their work.

The panel heard that in theory the National COVID-19 Coordination Commission was a good idea, but its effectiveness was limited by its continually evolving role, a lack of governance and transparency, and duplication with other engagement measures.[240] When it was set up, some believed the body duplicated the National Coordination Mechanism and the Coronavirus Business Liaison Unit within Treasury (see Chapter 6: The Australian Public Service: responding to a multi-sectoral crisis), and this caused confusion with business and industry.[241]

On 3 May 2021 the Prime Minister announced that the National COVID-19 Commission Advisory Board had concluded its work and was being disbanded[242] without any review of its functions and impact during the pandemic. However, it was suggested to the Inquiry that there may be value in establishing a body similar to the National COVID-19 Coordination Commission during the initial stages of a future emergency if it is staffed by experienced individuals with access to senior levels of bureaucracy and government.[243] In any event, there was broad agreement on the need to have better defined and understood communication pathways that drew upon the expertise in industry, business and community sectors.

4. Evaluation

The Australian Government's leadership role is pivotal and needs strong governance

The Australian Government demonstrated courageous leadership at the outset of the pandemic, which was a critical element of Australia's initial response. The Prime Minister, the Hon Scott Morrison MP, took on a visible and significant leadership role throughout the pandemic. The series of decisive and difficult decisions that the Prime Minister, Treasurer, Minister for Health and other ministers took to promote health and economic outcomes are discussed throughout this report. They include closing the international borders; formulating and implementing in a matter of weeks the biggest ever government payment, JobKeeper; and disbanding the Council of Australian Governments and replacing it with National Cabinet.

The panel strongly endorses the ongoing operations of effective federal Cabinet and parliamentary processes during the pandemic. This should include ensuring there is an effective emergency Cabinet committee to manage the Australian Government's response at the highest level. It is important that this committee has the right membership to address all elements of the response, and an operating style that allows for rapid and decisive responses that enhance national coordination. As detailed further in Chapter 6: The Australian Public Service: responding to a multi-sectoral crisis, it is also crucial that the public service has a governance structure at Secretary level that can be mobilised rapidly to drive the response.

In a public health emergency, it is essential that well-understood and exercised Australian Government-led coordination mechanisms can be rapidly adapted. The purpose-built National COVID-19 Coordination Commission played an important role in enhancing communications and engagement channels with business, particularly early in the pandemic. However, it lacked clarity of purpose, had poor governance and was seen by some stakeholders as duplicating other effective communication pathways (which are outlined in Chapter 6: The Australian Public Service: responding to a multi-sectoral crisis). Going forward, existing engagement structures should be leveraged before creating something new.

The ongoing operation of Australia's Parliament and the courts, as well as electoral processes, were also important factors in maintaining democratic checks and balances to ensure public trust during a period when the Australian Government was exercising extraordinary powers under the *Biosecurity Act 2015* (Cth) and engaging in significant fiscal expenditure.

The use of powers under the Biosecurity Act should be reviewed to ensure harm is minimised in a future pandemic

The panel notes the Health Minster's powers under the *Biosecurity Act 2015* (Cth) were important in providing authority for elements of the response. However, it was not clear that the economic, social, human rights and broader health, including mental health, impacts of these decisions were balanced against the need for significant restrictions. While rapid decision-making is required in a crisis, particularly in the alert phase, broader impacts should be considered, particularly in decisions to extend determinations under the *Biosecurity Act 2015* (Cth).

Questions have also been raised with the panel about whether it would have been appropriate for the Minister for Health to exercise his powers under the *Biosecurity Act 2015* (Cth) to a greater extent – in particular, whether in doing so the negative impacts that resulted from unilateral decisions by jurisdictions could have been mitigated, for instance the decisions to close state borders. As previously outlined, the panel considers that efforts should be made to proactively minimise the harm from state border closures. However, in a public emergency, legal uncertainty and national disunity might be created if the Commonwealth were to override state legislation, and this was a time when all levels of government needed to be operating cohesively.

We also heard that there was hesitation on the extent of these powers, which potentially led to them not being fully utilised and may also have contributed to the decision to swear the Prime Minister in as Minister for Health – so the powers were shared. This and the subsequent secret swearing-in of the Prime Minister for four additional ministerial portfolios has been found by the independent Bell review to have undermined public confidence in government.[244]

This was the first time these powers were used in a major crisis and no review of their use has been conducted. The panel considers the Australian Government should undertake a post-action review of the use of the human biosecurity provisions under the *Biosecurity Act 2015* (Cth), in consultation with state and territory governments. As part of the review, consideration should be given to:

- whether any changes are needed to better support a future emergency – for example, lessons learnt during the pandemic and informed by current challenges with avian influenza
- how the powers interact with other Commonwealth and state and territory legislation
- whether more tiered powers could be introduced to activate measures more proportionally before reaching national emergency level
- what potential escalation triggers could warrant the use of the full extent of the powers
- ways to ensure any decisions on extensions of determinations include consideration of broader advice on the health, economic, educational, social, equity and human rights impacts.

National coordination across all levels of government with clear roles and responsibilities is crucial

The establishment of a purpose-specific National Cabinet made up of the Prime Minister and First Ministers showed leadership and agility in quickly transforming Commonwealth–state relations to respond to the COVID-19 pandemic in a coordinated way. National Cabinet provided visible, national and united leadership at the highest levels of government and played a significant role in the success of Australia's response. The panel heard repeatedly that it provided a common sense of purpose – of being on Team Australia – and this underpinned the early decisive response.

We note the importance of National Cabinet's early establishment of the National Partnership on COVID-19 Response, which gave states and territories rapid access to funding. This agreement needed to be negotiated at the highest level because only the nation's leaders had the necessary authority to finalise it quickly. We also acknowledge that National Cabinet's commissioning of the National Mental Health and Suicide Prevention Agreement made Australia the first country to develop a pandemic mental health strategy.[245]

Despite its early success and ongoing role during the pandemic, the panel heard that unity of National Cabinet waned in the later phases of the pandemic. In part this reflected the reducing threat levels and prolonged pressure on leaders, but other factors contributed: implementation pressures associated with the lack of pre-existing planning structures, especially for complex logistical matters such as state border closures and vaccine rollouts; and perceived inconsistency in the states' responses, sometimes reflective of their local risk levels and other times not.

While it is not realistic to expect the unity that was present during the initial phases of a pandemic will be maintained, the extent to which more contentious issues are pre-agreed could aide cohesiveness in a crisis. The panel considers that National Cabinet should work together in the immediate future to agree and document the roles and responsibilities of the Australian Government, state and territory government and key partners in a national health emergency. This should include escalation (and de-escalation) triggers for National Cabinet's

activation and operating principles to enhance national coordination and maintain public confidence and trust.

Areas where in protracted health emergencies more clarity is needed on roles and responsibilities include quarantine management, vaccine procurement and rollouts, and the operation of the National Medical Stockpile. This would reduce key areas of tension that at times undermined a national approach during the COVID-19 pandemic.

National Cabinet would also benefit from developing principles to enhance national coordination and guide any unilateral responses by individual jurisdictions. For example, on state border closures the panel heard that they undermined the national response and drove previously unseen divisions between Australians. As noted above, the panel considers the Australian Government was right at that time not to override state and territory government responses, but the very negative impacts of border closures on food security, national supply chains and access to health care are now better understood.

The panel considers that in any future national health emergency National Cabinet should strengthen and better utilise existing Commonwealth–state governance structures. Ministerial councils and advisory bodies bring broader system-wide expertise and extensive networks with key stakeholders and should be tasked to address complex issues in their policy and operational areas. In a health emergency, National Cabinet should continue to rely on the Health Ministers Meeting as the primary source of broader health advice, as Health Ministers are best placed to apply a broader lens to the Australian Health Protection Committee's advice. This would provide a whole-of-health approach while retaining the benefits of direct access to expert public health advice.

This should not just be restricted to health-related issues. The panel considers that, in a whole-of-society emergency, National Cabinet decision-making would benefit from receiving broader advice – for example, on social and human rights issues, broader health impacts (including mental health), economic impacts and responses, and impacts on priority populations. Broader advice will ensure that response measures minimise harm and build public trust. National Cabinet should put in place mechanisms now that ensure it can rapidly leverage this advice in an emergency.

The panel heard varying views on the merits of local government representation on National Cabinet and acknowledge they were key to the implementation of many National Cabinet decisions through their community networks, support and service delivery role. The Prime Minister and other leaders were strongly committed to membership being restricted to the decision-makers and placed great importance on the trusted relationships between members. The panel considers that in a future pandemic response there would be value in more structured engagement and active consultation with local government to enhance the coordination and communication of a national response.

The panel has collated the following operating principles based upon lessons learnt:

Operating principles for a successful Commonwealth–state leaders' forum

Pillar: Leadership

- Maintain a unity of purpose throughout the health emergency by avoiding politicised public bargaining.
- Place a strong focus on national consensus but allow for deviation for jurisdictions based on their local systems, demographics, and circumstances. Where unilateral state decisions occur, aim to minimise flow-on impacts at the national level or on other states and territories through pre-agreeing operational settings including for cross-border movement of essential workers and local communities.

Pillar: Minimising harm

- Ensure expert advice is received on the broader health, economic, social and human rights implications of decisions during a pandemic, including for at-risk cohorts (noting these might vary according to the nature of the pandemic).
- Maintain structured engagement and active consultation with local government to ensure decision-making is informed by local knowledge and enhances the coordination and communication of responses.

Pillar: Trust

- Build trust through two-way communication and transparency.
- Maintain accountability measures including rapid and efficient mid-crisis reviews/regular reflection points.
- Remove barriers to information sharing between jurisdictions and technical advisory bodies to better support coordination in planning and delivery.

Pillar: Relationships

- Agree clear roles and responsibilities between the Commonwealth and states and territories at the ministerial, policy and operational levels to ensure responses are coordinated and harmonised.

Pillar: Agility and innovation

- Adapt and modify the governance and membership arrangements to enable rapid, shared decision-making in potentially uncertain situations, including flexibility in how advice is being received.
- Ensure rapid deployment of intergovernmental funding agreements at the earliest opportunity which accommodates flexibility for dealing with uncertainties.

Transparency in decision-making is essential for public trust

The panel has heard various views on the need for transparency, but has concluded that governments should share more of the evidence and advice that informs key decisions, to build public trust and allow the public to better understand the need for response measures. A community input survey conducted for the Inquiry shows that the initial high level of adherence and cooperative response to significant restrictions is unlikely to be repeated in a future public health emergency.[246] Community feedback suggests that since the pandemic some mainstream audiences have become more sceptical and critical of government decision-making,[247] highlighting the need for greater transparency in a future crisis.

National Cabinet should develop and agree transparency principles for the release of advice that informs decision-making in a public health emergency. This should include the rationale for why decisions are being made that result in the reduction of freedoms.

At the Australian Government level, there should be greater transparency on decisions made under the *Biosecurity Act 2015* (Cth). Determinations the Minister for Health makes under the Act in response to a health emergency are not subject to disallowance, which limits the Australian Parliament's ability to scrutinise or overturn decisions. While we support the need for the Australian Government to be able to make rapid decisions to support the response, we note that greater transparency in the advice used to make these decisions would increase public trust in the response.

Many consider this will be particularly important during protracted health emergencies that involve significant restrictions to individual freedoms. As noted above, the panel considers there is merit in exploring ways to ensure any decisions on extensions of determinations include consideration of broader advice on the health, economic, educational, social, equity and human rights impacts of extensions. We also consider that this advice, and the health advice used to make decisions, should be published.

Singapore's response

Singapore's COVID-19 response was largely successful, and there are lessons we can learn about how a unified and coherent governance model can assist in crisis decision-making.[248] Singapore has a centralised administration and political legitimacy. The Government of Singapore was therefore able to be agile, maintain public trust in government and ensure the public complied with its policies. During the pandemic, public health decisions were concentrated among a small number of key government officials who led various national-level executive groups and taskforces. Singapore's agile decision-making and response rested on the fact that its key decision-making bodies were integrated into a full crisis management structure.[249] All bodies had clearly defined roles and responsibilities, and this ensured that its whole-of-government framework was operating effectively.[250] These features of Singapore's response helped its government respond quickly to changes in the virus and the information available.[251]

5. Learnings

Commonwealth–state leaders' forum

- A national cabinet or similar entity is critical in bringing together national and state and territory leaders to act in the national interest of all Australians, utilising the strengths of a federated system to adopt a unified and holistic approach to minimise the protracted health, safety, economic and social impacts associated with a pandemic.
- Existing forums need to be modified to enable rapid and shared decision-making in uncertain circumstances.
- The Australian Government should, where necessary, lead efforts to better coordinate and harmonise the policy and regulatory responses relating to areas that impact safety, economic security, food security, key supply chains, essential workers and other areas with shared responsibilities across governments to support a greater consistency reflective of risks.
- There needs to be greater clarity regarding roles and responsibilities, communication pathways and the allocation of responsibilities for areas of shared responsibility between governments.
- Local governments are critical for the implementation of National Cabinet decisions and help to build and maintain public trust in government and drive the behaviour change necessary at the local level to implement restrictive measures required to respond effectively to the pandemic. In future crises, National Cabinet would benefit from having more structured engagement and active consultation with local government to ensure decision-making is informed by local knowledge and enhances the coordination and communication of a national response.
- Given the Minister for Health holds significant personal powers under the *Biosecurity Act 2015* (Cth) to make decisions during a health emergency and these powers were previously untested, it is important to embed the Minister for Health into the Commonwealth decision-making process, including the development, implementation and monitoring of decisions.
- Where states and territories intend to make unilateral decisions that could potentially have significant impacts at a national level during a public health emergency (e.g. domestic border closures, school closures), specific mitigations should proactively be considered by National Cabinet to minimise disruptions as a result of those actions. First Secretaries and senior officials could play a key role.
- Greater agreement at National Cabinet is needed about the escalation triggers that would warrant the activation of the Minister for Health's full set of statutory powers under the *Biosecurity Act 2015* (Cth) to adopt a coordinated response across all levels of government that minimises any flow-on impacts from unilateral state and territory decisions.

- The rapid deployment of Commonwealth funding to states and territories in the early stages of the pandemic through the National Partnership on COVID-19 Response was an important initiative and critical to building key responses at the state and territory level. This approach should be replicated in future health emergencies.

Maintaining democratic processes

- The continued operation of parliamentary and other oversight processes throughout the pandemic is vital given the extraordinary powers that underpin key emergency decision-making in a pandemic and the profound potential impacts on human rights, equity and health, economic and social outcomes.

Demonstrating unity of purpose

- National Cabinet was most effective in the alert phase of the pandemic when it had a strong galvanising event and was operating in great fear and uncertainty. There was a strong reliance on having collaborative, collegiate, and frank discussions in a timely way, providing equal access to national data and information, and removing of bureaucratic processes so members could hear directly from experts. This approach was pivotal to the success of the national response and should be maintained in a future pandemic.

Adopting a more holistic approach in decision-making

- The importance of making decisions based on key public health advice in a health emergency is described as a key pillar of Australia's response to the pandemic. However, the scale and likely differential impacts of a pandemic across the population and economy make it necessary for governments to consider and mitigate unintended consequences in parallel and seek to minimise negative impacts on broader health, mental health, educational, equity, economic and social outcomes. Decision-making should be informed by real-time data on efficacy of measures and impacts.

Building and maintaining trust

- Trust and confidence in government decision-making was negatively impacted by a number factors, including inconsistency in response by different jurisdictions, lack of clarity or acceptance of evidence supporting key decisions, misinformation and disinformation, perceived 'politics' being played and perceived unfairness of responses.
- There was an acknowledged need for greater transparency to assist in building and maintaining public trust in a protracted health emergency given the response's high reliance on people being prepared to change their behaviours and act in the collective good, while experiencing negative impacts on key relationships and economic security. This extends to providing greater public access to significant health advice supporting the emergency declaration and extensions of emergency determinations imposing significant restrictions on individuals and business and other mandated actions, as well as the nature of the risk.

- Under the *Biosecurity Act 2015* (Cth), in determining whether the Minister for Health should exercise his emergency powers, his decision-making process was informed by public health advice and consultation with a core list of ministers, and received endorsement by the National Security Committee. Depending on how the Minister for Health intends to respond to the emergency, relevant ministers should be consulted on any direct economic, social or human rights impacts in order to minimise any unintended consequences of a decision. The protocol for the Minister for Health's decision-making should be made public to increase public trust in the considerations that go into decision-making.

Enhancing sustainability and efficiency

- Australia was well served by the retention of Cabinet decision-making processes throughout the pandemic. Structures need to be pre-determined and able to be rapidly established in future pandemic emergencies to bring together key health, financial, legal, regulatory, social and industry decision-makers at ministerial levels. Membership of key Cabinet and supporting secretary-level committees may need to be reviewed to better reflect the nature and scale of the health emergency to include health, social services and other key ministers.
- Given the importance of rapid information sharing between governments and key statutory and technical advisory structures, coordination and consistent communication, confidentiality rules and other constraints on timely sharing of information may need to be reviewed based on lessons learnt during the pandemic.

6. Actions

6.1. Immediate actions – Do in the next 12–18 months

Action 3: Conduct post-action reviews of outstanding key COVID-19 response measures to ensure lessons are captured.

Review the human biosecurity provisions of the *Biosecurity Act 2015* (Cth), including to:

- examine whether further amendments are needed to ensure it can be deployed proportionately to the level of risk in human health emergencies
- explore ways to ensure any decisions on extensions of determinations include consideration of broader advice on the health, economic, educational, social, equity and human rights impacts
- consider inclusion of provisions for tabling or publishing relevant advice and rationale for the extension of determinations that implement restrictive measures under the *Biosecurity Act 2015* (Cth).

Action 5: Develop updated health emergency planning and response arrangements in conjunction with states and territories, and key partners, including consideration of escalation and de-escalation points, real-time review and a focus on post-emergency recovery.

The series of plans should:

- have clearly defined scope, ownership and accountability, including a clear legal basis and defined roles for Commonwealth bodies (including the CDC), states and territories, and industry partners such as aged care providers
- embed pre-planned review mechanisms to support the real-time, rapid review of consequences as they arise, including quick assessments and corrections to emergency response measures without a protracted inquiry process.

Action 8: Establish mechanisms for National Cabinet to receive additional integrated expert advice for a whole-of-society emergency, including advice on social, human rights, economic and broader health impacts (including mental health considerations), as well as specific impacts on priority populations.

In parallel with making decisions based on key public health advice, National Cabinet should consider the differential impacts of a pandemic across the population and economy. This must include considering and mitigating unintended consequences, and seek to minimise negative impacts on broader health, mental health, educational, equity, economic and social outcomes.

Human rights considerations should be embedded into National Cabinet's decision-making processes, particularly where measures are intended to significantly restrict rights and freedoms.

This might include mechanisms for a national health emergency that allow:

- Health Ministers' expertise to be utilised as a key source for whole-of-system health advice for National Cabinet
- Heads of Treasuries to be expanded in a crisis to include the Reserve Bank of Australia Governor (and other key economic regulators as required) to bring together national economic expertise to support National Cabinet.
- expert advice to be sought from the Australian Human Rights Commissioner and other commissioners (e.g. National Children's Commissioner) to support better understanding of the broader impacts of their decisions on human rights and priority populations.

Action 9: Agree and document the responsibilities of the Commonwealth Government, state and territory government and key partners in a national health emergency.

This should include escalation (and de-escalation) triggers for National Cabinet's activation and operating principles to enhance national coordination and maintain public confidence and trust, including:

- National Cabinet providing opportunities for more structured engagement and active consultation with local government to enhance the coordination and communication of a national response
- agreeing escalation (and de-escalation) triggers for activation and operating principles to enhance national coordination and maintain public confidence and trust, including in relation to state border closures
- greater clarification of roles and responsibilities, including around key areas of shared or intersecting responsibility such as vaccine distribution, health and social care of people with disability, older Australians and the provision of economic support in a national health emergency.

Action 10: Agree and test a national Australian Government governance structure to support future health crisis responses, including an appropriate emergency Cabinet Committee and a 'Secretaries Response Group' chaired by the Department of the Prime Minister and Cabinet that brings together the lead Secretaries and heads of relevant operational agencies, to coordinate the Australian Government response.

A purpose-specific governance structure, aligned with the revised Australian Government Crisis Management Framework, should be rapidly mobilised and tested in future pandemic incidents requiring a multi-sectoral response.

Plans should be tested to ensure they are ready to be mobilised ahead of a crisis.

The governance structure should include:

- an Emergency Management Cabinet Committee to manage the Australian Government's response, with appropriate membership and operating principles to reflect the nature of the risk, the role of statutory decision-makers and the importance of having the right people, with the right knowledge, at the right table, at the right time
- a 'Secretaries Response Group' with a similar role to the Secretaries Committee on National Security, to support the Prime Minister and Cabinet to lead the coordination, development and implementation of the Australian Government response.
    - The Secretaries Response Group should be chaired by the Department of the Prime Minister and Cabinet and include lead Secretaries and heads of operational agencies that reflect the specific circumstances of the emergency and response.

- There should be formal reporting lines between the Secretaries Response Group and other senior officials' bodies, including supporting clusters of officials across relevant departments to progress work and enhance coordination with the states and territories.

Action 16: Develop and agree principles for the transparent release of advice that informs decision-making in a public health emergency.

National Cabinet (and other key decision-making bodies) should be more transparent in disclosing the expert advice that underpins their decisions, and the other multi-sectoral factors that must necessarily influence policy decisions.

- This should include the rationale for why decisions are being made that result in significant reduction of freedoms.
- Principles should be developed in partnership with science communication experts to ensure consideration is given to how evidence and advice can be easily interpreted given the inherent complexities and nuances.

Chapter 5 – Trust and human rights

1. Context

During a crisis, trust in government is an essential foundation given the need for people to potentially drastically change their behaviour to avoid adverse outcomes (in the case of the COVID-19 pandemic, to protect themselves and the community from severe illness and death and the potential collapse of the health system and societal functioning.[252] Compared internationally, Australians enjoy a high level of access to human rights and freedoms.[253] During the pandemic, however, the significant restrictions that were in place to reduce the risk of the disease impacted on freedoms and human rights – disproportionately so for some occupations and population groups.

This chapter identifies the issues that impacted trust in government and institutions and were perceived as most detrimental to individual freedoms and rights during the pandemic. It also considers specific issues regarding digital technology and privacy in a pandemic.

Before the COVID-19 pandemic, an Organisation for Economic Co-operation and Development (OECD) survey indicated that almost half of the Australian population trusted government, which placed us 10 out of 19 countries.[254] Trust in public services was slightly higher (58 per cent) and trust in the healthcare system was higher still (66.7 per cent).[255]

Studies found that during the pandemic, societies with higher trust recorded lower excess mortality rates[256] and lower standardised infection rates.[257] Early success in combating COVID-19 increased trust in a government.[258] An increase in trust at the beginning of the pandemic could increase the success of government containment measures. However, there was a risk that the containment measures themselves would decrease trust the longer they were in place.[259]

The extraordinary measures implemented in Australia during the pandemic required the restriction of certain rights (e.g. freedom of movement and freedom of association). Levels of trust in governments, officials and experts, and the public's willingness to accept significant restrictions on their human rights, changed significantly throughout the pandemic. Trust in government was high in the alert phase of the pandemic, but the longer the pandemic continued, the more trust decreased from its peak in mid-2020.[260]

Australians were initially willing to forgo their usual high levels of freedom to unite for the common good. For example, they were willing to comply with strict international border restrictions and mandated supervised quarantine despite the significant restrictions these policies placed on individual freedoms. By the second year of the pandemic, restrictions on personal freedoms were less accepted as Australia's rate of infection remained low relative to other countries.

Many of the key data-sharing and digital measures in the pandemic relied on individuals trusting the safety and privacy protections around the use of their data. Digital technology was

important during the pandemic to support the government response. Digital solutions were developed to support contact tracing, and QR code check-in was introduced to enable the reopening of businesses. The speed of the response exposed gaps in Australia's outdated privacy legislation. Privacy issues became apparent in the public sharing of individual case information and through the use of digital technologies. There was also concern that contact-tracing data could be shared with police and used to build a case for breach of public health orders, or other criminal matters. A loss of trust in the security of public health data would have undermined contact tracing and the early identification and control of outbreaks.

2. Response

2.1. Trust

In the alert and suppression phases of the pandemic, public trust in government increased dramatically from pre-pandemic levels as governments took swift action to contain the virus and reduce severe illness and death.[261] The Scanlon Institute's Mapping Social Cohesion report found that 85 per cent of respondents believed that the Australian Government was responding 'fairly well' or 'very well' to the pandemic.[262]

Throughout the pandemic, governments collected data to assess the effectiveness of health and other response measures and assist in devising new measures. The Department of the Prime Minister and Cabinet's Behavioural Economics Team undertook a COVID-19 Barometer Survey over 13 weeks between March and June 2020. The survey aimed to measure people's behaviour and attitudes in response to the pandemic, with a particular focus on protective health behaviour. The results provided a real-time dataset on acceptance of protective health behaviours and its drivers, and informed modelling by a Doherty Institute led consortium. This information went to the Prime Minister, National Cabinet, the Department of Health and the National Health and Medical Research Council and was a key input into policymakers' understanding of compliance with lockdowns and other directives. Similar surveys were conducted at state level.[263]

The Department of the Prime Minister and Cabinet's Behavioural Economics Team's survey found a decline in compliance with protective health behaviours from 9 out of 10 in early April 2020, to 4 out of 10 in late June 2020. For example, the number of respondents reporting that they always kept 1.5 m from others fell from 6 out of 10 to 4 out of 10. The survey found that people were more likely to engage in protective behaviours when they perceived a threat from COVID-19, understood the benefits of protective behaviours, did not face costs in complying, trusted those advising them to engage in protective behaviours, and saw their peers complying.[264]

As the response continued into the suppression and vaccine rollout phases, trust steadily declined, eventually returning to pre-pandemic levels.[265] The reasons for this decline vary across studies and depend on the individual. However, lower confidence and trust have been associated with:

- older age
- lower education levels
- lower health literacy
- being born in Australia
- lower perceived COVID-19 risk in Australia
- not being personally concerned about getting COVID-19
- use of non-government information sources as a top information source (e.g. social media, news websites)
- chronic health conditions.[266]

As outlined in Chapter 11: Communicating in a crisis, there was significant demand for information regarding the virus and how to combat it. The mass of information had an undermining effect on trust, along with the pre-existing shift in the media landscape to non-traditional sources of information. It was not clear who had relevant expertise to comment on certain topics. This impacted trust in science, particularly in relation to COVID-19 vaccines.

2.2.Human rights

During the pandemic, Australians experienced significant restrictions on their freedoms and human rights[267].[268] At the Commonwealth level, most of these restrictions resulted from response measures agreed by National Cabinet (particularly during the alert phase) and enacted through the *Biosecurity Act 2015* (Cth). They included restrictions on movement and association, hotel quarantine and the international border closure.

States and territories were largely responsible for implementing public health measures following National Cabinet decisions. Through public health orders, directions and legislative instruments, they imposed state border closures, lockdowns, school closures, and vaccine and mask mandates. As the pandemic continued, individual states and territories became more divergent, taking unilateral response measures with varying levels of restrictions.

People interviewed for the Inquiry confirmed that many of these restrictions arose from government decision-making processes that were not pre-planned, were set up quickly and initially lacked clarity, transparency and avenues for review or appeal.[269] The panel has heard that human rights were not a primary consideration in decision-making at the National Cabinet or federal level. Instead public health advice was prioritised in decisions throughout the response.[270]

In Australia, human rights protections come from a diverse range of sources. At the federal level these include the Australian Constitution (express and implied protections), common law and statute law, and policy and practice. At the state/territory level each jurisdiction has different statutes relating to human rights.

The Australian Human Rights Commission has powers to investigate and conciliate discrimination and human rights complaints. It played a key role during the pandemic in investigating complaints about discrimination and human rights breaches. In the 2022–23 October Budget, the Australian Human Rights Commission received $31.8 million of additional resourcing for its core functions, including $3.6m to fund a temporary staffing increase to help clear the backlog of complaints, including the COVID-19 related complaints.[271]

The main role of the Parliamentary Joint Committee on Human Rights is to examine Bills, Acts and legislative instruments for compatibility with human rights. Under the *Human Rights (Parliamentary Scrutiny) Act 2011* (Cth), legislative instruments that are not subject to disallowance – such as emergency determinations made under the *Biosecurity Act 2015* (Cth) – need not be accompanied by a 'statement of compatibility with human rights'.[272] However, given the potential human rights impacts of legislative instruments dealing with COVID-19, the Parliamentary Joint Committee on Human Rights assessed them for compatibility with human rights and sought additional information from the responsible ministers where limitations to human rights were put in place.[273] The Parliamentary Joint Committee on Human Rights has no legislative function to assess legislation or legislative instruments made under state or territory legislation.

At the state level, three jurisdictions have human rights legislation, all of which list factors that determine whether a limitation on a right is justified. Some of the additional key features include:

- Victoria's *Charter of Human Rights and Responsibilities Act 2006* requires public authorities to only act in a way that is compatible with human rights.
- The Australian Capital Territory's *Human Rights Act 2004* requires public authorities to act and make decisions in a way that is compatible with human rights. In making decisions they must give proper consideration to relevant human rights.
- Queensland's *Human Rights Act 2019* requires public authorities to act and make decisions in a way that is compatible with human rights. In making decisions they must give proper consideration to relevant human rights.

2.3.Privacy

Privacy issues emerged early in the pandemic as public health data were shared at unprecedented levels and as digital tools to help with the response were quickly developed. The *Privacy Act 1988* (Cth) applies to Australian Government agencies and private sector organisations with annual turnover of $3 million or more, and regulates how business and Australian Government agencies must handle people's personal information.[274] The *Privacy Act 1988* provides 13 Australian Privacy Principles, which are the cornerstone of the privacy protection framework. They govern how organisations collect, use and disclose personal information; their accountability for these actions; integrity and correction of personal information; and people's rights to access their personal information.[275] The states and

territories have privacy legislation that covers how their public sector agencies must handle personal information.[276]

The Australian Government was quick to develop the COVIDSafe smartphone app for contact tracing. Privacy was a key consideration during the development of the app. The Australian Information Commissioner was consulted and their recommendations were implemented.[277] The app was launched on 26 April 2020 and received legislative backing from the *Privacy Amendment (Public Health Contact Information) Act 2020* (Cth), passed on 12 May 2020.[278] Within a month there were over 6 million registrations – approximately 25 per cent to 30 per cent of Australian adults.[279]

From September 2020 onwards all state and territory governments released QR code based check-in apps. Most mandated the use of their app to support contact tracing.[280] State owned and managed QR check-in apps were not subject to the *Privacy Act 1988* but rather to the state's privacy laws.[281]

In 2021 the Office of the Australian Information Commissioner collaborated with state and territory privacy commissioners to develop a set of universal privacy principles to address the risks relating to information security and privacy.[282] These principles supported a nationally consistent approach to resolving privacy issues, guided best practice for government and business, and ensured that 'privacy by design' would be built into any COVID-19 response to help maintain public trust.[283]

3. Impact

3.1. Trust

3.1.1. Increase in trust during the alert phase of the pandemic

During the alert phase of the pandemic, the general public knew very little about the virus. People turned to government for information and protection of their health, interests, livelihoods and families. This was markedly different from expectations of government during normal times.[284]

Initially the government lived up to people's expectations. The creation of National Cabinet, the perceived unity among political leaders, the reliance on health advice and the regular communication from political leaders alongside health experts signalled to the public that government was prioritising the protection of its citizens' lives.[285] The government also rapidly established economic relief and social support programs to address concerns about the broader economic and social impacts of the pandemic. This unified, timely response that considered both health and economic security had a direct positive impact on trust. In turn the increase in trust encouraged people to comply with public health orders, and this made containment measures more effective.[286] The success of Australia's response in containing the

spread of COVID-19 during the alert phase supported the government's message that it was doing all it could to keep Australians safe, which reinforced trust.

> *The Australian Government provided adequate information on the pandemic and made sure the population were aware of the impacts, and also … how to respond and manage the symptoms without panic. Moreover, the financial support given to the citizens who were impacted was very helpful. – Survey participant*[287]

The reported increase in trust in government is consistent with numerous studies showing that trust increases during and after disasters.[288] It is common for people to look to authorities to guide them through a crisis and to put aside partisan matters and band together for a common cause – the 'rally around the flag' effect.[289]

> *Overall, I think the government did a good job at keeping people safe compared to other countries who didn't take action quick enough or were not as strict. I was always happy to comply with the restrictions as I knew it was for the greater good. – Survey participant*[290]

3.1.2. Growing loss of trust as the pandemic restrictions remained in place

The panel overwhelmingly heard about a decrease in trust as the pandemic wore on.[291] This arose from concerns about the lack of transparency and supporting evidence for decision-making, the stringency and duration of restrictions and mandated measures, access to vaccines and inconsistencies in state and territory responses.

Government leaders held daily press conferences, released case and death statistics and some modelling, and later released statistics on vaccine uptake. However, the perception that governments were not transparent was a strong theme in what the panel heard.

> *In the future we need more transparency which means more trust … they need to communicate more, for example why we are doing this or stopping this. – Focus group participant*[292]

Focus group participants said that governments resisted releasing information that may have contradicted the policies they were pursuing.[293] This opinion led to a view that government did not trust the public to understand or interpret information correctly.[294] A lack of transparency around vaccination prioritisation decisions reduced trust in government, particularly among people with disability. The panel heard that a lack of transparency also increased the perception that the government was hiding adverse information.[295] This view fuelled the spread of misinformation and disinformation.

People felt they were unable to criticise or question government decisions and policies. Focus groups described how fear-based, patronising and heavy-handed communication from political leaders added to the perception that restrictions were not up for debate.[296] Fear-based communication coupled with punitive approaches caused some people to turn away from official and credible sources of information, further eroding their trust in government.

> *I'm not a fan of how it was handled, it was very aggressive … we had no freedom of choice or bodily autonomy … I have less trust in government and health officials now. – Focus group participant*[297]

One of the greatest challenges to trust in science was when jurisdictions took different approaches in similar situations while telling the public they were listening to the science. The Australian Government encouraged national consistency, but by mid-2020 it had become increasingly difficult to achieve.[298] We heard that criticisms of and comparisons between different state and territory approaches were not helpful and may have added to the questions people had about the science itself and the application of science in policymaking (see Chapter 9: Buying time for more detail).[299]

Opinions were particularly polarised on mandatory public health measures. Concerns about the safety, effectiveness and legality of these measures were strongly influenced by social media sources. The panel heard that mandating restrictions and actions, especially vaccination, had the biggest negative impact on trust and increased rejection of these measures (see Chapter 10: The path to opening up for a broader discussion of vaccine mandates). A significant number of submissions, focus group participants and survey respondents voiced negative opinions about mandates.[300] People reflected that mandating certain behaviours made them feel 'forced' and 'disempowered'.[301]

> *I don't think anything should be made mandatory, and having people backed into a corner takes trust away from the government. Where's the freedom of choice when our only options were get vaxxed or lose your job? How is that fair? – Survey participant*[302]

Focus groups revealed that many people had strong negative feelings about vaccine mandates and that these feelings had a strong correlation to mistrust in government and medical science.[303] In a community input survey conducted for the Inquiry in 2024, 21 per cent of respondents said they would not get a vaccine offered by the government in a future public health emergency, and 17 per cent said they might or might not.[304] This is consistent with what we heard from our roundtable, where people raised concerns that erosion of trust coupled with loss of agency in vaccine choices in a pandemic can reduce uptake of non-mandated vaccines.[305]

The panel heard different views on the causes of decreased trust. The range of views highlights how complex it is to define, and therefore improve, trust in government. We heard how individual negative experiences undermined people's trust in government.[306] People who were stranded overseas, not permitted to see dying loved ones, frustrated by changing restrictions and unable to access supports expressed their resentment towards and distrust of government.[307]

> *COVID has completely changed my views on the medical field and profession … my trust is at rock bottom, gone completely. – Focus group participant*[308]

Don't lie. Most people have good intuition. Unfortunately, you lied so much during this event. Most will never ever trust you. – Survey participant[309]

People's perceptions of the handling of the pandemic have changed over time. In a survey conducted in 2024, 54 per cent of survey respondents said the government's response at the time was appropriate, compared with 80 per cent of survey respondents during the peak of the pandemic in 2020 and 2021.[310] In 2024, 29 per cent of survey respondents said the Australian Government had overreacted to the situation and were more likely to rate its performance poorly compared to survey respondents during the peak of the pandemic.[311] This change reflects the feelings of some that, with hindsight, pandemic measures did not align with the threat level and were kept in place for too long. It also shows a potential decrease in people's likelihood to follow significant restrictions in future public health emergencies.

The panel heard multiple strategies to increase trust before and during the next public health emergency. The most common suggestion was to provide greater transparency. Many people told us that publicly releasing the evidence, advice and data that were relied on for decision-making was a non-negotiable strategy for the next pandemic.[312] Greater transparency was also linked with more open and frank communication with the public on government decision-making processes.[313] We heard that the government needs to be prepared to admit to the public that decisions cannot solely be based on health advice, that it may not have all the information, or that restrictions may change as information changes.[314] Collecting and sharing real-time effectiveness data beyond case counts is critical to justifying decisions to introduce, continue or intensify response measures, and their duration.[315]

The panel heard that open dialogue and robust public debate improves policies and will be essential to maintaining trust in government during the next pandemic.[316] Government must establish partnerships with community groups to ensure people feel heard and valued and see their views reflected in policies.[317] The panel heard that community input is particularly important for structurally disadvantaged and marginalised groups whose experience differs from that of the general community.[318]

Survey respondents were asked specifically what factors would increase adherence with significant restrictions in a future public health emergency. Responses highlighted the importance of communicating requirements in a clear and easy to understand manner, and providing explicit justifications for why significant restrictions are in place.[319]

3.1.3. Impact of the enforcement approach on trust and future compliance

Both the level of restrictions imposed and the approach used by states and territories to enforce these restrictions impacted trust. This is likely to affect future levels of compliance with public health orders, and community trust in police. The panel heard that governments need to consider how to manage compliance with significant restrictions more consistently across different locations and groups, particularly the use of the police and the Australian Defence Force, to ensure any future compliance approach is reasonable and proportionate to the public health risks.[320]

States and territories were largely responsible for implementing many of the restrictive measures and determining how they would drive compliance and enforce restrictions. The Australian Government offered states and territories the assistance of the Australian Defence Force, which was accepted by some jurisdictions during various phases of the pandemic.

During the suppression phase, state and territory public health directions and orders began to vary across jurisdictions. Local variation did not always align with overt differences in outbreak control challenges or risks. Restrictions sometimes changed frequently, becoming more complex and difficult for the community to understand.

Jurisdictions also took differing approaches to compliance. Some states used enforcement (e.g., New South Wales and Victoria – see Melbourne tower lockdowns). Others chose a more health-driven, educational approach. For example, we heard that the Australian Capital Territory chose to balance the risk of spreading COVID-19 with the protection of human rights and displayed better engagement overall.[321] Evidence suggests that relying on an enforcement approach does not necessarily provide the intended outcome and can have negative impacts. For example, we heard that it eroded trust in the police and health authorities, had a disproportionate impact on specific populations, reduced the likelihood of future compliant behaviour, and in some circumstances led to violence – such as the violent anti-lockdown protest in Melbourne and violent threats against local councils.[322]

The panel heard that New South Wales relied on a policing response as the New South Wales Police Force alone had the requisite legislative powers and responsibilities to enforce compliance with public health orders.[323] The New South Wales Government acknowledged the need to balance the social and cultural wellbeing of the public against the requirement for policing actions, but the panel heard they did not always find the correct balance. [324] We heard that the use of on-the-spot fines for non-compliance of public health orders was viewed as largely chaotic, unfair and discriminatory.[325] COVID-19 related fines were higher than fines for existing criminal offences and were disproportionately issued to specific population groups:

- Aboriginal and Torres Strait Islander people
- people who were most likely to be outside their home, such as people experiencing homelessness and children with socio-economic challenges or unsafe home environments
- people whose main language was not English, because public health orders were only published in English for a considerable period during lockdown.[326]

Rapid changes to public health orders also made it almost impossible for the police to maintain a current understanding of the measures in place and issue infringement notices appropriately. For example, the New South Wales Government withdrew over 33,000 COVID-19 fines following a New South Wales Supreme Court decision in November 2022 that found that fines must clearly specify the offence committed in order to be valid.[327] New South Wales residents had 21 days to claim a refund of invalid COVID-19 fines.[328]

Melbourne housing tower lockdowns

In July 2020 the Victorian Government locked down around 3,000 residents in nine Flemington and North Melbourne public housing towers for five to nine days without warning.[329]

'Hundreds of uniformed Victorian Police officers were immediately deployed to the North Melbourne and Flemington estates. Police perimeters were formed around the affected public housing towers. Residents were directed to remain inside their homes. – Victorian Ombudsman'[330]

The residents of these blocks were mainly from refugee and migrant culturally and linguistically diverse backgrounds.[331]

In December 2020 the Victorian Ombudsman, Deborah Glass, found that the state government breached the human rights of residents by locking down the towers without notice and that the timing of this measure did not reflect health advice.[332] On 17 August 2023 the Supreme Court approved a $5 million settlement from the Victorian Government to the residents of the towers (approximately $1,600 per resident).[333]

This lockdown was the 'first use of emergency detention powers to manage an outbreak of COVID-19 within the Victorian community, and the first "hard lockdown" of a high-density residential building anywhere in Australia in response to the global pandemic. There were no Victorian or Australian Government guidelines relating to such an intervention'.[334]

'The heavy police intervention, coupled with a lack of early engagement with communities and appropriate health prevention measures in an at-risk environment, reinforced the perception that, unlike other Victorians, migrant and refugee communities, particularly those who are socio economically disadvantaged, can be treated in ways that deny them voice, recognition or their knowledge, and agency.'[335]

The impact of restrictions and enforcement measures was borne out in individual submissions and in the Inquiry's focus groups. People told us that, since the COVID-19 pandemic, there continues to be resentment about what they lost (e.g. choice, connections, freedoms and autonomy).[336] Focus groups suggested a need to rebuild the social fabric of society as this will be critical to effective management in future public health emergencies.[337] They also suggested that in a public health emergency the government needs to use positive methods to encourage adherence, goodwill, openness to information and trust, rather than the 'stick-based' approach taken in some jurisdictions that were perceived as 'punitive' and 'forceful'.[338]

3.2.Human rights

The panel heard acknowledgement that there were legitimate reasons for governments to impose restrictive measures. However, the panel heard these restrictions had to meet the requirements of legality, necessity and proportionality, and be non-discriminatory.[339] Restrictions that continued to meet these requirements were not considered to impact on human rights.

We heard that it was critical to strike a balance between competing rights such as the right to health and the right to freedom of movement and association.[340] However, how the public perceived this balance depended on the phase of the pandemic and the level of trust people had in the government's response. According to focus groups, the public were initially tolerant of restrictive measures but their tolerance decreased as the country shifted into the suppression and vaccination rollout phases.[341] People felt that restrictive measures were not appropriate for the long term and were too heavy-handed and controlling.[342] There was a perception that authorities lacked compassion and refused to make exceptions based on need and circumstance.[343] For example:

- as some restrictions were for long periods of time, they came with a significant human cost. We heard that this was increasingly perceived as disproportionate to the risk, especially in relation to cohorts such as children and young people[344]
- significant concerns were raised about vaccine mandates and people's freedom to make their own medical choices – whether to take a COVID-19 vaccination – and the consequences of choosing not to
- public health restrictions left older Australians, particularly those in residential aged care facilities and palliative care, socially isolated with very limited access to their families and communities.[345] In this case, there needed to be more consideration of individual choice when balancing the competing rights of spending time with family or remaining more isolated to reduce exposure risk.

In addition to the public's concerns, the Australian Human Rights Commission highlighted concerns about the lack of transparency in explaining the continued justification for some restrictive measures.[346] The former President of the Australian Human Rights Commission identified that the usual checks and balances were not in place to ensure the appropriate transparency and accountability in decision-making, and that Australians had been potentially subjected to unnecessary restrictions of their rights and freedoms.[347]

The panel heard that having a national human rights framework or a national Human Rights Act would ensure that the government accounts for the necessary human rights considerations in its decision-making. The panel heard from some stakeholders that it could also provide a clear set of enforceable human rights standards that offer an avenue for people to challenge potential breaches of their rights.[348] At a state level, the Victorian, Australian Capital Territory and Queensland governments were required to comply with their human rights legislation. For example, we heard from the Australian Capital Territory government that human rights were always a key consideration in its decision-making processes.[349] In particular, the Chief Health Officer would regularly speak with the Australian Capital Territory Human Rights Commissioner.[350] We heard that in Victoria, consultation on human rights was mandatory.[351]

However, we heard that even in jurisdictions with human rights legislation there can still be issues given there is no Commonwealth-level Human Rights Act, particularly where responsibilities are shared between the Commonwealth and the states and territories.[352] The

panel heard from constitutional lawyers and human rights leaders that the federal government and National Cabinet need to further embed human rights into decision-making processes, especially when decisions with a strong potential impact on human rights are being made in a rapidly changing and uncertain environment. [353] They considered this would strengthen the quality of decisions and improve accountability. Roundtable participants identified the importance of developing policy measures within existing frameworks that already have human rights protections built in.[354] For example, JobKeeper was an important support but was managed outside the existing social security system, so there was a lack of clarity about the protections available and rights of appeal.[355]

The panel heard that there were limited community engagement channels for human rights concerns to be fed into decision-making. Real-time input would help governments to better understand potential human rights impacts on different communities and how best to balance any competing rights. This would also support more open and frank communication with the public on decision-making processes, and help all levels of government to explain why decisions are made and what circumstances could lead to a change in decision or the end of an intervention.[356]

3.2.1. Disproportionate impacts of restrictions on specific populations

The panel heard that the impacts of restrictive measures were felt disproportionately across various populations – such as children and young people, culturally and linguistically diverse communities, people with disability, people experiencing homelessness and Aboriginal and Torres Strait Islander people – and by occupation and geographic location. The cause of this was governments not adequately considering the specific characteristics and needs of these populations in their decision-making processes. We heard that it often reflected lack of understanding, knowledge and direct input from peak bodies and population-specific non-government organisations and communities (see the Equity section). We heard that:

- for Australians in residential aged care, restrictions imposed during the pandemic had a significant and disproportionate impact. This included restrictions on access to broader health care and visits from family members. We heard that the restrictions made residents feel like 'second class citizens' without agency in the final years of their lives.[357] More on this is covered in Chapter 18: Older Australians
- for people with disability, there were particular concerns about restrictions on visits to closed indoor settings, including the homes of people with disability. For example, denying family and carers access to these settings during lockdowns increased the risk of human rights breaches through forced isolation and reduced basic care. We also heard that people with disability felt that their right to equitable healthcare access was undermined during the pandemic. More on this is covered in Chapter 16: People with disability
- children's rights were deprioritised to support the public health response. This had significant long-term impacts that outweighed the risk to children and the wider

community. The key decision-making forums had no representative for the rights of children. More on this can be found in Chapter 14: Children and young people

- Australian citizens' rights were restricted as a result of the international travel restrictions and the India Travel Pause. Some Australians were left stranded overseas for extended periods of time, encroaching on their rights as citizens. More on this can be found in the Chapter 7: Managing the international border
- for regional, rural and remote communities, measures imposed in metropolitan areas were not always appropriate. It was also difficult, particularly in more remote areas, to find locally relevant information about risk and pandemic response measures from the government.[358]

Rights of people in detention

Correctional facilities and places of detention were hotspots for COVID-19 outbreaks and carried additional risks due to the close living environment, security requirements and inflexible infrastructure, and the physical and mental health vulnerabilities of detainees.[359] Detainee populations also have a higher prevalence of health conditions associated with greater risk of severe COVID-19 disease.[360] While people in correctional facilities and places of detention have limits placed on their movement and activities in 'normal' times, during the pandemic they faced greater infection risk than the general public because of the congregated living arrangements, and even stricter restrictions impacting their human rights.

We heard that at least one prison initiated an immediate lockdown and restricted people to their cells for 23 hours a day if there was a COVID-19 outbreak.[361] The prison was 'in a state of panic', which heightened everyone's stress levels. Detainees were only able to speak to a social worker for approximately 10 minutes to identify suicide risk.[362] There was increased separation and isolation within correctional facilities, and less access to programs, education, family and legal visits. Incoming prisoners, including children and young people, were forced to quarantine.[363] Aboriginal and Torres Strait Islander people who were incarcerated were prevented from attending critical cultural practices, such as Sorry Business, and there were fewer transfer requests approved for those wanting to move to a prison closer to their community and country (see Chapter 13: Aboriginal and Torres Strait Islander people for more).[364]

The panel heard that if human rights considerations had been prioritised and fed into regular reviews of decision-making, it would have helped minimise the unintended negative and inequitable consequences of some measures for at-risk populations.[365] For example, it was suggested that a human rights informed approach to the vaccine rollout could have led to better organisation and prioritisation.[366]

Certain business sectors were also disproportionately impacted by restrictions. Measures were progressively introduced to support some sectors (e.g. child care, arts and tourism) but were not always equally beneficial to all businesses within sectors.[367] See Chapter 24: Supporting industry for further details. We are still seeing legal challenges to the proportionality of

interventions play out in courts across the country. For example, the Supreme Court of Victoria has recommended a class action representing over 100,000 businesses claiming disproportionate impacts during lockdowns to proceed to mediation in November 2024.[368] Only after all cases are resolved will the true cost burden for taxpayers be revealed, and the lessons for future pandemics be fully understood.

3.2.2. Human rights complaints mechanisms and parliamentary scrutiny

The panel heard that during the pandemic people raising significant issues with government about how their rights and freedoms were being impacted by government decisions frequently did not receive a timely response on how their concerns would be addressed.[369] This was true across jurisdictions regardless of the tools for human rights protection at state level.

During the pandemic, the Australian Human Rights Commission received 3,070 complaints related to COVID-19 (in addition to 14,310 enquiries).[370] These consisted of complaints under the *Disability Discrimination Act 1992* (Cth) (mostly relating to mask-wearing requirements and vaccinations, and complaints alleging breaches of human rights, particularly in relation to international travel restrictions).[371] This was the single issue that had the most impact on complaint numbers in the Australian Human Rights Commission's history.[372]

People who made complaints relating to international travel restrictions had no way to seek formal review of exemption decisions. This left Australians with no access to remedies when they were stranded overseas during the pandemic. This was particularly felt by those applying for 'compassionate and compelling' travel exemptions, the category that had the lowest approval rates for both inward and outward travel.[373] Timeliness of exemptions that were granted was also a concern. There was limited response or action from the Australian Government on the concerns being raised – including for people seeking to be reunited with dying relatives or in need of critical medical support back home.[374] (See Chapter 7: Managing the international border.)

The Senate Standing Committee for the Scrutiny of Delegated Legislation reported on the need for greater scrutiny of the declarations, determinations and orders made under Commonwealth Acts to respond to the pandemic. Of the 249 legislative instruments made during the pandemic, approximately 20 per cent were exempt from disallowance by the parliament and scrutiny by the committee, including all determinations made under the *Biosecurity Act 2015* (Cth). These instruments covered measures such as travel bans on Australian citizens and the declaration and extension of the human biosecurity emergency period.[375]

To improve the future effectiveness of complaints and scrutiny mechanisms, the New South Wales Ombudsman has proposed integrating external oversight and complaint handling into crisis response planning by:

- identifying and briefing independent oversight bodies
- designating a single oversight body to handle complaints

- granting this designated body the role of monitoring the internal complaint-handling processes of the agencies involved in the crisis response. [376]

A number of Federal Court cases sought to challenge the validity of human biosecurity emergency powers to make emergency determinations made under the *Biosecurity Act 2015* (Cth). These included cases relating to the India Travel Pause and the overseas travel ban.[377] Each case was unsuccessful. The Fair Work Commission also heard cases arising from the pandemic response – for example, challenges to the reasonableness of private sector vaccine mandates under the *Work Health and Safety Act 2011* (Cth).[378]

3.2.3. Privacy issues and the use of digital technology

The panel heard that during a public health emergency, Australians are willing to accept privacy trade-offs as long as there are sufficient protections, including oversight and expiration dates.[379] The COVID-19 pandemic dramatically increased the use of myGov, the Australian Government's main digital services platform.[380] In 2017 there were 11.7 million myGov accounts; in 2023 there were over 25 million.[381] Through myGov almost 20 million Australians downloaded their digital COVID-19 vaccination certificate and 4.6 million downloaded their international COVID-19 vaccination certificate.[382] Two other main types of digital technologies were widely used during the pandemic: the Commonwealth's COVIDSafe app, and the state owned and managed QR code check-in apps. Both had potential privacy implications.

The panel heard that the government did consider key privacy issues when developing COVIDSafe. The main criticism of COVIDSafe was that it was ultimately not successful. Public health officials had limited need for it, as there were existing contact-tracing processes and relatively low community transmission.[383] The app cost over $7.7 million and in New South Wales only detected 17 (<0.1 per cent) additional close contacts who were not identified by conventional contact tracing.[384]

> *While it [the COVIDSafe app] was well developed for consumer usability, it was perceived as burdensome for public health staff who undertook contract tracing. The app generated a large volume of data creating additional workloads. Public criticism of the app included fears of government tracking personal information. Despite taking privacy considerations seriously, management of this public perception could have been stronger to alleviate these concerns – Department of Health and Aged Care*[385]

From individual submissions, we heard views that the COVIDSafe app 'wasted an outrageous amount of taxpayers' money', and was useless as the states replaced it with their own apps, referring to the apps that allowed QR code check-ins at venues.[386]

Initially privacy and cybersecurity experts warned that the lack of due diligence in vetting registration platforms used for these apps left the system – and the 'gold standard' personal data it managed – vulnerable to exploitation.[387] These concerns undermined trust and quickly led state governments to develop their own QR code apps.[388] The rapid uptake of these apps allowed businesses to reopen while complying with public health orders, particularly when

there were different rules based on vaccination status, and enabled greater individual freedom and movement than might have otherwise been tolerated by health departments. We heard that the QR codes were easy to use and straightforward.[389] However there were people who had older mobile phones that could not scan QR codes or download apps, or had no access to an internet connection or a mobile phone.[390]

We heard about the inconsistency in Australia's privacy laws, and different requirements for data collection and privacy considerations across jurisdictions. State owned and managed QR check-in apps were not subject to the Commonwealth *Privacy Act 1988* but rather to the privacy laws in their specific jurisdiction.[391] Small businesses with an annual turnover of less than $3 million are also not generally covered by the *Privacy Act 1988*. This meant that small businesses collecting personal information for contact-tracing purposes were not covered by the Australian Privacy Principles.[392] The Australian Government has agreed in principle to remove this exemption in response to the 2022 Privacy Act Review Report.[393] Interviewees and the Office of the Australian Information Commissioner submission emphasised the need for cohesive federal and state privacy laws and regulators.[394] We heard from an interviewee that Australia needs legislation to ensure that individual data are not passed on to police or insurance companies, and that the perception that this could occur reduced trust in government technologies.[395]

Concerns were raised about contact-tracing data from state-based apps being made available to police and enforcement authorities. Police in Queensland, Western Australia and Victoria acknowledged that they tried to access data from these apps as part of their investigations, and that police could access these data using a warrant.[396] This is closely tied to trust in data security, and could have undermined contact tracing if people had stopped sharing full information on and about their movements.

In March 2020 the Australian Bureau of Statistics introduced a range of COVID-19 related products as the pandemic increased the demand for more up-to-date and specific data on the impacts of the pandemic.[397] The Australian Bureau of Statistics continuously reviewed the new range of products to ensure they met Australia's data needs and protected the privacy, confidentiality and security of the information collected.[398]

The panel heard significant concerns about the handling of personal information that could potentially lead to easy identification of individuals. When this did occur, these people became pariahs and were condemned in the media.[399] Leaders and those in the surge workforce who had not been trained in communicating and handling personal information were suddenly required to do so. This raised concerns about the adequacy of privacy protection mechanisms to mitigate this risk.

4. Evaluation

Trust is critical to any pandemic response and must be rebuilt and maintained

To deliver an effective response to a health emergency, the government must have and maintain the trust of the public, including through clear communications and mechanisms to assess the ongoing efficacy of measures and minimise unintended consequences. The relative success of Australia's response to the pandemic was highly reliant on individuals and communities trusting and adhering to the advice of governments and experts to make significant changes to their behaviours and lifestyle in the interests of the collective good. The pre-existing level of trust in governments and institutions at the onset of the pandemic was a key foundation for the overall effectiveness of the response and our low transmission and morality rates. Government cannot rely on people willingly adhering to similar public health restrictions in a future public health emergency.[400]

There is broad agreement on aspects of the response that diminished trust and eroded public confidence. Notably these were lack of transparency, fairness, compassion and proportionality. National planning for future pandemics must be based on proactively rebuilding trust and resilience with populations, communities and settings that were most negatively impacted by the pandemic and related measures. This is particularly important as the recent increase of Australia's national terrorism threat level from 'possible' to 'probable' has been linked to the growth of anti-authority beliefs and the erosion of trust in institutions.

The Inquiry consistently heard that lack of transparency significantly undermined trust. Feedback from operational leaders, interviews, surveys and roundtables confirmed the need for greater transparency to build and maintain trust. This particularly applies to the evidence underpinning decisions on the use of restrictive measures. The risks and rationale behind decision-making must be made transparent. Communications need to be tailored for different audiences and involve greater engagement with experts, spokespeople and community voices (see Chapter 11: Communicating in a crisis).

Planning must include strategies to proactively manage the risk of misinformation and disinformation. It should start by using the existing expertise at the national level to support the work of the Australian Centre for Disease Control and emergency management agencies in developing communication strategies and tools. Pandemic plans need to reflect what we have learned about compliance and enforcement from the COVID-19 response – notably the disproportionate and inequitable impacts on particular demographic groups.

The panel supports the government's ongoing active engagement with priority populations and at-risk groups to build and maintain trusted relationships and key foundations for pandemic preparedness. This task involves rebuilding trust and establishing ongoing feedback mechanisms to shape proportionate response measures.

The panel affirms the need to increase the use of behavioural insights in shaping pandemic-related response measures, monitoring effects and minimising unintended consequences. We

heard that sentiment and other targeted surveys and integrated modelling were important tools used to forecast, shape, adapt and evaluate health responses.

Privacy must be at the forefront of design and evaluation of the use of technology

The ethical use and protection of people's data are essential in any future public health emergency response. Governments must ensure that people do not have their data used in unethical or unauthorised ways and are not identified in ways that could expose them to public shame. At the same time, there must be robust consideration of balancing privacy implications against the value of using technology, and the need for real-time rapid research based on these data sources to identify people at risk and unintended response impacts. Actions to enable the use of technology must be rooted in legislation and guided by the principles set out by the Office of the Australian Information Commissioner.

When considering the use of contact-tracing apps, governments need to focus on not only user-based concerns (including uptake and privacy) but also how the data collected interact with public health data systems and operations. A study using situational mapping to enable a more nuanced understanding of contact-tracing apps and how they interface with digital epidemiology, based on consultation with 21 international experts, highlights the complexity of the information systems these apps sit within.[401] Such technology cannot be developed on the fly in a pandemic; it must be a focus in pandemic planning. As part of preparing for a future pandemic, governments need to determine if and when such investments might be appropriate and to lay the groundwork to ensure they meet stakeholder needs while protecting individual privacy and trust. Digital solutions should be developed in consultation with experts, community leaders and the public to ensure safety, uptake and effectiveness.

The panel affirms the importance of early action by the national government to proactively confirm privacy protections in legislation, given the growing reliance on digital technologies and the criticality of maintaining public trust regarding the use and security of personal data in a pandemic. Experience during the pandemic highlighted other areas relating to data security that warrant further consideration as cybersecurity risks increase. The panel welcomes the work recently announced by the government to develop a 'Trust Exchange' digital ID scheme to let people verify their identity and credentials based on information already held in their MyGov accounts.[402]

The panel notes that in October 2020 the Attorney-General's Department began a review of the *Privacy Act 1988*. The report of the review was published on 16 February 2023. Its proposals were aimed at strengthening the protection of personal information and the control individuals have over their information. The government agreed to 38 proposals, agreed in principle to 68 and noted 10.[403] As technology evolves and will be increasingly important in future public health emergency responses, the proposed reforms are important to ensure robust privacy protections are in place.

Recommendations arising from an overview of data use in the pandemic conducted in North America are equally applicable in Australia. They address concerns about the potential harms of

criminalising illnesses as a result of healthcare systems sharing COVID-19 data with police agencies, especially the risk that this will undermine the quality of information people provide to health departments.[404] The recommended approach to address the issue also involves healthcare first responders. The recommendations are:

1. Treat COVID-19 data as sensitive health information or public health surveillance data, and thus subject to similar restrictions on disclosures to law enforcement.
2. Implement segmented COVID-19 data interoperability with first responder agencies.
3. Designate a panel to review applications from police for COVID-19 data.
4. Decline to share COVID-19 data with police.
5. Decline to build COVID-19 data infrastructures that are interoperable with law enforcement.
6. Advocate for policies to limit COVID-19 data sharing with police.
7. Report improper data sharing.

Embedding human rights into decision-making on restrictive measures minimises harmful impacts

During the pandemic, restrictions on people's rights were put in place to drastically change behaviour in order to prevent the spread of COVID-19 and to protect the health system so it could maintain key operability. The majority of the public understood the necessity for these restrictions and demonstrated a willingness to adhere to them, particularly during the alert phase. However, as the vaccine rollout progressed, the public increasingly wanted a clearer view of the reasoning behind decisions to prolong measures despite the perceived risk decreasing.

Governments could legitimately restrict certain human rights in implementing their response to COVID-19. However, the evidence suggests that some restrictions were poorly justified in extent and/or duration, disproportionate to the risk and inconsistently applied across the country, and that specific groups were disproportionately impacted. These groups included children, older Australians (especially in aged care facilities), Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities, and people with disabilities. A future pandemic response needs to ensure that the human rights of at-risk groups are central to decision-making. The panel supports the prioritisation of a rights-based approach to the proposed Aged Care Act, including a statement of rights of people in the aged care system. This may help to ensure that the rights of older Australians are taken into consideration in future emergencies.

The panel heard and agrees that National Cabinet, the Australian Government and the Australian Health Protection Committee need to embed human rights considerations into their decision-making processes. While we acknowledge the need for rapid action in a crisis, human rights should be considered, particularly where measures are intended to significantly restrict the rights and freedoms of individuals and communities. The panel also agrees with

Recommendation 3 of the Joint Committee of Public Accounts and Audit's Report 494: *Inquiry into the Department of Foreign Affairs and Trade's crisis management arrangements* that crisis planning should incorporate human rights considerations and outline measures to ensure that any crisis response limiting or restricting human rights is necessary, reasonable and proportionate.[405] Giving more weight to the impacts on people's rights in future decision-making will help to ensure measures are proportionate and minimise the unintended negative and inequitable consequences of public health restrictions. National Cabinet should consider seeking advice from experts such as the Australian Human Rights Commissioner and the National Children's Commissioner where appropriate to better understand the broader human rights impacts of their decisions.

At the Commonwealth level, most restrictive measures were adopted through emergency determinations made under the *Biosecurity Act 2015* (Cth). Such determinations are not disallowable in the Senate; however, we consider there would be benefit if they were accompanied by an explicit human rights assessment. This would enable the Parliamentary Joint Committee on Human Rights to more effectively retain its practice of assessing emergency determinations to ensure their compatibility with human rights. As noted in Chapter 4: Leading the response, we also consider that the advice used to make determinations under the *Biosecurity Act 2015* (Cth) should be published.

According to the Australian Human Rights Commission, its scrutiny role in examining human rights compliance was significantly limited due to many decisions on restrictive measures being implemented at a state level. This meant that the Australian Human Rights Commission was not in a position to assess whether these measures complied with Australia's human rights obligations.

In the absence of a national human rights framework, incorporating human rights considerations into decision-making on and implementation of restrictive measures should be a priority in a public health emergency. To achieve this, the panel supports the work underway by the Australian Human Rights Commission to develop a human rights emergency response framework that will put rights and freedoms at the heart of responses to all future emergencies and disasters in Australia.[406]

5. Learnings

- Trust and communication: Australia's relatively high level of public trust in government had a significant impact on the success of our response to the pandemic, as it meant people were prepared to adhere to public health measures.[1] In a future pandemic it is important that the government maintain trust by communicating openly, consistently and in ways that meet the needs of all groups.
- Transparency: It is important for government to ensure the timely release of data, information on decision-making considerations, use of experts/expert advice, and results of surveys to test community sentiment.

- Digital technology: Any digital technologies developed as part of pandemic responses must be fit for purpose and address privacy concerns.
- Human rights: During any future health emergency, human rights must be considered, and appropriately balanced between the right to be protected from disease exposure, and the impacts of public health interventions.
- Government responses need to consider the diversity of needs and experiences of different cohorts when making policy decisions in a pandemic, including through establishing and maintaining community engagement channels to provide real-time input into decision-making. Embedding human rights considerations into government decision-making processes will minimise the impact on individuals' rights in future pandemics, help inform how best to balance any competing rights, and support a more balanced assessment of risk.
- There is a need for ongoing oversight of pandemic-related measures across governments in a future public health emergency. Emergency determinations made under the *Biosecurity Act 2015* (Cth) should be accompanied by explicit human rights assessments.
- How the Commonwealth implements Australia's human rights obligations in legislation and decision-making needs to be examined to ensure they are fit for purpose if and when there is a future health emergency (e.g. considered as part of a new National Human Rights Framework or Act). The lack of a national human rights framework and the inconsistency between jurisdictions in how they apply their human rights obligations complicates the protection of people's human rights in a crisis.
- There was limited real-time evaluation of public health measures and policy decisions to determine if they worked as intended, to refine them as the risk environment changed in order to minimise adverse outcomes, and to monitor and manage any unintended consequences. Real-time evaluation of interventions should monitor for infringements on human rights. Our crisis response planning should integrate external oversight and complaint handling.
- The risks of exposure to disease on one hand, and the many costs associated with compromises to social liberty on the other, need to be balanced at the population level to achieve disease control. However, within defined settings with more severe and enduring restrictions in place, such as residential aged care, efforts should be made to enable individual choice on that balance – spending time with family aligned with wider community rules, or remaining more isolated to reduce exposure risk.

6. Actions

6.1. Immediate actions – Do in the next 12–18 months

Action 5: Develop updated health emergency planning and response arrangements in conjunction with states and territories, and key partners, including consideration of escalation and de-escalation points, real-time review and a focus on post-emergency recovery.

The series of plans should:

- include external oversight and complaints handling and embed privacy principles.

Action 7: Finalise establishment of the Australian Centre for Disease Control (CDC) and give priority to the following functions for systemic preparedness to become trusted and authoritative on risk assessment and communication, and a national repository of communicable disease intelligence capability and advice.

The CDC must:

- Establish an evidence synthesis and public communications function, including:
    - support for both business-as-usual communication activity and crisis communications in a public health emergency
    - making communication a focus for technical advisory group input, drawing from public and private channels to provide risk communication data synthesis and behavioural and social science expertise
    - in-house expertise in evidence synthesis and communication.
- Build foundations of in-house behavioural insights capability, including:
    - mapping existing behavioural insights functions across the Australian Government with the Behavioural Economics Team of the Australia Government
    - working with experts to develop a fully scoped and costed business case for an in-house behavioural insights capability.

Action 8: Establish mechanisms for National Cabinet to receive additional integrated expert advice for a whole-of-society emergency, including advice on social, human rights, economic and broader health impacts (including mental health considerations), as well as specific impacts on priority populations.

- In parallel with making decisions based on key public health advice, National Cabinet should consider the differential impacts of a pandemic across the population and economy. This must include considering and mitigating unintended consequences, and seek to minimise negative impacts on broader health, mental health, educational, equity, economic and social outcomes.

- Human rights considerations should be embedded into National Cabinet's decision-making processes, particularly where measures are intended to significantly restrict rights and freedoms.
- This might include mechanisms for a national health emergency that allow expert advice to be sought from the Australian Human Rights Commissioner and other commissioners (e.g. National Children's Commissioner) to support better understanding of the broader impacts of their decisions on human rights and priority populations.

Action 16: Develop and agree principles for the transparent release of advice that informs decision-making in a public health emergency.

- National Cabinet (and other key decision-making bodies) should be more transparent in disclosing the expert advice that underpins their decisions, and the other multi-sectoral factors that must necessarily influence policy decisions.
- This should include the rationale for why decisions are being made that result in significant reduction of freedoms.

Action 17: Develop a national strategy to rebuild community trust in vaccines and improve vaccination rates.

As part of this:

- Health Ministers should urgently agree a strategy for addressing the broad decline in COVID-19 vaccination, especially among priority cohorts, with a view to formalising policy responsibility to improve these vaccination rates by target dates.
- There should be an emphasis on lifting early childhood vaccination rates for other communicable diseases to pre-pandemic levels.

Action 19: Develop a communication strategy for use in national health emergencies that ensures Australians, including those in priority populations, families and industries, have the information they need to manage their social, work and family lives.

This should include a strategy for addressing the harms arising from misinformation and disinformation, which incorporates:

- information environment and ongoing narrative monitoring to combat misinformation
- transparent engagement with social media companies
- promotion and coordination of policies to increase the resilience of the information environment
- partnership between government and trusted organisations, experts, media, and other influencers to pre-bunk and debunk misinformation.

Chapter 6 – The Australian Public Service: responding to a multi-sectoral crisis

1. Context

The COVID-19 response required almost every department and agency in the Australian Public Service to activate supporting structures during different phases of the pandemic. Australian Government departments and agencies demonstrated leadership, agility, unified commitment and capacity to pivot rapidly to support the design and delivery of the response.[407]

At the outset of COVID-19 in March 2020, key parts of the Australian Public Service had been operating in an emergency context for months, having spent the summer of 2019–2020 responding to the extreme bushfires across Australia.[408] This meant important relationships had already been established and there were some systems in place that could quickly pivot to the pandemic response. However, it also meant that people in key roles who had already spent months working intensely had to shift focus to the COVID-19 response, with no opportunity for respite.

The pandemic required a major shift in priorities and service delivery models across the national government, which continued to evolve as the response progressed. It led to a major shift in working arrangements for the public service, with workers across the Australian Public Service quickly starting to work from home. Departments adjusted their priorities and risk tolerances to meet the changing needs of the government. Many substantially altered their internal structures, ways of working, and coordination and communication pathways with each other and external stakeholders. They did all this while continuing their essential business-as-usual functions.

In future we will need a greater level of national coordination to better plan, deliver and transition from pandemic crisis management incidents.

2. Response

Appendix E: Key actions delivered by the Australian Public Service relating to COVID-19 outlines the roles and responsibilities of policy and operational departments and agencies during COVID-19.

2.1. Leadership and coordination across the Australian Public Service

In recent times, national public health emergencies have been contained and largely managed by state and territory departments and specific Australian Government departments and agencies such as the Department of Health and Aged Care; Department of Agriculture, Fisheries and Forestry; and National Emergency Management Agency.[409] In March 2020, as noted in Chapter 4: Leading the response, the Australian Government made the early decision that the pandemic warranted a more centralised and coordinated response, led from the

highest levels of governments, to fully access multi-sectoral supports proportional to the likely health, economic and social impacts.[410]

Many departments had coordination and leadership responsibilities in supporting the government's response, as detailed in Appendix E. As the Prime Minister led the response, the Department of the Prime Minister and Cabinet had significant responsibilities in supporting the Prime Minister, federal Cabinet processes and National Cabinet meetings. It also led related coordination across the Australian Public Service and with states and territories through existing and purpose-built groups such as the Secretaries Board, the COVID-19 Deputies Group, and First Secretaries and First Deputies Groups (which convened Secretary and Deputy Secretary level officials from First Ministers' departments).[411]

The Secretaries Board, established under the *Public Service Act 1999* (Cth), has responsibility for the stewardship and strategic priorities of the Australian Public Service.[412] It develops and implements improvement strategies, and models leadership behaviours. [413] During the pandemic, the Secretaries Board met regularly to share information. Its membership expanded to temporarily include the heads of the Australian Taxation Office, Services Australia and the Digital Transformation Agency. It established cross-sectoral subcommittees to address key challenges to the Australian Public Service response, including workplace health and safety, deployments, surge workforce and flexible working arrangements.[414]

The COVID-19 Deputies Group was established in the alert phase of the pandemic. It supported the coordination of the response and the operationalisation of government and National Cabinet decisions. It comprised Deputy Secretaries from the Department of the Prime Minister and Cabinet (Chair); the Department of Health; the Treasury; the Department of Home Affairs; the Australian Border Force; the Department of Foreign Affairs and Trade; the Department of Infrastructure, Regional Development and Communication; and the Department of Employment, Skills and Education.[415]

Treasury and the Department of Finance played key leadership roles in developing and delivering the economic response and ensuring the government's budget processes continued. Treasury led the design of important COVID-19 economic measures to support the response. These included JobKeeper, the Homebuilder program, and the early release of superannuation (measures that are discussed in more detail in Chapter 20: Managing the economy and Chapter 21: Supporting households and businesses).[416] The Department of Finance expanded its role in government-wide prioritisation and reporting processes to support financial decision-making, including for the Budget and Mid-Year Economic and Fiscal Outlooks. It delivered major services and capital works, such as the rapid design and delivery of the Commonwealth's purpose-built quarantine facilities.[417] The Department of Finance also supported agencies by enabling flexibility in the Commonwealth Procurement Framework and established a procurement hub (jointly with the Department of Defence) to provide real-time expertise to agencies.[418]

The Department of Home Affairs, primarily through Emergency Management Australia (now the National Emergency Management Agency), supported crisis management and pandemic

planning. This role included designing, coordinating and facilitating non-health responses by establishing and convening the National Coordination Mechanism. The Department of Home Affairs also helped to manage significant international components of the response, working with the Australian Border Force; the Department of Infrastructure, Transport, Regional Development and Communications; the Department of Health and the Department of Foreign Affairs and Trade. These shared responsibilities included managing the international border, deployments of an Australian Medical Assistance Team (AUSMAT) and providing assistance to Australians overseas.[419]

2.2.Health responsibilities, coordination and engagement

The Department of Health (now Department of Health and Aged Care) was the main coordination point and advisory body for the national health response. It implemented a wide range of measures to increase the capacity of the primary health sector (e.g. telehealth), address mental health issues, and support priority populations and the aged care sector.[420]

In January 2020 the National Incident Room (now National Incident Centre) was set up to lead the early health response. Its role was to connect all levels of government and international partners.[421]

In February 2020 the Department of Health published the Australian Health Sector Emergency Response Plan for Novel Coronavirus (the COVID-19 Plan) and activated the Emergency Response Plan for Communicable Disease Incidents of National Significance: National Arrangements (National Communicable Disease Plan).[422]

The department's responsibilities include setting national policies, contributing funding for public hospitals, and funding and regulating the aged care system and other targeted primary care health programs. During COVID-19 it had to quickly take on new and expanded responsibilities. These included scaling up the National Medical Stockpile; procuring and distributing essential medical supplies including vaccines, ventilators, personal protective equipment, COVID-19 tests and treatments; and managing the National COVID-19 Vaccine Program. Under the National Partnership on COVID-19 Response, the Australian Government contributed funding to ensure the viability and increased capacity of private hospitals.[423] The National Incident Centre was expanded to meet the demand of the COVID-19 response, consisting of 200 officers at its peak drawn from the Department Health, the Department of the Prime Minister and Cabinet, the Department of Foreign Affairs and Trade, and the Australian Border Force.[424]

The Department of Health also supported older Australians and aged care providers. It provided funding packages and grants, on-site vaccinations, guidance on infection prevention and control and visits to aged care homes, daily monitoring and case management, regular on-site polymerase chain reaction (PCR) testing, surge workforce, rapid antigen tests, personal protective equipment and oral antiviral treatments, and regular communication with the aged care sector on outbreak preparedness and management. This was in addition to providing assistance with backfilling the aged care workforce at scale. The Department of Health also

established the Victorian Aged Care Response Centre, which was Australian Government led with support from the Victorian Government. [425]

More detail on the health and aged care responses is in Chapter 9: Buying time, Chapter 10: The path to opening up, Chapter 12: Broader health impacts and Chapter 18: Older Australians.

The Department of Health provided support for Aboriginal and Torres Strait Islander people which included engaging and partnering with Aboriginal and Torres Strait Islander organisations to ensure support was community led and culturally appropriate. Vaccinations, provision of rapid antigen tests and personal protective equipment, COVID-19 testing (including at the point of care) and case management were implemented by or in partnership with national or local Aboriginal and Torres Strait Islander organisations.[426] More detailed information is in Chapter 13: Aboriginal and Torres Strait Islander people.

2.2.1. Coordination and engagement

A range of purpose-built and existing expert advisory bodies supported the health response. The Department of Health provided support to these advisory bodies including through secretariat support, and the drafting of briefings, public statements, guidelines and related communications materials.

The Australian Health Protection Principal Committee, which included the Chief Medical Officer and Chief Health Officers from all jurisdictions, was the main advisory body to National Cabinet on public health issues, which resulted in an increased workload for the Australian Health Protection Principal Committee and the staff supporting it (discussed in more detail in Chapter 4: Leading the response).[427] The Australian Health Protection Principal Committee was supported by advice from its subcommittees, including the Communicable Diseases Network Australia, the Public Health Laboratory Network and the National Health Emergency Management Standing Committee.[428]

Several expert bodies collaborated to support and advise the Australian Government on COVID-19 vaccines and treatments. The Australian Technical Advisory Group on Immunisation advised on immunisation and prioritisation of cohorts. The Science and Industry Technical Advisory Group was established to advise on the purchase and manufacture of COVID-19 vaccines and treatments.[429] The Therapeutic Goods Administration, as the medicines regulator, evaluated, assessed and monitored COVID-19 vaccines, treatments and testing kits.[430] Further details are in Chapter 10: The path to opening up.

The Department of Health progressively set up a range of bodies to provide expert advice about the specific needs of potentially at-risk populations (see the Equity section for further details):

- The Aboriginal and Torres Strait Islander Advisory Group on COVID-19 was established in March 2020 to provide clinical expertise to inform health decisions for Aboriginal and Torres Strait Islander people and communities. It advised National Cabinet via the Australian Health Protection Principal Committee. The Department of Health and the National Aboriginal Community Controlled Health Organisation drew on existing

trusted relationships to co-convene the group. It was the primary mechanism used by the department to consult and coordinate across governments, the Aboriginal community-controlled health sector and public health experts. In October 2022 it was made permanent and became the National Aboriginal and Torres Strait Islander Health Protection Sub-committee of the Australian Health Protection Principal Committee. [431]

- The Advisory Committee for the Health Emergency Response to COVID-19 for People with Disability was convened in April 2020 to advise the Chief Medical Officer on the needs and experiences of people with disability. [432] The group is currently only in place until 31 December 2024.
- The Aged Care Advisory Group was established on 21 August 2020 as a time-limited group to support the Australian Government's ongoing response to COVID-19 in aged care. On 1 October 2020, on recommendation from the Royal Commission into Aged Care Quality and Safety, the Aged Care Advisory Group was made a permanent advisory group under the auspices of the Australian Health Protection Principal Committee to advise on matters relevant to health protection in the aged care sector.[433]
- The Culturally and Linguistically Diverse Communities COVID-19 Health Advisory Group was established in December 2020 to advise on the COVID-19 experiences of multicultural communities.[434] The group is currently only in place until 31 December 2024.

The department also led consultation and engagement with regional, rural and remote communities including:

- the Primary Health Care COVID-19 Response Committee (including representatives of the Rural Health Commissioner and the National Rural Health Alliance)[435]
- the Minister for Regional Health's Rural Health Stakeholder Roundtable[436]
- the Office of the National Rural Health Commissioner's National Rural General Practice Respiratory Clinics Leaders Network[437]
- the National COVID-19 Health and Research Advisory Committee (including representation from all states and territories and from rural and remote Australia).[438]

2.3.Australian Public Service workforce and service delivery

COVID-19 had a significant immediate and longer term impact on the Australian Public Service workforce. On 26 March 2020 the Prime Minister issued a direction under the *Public Service Act 1999* (Cth) that required agency heads to identify:

- functions critical to the continued delivery of services to the public or the operation of the Australian Public Service
- staff capable of undertaking critical work for other Australian Public Service agencies, state or territory government agencies or community organisations.[439]

This meant that Australian Public Service leaders de-prioritised or paused non-essential work in order to redeploy staff to urgent priorities. For example, the Department of Health redeployed staff to focus on priorities, particularly the operation of the National Incident Centre.[440] The Chief Operating Officers Committee, a subcommittee of the Secretaries Board that was newly established in February 2020, helped to manage the Australian Public Service response.[441]

The Australian Public Service Commission led all COVID-related workforce matters to support Australian Public Service business continuity.[442] The Australian Public Service Commission set up two cross-agency taskforces: one to provide consolidated guidance on workforce measures to Australian Public Service agencies and staff; the other to facilitate the redeployment of Australian Public Service employees. Their roles included providing advice on public health measures, leave arrangements, remote and flexible working arrangements, travel and vaccinations.[443]

The Australian Public Service Commission established a temporary workforce to respond to the rise in demand for critical government services.[444] During the alert phase of the pandemic, the government relied heavily on redeployment of the Australian Public Service workforce to agencies experiencing the greatest surge in workload. By August 2020, out of the roughly 150,000 Australian Public Service employees, approximately 1.5 per cent had been redeployed to other agencies on a temporary basis, the majority to Services Australia.[445] Services Australia also added staff through other mechanisms, including labour hire, service delivery partners and direct engagement.[446] Overall, more than 13,000 staff joined Services Australia between March and September 2020.[447]

The surge workforce allowed Services Australia to scale up services to meet the significant increase in demand for essential government support payments such as JobSeeker, the Coronavirus Supplement and the COVID-19 Disaster Payment.[448] For instance, between January and May 2020, JobSeeker recipients more than doubled from 790,710 to 1,623,505.[449] In one 55-day period, Services Australia processed 1.3 million JobSeeker claims, a volume normally processed in 2.5 years.[450] To support implementation of COVID-19 response measures, Services Australia accelerated delivery of government services via digital channels. This included providing easy access to vaccination certificates through the Australian Immunisation Register.[451] The agency also delivered payments on behalf of other levels of government through its Payment Utility platform, including of COVID-19 support payments on behalf of the Australian Capital Territory and Victoria.[452]

The Australian Taxation Office also pivoted its workforce and employed new staff to deliver key economic measures, including the JobKeeper Payment, Boosting Cash Flow for Employers, and Early Release of Superannuation.[453] By 22 June 2020 over 10,000 employees had been redeployed within the Australian Taxation Office and over 750 more were prepared to provide additional surge capacity.[454] Between April and May 2020 the Australian Taxation Office also employed over 1,500 casuals to assist with COVID-19 economic measures and the tax time workload – roughly two to three times the normal tax time recruitment.[455]

In April 2021 the Secretaries Board established a permanent Australian Public Service Surge Reserve, which allows Australian Public Service employees to register their interest to move temporarily at short notice to another agency to deliver critically needed services. The Surge Reserve has since been used to respond to severe weather events, including flooding in 2021 and 2022.[456]

2.4. Engagement with business and community sectors

Coordination and engagement with the business and community sectors was essential to supporting an effective national response. Many departments used existing forums or established new engagement mechanisms to draw on sectoral expertise and support coordination with states and territories, industry and the community on specific elements of the COVID-19 response (as discussed in the relevant chapters).

In addition to the establishment of the National COVID-19 Coordination Commission (see Chapter 4: Leading the response for details), the National Coordination Mechanism and the Treasury's Coronavirus Business Liaison Unit provided real-time input from business and industry into the pandemic response.

The National Coordination Mechanism was established on 5 March 2020 as a consultative, operational forum led by the Department of Home Affairs (through Emergency Management Australia). Its role was to coordinate and facilitate nationally consistent approaches to non-health planning and operational responses to COVID-19, by bringing together the Commonwealth, state and territory governments, non-government organisations and industry to identify and solve common problems.[457] From 6 March 2020 to 15 November 2022, the National Coordination Mechanism operated in 23 different sectors. These included food and grocery, managing international arrivals, emergency management, rapid antigen test supply, supply chains, remote and regional communities, essential goods prioritisation, aged care, freight and planning.[458]

Emergency Management Australia, through the National Coordination Mechanism, also created the Supply Chain Taskforce to coordinate and problem solve any supply chain matters.[459] The Supply Chain Taskforce initially reported to the Minister for Home Affairs and to the Treasurer.

The Coronavirus Business Liaison Unit was established by Treasury on 15 March 2020. Originally led by a former Secretary, it met daily with peak business groups. It brought together senior officials and business leaders, providing an avenue for two-way communication on systemic issues relating to COVID-19.[460] The Coronavirus Business Liaison Unit provided a forum where the government could explain its frequently changing policies, receive feedback and brief on key issues and developments quickly and effectively.[461] Reflecting its usefulness, it has been retained by Treasury as a business-as-usual function (as the Stakeholder Liaison Branch).[462]

Departments also engaged with a range of community-based peak bodies, advocacy groups, providers and organisations. They did this both informally and through formal coordination mechanisms. These are highlighted throughout the report, particularly in the Equity section.

One of the most important community services sector-led bodies set up as part of the pandemic response was the National Coordination Group. Established in April 2020, the National Coordination Group provided advice to the Minister for Social Services to inform decisions on how emergency relief, food relief and financial counselling could help people in need who were impacted by COVID-19, and on associated funding requirements. The group comprised Department of Social Services officers and senior representatives from the emergency relief, food relief and financial counselling and volunteering sectors. The National Coordination Group was in place until 30 June 2024.[463]

3. Impact

3.1. Leadership and coordination across the Australian Public Service

When the scale and the potential duration of the pandemic became clear, significant efforts were made to enhance coordination across the Australian Government and with other jurisdictions and sectoral stakeholders. The Inquiry heard from stakeholders that coordination efforts were more effective where there were existing relationships and structures to rapidly bring agencies and stakeholders together to better anticipate or solve problems.[464] We heard that in the absence of a visible and understood governance structure, there was uncertainty regarding roles and responsibilities – especially about identifying the lead agencies on supply-related issues and the intersection of health and disability responsibilities.[465] Feedback from industry and community stakeholders and from the states and territories noted that communication across and between governments largely depended on existing contacts and knowing who to talk to, rather than being driven by any known and agreed governance structure.[466]

We heard that the Secretaries Board was central to coordination and decision-making on Australian Public Service workforce and related enterprise risks. While it had an important information-sharing function its remit does not include a focus on policy design and implementation, and it therefore did not play an active role in planning and management of the pandemic response. We heard it was not an appropriate forum to quickly resolve critical policy or operational issues.[467]

The COVID-19 Deputies Group and Commonwealth-State First Deputies Group were consistently mentioned as playing influential roles in sharing information across the Australian Public Service and with states and territories and in supporting National Cabinet and the First Secretaries Group.[468] We heard that Ministerial councils and supporting chief executive groups were progressively better used to improve coordination and engagement between the national government and jurisdictions in areas such as transport and health.[469]

The panel heard that the Department of the Prime Minister and Cabinet had played a strong role in chairing many of these groups and Cabinet and National Cabinet processes but had lacked the necessary operational experience, structures and capability for crisis coordination of the scale and duration being experienced. In the face of these gaps, existing mechanisms were

adapted and the response relied heavily on key people and existing relationships at senior levels across governments to undertake coordination activities.[470]

Treasury led the design and coordination of the economic response across all key government policy and regulatory entities.[471] In particular, the collaboration between Treasury and the Australian Taxation Office was crucial to the successful implementation of JobKeeper.[472] We heard that an innovative partnership with the Doherty Institute allowed Treasury to provide integrated health and economic advice to government, and was pivotal in informing the National Plan to Transition Australia's National COVID-19 Response.[473] However, we also heard there was a bias towards tasking Treasury with additional roles that perhaps sat better with other departments. This was perceived as reflecting leaders' trust and capability bias towards Treasury and particularly applying to industry policy.[474] There may be future opportunities to further enhance coordination of the broader economic response between governments through existing structures such as Heads of Treasuries meetings (see Chapter 20: Managing the economy).[475]

The Department of Finance adapted quickly to the increased demand for support and budget advice to Cabinet, the Expenditure Review Committee and the National Security Committee. It facilitated amendments to the *Financial Framework (Supplementary Powers) Regulations 1997* (Cth) to give legislative authority to spending activities across the Commonwealth. In the absence of other options, the Department of Finance took on broader leadership including delivering the Commonwealth's quarantine facilities. The Department of Finance also provided dedicated assistance to the Department of Health on vaccine procurement strategies and implementation.[476] The Department of Finance set up a procurement hub to assist agencies having difficulty with procurements, providing general advice and guidance on the flexibility within the procurement framework for streamlined procurement processes.[477] However, we heard that, given the significant amount of procurement occurring across the public service, there were missed opportunities. The Department of Finance could in future more actively assist with streamlining procurement processes to minimise barriers to the pandemic response, facilitate more flexible funding arrangements and provide more help with the complex procurement arrangements such as required for new vaccines.[478] We note that the need for flexibility in funding arrangements should also extend to grants to ensure funding can be quickly provided to community organisations to meet immediate needs (see Chapter 13: Aboriginal and Torres Strait Islander people).

The Department of Home Affairs, including through Emergency Management Australia, often took a leadership and coordination role in areas where the pandemic response lacked direction or where multiple policy areas overlapped – for example, the establishment of the National Coordination Mechanism to engage with industry on non-health issues. The Department of Home Affairs also did important work on scenario planning and ongoing risk assessment, positioning it to anticipate and respond rapidly when challenges arose.[479] At the same time, the panel heard the connection between these initiatives and broader government responses was unclear to external stakeholders and within government, in the absence of an agreed governance framework.[480]

3.2.Health responsibilities, coordination and engagement

The Department of Health had extensive policy, regulatory and operational roles key to the national pandemic response. All 20 agencies, eight statutory office holders and five regulators in the Health and Aged Care portfolio worked with the department to collectively deliver the government's health response. The portfolio faced sustained and protracted demands as it worked closely with its state and territory counterparts, with which it shares responsibility for the broader health system.[481] The Health Ministers Meeting and the Health Chief Executives Forum played key roles in bringing together Commonwealth and state and territory ministers and heads of department to drive the national response.[482]

We heard there were no pre-existing structures to bring together key decision-makers from across the Australian Government and rapidly integrate intelligence from the operational response into the policy process. This also made it difficult to efficiently and effectively take a more holistic view of public health decision-making and balance broader health, social, educational and other civil society impacts.[483] The critical alignment of the health response and the economic response was highly reliant on strong bilateral relations between the Department of Health and the Treasury, and the Department of Health and other Australian government and jurisdictional departments and agencies.[484]

Public health expertise was in high demand and focused on managing the response. This capability was challenged in responding to the volume of requests for additional advice from political leaders, governments and other stakeholders and in conducting related communication activities. The Department of Health is primarily a policy agency, so the operational demands put on it rapidly expanded beyond its capacity and reach.[485] This was notably the case in relation to aged care, primary care expansion, access to medical supplies and the vaccine rollout. For instance, between 2020 and 2022 the department significantly expanded the number of staff working on aged care. Staff numbers increased between 18 per cent and 32 per cent to provide 24/7 primary support to residential aged care homes. In future, the Australian Centre for Disease Control will provide an important additional communication pathway and source of advice to industry and the community on public health measures.

During the pandemic, a number of health expert bodies were thrust into the public domain for the first time. The panel heard that key health advisory and regulatory bodies were largely effective in their delivery of advice to the Australian Government. The Therapeutic Goods Administration was widely praised by stakeholders for its efficiency and for having effective processes in place to deal with the surge in work.

However, the panel heard there was widespread public confusion around the roles and responsibilities of the Australian Health Protection Principal Committee, the Australian Technical Advisory Group on Immunisation and the Therapeutic Goods Administration, as there was perceived crossover in their remits, and uncertainty whether they were advisory or decision-making bodies. We heard about unintended consequences of Cabinet confidentiality provisions due to the Australian Health Protection Principal Committee providing advice to National Cabinet that constrained necessary coordination between expert committees and their ability to assist in communication to the public. The speed at which new evidence emerged, and the complexity of the evidence, also led to challenges in evidence synthesis and communication in

the advice provided through expert bodies. The panel heard that confusion and suspicion arose where governments were not transparent about health advice or did not provide a clear enough explanation of the evidence that informed the advice.[486]

The panel also heard that many members of key health advisory and regulatory bodies worked brutal hours in addition to their clinical, public health and/or other roles. It was agreed that backup surge capacity of skilled experts should be planned for to provide respite and in recognition of their other roles.[487]

The impacts of the key advisory groups are detailed in Chapter 13: Aboriginal and Torres Strait Islander people, Chapter 15: Culturally and linguistically diverse communities, Chapter 16: People with disability and Chapter 18: Older Australians.

3.3.Australian Public Service workforce and service delivery

The Inquiry heard that the Chief Operating Officers Committee was vital in supporting business continuity in the Australian Public Service and had a strong relationship with the Australian Public Service Commission. It provided clear direction and advice that increased consistency across departments and facilitated knowledge sharing on workplace health and wellbeing, safety and flexible working practices.[488] The Chief Operating Officers Committee's working groups were uniformly considered to be highly useful for sharing insights and expertise and keeping track of work across agencies.[489]

Redeployments proved vital to delivering government priorities and highlighted a number of issues that need to be anticipated in future planning. These include complications with varying wages and conditions between agencies and a lack of understanding of the needs of service delivery agencies compared to policy agencies.[490] Surge staff reported mixed experiences. There were some mismatches of expectations and there was uncertainty about roles, including whether redeployment was voluntary, whether there were opportunities to select the work area, the nature of the work and the skill mix required.[491] A survey of the Australian Public Service surge workforce conducted by the Australian Public Service Commission in September 2020 found that 64 per cent would volunteer again for a temporary assignment to support critical government functions.[492] The panel heard of the important role that the Australian Public Service Commission and the Secretaries Board can take to identify, train and maintain a surge capacity at the national level (not as an adjunct to activities of the states and territories) as an enduring priority.[493]

Strong relationships across the Australian Public Service, particularly at Senior Executive Service level, were integral to its success in quickly responding to change, and this experience reinforced the importance of working as 'one Australian Public Service'.[494] However, the length and scale of the pandemic and its proximity to recent significant flood and fire emergencies raised issues about the sustainability of the response and the significant loss of human capital post pandemic. This was compounded by heavy reliance on a relatively small number of senior staff, raising significant concerns about the need to proactively consider sustainability in future protracted emergencies.[495] Australian Public Service employment data shows that the separation rate for Senior Executive Service Band 3 (Deputy Secretary level) officers was 17.5 per

cent in 2022, compared to 5.9 per cent in 2019.[496] The 2023 Australian Public Service Employee Census found that 33 per cent of public servants felt burned out.[497] Our engagement suggests that those in frontline agencies, such as the Department of Health and Services Australia, were most impacted because they felt they were unable to take leave, even in the pandemic's quieter periods, due to the importance of continuity.[498] We also heard staff working in the National Incident Centre were required to be at work and on call every day during the emergency phase of the pandemic response.[499]

Increasing the redeployment of senior staff and providing appropriate rostering and rotations in a crisis could increase sector-wide emergency management capacity and reduce pressure on key personnel.[500] Leaders in central and key line agencies also carried significant workloads. Some Secretaries made arrangements that allowed them to delegate functions to Deputy Secretaries and other leaders. Formalising this arrangement in a pairing model for key senior staff could assist in future crises. At the peak of the pandemic, rostering arrangements were put in place in some areas to maintain staff resilience and wellbeing.[501] Staff worked long hours and experienced burnout and mental fatigue.[502] Some staff in public-facing roles reported feeling unsupported at times, and some had felt physically unsafe due to death threats and demonstrations outside their place of work, and required police intervention and protection.[503]

Like organisations across the globe, the Australian Public Service moved to remote working in 2020. Before the pandemic, 22 per cent of employees indicated that they worked away from the office some of the time.[504] At the highest recorded point in 2020, 56 per cent of all Australian Public Service employees were working from home. This number increased to 69 per cent when Services Australia (which required the majority of its employees to attend usual workplaces for operational reasons) was excluded.[505] Flexible working practices are now a common feature across the economy, and the proportion of Australian Public Service employees accessing flexible working arrangements has remained consistent since 2022.[506] The 2023 Australian Public Service Employee Census results suggested that 57 per cent of employees worked away from the office or from home at least some of the time.[507] In March 2023 the Secretaries Board endorsed a service-wide, principles-based approach to embedding flexible work in the Australian Public Service. These principles were developed through extensive consultation with Australian Public Service agencies and research into best-practice approaches.[508] As part of the service-wide bargaining process in 2023, agreement was reached to include a common clause on workplace flexibility in all Australian Public Service enterprise agreements.[509]

3.4. Engagement with business and community sectors

The National Coordination Mechanism was widely acknowledged to have filled an important gap in providing rapid feedback to decision-makers on the pandemic response. Similarly, engagement and advisory structures in the health and broader social care spheres were reported to have become progressively more effective in shaping and coordinating the national response. However, the Inquiry heard concerns that clear feedback loops were not always in place across key industry and community sectors to link policy and operational mechanisms so that emerging issues could be raised with decision-makers for solution.[510] This was

compounded by the absence of more formal engagement structures.[511] Clearly articulated and formal linkages would have ensured prompt consideration of gaps, reforms and investments required to mitigate or treat unintended consequences.

We heard that the National Coordination Mechanism gave the private and not-for-profit sectors a valuable avenue for direct feedback to government on operational issues in the absence of agreed communication pathways.[512] But we also heard that the National Coordination Mechanism was not used as well as it could have been and that it initially duplicated some roles with the Coronavirus Business Liaison Unit.[513] A number of gaps were raised with the panel, such as the need for greater initial clarity on the National Coordination Mechanism's role, governance structure and reporting arrangements.[514] We heard that the National Coordination Mechanism often assumed authority on issues after being tasked by the Prime Minister, the Treasurer or the COVID-19 Deputies Group, and it also brought matters to National Cabinet through a range of pathways such as via the Australian Health Protection Principal Committee or National Security Committee processes.[515] The National Coordination Mechanism would have benefited from an agreed formal feedback loop into policy mechanisms to rapidly raise and resolve operational issues.[516]

The Coronavirus Business Liaison Unit was seen as a valuable central coordination point on issues across government, particularly during the first weeks of its establishment in March 2020.[517] It gave Treasury valuable real-time insights from business on what they were experiencing, forecasting and feeling, which provided useful context for government decision-making.[518] The Coronavirus Business Liaison Unit also gave business an important mechanism for bringing proposals to government.[519] We heard that the establishment of the National COVID-19 Coordination Commission in parallel to the Coronavirus Business Liaison Unit created confusion and duplication of effort and was perceived by industry as a lack of communication within government (see Chapter 4: Leading the response for further details on the National COVID-19 Coordination Commission).[520]

The panel heard the national government did not appear to understand the role of community services providers and failed to use their expertise in service delivery. Providers told us that trying to build understanding within government while in crisis mode was very difficult. Concerns were raised whether the membership of the existing groups was sufficiently broad. They proposed that departments should look at the community services sector as a critical partner in providing services to the community in an emergency and as an effective advisory group. Having the right people in the room is essential to an emergency response.[521] Stakeholders noted that this includes investing in community services to maintain their viability and sustainability and to ensure that systems and processes are adequate.[522] During the pandemic the National Coordination Group met weekly to discuss issues for the community services sector such as demand for emergency relief and where it needed to go. We heard that this had enabled progress for community service providers but that the delay in setting up the National Coordination Group meant that it had to play catch-up.[523]

4. Evaluation

Pandemic preparedness requires sector-wide leadership

A strong unity of purpose, existing trusted relationships and an agile strategy enabled the Australian Public Service to progressively support a whole-of government response to COVID-19. We acknowledge the significant efforts across all levels of the Australian Public Service in policy and operational roles – both those directly involved in the response and those maintaining key functions including Parliament, courts, and health and social supports. The impacts on the workforce were profound and there has been a significant turnover of personnel post pandemic. We acknowledge their achievements and thank them for their contribution to enhancing Australia's future pandemic preparedness through their involvement in this Inquiry process.

A health crisis of the magnitude and duration of COVID-19 requires a whole-of-government response. The Australian Public Service showed great agility. We heard many examples of new measures and systems being rapidly mobilised, such as the provision of economic supports to families and business. However, leaders acknowledged that the sector was largely unprepared for an incident of this scale and duration. A lack of preparedness in the public service is no longer acceptable to its political leaders or to the community.

As set out in Chapter 3: Planning and preparedness, the panel considers that we need to update our health emergency plans and ensure we have a 'playbook' of responses and actions. These must build in sufficient flexibility so responses can be rapidly tailored to the specific circumstances. The Australian Public Service is central to supporting this work. The panel notes and strongly supports work underway to embed greater alignment of the health emergency response to the broader emergency response framework, including through the Australian Government Crisis Management Framework. The updated Australian Government Crisis Management Framework provides greater clarity regarding the roles of specific ministers and key agencies.[524]

Clarity of governance arrangements is vital for national coordination

While relationships were the foundation of the Australian Public Service's COVID-19 response, with the wisdom of hindsight, leaders acknowledged the need for a coherent and visible crisis governance structure that provides clarity on roles and responsibilities and mobilises whole-of-government capabilities. The panel welcomes the recent work to clarify the roles of the Prime Minister and key ministers and to enhance the coordination role of the Department of the Prime Minister and Cabinet through the Australian Government Crisis Management Framework.

The Secretaries Board plays an important part in the stewardship of the Australian Public Service both during a crisis and more generally. We strongly support the work underway through the Secretaries Board and its support structures to build relationships and connectedness at senior levels, build and maintain a surge workforce capacity, and develop and value emergency management capabilities. The Board's stewardship responsibilities can also extend to overseeing and providing support to broader pandemic and related emergency

management preparedness. Building on the action in Chapter 3: Planning and preparedness regarding biannual reviews of preparedness, the panel considers that Australian Public Service preparedness would be enhanced by the Australian Centre for Disease Control and the National Emergency Management Agency providing regular preparedness updates to the Secretaries Board.

The panel considers that a purpose-built governance structure would offer significant benefit in supporting national leadership and coordination in a future health crisis. This would bring together key secretaries and senior leaders in a designated Secretaries Response Group – analogous to the Secretaries Committee on National Security – to support the Prime Minister and Cabinet to lead the coordination, development and implementation of the Australian Government response. This group's membership would reflect the specific circumstances of the emergency and response. The inclusion of lead service delivery agencies would be critical to the group's success. It would report to a Cabinet committee that has emergency management responsibilities and authority to make rapid decisions and whose membership reflects the multi-sectoral nature of the response required (see Chapter 4: Leading the response).

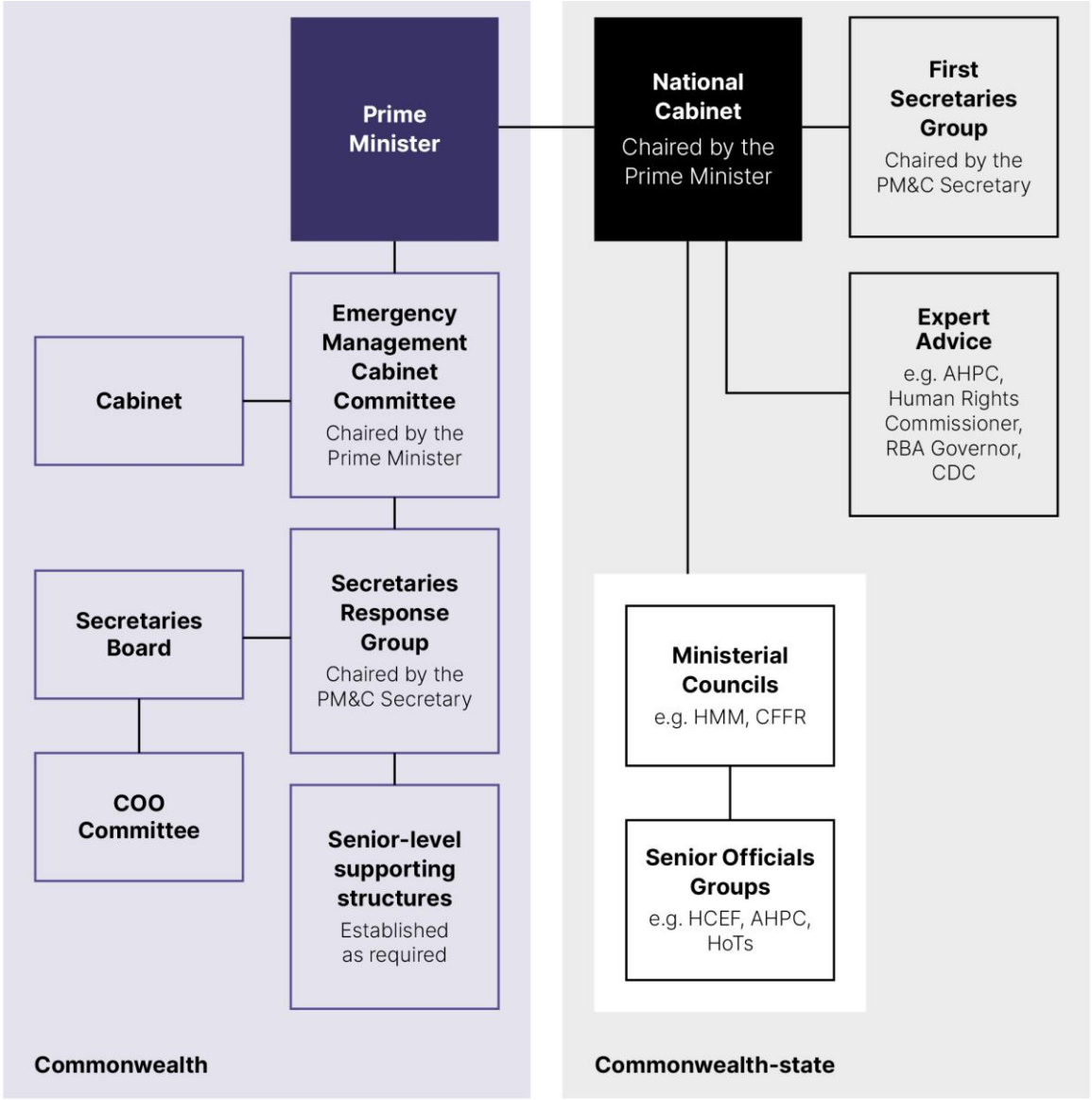
Given its proximity to the Prime Minister, Cabinet processes and existing Commonwealth–state relationships, the Department of the Prime Minister and Cabinet is best placed to chair the Secretaries Response Group and have accountability for coordinating and oversighting the response across the national government. This aligns with changes to the Australian Government Crisis Management Framework and more clearly defines the Department of the Prime Minister and Cabinet's formal role as the coordination lead in incidents requiring multi-sectoral responses. In chairing this group, the Department of the Prime Minister and Cabinet should draw on the crisis management systems, policy and operational capabilities from across the Australian Public Service to support a successful response effort. Formal reporting lines should be put in place between the Secretaries Response Group and other senior official bodies. This process should include identifying areas that require dedicated and specific attention and establishing supporting clusters of officials across departments and agencies to progress this work.

The Department of the Prime Minister and Cabinet's role should include 'watching the field' to ensure that resources can be rapidly deployed to meet demand and minimise the risk of key agencies being overwhelmed. Agencies would clearly retain responsibility for carrying out their roles but understand that they might be required to actively assist broader government efforts when required. Such a structure would enable operational feedback to be rapidly shared and integrated with the key policy agencies, strengthen the monitoring and adaptability of the response, and mitigate the risk of unintended consequences (as experienced in supply chains during the COVID-19 pandemic).

As chair of the Secretaries Response Group, and chair of the inter-jurisdictional First Secretaries Group, the Department of the Prime Minister and Cabinet would be a key link with the states and territories in developing, coordinating and implementing National Cabinet decisions. This would strengthen national leadership and coordination. This structure would also ensure a holistic approach to engagement with relevant sectors outside government, and the ability to

leverage non-government capability and expertise to contribute to the response. It would also promote a more holistic consideration of broader health, economic, social, equity and human rights impacts in Cabinet decision-making and oversight processes.

Figure 1: Proposed future governance structure for public health emergency



AHPC Australian Health Protection Committee
CFFR Council on Federal Financial Relations
COO Chief Operating Officers
HCEF Health Chief Executives Forum
HMM Health Ministers Meeting
HoTs Heads of Treasuries
RBA Reserve Bank of Australia

The Australian Public Service should build links with stakeholders and focus on the groups most at risk from the outset

It is crucial that the Australian Public Service engage effectively with stakeholders and the community in the design and delivery of the response. We heard that during COVID-19 there

were areas where engagement was strong and other areas where more could have been done. The panel was pleased to hear that key engagement mechanisms such at the National Coordination Mechanism and the Coronavirus Business Liaison Unit have been embedded in business-as-usual arrangements. These whole-of-government engagement mechanisms were vital, but industry-specific responses were also needed to address the individual needs and challenges of different sectors. The panel is concerned that some important relationships built during the COVID-19 pandemic have already fallen away. The panel considers that the Australian Public Service should ensure there are appropriate coordination and communication pathways in place with industry, unions, primary care stakeholders, local government, priority populations and community representatives on issues related to public health emergencies. Structures should be maintained outside of an emergency, and be used to provide effective feedback loops on the shaping and delivery of response measures in in a public health emergency.

In particular, lessons learnt from the COVID-19 experience confirm the need to identify and consider the groups that are most at risk from the outset – this is essential to minimise harm and ensure equity. The COVID-19 pandemic demonstrated that while everyone will experience some negative effects, certain groups of people will experience a disproportionate level of risks and impacts. The Equity section details how existing inequities were amplified by the pandemic and the response.

In any future crisis, early engagement and responses for groups most at risk should be prioritised. Ahead of the next crisis, key advisory mechanisms should be made permanent and embedded into planning and decision-making structures. We note that the Australian Health Protection Committee has now embedded the Aged Care Advisory Group and the National Aboriginal and Torres Strait Islander Health Protection subcommittees into its permanent structure. Similar action is warranted for advisory groups such as the Culturally and Linguistically Diverse Communities COVID-19 Health Advisory Group and the Advisory Committee for the Health Emergency Response to COVID-19 for People with Disability. We also note the value of aligning responses around existing structures and national commitments to support at-risk groups, such as Closing the Gap and the National Plan to End Violence against Women and Children 2022–2032.[525]

Governments rely on the community services sector to provide critical services and support to some of the most disadvantaged people in our communities. More formalised engagement channels between this sector and the public service will foster stronger relationships and enable their expertise and knowledge to be more effectively leveraged to support future responses. It would also support effective communication at the community level.

Crisis planning should embed review cycles and build strong feedback loops

Experience during the pandemic confirmed the need for greater access to real-time data and rapid and ongoing feedback on the efficacy of response measures. The Australian Centre for Disease Control can play a key role in accessing and synthesising emerging evidence, coordinating real-time research efforts, and monitoring surveillance and other data collection at

the national level to ensure responses are and remain proportionate to risk. Regular review cycles need to be embedded into emergency planning and decision-making on pandemic response measures. Reports from these rolling reviews will provide Cabinet with ongoing assessments of the effectiveness of responses and strategies to mitigate unintended consequences. The Coronavirus Business Liaison Unit and the National Coordination Mechanism demonstrated the benefits of strong feedback loops with clearly understood communication and reporting pathways in designing and adapting pandemic measures.

The importance of real-time evaluation cannot be underestimated. The panel noted that where reviews had been undertaken during the pandemic, such as the reviews of JobKeeper, aged care, hotel quarantine and contact tracing, they were influential in modifying the response. It is concerning that relatively few post-action reviews were completed. Where these had occurred, such as in the Reserve Bank of Australia, the Department of Home Affairs and the Department of Foreign Affairs and Trade, work is underway to implement changes. Given the scale of resources deployed, the panel recommends that the government make a commitment to undertake post-action reviews of all major pandemic programs. As noted in Chapter 4: Leading the response, we also recommend undertaking a post-action review of the human biosecurity provisions under the *Biosecurity Act 2015* (Cth), as this was the first time they had been activated for a pandemic.

Australian National Audit Office – revised approach to audits during COVID-19

The Australian National Audit Office created a specific COVID-19 multi-year audit strategy in response to the changed risk environment during the pandemic. This strategy was designed to 'respond to the interests and priorities of the Parliament of Australia; provide a balanced program of activity that is informed by risk; and promote accountability and transparency of, and improvements to, public administration'.[526] The strategy was flexible so that it could evolve with the rapid implementation of government policies and initiatives while addressing the changing pandemic situation and how this impacted on Australians and the economy.

The COVID-19 audit strategy was delivered in three key phases, with five audits completed in Phase 1 (2020–21), seven in Phase 2 (2021–23) and three additional potential audit topics in Phase 3.[527] We heard that the 'performance bar' for these Australian National Audit Office audits was dropped during the pandemic to account for the speed at which policies were implemented during emergency circumstances. The Australian National Audit Office's strategy reflected the agility and innovation needed during a crisis. It helped to keep the Australian Government accountable and maintain public trust in decision-makers.

This approach demonstrated agility in adjusting existing processes to quickly deliver rapid reviews and should be repeated in future public health emergencies. It could also provide a model for broader rapid review mechanisms in a crisis.

The Australian Public Service must build, value and maintain key capabilities

The panel acknowledges the importance of the Australian Public Service building, valuing and maintaining key emergency management and surge capabilities. Sustainability and wellbeing

are as important for the Australian Public Service as they are for first response agencies within state governments.

The establishment of the Australian Public Service Surge Reserve in April 2021 was a key foundational step in increasing emergency management expertise and capability across the Australian Public Service.[528] This has been demonstrated by its use in subsequent multiple flooding events in Australia. The panel welcomes the work underway, driven jointly by the Australian Public Service Commission and the National Emergency Management Agency, to strengthen emergency management and related capabilities. The Australian Public Service must continue to invest in the capability of its people to ensure departments can quickly draw on a large pool of officers in future crises. The Secretaries Board should retain an enduring leadership role in managing these priority capabilities in the Australian Public Service.

There is a need for Australian Public Service workforce plans for future multi-sectoral incidents. The panel supports the findings of the Australian National Audit Office's 2020 report *Management of the Australian Public Service's workforce response to COVID-19*[529] with respect to the governance oversight of the Australian Public Service workforce by the Australian Public Service Commission, Chief Operating Officers Committee and Australian Public Service leadership. We suggest that whole-of-government crisis management frameworks be updated to include Australian Public Service workforce matters, including surge arrangements.

In major crises, there will be limits to the Australian Public Service's ability to fill large-scale gaps while continuing business-as-usual work. Workforce planning should recognise that external capability needs to be quickly incorporated. Planners must proactively consider employee health, safety and wellbeing, and include employee rotations and other standard measures to provide support and respite for key leaders and frontline staff during protracted incidents. In preparation for and during protracted crises, redundancy must be built into the formal system to ensure both an effective response and the wellbeing of the Australian Public Service workforce.

5. Learnings

- Many of the most significant national achievements during the pandemic response were highly reliant on key individuals and existing trusted relationships. This is not sustainable or efficient in protracted or concurrent emergencies. There is a need for more structured governance arrangements and agreed communication pathways.
- Governance structures need to be pre-agreed and able to be rapidly established or scaled up in pandemic emergencies to bring together key public sector decision-makers to support a multi-sectoral response and drive national coordination.
- Greater alignment of health emergencies with the broader Australian Government Crisis Management Framework enables the health response to more readily access and leverage additional capability and expertise. Escalation triggers for a whole-of-government response need to be clearly defined and understood within government and the broader health ecosystem.

- The National Coordination Mechanism played an important role in national coordination. Its operating model may be utilised in partnership with health leaders to support broader health responses.
- Clear engagement mechanisms with business and community groups need to be in place ahead of any crisis to ensure they can be quickly mobilised.
- Stronger real-time feedback loops need to be developed between operational and policy agencies to enhance coherence and coordination within and between government, industries and community partners.
- Crisis workforce plans and surge arrangements for the Australian Public Service need to be in place for future multi-sectoral incidents. Workforce planning needs to include building an emergency management capability within the Australian Public Service.

6. Actions

6.1. Immediate actions – Do in the next 12–18 months

Action 10: Agree and test a national Australian Government governance structure to support future health crisis responses, including an appropriate emergency Cabinet Committee and a 'Secretaries Response Group' chaired by the Department of the Prime Minister and Cabinet that brings together the lead Secretaries and heads of relevant operational agencies, to coordinate the Australian Government response.

A purpose-specific governance structure, aligned with the revised Australian Government Crisis Management Framework, should be rapidly mobilised and tested in future pandemic incidents requiring a multi-sectoral response.

Plans should be tested to ensure they are ready to be mobilised ahead of a crisis.

The governance structure should include:

- A 'Secretaries Response Group' with a similar role to the Secretaries Committee on National Security, to support the Prime Minister and Cabinet to lead the coordination, development and implementation of the Australian Government response.
    - The Secretaries Response Group should be chaired by the Department of the Prime Minister and Cabinet and include lead Secretaries and heads of operational agencies that reflect the specific circumstances of the emergency and response.
    - There should be formal reporting lines between the Secretaries Response Group and other senior officials' bodies, including supporting clusters of officials across relevant departments to progress work and enhance coordination with the states and territories.

Action 12: Develop a plan to build, value and maintain emergency management capability within the Australian Public Service, including planning and management of a surge workforce.

This should:

- prioritise investment in emergency management capability uplift across the public sector, especially within the Department of Health and the Department of the Prime Minister and Cabinet, to ensure there is a sufficiently large pool of people who have knowledge and understanding of crisis management and delivery principles and approaches
- establish arrangements to ensure agencies are able to appropriately fulfil their emergency management obligations and agreed roles and responsibilities under the Australian Government Crisis Management Framework.
- establish arrangements to train agency staff to better equip them to surge to contribute to whole-of-government crisis responses
- ensure the Secretaries Board maintains a role in stewarding these priority emergency management capabilities
- be aligned with the work done under Action 21 to improve capability and readiness, including through exercises and readiness reviews.

Action 14: Embed flexibility in Australian Government grant and procurement arrangements to support the rapid delivery of funding and services in a national health emergency, for instance to meet urgent community needs and support populations most at risk.

This should include:

- funding arrangements for community organisations and industry, and procurement processes
- funding mechanisms that allow organisations to rapidly develop and deliver solutions tailored to their communities
- guidance and random audits embedded in program delivery.

Action 15: Ensure there are appropriate coordination and communication pathways in place with industry, unions, primary care stakeholders, local government, the community sector, priority populations and community representatives on issues related to public health emergencies. Structures should be maintained outside of an emergency, and be used to provide effective feedback loops on the shaping and delivery of response measures in a national health emergency.

- Build and maintain engagement mechanisms outside of an emergency with the community sector and industry (including businesses and entities across the supply chain).
- Maintain and build on effective structures that were established before or during the COVID-19 pandemic, including those with priority populations such as Aboriginal and Torres Strait Islander people, people with disability, culturally and linguistically diverse communities and older Australians.
- Consult these groups on the development and updating of pandemic plans, and ensure they participate in stress-testing exercises.
- Ensure there are clear mechanisms to feed into decision-making processes in an emergency, and genuinely engage relevant bodies in pandemic preparedness activities and responses to future emergencies.
- Utilise these structures in national health emergencies to provide effective feedback loops on the delivery of response measures.

6.2.Medium-term actions – Do prior to the next national health emergency

Action 21: Build emergency management and response capability including through training for a pandemic response.

Led by the National Emergency Management Agency, this should include:

- arrangements to train agency staff in emergency management to better equip them to surge to contribute to whole-of-government crisis responses
- establishment of training programs to address technical expertise gaps identified through emergency exercises and add to response capacity at jurisdictional level when a crisis occurs during an active training period
- a primary coordination role for the CDC/NEMA with input from technical advisory committees and states and territories, and embedded within jurisdictions.

Action 24: Maintain regularly tested and reviewed agreements between relevant national and state agencies on shared responsibilities for human health under the *Biosecurity Act 2015* (Cth) with a focus on facilitating a 'One Health' approach that considers the intersection between plant, animal and human biosecurity.

- Agreements should ensure clarity and agreement on roles and responsibilities between governments and government agencies under the *Biosecurity Act 2015* prior to the next crisis.

Action 26: Include a focus as part of ongoing systems upgrades on modernising and improving data, systems and process capabilities to enable more tailored and effective program delivery in a crisis.

- Consider preparedness for future crisis as part of ongoing investment in key data, system and process capabilities.

International Border Closures and Quarantine

Overview

In the early stages of the pandemic, there was extreme uncertainty about how the SARS-CoV-2 virus spread, how our health system would withstand high numbers of COVID-19 patients, and whether and when a vaccine would become available. The Australian Government acted quickly and decisively to close Australia's borders and to quarantine returning travellers. This has been referred to by many as the most important decision Australia made during the pandemic response. It was also a massive and unprecedented decision that had not been in any way planned for. The Australian Government's pandemic preparedness planning had not anticipated or suggested the restriction of international travel or mandatory quarantine as viable options.[530]

The early decisions to progressively close our international borders and require returning travellers to quarantine played a key part in Australia's strategy to delay the onset of community-wide transmission and then slow the spread of the virus. The impacts were significant. Families and friends were separated for long periods of time, businesses closed, Australians had their ability to travel freely in and out of the country curtailed for significant periods, international students had to decide whether to remain in Australia for an extended period to complete their degree or risk not being able to return from a home visit, and migration flows were heavily disrupted.

Between January and March 2020 the Australian Government progressively introduced restrictions that banned entry to Australia, initially from certain virus-impacted countries, then for all travellers except Australian citizens, permanent residents and their immediate families, diplomats, celebrities and certain other exceptions.

Initially Australian citizens and permanent residents returning from China were required to self-isolate at home for 14 days upon arrival. However, as COVID-19 cases sharply increased through March 2020 there was heightened concern about the risk that the hospital system could be overwhelmed.

With no system in place to monitor whether arrivals were complying with home quarantine requirements, on 27 March 2020, National Cabinet agreed to a new system of mandatory supervised quarantine. State and territory authorities accepted operational responsibility for quarantine. Within 72 hours of the announcement, they implemented quarantine arrangements using converted hotels. In the absence of centralised coordination and operational guidance, each state and territory adopted a distinct approach to hotel quarantine. The arrangements they put in place at the end of March generally remained until 1 November 2021. A notable exception was Victoria, where recommendations from three reviews led to substantial improvements.[531]

Closing the border was never expected to guarantee that Australia could remain COVID-19 free, even with mandatory quarantine in place. There were still many people crossing the border, and the nature of the virus – including people being infectious before having symptoms – meant that mandatory quarantine was unlikely to be bulletproof. However, the implementation of both international travel restrictions and mandatory managed quarantine for returned travellers effectively reduced the seeding of COVID-19 variants into Australia. This made it possible for health departments to contain outbreaks from the initially infrequent quarantine breaches that occurred. Unfortunately, the effectiveness of mandatory quarantine was partly undermined by national inconsistencies in the implementation of managed quarantine. This led to viral escape events through infected workers or residents being discharged while infectious, seeding community transmission. Even so, studies have concluded that the early border closure likely reduced the number of COVID-19 cases and deaths by up to 86 per cent, modelled against a scenario where the international border remained open.[532]

The first chapter of this section examines the Australian Government's implementation of international travel restrictions, including international travel bans, repatriation efforts, and the impact of the border closures on Australia's health and economic responses and on Australian residents.

The second chapter examines the implementation of managed quarantine, the interplay between the Australian and state and territory governments, and the impacts of hotel quarantine on occupants and workers. It also explores how governments attempted to improve the system following numerous breaches.

Timeline

- 1 February 2020: Australian citizens and permanent residents returning from China must self-isolate for 14 days.[533]
- 1 February 2020: foreign nationals who were in mainland China were banned from entering Australia for 14 days
- 3 February 2020: 241 Australians evacuated from Wuhan arrive on Christmas Island.[534]
- 13 February 2020: Australian Government extends entry ban for foreign nationals who had been in China.
- 15 March 2020: Everyone entering Australia is required to self-isolate for 14 days.[535] *Customs Act 1901* (Cth) is used to ban cruise ships from entering Australia.
- 18 March 2020: A human biosecurity emergency is declared by the Governor-General.[536] Cruise ship ban is formalised through a *Biosecurity Act 2015* (Cth) determination.[537]
- 19 March 2020: Passengers disembark from the *Ruby Princess*.[538]
- 20 March 2020: Australia's international borders closed to all non-citizens and non-residents.[539]
- 25 March 2020: Overseas travel ban enforced for Australian citizens and permanent residents.[540]
- 10 July 2020: National Cabinet announces the implementation of international passenger arrival caps.[541] Prime Minister announces a national review of hotel quarantine. Move towards a user-pays model for hotel quarantine is announced.
- 16 October 2020: Australia–New Zealand one-way quarantine-free travel zone commences.
- 20 October 2020: Howard Springs formalised as Australia's first Centre for National Resilience.[542]
- 23 October 2020: Three-step framework agreed for national reopening. The National Review of Hotel Quarantine final report recommendations accepted.
- 5 March 2021: Howard Springs quarantine capacity increased to 2,000 individuals a fortnight.
- 30 April 2021: 14-day 'India Travel Pause' begins.
- June 2021: Prime Minister agrees to establish a quarantine facility in Melbourne,
- 23 July 2021: National Cabinet commissions a second review of quarantine arrangements.

- 1 October 2021: Seven days home quarantine for vaccinated Australians; 14 days managed quarantine for non-vaccinated people.[543]
- 1 November 2021: Quarantine abolished for vaccinated Australians.[544]
- 1 December 2021: Australia's borders open to fully vaccinated holders of eligible visas.[545]
- 21 February 2022: Australia's borders open to fully vaccinated visa holders.[546]
- 6 July 2022: Australia's borders open for all eligible visa holders regardless of vaccination status.[547]

Chapter 7 – Managing the international border

1. Context

In the early stages of the pandemic, the Australian Government moved quickly to progressively close our international borders, first to specific countries and then to the rest of the world. The international border closures aimed to keep the levels of the virus low to reduce risks to the population and help ensure the health system was not overwhelmed. The government implemented full border closures with very little notice. The sudden closures and their extended duration necessitated a government-wide effort to support citizens overseas and develop systems to repatriate them at scale. Considerable efforts were also made to assist foreign nationals to return home, including those needing to transit through Australia. This had not previously been contemplated or planned for and stretched existing systems and emergency capacity. The difficulty of establishing and managing international travel restrictions was compounded by the fact that decision-making powers on international border closures were held by the Commonwealth, but the implementation powers were held by the states and territories.

The international border closure also had compounding impacts on Australia's economy and workforce due to the impact on migration, the reduction in visitors from overseas, and the disruption to supply chains. Certain sectors of the economy were more exposed to these impacts, including the travel and tourism industry and the education sector (see Chapter 24: Supporting industry). There was also a cascading effect on skilled workforce capacity, including on the health workforce.

A note on terminology

In this report, we use the terms 'international border closure' and 'closing the international border' to refer to the international travel restrictions implemented by the Australian Government between February 2020 and July 2022. Though subject to considerable restrictions, Australia's international border never fully closed. Low levels of travel continued throughout the pandemic through inward and outward travel exemptions. Whilst Australian citizens and permanent residents were prohibited from leaving Australia, with limited exceptions, Australian citizens, permanent residents and their families were always exempt from inwards travel restrictions (except for a two-week period in May 2021 known as the India Travel Pause). The difficulties Australian citizens and permanent residents faced returning to Australia arose because of limited/expensive flights, flight caps and limitations on quarantine places. This report uses the terms 'international border closure' and 'closing the border' because this is how international travel restrictions were understood by the public, and how they were referenced by the Prime Minister and other leaders when announcing decisions regarding the international border.

2. Response

2.1. International travel bans

Restrictions on entry to Australia were implemented in stages. From 1 February 2020 the Australian Government implemented a 14-day ban on foreign nationals entering Australia from China and required Australian citizens, permanent residents and their immediate families to self-isolate for 14 days. This decision was based on Australian Health Protection Principal Committee advice.[548] During February and early March 2020, additional travel bans applied to arrivals from Iran, South Korea and Italy in response to the high levels of COVID-19 transmission in those countries.

From mid-March 2020, the Australian Government introduced four broad international travel restrictions, which remained in place until November 2021 (~20 months).[549]

- Cruise ship requirement: On 15 March 2020, after multiple COVID-19 outbreaks on international cruise ships, the Australian Government used the *Customs Act 1901* (Cth) to ban international cruise ships with more than 100 passenger berths from entering Australian ports. The Minister for Health formalised this ban through a human biosecurity emergency determination under the *Biosecurity Act 2015* (Cth) on 18 March 2020, based on the advice from the Chief Medical Officer about the risk of transmission on cruise ships and the risk of widespread transmission from passengers arriving on shore.[550]
- Mandatory quarantine: From 15 March 2020 all international travellers, including Australians, arriving in Australia were required to self-isolate for 14 days.[551] On 27 March 2020 the Australian Government announced that as of 28 March 2020 all incoming travellers were required to undertake a 14-day supervised quarantine period in a designated facility at their port of entry. (See Chapter 8: Implementing quarantine.)
- Inward travel restrictions: On 20 March 2020 the Australian Government closed its international border to all non-citizens and non-residents from 9 pm.[552] This decision was based on data showing that around 80 per cent of known COVID-19 cases in Australia were imported.[553] A range of exemptions were put in place, including for immediate family of Australian citizens and permanent residents, which were expanded over time.
- Outward travel restrictions: On 25 March 2020 the Australian Government banned Australian citizens and permanent residents travelling overseas, unless they had an exemption, through an emergency determination under the *Biosecurity Act 2015* (Cth).[554] The Prime Minister announced that this decision was to 'help avoid travellers returning to Australia with coronavirus and the risks of spreading coronavirus to other countries'.[555]

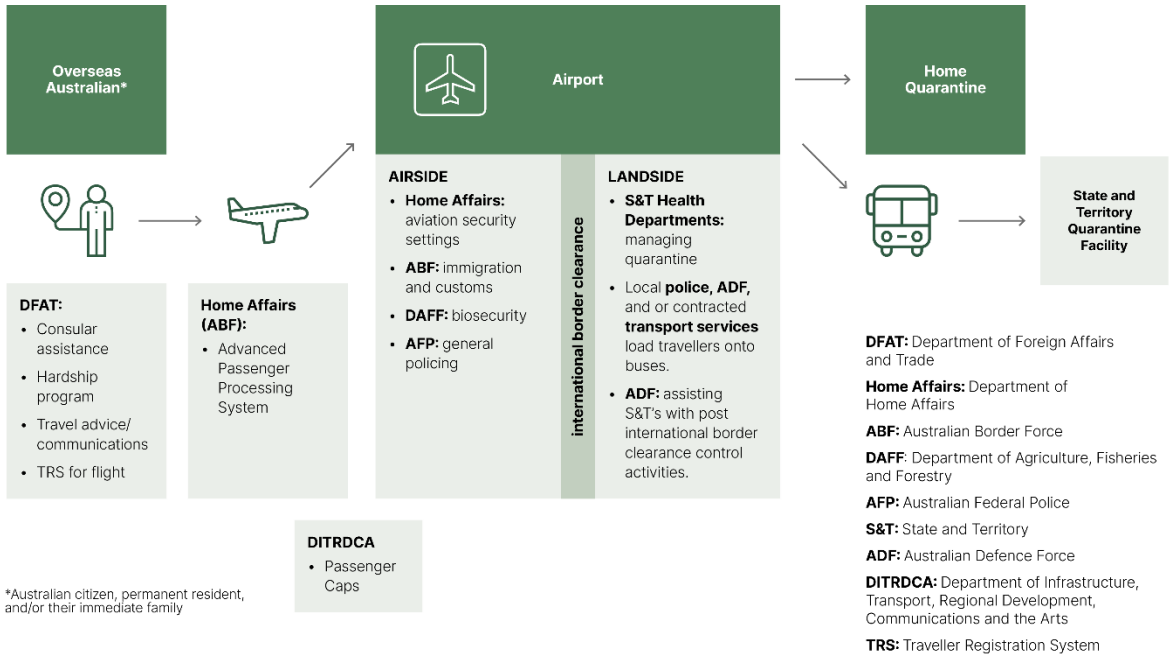
The decisions to restrict both inward and outward international travel were made by the Australian Government, primarily based on Australian Health Protection Principal Committee

advice. The government and later National Cabinet frequently agreed to international travel restrictions on the same day that they received Australian Health Protection Principal Committee advice, and the decisions took effect soon after.[556] In providing its advice, the Australian Health Protection Principal Committee considered the readiness of our public health capability to manage community spread and protect the hospital system so that it could cope with the numbers (based on early projections) of patients requiring hospitalisation.

The scale and complexity of the pandemic required the largest ever consular response Australia has undertaken.[557] Managing the implications of international border closures also required a significant coordinated effort across Australian Government agencies and with state and territory government health authorities. This included:

- enforcing travel restrictions at the border through physical checks of travel documents and exemptions, and managing online systems for granting discretionary exemptions – Department of Home Affairs and Australian Border Force
- supporting Australians overseas, facilitating repatriation flights, liaising with airlines to advise of the need for additional commercial flights, and negotiating seats for Australians on flights organised by a foreign government or non-government entity – Department of Foreign Affairs and Trade (with support from Services Australia)
- supporting National Security Committee and National Cabinet discussions, coordinating a national response across departments and governments, and negotiating passenger arrival caps with states and territories based on quarantine capacity and flight operations to maximise the number of returning Australians – Department of the Prime Minister and Cabinet (with support from state central/health agencies)
- regulating international airline timetable approvals (capping international passenger arrivals) – Department of Infrastructure, Transport, Regional Development, Communications and the Arts
- assisting states and territories with airport border control activities – Australian Defence Force
- cooperating with states and territories, the Australian Border Force, the Australian Defence Force and airport operators to administer border controls – Australian Federal Police
- screening, collection and testing for passengers and aircrew returning to Australia; operating and staffing mandatory hotel quarantine; issuing quarantine notices; and managing intersections with interstate border closures and testing requirements – state and territory governments.

Figure 1: The journey from overseas to home in Australia[558]



2.1.1. International cruise ship bans

The 15 March 2020 decision by the Australian Government to ban international cruise ships from entering Australian ports made it an offence under subsection 58(1) of the *Customs Act 1901* (Cth) to bring an international passenger cruise ship into any of Australia's ports unless permission had been granted by the Australian Border Force under subsection 58(2). This decision was initially made for 30 days.

The government then introduced a second measure, the 18 March 2020 Biosecurity Determination, which stated that an international cruise ship could not enter a port in Australia without permission from the Comptroller-General of Customs (the Australian Border Force Commissioner). Permission could only be provided if the ship was in distress or emergency circumstances existed, or if it had been at sea before the 15 March ban was declared (i.e. had departed a port outside Australian territory before the end of 15 March 2020 and was bound directly for a port in Australian territory). In the weeks that followed, a targeted Australian Border Force effort saw the departure of the 32 internationally flagged cruise ships and their 20,000 or so crew from Australian waters; the last vessel departed on 28 April 2020.[559] International passengers were allowed to complete their onward travel, domestic or international, but were required to self-isolate until travelling to the airport for their return home.[560]

On the morning of 19 March 2020, passengers who were later discovered to be infectious disembarked from the cruise ship *Ruby Princess*. A New South Wales Government Special Commission of Inquiry closely examined how this happened. The inquiry, which reported to the New South Wales Government on 14 August 2020, found that the human biosecurity

arrangements in place did not operate as intended, there was poor communication between responsible agencies, policies were ignored and all parties involved did not have a clear understanding of their role in a pandemic emergency.[561]

2.2.Repatriating and supporting Australian citizens travelling overseas

A key part of the government's response was supporting Australians who were overseas but wanting to return home, and determining exemption rules for Australians seeking to travel in and out of Australia for compassionate and other reasons such as business.

In March 2020 the Department of Foreign Affairs and Trade estimated there were around 879,000 Australians living or travelling overseas.[562] Between 1 April 2020 and 31 March 2021, 154,321 Australian citizens and 47,938 permanent residents returned to Australia. [563] Many had help from the Department of Foreign Affairs and Trade through consular support, financial support, and coordination and communication.

- The Australian Government facilitated 150 commercial flights from 22 October 2020 to 24 February 2022, costing it $60.4 million.[564] The Department of Foreign Affairs and Trade also enabled flights chartered for targeted evacuation operations (assisted departures) (e.g. flights from Wuhan).
- The Department of Foreign Affairs and Trade's Smartraveller program provided advice to Australians overseas. The Department of Foreign Affairs and Trade used its website, social media channels and a paid advertising campaign to provide information.
- The Department of Foreign Affairs and Trade developed an online portal, the Traveller Registration System, on the Smartraveller website. The Traveller Registration System was supported by the COVID-19 Crisis Citizen Information system, which recorded individual registrant details and supported the Department of Foreign Affairs and Trade's monitoring and reporting on the status of returning Australians. Services Australia called those who had registered with the Department of Foreign Affairs and Trade to discuss their vulnerability status.[565]
- On 2 September 2020 the Australian Government announced the Special Overseas Financial Assistance (Hardship) Program to help vulnerable Australians secure flights and return to Australia, including by covering the costs of people's airfares home. The Department of Foreign Affairs and Trade received just over 10,000 Hardship Program applications and approved about half.[566] This program operated until the end of March 2022 and provided $44.54 million in funding to overseas Australians. It was set up with the guidance of Services Australia to ensure it was effective.[567]

There were two main limiting factors for the Australian Government in bringing home such a large number of Australians from overseas: the state and territory hotel quarantine capacity, and limited operations of international airlines.

From July 2020 National Cabinet agreed to passenger arrival caps (a limit on how many people could fly from overseas into a state or territory on any given day) each week for each state and

territory based on the hotel quarantine capacity, operational workforce and flight data from each jurisdiction.[568] State and territory governments provided daily advice on quarantine capacity and forecasts to the Department of the Prime Minister and Cabinet to inform the weekly cap; and the Department of Infrastructure, Transport, Regional Development, Communications and the Arts helped to implement the caps through its regulation of international flight timetables and engagement with airports and airlines. As Sydney and Melbourne are the busiest international airports in Australia, New South Wales and Victoria received the most international arrivals. New South Wales quarantined 50 per cent of all international arrivals into Australia in the first (alert) phase of the pandemic.[569]

3. Impact

3.1. Impact of international border closure on COVID-19 cases and deaths

The panel consistently heard that the early decision to close the international border enabled a strong initial response to the pandemic. We heard from a stakeholder it was the single most important decision made by the Australian Government during the crisis.[570]

> *Australia is closing its borders to all non-citizens and non-residents … Our number one priority is to slow the spread of coronavirus to save lives. Our government has taken this unprecedented step because around 80 per cent of coronavirus cases in Australia are people who caught the virus overseas before entering Australia, or people who have had a direct contact with someone who has returned from overseas. – Prime Minister Scott Morrison, 19 March 2020*[571]

During the alert phase, little was known about the virus, its impact and how infections could be effectively treated and transmission controlled. During this time, testing of incoming passengers confirmed that international arrivals were bringing COVID-19 into Australia. The initial border closure significantly limited the number of new cases of the virus entering Australia, which helped reduce the spread of the virus into the Australian community. This meant outbreaks were limited in the first wave and controllable through lockdowns implemented across the country in March 2020. Case numbers peaked at over 400 a day in mid to late March 2020, but rapidly decreased to below 20 new cases a day on average by the start of May 2020.[572] All SARS-CoV-2 variants of the virus circulating in the first wave were successfully eliminated in all jurisdictions. Most states and territories returned to zero case detections for an extended period. Victoria experienced a second wave comprising newly imported variants.[573] International travel restrictions remained in place throughout 2020 as case numbers rose through various localised outbreaks after quarantine breaches, and for most of 2021 until vaccinations were rolled out in Australia.[574]

Participants in Inquiry focus groups said that the international border closure was important and appropriate, particularly in the early stages.

> *I agreed with the international border closures … Australia is lucky it's a single island, good to protect … I was very scared of COVID and I think the government should have closed the border more quickly to protect [people]. – Focus group participant, online*[575]

Health research reinforces what the panel has heard. Studies have found that the early border closure reduced the number of cases and deaths from COVID-19 by up to 86 per cent when modelled against a scenario where the international border remained open.[576] Australia would have had between 15 and 46 times the number of deaths if it had experienced the same COVID-related death rates as comparable countries like Canada and Sweden.[577]

We heard from the Australian Government that there were legal risks associated with enforcing the international border closure because of fragmented policy settings and limited legislative authority. This was not addressed in the course of the pandemic and is likely to pose legal risks should border closures be necessary in a future public health emergency.[578]

States and territories have described a lack of clear and agreed roles and responsibilities and information pathways between the Australian Government and state and territory governments at the international border. They have called for clearer emergency arrangements and governance to be agreed, regularly stress-tested and updated to reflect changing and concurrent risks before the next public health emergency.[579] State officials noted that it could take up to five days to receive passenger data.[580] States and territories strongly reaffirmed the need for a shared database in a future public health emergency. They noted that this was a key role the Australian Centre for Disease Control could play. This shared database would assist with national-level issues such as timely contact tracing, by connecting all jurisdictions with international flight data.[581]

The transition phase began with the reopening of the international border from November 2021. It unfortunately coincided with the emergence of the Omicron BA.1 variant. The combination of the easing of international travel restrictions and the higher transmissibility of the new variant led to the total recorded incidence of COVID-19 in Australia rising to 231,000 cases per million by 30 April 2022, compared to around 1,000 cases per million in June 2021.[582] This brought Australia into alignment with other high-income countries, which had averaged 241,000 cases per million since the start of the pandemic.[583] However, the COVID-19 related hospitalisations and death rates were much lower during the Omicron wave than during earlier waves. The case fatality rate of COVID-19 related deaths fell from a peak of 3.3 per cent in October 2020 to 0.1 per cent in April 2022.[584] This was a marked increase from the first two years of the pandemic, during which international travel restrictions were in place, when Australia's average cases per million were far below the averages of other high-income countries.[585] The benefit of delaying Australia's community-wide transition until after vaccination is clear from the fact that fewer lives were lost to COVID-19.

3.2.Impact of international border closure on overseas Australians

At the start of the pandemic, the Department of Foreign Affairs and Trade estimated there were around 879,000 Australians abroad.[586] Approximately 30 per cent of the population were born outside Australia, and millions of Australians have relatives living overseas.[587] Outward travel restrictions imposed large personal costs for these Australians, including extended separation from children, parents and partners.

High levels of distress and anger were expressed about the difficulties for Australian citizens visiting families or trying to return home. Some described this as a societal failing. Limited information on the location of Australian citizens compounded the difficulty of the government's repatriation efforts.[588] Agencies in their own post-action reviews identified areas to improve communications with and about the different categories of Australians overseas – those who did not want to return, those who did want to return, and those who were acutely stranded. [589]

There were Australians needing urgent assistance in almost every foreign country. This required the largest and most complex consular exercise Australia has ever undertaken. The Inquiry heard that the pre-existing consular supports, while well tested in less complex emergencies contained within individual countries and regions, were not built for, or at a scale to respond to, an extended global emergency. This included the responsibilities for the health and safety of consular staff. We heard that significant redeployments of staff were required from other key consular work and that staff experienced extended separations from their families.[590]

The Australian Government worked hard to support vulnerable overseas Australians. However, the Inquiry heard strong feedback about the adequacy, compassion, fairness and timeliness of the communications and supports.[591] There was a reported lack of transparency regarding the criteria used to determine people's level of 'vulnerability' and therefore prioritisation of support.[592] Submissions to the Inquiry said that this support fell short of meeting expectations and what they saw as the government's duty of care towards them.[593] Individual submissions highlighted a delay in receiving support and a perceived inequity of access to support. Submissions expressed the feeling that support for overseas Australians was not accessible for all.[594] Some said that access to return flights home was 'a lottery' with no transparent framework for prioritisation of some people over others.[595]

> *The Australian Government almost ruined me financially, and to be fair, cost me anywhere upwards of $60,000 to look after myself due to being left overseas, and further travel restrictions imposed on me by the Australian government … Don't cap Australians from re-entering Australia. Assist, don't create stranded Australians … – Submission 942*[596]

Overseas Australians described a lack of compassionate communication from the Australian Government regarding flight availability and criticised the cost of commercial flights to Australia as prohibitive. They also noted financial hardship and distress. Concerns were raised that the term 'returning travellers' used to describe Australian citizens and permanent residents trying to return home was almost derogatory.

> *Having registered on SmartTraveller, and each relevant Australian country consulate that I was in, I continued to solely get home somehow. The consulates never had telephone or email response support available other than automated non-updated information that they were doing what they could. – Submission 942*[597]

Inquiry focus group participants generally supported international border closures but most felt that the implementation of these closures could be improved to make the measures more effective and reduce the negative impacts.[598] Participants also reported a perception that closures were inconsistent, confusing and unfair for some.[599] Many felt that repatriating citizens should be a key priority for the Australian Government when implementing border closures and that the process for returning citizens during the pandemic was ineffective.[600] We heard from one stakeholder that the Australian passport's worth was tested and devalued during the implementation of country-specific restrictions.[601]

> *I registered for repatriation and was not helped at all; there was no system in place to progress, it became a lottery. Australians that had left after the pandemic started or who had not lived in Australia for 10 years+ got flights before me. – Submission 217*[602]

3.3.Decision-making on travel exemptions

The Australian Government established a range of automatic and discretionary exemptions to allow for inward and outward travel in specific circumstances.[603] Those automatically exempt from the inwards travel restrictions did not have to request an individual exemption but had to provide evidence. Groups with exemptions included Australian citizens and permanent residents and their immediate family members, people transiting Australia for 72 hours or less, and commercial maritime crew.[604] All others had to specifically apply for exemptions. The Department of Home Affairs encouraged applicants who were not satisfied with the outcome of their travel exemption requests to reapply with additional information. This policy was in place throughout the pandemic as there was no avenue for independent review or appeal of exemption decisions.

The Australian Government allowed the Australian Border Force Commissioner and delegated officers in the Department of Home Affairs, including the Australian Border Force, to grant discretionary inward and outward travel exemptions.[605] Between March 2020 and June 2021, only around 30 per cent of all discretionary inward travel exemptions (around 50,000), and approximately 65 per cent of discretionary outward travel exemptions (around 170,000) were approved.[606] In both inward and outward exemptions, 'compassionate and compelling' exemption categories had the lowest approval rate: 11.8 per cent for inward, and 46.1 per cent for outward.[607] By contrast, 75.9 per cent of critical industries and business and 95.2 per cent of national interest discretionary outward exemptions were approved. [608] This appears to align with what we heard about the lack of fairness and compassion some people felt regarding the exemption process.

> *Watching the procession of celebrities, sportspeople, seasonal workers, and wealthy business people enter the country, when so many were still stranded, only reinforced the fact that Australian citizenship or permanent residency meant absolutely nothing anymore. – Submission 779*[609]

Between March 2020 and July 2020 there was no service standard for how quickly travel exemption applications would be processed. From July 2020 a seven-day service standard was established for the finalisation of inward travel exemptions.[610] Between August 2020 and May 2021 more than 80 per cent of inward travel exemption requests were finalised within seven days.[611] The number of complaints the Department of Home Affairs received on the timeliness of exemption requests significantly decreased from its peak in July 2020, coinciding with the new service standard. However, the policy to recommend that people reapply, without feedback, when they were not satisfied with the decision was not seen as a sufficient review process.[612] Concerns were also raised regarding the lack of transparency about the reasons why some exemptions were approved and others were not.[613] The Australian National Audit Office found that complaints focused on extensive wait times (in some cases up to four weeks); not receiving a response to a request; website upload limits restricting the provision of evidence; and inability to determine the status of an open exemption request.[614]

The Australian National Audit Office reviewed the travel exemption process in December 2021.[615] It found that applicants did not receive sufficient feedback about refused travel exemption requests and that there was not an adequate review mechanism for these decisions.[616]

Many people faced similar difficulties attempting to leave Australia for legitimate reasons. The outward travel exemption process has also been criticised as lacking in compassion and humanity, as well as encroaching on people's human rights – specifically those relating to liberty of movement and family reunification.[617] Distressingly, the Inquiry received submissions from multiple Australians who were denied outward travel exemptions to see dying family members or attend family members' funerals.

> *My belief was that given some people were moving around globally for relatively superficial reasons, having a terminally ill direct relative who was on death's door, would qualify me for compassionate travel. Clearly not … to have my application rejected, despite my circumstances, and for this rejection to be delivered in such a manner had a mental, emotional and physical impact on me that I cannot articulate in words – an impact that I am still grappling and struggling with on a daily basis. Please do not underestimate the ramifications of this decision and how it was managed. – Submission 18*[618]

Some people emphasised that leaving Australia was a right that should be protected in a future public health emergency.

> *I understand the reason was to a) reduce the demand on consular services abroad at a time of increased demand and reduced ability to provide those services, and b) reduce the pipeline of those who would then seek to return back into an already stretched quarantine program. However, once a state takes upon itself the power to grant the ability to exit as a privilege and not a right, it has ceased to be a genuine liberal democracy. – Submission 1126*[619]

The panel heard that international travel restrictions had a disproportionate impact on culturally and linguistically diverse people in Australia who were isolated from family in their home country. This is of particular importance as 27.6 per cent of Australians are born overseas and 48.2 per cent have a parent born overseas.[620] Some culturally and linguistically diverse families were separated. We heard about people in Australia being unable to help members of their family who were trapped overseas – including some who were unwell and needed to return to Australia for treatment – despite being Australian citizens or permanent residents. An example of the difficulties faced by culturally and linguistically diverse people whose families were stranded overseas is captured in the case study below. Further impacts on culturally and linguistically diverse communities are explored in Chapter 15: Culturally and linguistically diverse communities.

Struggles of family separation

Kamal* and his family are from India and have lived in Australia for nine years. In the months prior to COVID-19, Kamal and his wife flew back home to Delhi for family support for their newborn child. In January 2020, Kamal needed to return to Sydney to begin work, leaving his wife and newborn behind. However, soon after his departure, international borders closed abruptly, separating Kamal from his family. Despite Kamal being an Australian citizen, his family could not return from Delhi and he was unclear about why they couldn't return when those from other countries could. He assumed this was due to negative stereotypes about India. Isolated and concerned for both his young family and his mother, who was alone following his father's passing, Kamal grappled with anxiety, mounting debts and the responsibility of sending money back home. The inability to fulfil cultural rites, especially when two family members succumbed to the virus in India, added to his stress. Kamal could 'only pray for the health' of his family and was separated from them for six months.[621]

3.4. Impact of international border closure on human rights

It is well established under international human rights law that many human rights and freedoms can be legitimately restricted as part of an emergency response.[622] However, restrictions on human rights must always be justified, reasonable, necessary and proportionate, and should only continue for as long as this is the case.[623] In fact, the United Nations Human Rights Committee in General Comment No. 27 (Freedom of Movement) have stated that 'there are few, if any, circumstance in which deprivation of the right to enter one's own country could be reasonable'.[624] Internationally recognised human rights include the right to leave a country and the right to enter your own country. Both rights were at risk of being limited as a result of international border restrictions and other COVID-19 related measures affecting international travel.[625]

Human rights advocates acknowledged the effectiveness of the international border closures from an Australian public health perspective and the need for rapid action. At the same time, they raised questions about the adequacy and equity of the decision-making systems and the impact the restrictions had on the human rights of individuals and families. These concerns were echoed by other organisations such as Amnesty International Australia, which stated that

everyone has a right to return to their own country.[626] Broader human rights implications are discussed in Chapter 5: Trust and human rights.

The India Travel Pause

Country-specific travel restrictions during the pandemic impacted Australians across the world. They also affected Australia's diplomatic standing with specific countries, and pre-existing trade deals. The most impactful of the country-specific travel restrictions was the India Travel Pause, as it was the only time Australian citizens and permanent residents were completely barred from entering their own country under threat of criminal conviction. The India Travel Pause, made effective by a determination under the *Biosecurity Act 2015* (Cth) on 30 April 2021, lasted 14 days. Flights resumed from India on 14 May 2021.[627] The pause was based on advice provided by the Chief Medical Officer to National Cabinet, at a time when 300,000 new cases of a new COVID-19 virus subvariant, Delta, were being reported in India every day for a week.[628] There were early indications that this variant was more transmissible and caused more severe disease than previous strains.[629]

I consider [the pause] *to be an effective and proportionate measure to maintain the integrity of Australia's quarantine system …* [and] *will likely allow the system to recover capacity, which is a critical intervention in preventing and managing the spread of COVID-19 in Australia. – Greg Hunt, Minister for Health, 30 April 2021*[630]

The India Travel Pause was criticised as racist, as similar restrictions had not been placed on countries such as the United Kingdom or the United States despite high levels of cases and deaths. It also brought into question Australia's duty of care to citizens stranded in a setting at risk of exposure to more severe disease.[631]

The pause raised serious concerns regarding Australia's human rights obligations and was tested legally. Gary Newman, an Australian citizen living in India during the pause, challenged the ban in the Federal Court of Australia. Mr Newman argued that Minister Hunt failed to ensure the ban was 'no more restrictive or intrusive than is required' – a key safeguard in the *Biosecurity Act 2015* (Cth) – because he failed to consider alternatives, and that Australians have a 'common law right of citizens to re-enter their country of citizenship'.[632] The Federal Court dismissed the case on 10 May 2021.[633] Justice Thawley stated that while Australian citizens have a common law right to re-enter Australia, he found that section 477 of the *Biosecurity Act 2015* (Cth) was created to allow flexibility in dealing with biosecurity arrangements and this flexibility would be significantly reduced if a determination under the Act was unable to prevent the entry of citizens. Justice Thawley also found that Minister Hunt had in fact considered how to make the ban no more restrictive or intrusive than necessary.[634]

The United Nations High Commissioner for Human Rights also raised serious concerns about whether the India Travel Pause meant Australia was in contravention of its international human rights obligations in reference to article 12(4) of the International Covenant on Civil and Political Rights, which states that 'No one shall be arbitrarily deprived of the right to enter his own country'.[635]

3.5.Impact of international border closure on business

The international border closures had significant economic impacts, due to the reduction in net overseas migration, the cessation of international tourism, and the flow-on consequences for trade and supply chains.

In June 2021 Griffith University calculated that the international border closure was costing $36.5 million a day in lost expenditure solely due to the decrease in international tourists and international students.[636] The reduction in international students not only represented a loss of substantial income for universities but also highlighted the significant contribution to the economy international students make as part of the pipeline for the skilled workforce.[637] The impact of the international border closure on certain sectors of the economy, including higher education, is explored further in Chapter 24: Supporting industry.

The panel heard that a coordinated approach to international border closures would have improved the ability of travel and tourism businesses to plan and operate during the pandemic.[638] We heard that this coordination must extend to the reopening timeframes and easing of public health measures to help businesses service the resulting surge in demand.[639] The panel also heard strong calls to increase transparency in decision-making, allowing access to industry and the public to see the evidence behind decisions that would have profound and long-term impacts.[640]

There was a 95 per cent decrease in international and domestic passenger flights between January and April 2020, which significantly disrupted the operation of the aviation industry, export and trade, as well as critical supply chains. Submissions to the Inquiry highlight the impacts of international arrival caps on Australia's five major airports, revealing the increased operating costs associated with turning around international services with exceedingly small numbers of passengers.[641]

Organisations highlighted the lack of communication and coordination between the Australian Government and the travel and transport industries. Some claimed to have heard about the changes to border restrictions and arrival caps and the reopening through the media rather than from the government itself.[642] The sudden changes gave them little opportunity to develop strategies to source, retrain and on-board staff and otherwise kick-start operations, which led to further disruptions or delays.

Australia's economy relies on international supply chains for a range of critical products. These include medical items vital to the pandemic response, and everyday household items. Aviation and maritime transport are critical components of Australia's domestic and international supply chains, and the impact on the industry had compounding effects across the economy.[643] Maritime industry representatives told the Inquiry that stranded seafarers and shipowners were inadequately supported, including in relation to their health care, during international border closures, and that this affected international supply chains. Cruise line industry representatives told the Inquiry that seafarers were stuck on ships for many months and that this could have been avoided with more open dialogue and collaboration between the Australian Government,

health authorities and the cruise industry.[644] This is discussed further in Chapter 22: Supply chains and Chapter 24: Supporting industry.

3.6.Impact of border closures on migration

The restriction of international travel had a marked impact on overseas migration and consequently on Australia's population and workforce. For the first time since World War II, Australia experienced a net loss of migrants, with a net outflow of more than 85,000 people in the 2020–21 financial year.[645] The Australian Government continued to grant permanent places in its migration and humanitarian programs, but the 2020–21 migration program was focused on granting the majority of places to people already in Australia.[646] This meant the government did not add significantly to the cohort of citizens and visa holders wanting to travel or work in Australia, which would have increased pressure on arrivals caps and quarantine capacity.[647]

While the policy of granting permanent places to people already in Australia aided Australia's public health response to COVID-19, reduced inflows through permanent and temporary visa programs (as a result of a lack of visa grants and travel restrictions) had a substantial impact on specific sector workforces. Many of these workforces were critical to the pandemic response and economic recovery. The drop in migration also added to significant skill shortages both during and in the aftermath of the pandemic.

- The health, aged care, and disability workforces increasingly rely on overseas-trained migrants to supplement their labour supply. The closure of the international border limited this supply of overseas workers when they were needed most. This issue is discussed further in Chapter 18: Older Australians and Chapter 20: Managing the economy
- The agriculture industry relies on working holiday makers and workers coming to Australia under the Pacific Australia Labour Mobility scheme. It therefore faced a workforce shortage as a result of the international border closure. This issue is discussed further in Chapter 24: Supporting industry.
- Temporary migrants were excluded from economic supports such as JobSeeker and JobKeeper, which may have contributed to temporary migrants choosing to leave Australia. This issue is discussed further in Chapter 20: Managing the economy.
- The exclusion of temporary migrants from economic supports had a critical impact on industries such as the travel and tourism industries. Many workers in this sector depend on temporary international visas to work, so the reduction of temporary migrants entering Australia, and the exodus of temporary migrants leaving Australia, had a critical impact on these industries. This issue is discussed further in Chapter 20: Managing the economy.
- One of the largest cohorts of visa holders affected by international travel restrictions were international students. The closing of the international border coincided with the beginning of Semester 1 2020, and international students already in Australia were

encouraged to return home along with other temporary visa holders. This issue is discussed further in Chapter 20: Managing the economy.

With the easing of international travel restrictions in November 2021, migration into Australia rebounded significantly. Net overseas migration reached 536,547 people in the 2022–23 financial year, the largest increase since records began.[648] One of the largest contributors to this rebound has been the rapid increase in international students, with 370,000 student visas being granted to people outside Australia in 2022–23, 48 per cent above the pre-pandemic peak of 249,000 over the year to April 2019.[649]

However, the 2023 Population Statement attributed much of this rebound to a catch-up of the low migration experienced during the international border closure. Net overseas migration is still expected to be 185,000 lower over the period of 2019–20 to 2022–23 than was forecast in the Australian Government's 2019–20 Mid-Year Economic Forecast.[650] The 2024–25 Budget noted: 'Net Overseas Migration is forecast to approximately halve from 528,000 in 2022–23 to 260,000 in 2024–25 and return to pre-pandemic levels of 235,000 from 2026–27 and beyond.'[651]

4. Evaluation

Planning to support implementation was lacking

The early decision to close the international border demonstrated courage, leadership and agility by Australia's elected leaders and key officials. It protected Australia from a significantly higher COVID case burden and death rate. The decision was based on the best available health advice and concurrently drew on emerging evidence, international experience, government capability and academic expertise, which was vital given the rapidly changing risk environment. Leaders acknowledged that the decision was a very difficult one given its impacts on Australians. It signalled to the Australian public that governments were unified in taking a precautionary risk-informed approach to protect the health of their citizens and residents.

Given its importance to the success of Australia's pandemic response, it is therefore somewhat surprising that the decision to close borders was made without a recent precedent, plan or playbook, without scenario testing and without appropriate and agreed systems in place in key national policy and operational agencies, state/territory agencies or key industry sectors.[652] Existing pandemic plans had not contemplated such a decision, with governments expected to be reluctant to embark on such a far-reaching mitigation strategy given its potential impacts on people and trade.

Preparedness across national agencies and key sectoral partners varied. It was more focused on business continuity planning than on responding to a pandemic of this scale and duration. The Inquiry heard that in the absence of 'grilled and drilled plans' to guide action and clarify expectations and accountabilities, implementation of international travel restrictions was made up on the run and it felt like we had to build the plane while flying.[653] This approach carried greater risk, had the potential for confusion and inefficient use, and absorbed a lot of much-needed capability.

The lack of planning and agreed operating frameworks meant significant agility was required. The success of the international border closure is a testament to the many people across and between government, industry and industrial bodies who used a common sense of purpose and trusted relationships to make it work to the best extent practicable. The merits of new forums such as the National Coordination Mechanism were acknowledged to have improved coordination. The COVID-19 Deputies Group facilitated rapid information exchange between governments, government agencies and industry to operationalise restrictions. The panel heard, however, a consistent view that the lack of planning and preparedness must not be replicated, given the changing risk environments and the scale of the consequences.

The panel heard from the travel and tourism and aviation industries that a more coordinated approach to international border closures could have minimised the impacts on the public and trade and helped travel and tourism businesses to plan and operate during the pandemic.[654] We heard that coordination and information sharing must extend to the reopening timeframes and easing of public health measures, so that businesses can prepare for the resulting surge in demand.[655] We also heard strong calls to increase transparency in decision-making, giving the public and industry more access to the evidence behind decisions that would have profound and long-term impacts.[656] The panel supports these suggestions as key components of future pandemic planning.

The inquiry heard that timely sharing of information and key operational data is a potential means of minimising transmission risks, increasing flexibility and potentially reducing the duration of restrictive measures. The panel agrees with state and territory health departments that a national database should be established by the Australian Centre for Disease Control to ensure critical incoming passenger information is available to all jurisdictions in a future public health emergency to assist with national-level surveillance and contact tracing.

The panel acknowledges that many system improvements made during the pandemic better reflect an end-to-end approach that focuses on the passenger journey. There was rapid improvement of systems to enable national and state and territory agencies to manage passenger movements. This included the deployment of the Australian Border Force's Advanced Passenger Processing system, which was eventually adapted to create an electronic form of the Australia Travel Declaration, enabling the electronic collection of critical health information on vaccination status and international travel history.

Pandemic-related plans must be regularly updated to reflect technology changes. In a future pandemic, artificial intelligence (AI) may assist international travel restriction processes such as assessing exemptions. We may also have more effective end-to-end quarantine systems that allow more people to cross the international border without compromising disease control. The system as it stood did experience breaches, indicating that during the COVID-19 pandemic it probably could not have been less stringent and still achieved the same outcomes. The future challenge is to build more compassion and flexibility into decision-making while maintaining effective international border restrictions in a pandemic.

The nature of the pathogens responsible for future pandemics and their timing and origin will determine the likely relative merits of international travel restrictions in disease control. The pandemic experience highlights the importance of foresight planning and the consideration and stress-testing of various scenarios to ensure that we are not again 'caught flat-footed' and are better prepared to deal with the full range of potential risks and mitigation strategies.

As we learned in this pandemic, the success of international travel restrictions is closely tied to the ability to rapidly make and successfully implement the decision to close the border. New systems and programs, such as the online Traveller Registration System and the Special Overseas Financial Assistance (Hardship) Program, were developed at scale to assist in supporting and repatriating Australian citizens. These initiatives helped to mitigate some of the harm of the border closures on impacted individuals.

Need for a plan for implementation of international border restrictions

Feedback to the panel highlighted the need for clearer and more coherent legislative authority and decision-making processes to support international border management in any future public health emergency. The panel supports this view and the opportunity this provides to ensure that more coordinated emergency powers and structures are available if they need to be deployed.

Priority also needs to be given to the development of modular plans with states, territories, local governments and key industry partners for border closures and quarantine, as well as other issues outlined in Chapter 3: Planning and preparedness. This plan should be informed by the operational and policy learnings of the pandemic, including the human impacts. It should:

- clarify agreed roles and responsibilities and communication flows across and between governments and key industry partners
- outline supporting decision-making systems that are built on a strong legislative basis and respect equity, human rights principles and compassion
- be frequently reviewed and updated to reflect technological and other changes
- include provisions for regular scenario testing to ensure that unforeseen impacts can be mitigated.

Importance of learning from unintended consequences and hardwiring preparedness

The Australian Government attempted to support Australians overseas; however, there was a mismatch of expectations and the level of support that could be provided. This was limited by the lack of scalability of consular support services to a global crisis, the quarantine capacity of each state and territory, the availability of flights, and the consequent use of caps on international passenger arrivals. This meant many Australians were left overseas for months longer than they anticipated, which caused substantial financial and emotional distress for some, as well as exposing them to increased health risk in countries impacted more severely by the pandemic. This is particularly important given the multicultural profile of the Australian population and the many family, personal and business connections abroad.

Australia's economy relies heavily on overseas supply chains. Our economy, trade, international workforce, and specific industries all suffered consequences from the international travel restrictions and extended border closures. The disruption to migration, and its impact on the economy given Australia's reliance on migration to supplement skills shortages and boost productivity, highlights the importance of learning from the unintended consequences of the border closure.

The Australian Government needs systems to manage an international crisis of this scale in the future. While acknowledging privacy considerations, Australians provide considerable data to officials about their movements and personal circumstances. Systems must be ready to make better use of existing data capture processes and to assist in mobilising the core consular structures to be scaled up in a global crisis, minimising wherever practicable the impacts on other essential areas of the Australian Government. The government must plan for the types of support packages which could be provided to Australians overseas, and consider access and equity in doing so.

We note that during and since the COVID-19 pandemic, the Department of Foreign Affairs and Trade has uplifted its domestic and international crisis preparedness work and response capability in Australia's international network to effectively respond to developing crises overseas. The Department of Foreign Affairs and Trade has also recently updated the International Crisis Management Framework, which promotes effective crisis management, accountability and transparency.

The panel acknowledges the effectiveness of the International Crisis Management Framework but recommends the Department of Foreign Affairs and Trade develop a specific modular plan and maintain resources and capability to support returning overseas Australians in a global-scale crisis to ensure the lessons learnt from the COVID-19 pandemic are addressed.

International travel restrictions were in place for much longer than leaders anticipated when they were originally implemented during the alert phase of the pandemic. To minimise the harms from border closures on human rights and social and economic outcomes, ongoing review of the relative risks from incursions of COVID-19 was warranted, as was regular public communication on these issues. There was no evidence or public communication regarding such a systematic assessment by the Australian Government. It is possible that the border remained closed longer than justified. Certainly the lack of perceived evidence to support the continuation of border closures escalated industry and public concerns.

5. Learnings

- Closure of Australia's international border is a tool that, appropriately deployed during a pandemic, can provide the Australian population with a time-limited means of protection in a pandemic.
- Border closures must be deployed quickly if they are to be effective, even for an island nation. A decision to close the borders needs to be reviewed to assess whether ongoing impacts are warranted as evidence emerges about the threat posed in a pandemic.
- Effective deployment is also highly reliant on rapid, well-planned, stress-tested and highly coordinated supporting response structures that are continually subject to review and adapted to mitigate unintended harms. These supporting response structures must incorporate lessons learnt from a global-scale crisis, particularly given Australians are travelling at record levels and to destinations which are increasingly dispersed, and globally we are seeing heightened geopolitical tensions and more frequent and severe climate-induced disasters.
- There needs to be clarity about the purpose of the closure, and transparency about the supporting evidence and the preconditions for reinstating closures and reopening. Coordinated communication and transition strategies need to be planned with key partners.
- Given the significant impacts on human rights, economic and social outcomes, the closure of Australia's international borders and border reopening measures should be built on evidence, risks and values and be reviewed regularly to consider the broader health, social, economic and human rights issues, especially in a protracted health emergency.
- Pandemic plans need to contemplate a range of feasible scenarios regarding international travel restrictions. These pandemic plans should not rule out potential measures (such as international border closures) so that planning takes place to better anticipate and support flexible operational and policy responses. They must also include feasible mitigation measures to ensure proportional responses that reflect changes in the evidence base regarding transmission and disease risks, and balance consideration of broader health, economic, social and fundamental human rights considerations (see Chapter 3: Planning and preparedness).
- There should be joint planning with key partners to build strong relationships and foundations to manage emergency response measures.
- It is important that there is clarity and agreement on roles and responsibilities between governments and government agencies in the event of a public health emergency, and recognition of the interdependencies between quarantine arrangements and international border controls (arrival caps, entry approvals and supply chains), aviation and maritime sectors, and diplomatic relations.

- Pandemic plans need to consider the importance of Australia's migration program and provide related exemptions for specific sector workforces.
- There is a need for legislative clarity to underpin key potential elements of future pandemic response measures, including international travel restrictions and associated exemptions, with effective checks and balances on their implementation.
- It is important to build greater compassion and humanity into decision-making processes on supports and exemptions – in addition to fairness and transparency. A humanitarian approach should be taken in determining exemptions, appeals handling and the length of the travel restrictions.
- Appropriate record management systems must be established and maintained to record accurate and reliable data on registered Australians, including those identified as vulnerable, to ensure access to up-to-date information on Australians overseas in future public health emergencies.
- It is important to establish and maintain effective channels to communicate real-time data and policy changes, to enable the continued movement of freight/maritime and airline workers and manage the economic and supply chain upheaval.

6. Actions

6.1. Immediate actions – Do in the next 12–18 months

Action 5: Develop updated health emergency planning and response arrangements in conjunction with states and territories, and key partners, including consideration of escalation and de-escalation points, real-time review and a focus on post-emergency recovery.

As part of this, develop:

- Modular operational plans for specific sectors, including high-risk settings, which can be deployed in response to a variety of hazards.

The Managing the International Border plan should:

- document and stress-test pre-agreed roles and responsibilities across decision-making powers (Commonwealth) and implementation powers (states and territories), to ensure that the interface between the Australian Government agencies (such as the Department of Foreign Affairs and Trade, the Department of Home Affairs and the Australian Border Force) and state and territory agencies (such as state police, health and hotel quarantine providers) is seamless – operationally and legally
- recognise the interdependencies between any quarantine arrangements and international border controls (arrival caps, entry approvals and the movement of goods), the aviation and maritime sectors, and diplomatic relations.

The Repatriation plan should:

- clearly define how repatriation systems will be scaled up in a future pandemic and pay due consideration to humanitarian and domestic border intersections
- include processes to review the exemption decision-making process and its underpinning rules during a future public health emergency to ensure exemptions are timely and equitable, align with the key health objectives they are intended to support, and seek to better balance health risks with personal circumstances and human rights.

Action 6: Develop legislative and policy frameworks to support responses in a public health emergency, including for international border management.

The international border management framework should:

- formalise a targeted legislative framework to give clear legal power to 'close the border' in an emergency that minimises any legal risks.

6.2.Medium-term actions – Do prior to the next national health emergency

Action 24: Maintain regularly tested and reviewed agreements between relevant national and state agencies on shared responsibilities for human health under the *Biosecurity Act 2015* (Cth) with a focus on facilitating a 'One Health' approach that considers the intersection between plant, animal and human biosecurity.

- Agreements should ensure clarity and agreement on roles and responsibilities between governments and government agencies under the *Biosecurity Act 2015* prior to the next crisis.

Action 26: Include a focus as part of ongoing systems upgrades on modernising and improving data, systems and process capabilities to enable more tailored and effective program delivery in a crisis.

Consider preparedness for future crisis as part of ongoing investment in key data, system and process capabilities, including:

- Prioritising the modernisation of Department of Foreign Affairs and Trade repatriation systems, which must be:
    - ready to make better use of existing data capture processes and to assist in mobilising the core consular structures to be scaled up in a global crisis
    - scalable in a future crisis to ensure those who want to come home can be regularly communicated with and supported.

Chapter 8 – Implementing quarantine

1. Context

Australia was unprepared for a pandemic-related quarantine experience.[657] Quarantine had not been anticipated as a preferred measure and there was no planning and guidance available to implement quarantine arrangements in the safest possible manner informed by evidence and good practice.[658] Hotel quarantine had been specifically identified in influenza pandemic planning documents as a 'problematic' arrangement.[659]

The goal of the quarantine system was to minimise covert introductions of the virus into Australia and the community transmission of the virus that would follow, causing significant deaths and overburdened health systems as witnessed internationally.[660] The level of scientific understanding of the virus at the time and immediate challenges experienced in processing returning travellers were important contextual considerations when implementing quarantine. Factors considered in setting up the system included:[661]

- an understanding that a COVID-19 infection lasted 14-days on average, and that people could be infectious before they showed symptoms[662]
- a sharp increase in domestic COVID-19 cases (moving from 12 confirmed cases on 1 February 2020 to 4,003 by late March 2020), driven in part by the unrestricted movement of passengers from the *Ruby Princess* cruise ship – more than 900 COVID-19 cases have been estimated to be linked to Australians from the ship[663]
- concern that arrivals might not be complying with home quarantine requirements[664]
- concern that rising international case numbers would increase the risk of incoming passengers having the virus, and the risk that the Australian hospital system could be overwhelmed if infections climbed to the same level in Australia.[665]

2. Response

Australia's quarantine arrangements began with the Australian Government's 29 January 2020 announcement that Australians on assisted departure from Wuhan China were required to undergo 14 days of mandatory quarantine on Christmas Island, based on then-current medical advice and to prioritise public health in Australia.[666] From 20 March 2020 and for the next 20 months the Australian Government closed the border to non-citizens.

At this time, the impact of COVID-19 on health systems was reported as the 'single most important concern' of health experts, and the main transmission route of the virus in Australia was from returned overseas travellers.[667] On 27 March 2020 National Cabinet agreed that by 29 March all travellers arriving in Australia would be required to undertake mandatory managed quarantine at designated facilities such as a hotel for 14 days. On 1 November 2021 mandatory quarantine was removed for Australian international arrivals who had received two doses of a

COVID-19 vaccine, but remained in place until the end of the first quarter of 2022 for unvaccinated arrivals.

The Australian Constitution gives the Commonwealth Parliament power to authorise quarantine for the purpose of managing risks to the Australian community. States and territories also have authority to enact quarantine requirements under their respective laws. The decision to use hotels for quarantine was based on the advice of the Chief Medical Officer. Quarantine arrangements began within 72 hours of the measure's announcement. Each state and territory adopted a distinct approach to mandatory managed quarantine consistent with their differing administrative, clinical governance, policing and health arrangements and their geography.[668]

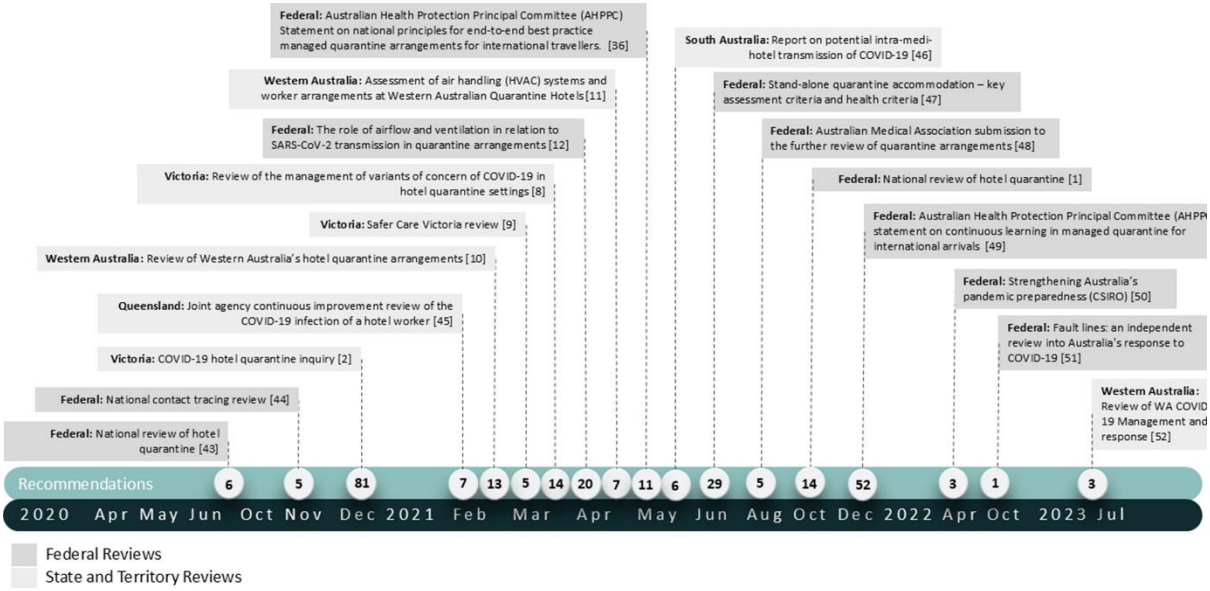
Despite the lack of a national plan or coordinating entity, it was agreed that the states and territories would operate, enforce and meet the costs of quarantine, with support from the Australian Border Force and Australian Defence Force where necessary.[669] From March to July 2020, the cost of quarantine was borne by the states and territories. All states and territories moved to a user-pays model for hotel quarantine, with support from National Cabinet, on 10 July 2020.[670] According to ABC reporting from March 2024, at least $70 million was owed to state governments in outstanding fees at that time.[671]

Quarantine arrangements also evolved to support domestic travellers as states and territories closed their internal borders, starting with Tasmania. Tasmania closed its border from 20 March 2020 and mandated that all non-essential travellers entering Tasmania had to quarantine for 14 days.[672] The states and territories adopted different models to accommodate domestic travellers. Some used existing hotel programs while others developed other options, including allowing home quarantine and self-isolation. These state and territory models were also used to manage COVID-19 positive cases and close contacts during local outbreaks. Some people had to quarantine at a hotel if they could not do so safely at home, to minimise transmission risk.

The Howard Springs facility in the Northern Territory was the first mainland quarantine site. Its use as a designated mass quarantine facility was agreed in October 2020, although it had already been in use in this capacity sporadically since February 2020.[673] At Howard Springs, each room had a door opening to a shared open-air walkway, and a veranda. However, most states and territories used designated quarantine hotels and/or apartment accommodation where each person (or group of people) was isolated to a room opening to a common indoor corridor. Australian residents on low incomes who quarantined in Howard Springs were eligible for a 50 per cent quarantine fee reduction and were offered a payment plan over multiple years. Some Howard Springs quarantine fees have been written off as they were deemed uneconomical to recover, and at least $3.4 million was still owed to the Australian Government as at September 2024.[674]

Over the period when mandatory quarantine was in place, various reviews were commissioned by National Cabinet, states and territories. Figure 1 provides a timeline of these reviews.[675]

Figure 1: Timeline of reviews of mandatory quarantine[676]



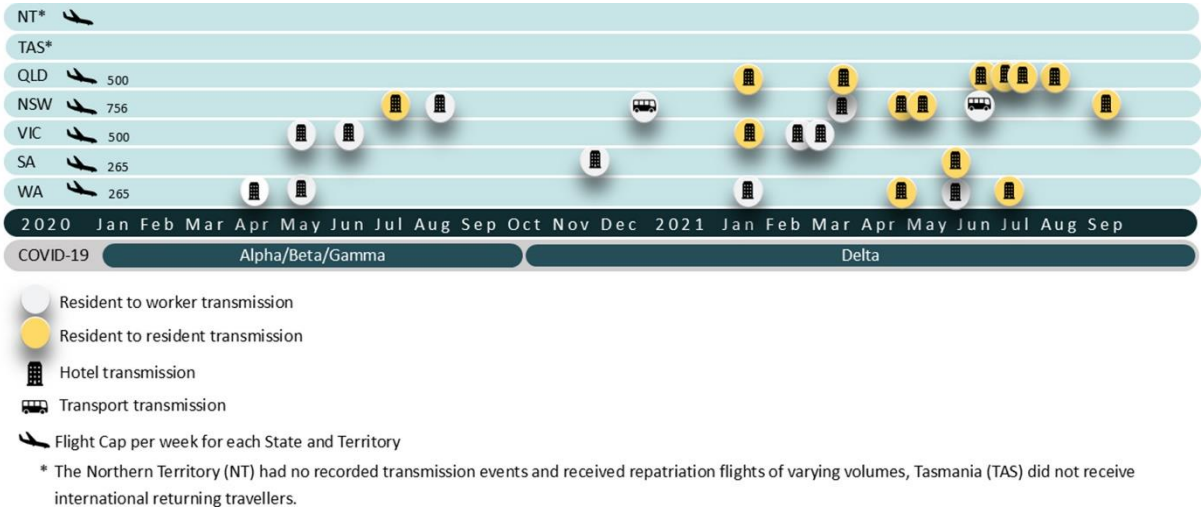
In total, these reviews made 282 recommendations to improve Australia's various quarantine arrangements.[677] Broadly the recommendations were targeted at improving quarantine models (e.g. non-hotel quarantine), governance systems, the experience of particular quarantine cohorts, and infection prevention and control standards and ventilation.[678]

As greater numbers of Australian travellers sought to return home from overseas, and as states introduced domestic border quarantine requirements, there was increasing pressure on quarantine capacity, particularly for New South Wales and Victoria as the major ports of international entry.

Evolving multiple strains of the virus arose alongside breaches of hotel quarantine in every state. Some of these breaches had devastating consequences. Victoria's second wave of COVID cases (July to November 2020) was attributed to breaches in two Victorian hotel quarantine facilities.[679]

Figure 2 shows the timeline, nature and location of viral escape events through 2020 and 2021.[680]

Figure 2: Viral escape events, January 2020 to September 2021[681]



To help control the spread of COVID-19 and develop a robust quarantine system, from mid-2021 the Australian Government agreed with the Victorian, Western Australian and Queensland governments to coordinate the construction of three purpose-built Centres for National Resilience, costing the Australian Government $1.37 billion.[682] The first stage of completion (250 beds) was achieved in December 2021 for the Melbourne site, May 2022 for the Perth site, and July 2022 for the Brisbane site. Contract completion was achieved in March 2022 for the Melbourne site and October 2022 for the Perth and Brisbane sites. When completed, the Melbourne site provided 1,000 beds, the Perth site 500 beds, and the Brisbane site 500 beds. To date, only the Victorian site has been used for quarantine purposes.

In response to the reduced risk from COVID-19 in a highly vaccinated population, and in line with Australia's National Plan to Transition Australia's National COVID-19 Response, New South Wales trialled in-home quarantine for international arrivals in October 2021 to remove the quarantine capacity cap on returning Australians. This quickly became the preferred method of mandatory quarantine for all Australians.[683] This trial used a location-based app which had been used in South Australia during its August 2021 trial of home quarantine for interstate arrivals. The app allowed health and police services to do home quarantine check-ins, using geolocation and facial recognition technology.[684] This signalled a shift from managed to modified quarantine using homes or rental accommodation instead of hotels and designated facilities. This shift was supported by Australian Health Protection Principal Committee advice and was consistent with key learnings and recommendations from contemporary reviews endorsing home quarantine, including Jane Halton's October 2021 National Review of Quarantine.[685]

3. Impact

3.1. Operation and logistics of quarantine

From the end of January 2020 to January 2022, international travellers arriving in Australia were required to quarantine. Before March 2020 the Commonwealth was responsible for the management of quarantine, and contracted the Northern Territory Government to operate the Howard Springs facility. After March 2020 the states and territories agreed to manage quarantine in their jurisdictions, and operated quarantine facilities through different government departments, led by either police or health agencies. In the Commonwealth, quarantine management was split across several agencies, including the Department of Foreign Affairs and Trade, the Australian Border Force, the Department of Home Affairs, the Department of Health, and the Department of the Prime Minister and Cabinet. The Department of Health managed the bilateral arrangement with the Northern Territory Government to fund the cost of quarantining repatriated Australians at Howard Springs, and the Department of Finance oversaw the construction of increased quarantine capacity.

The rapid decision to implement managed quarantine meant that complex logistics had to be put in place within 72 hours.[686] The panel heard that hotels were used for quarantine because they were largely vacant, could be got ready quickly, and could accommodate large numbers of returned travellers close to international points of entry.[687] However, there was little consideration about an appropriate workforce, and minimal time for planning and consideration of risk.[688] Lack of central planning and guidance was consistently reported as complicating the day-to-day operation of quarantine, and a lack of coordination meant that learnings were not shared between the states and territories.[689]

Submissions to the Inquiry from accommodation providers note that they had to quickly upgrade or retrofit air conditioning and filtration systems to mitigate transmission. This was at significant unbudgeted expense. They also reported that housing mandatorily constrained travellers brought reputational damage to accommodation providers.[690]

> *While providing much-needed income to hotels that participated, it did not come without cost, with damage to hotel property and reputation, and the need to deal with customers who were frustrated and trapped by the requirement to quarantine. – Accommodation Australia*[691]

The reliance of the Australian Government on the states and territories to provide an operational workforce for quarantine had consequences for the broader response. States diverted health, police and other key personnel to manage hotel quarantine facilities at a time when these workforces were already stretched thin.[692] Critical resources were diverted from other aspects of the health response, and workforces had to be scaled back at times to implement other preventive measures like lockdowns.[693] This workforce was supplemented by Australian Defence Force and Australian Federal Police personnel, but we heard that this was not a comprehensive or sustainable solution.[694] Employment of inexperienced security guards

and other casual workers put the health of those people, and the integrity of the infection control measures, at risk.[695]

Legal advice about the constitutionality of quarantine suggests that it is a shared power between the Commonwealth and the states and territories. There are divergent views on how this should work in practice. States and territories have called for clarity on roles and responsibilities for future quarantine arrangements, especially around workforce, support systems and communication protocols.[696]

There was not enough capacity to accommodate all Australians who wanted to return home from overseas. The use of hotel quarantine for travellers across domestic borders further reduced available capacity.[697] Many travellers had to quarantine twice to get back to their home states, in accordance with international and domestic border restrictions. This compounded the financial and personal burden of returning to Australia and the demands on the workforce.

To alleviate pressure on the states, National Cabinet agreed to establish flight caps based on hotel quarantine capacity, operational workforce and flight data in each jurisdiction.[698] Determining this capacity required collaboration between the states and territories, which was not easy without a centralised hub for quarantine data.[699] For more detail on flight caps see Chapter 7: Managing the international border.

3.2.Efficacy of quarantine and system improvement

The decision to implement mandatory 14-day quarantine at the borders has been described as critical to curbing the spread of COVID-19 in Australia in the early stages of the pandemic, including by the Australian Health Protection Principal Committee.[700]

The Inquiry consistently heard of poor quarantine data integration between the states and territories.[701] Without this national dataset, it is challenging to empirically evaluate the effectiveness of hotel quarantine. Independent research into the efficacy of the system identified 27 escape events in 2020 and 2021, 24 of them starting in hotels.[702] Infection prevention and control breaches were identified in seven of these events; 20 had no transmission route identified or were inconclusive.[703]

Variability in infection prevention and control protocols undermined the overall stability of the hotel quarantine system. The 2021 Halton review found that transmission of COVID-19 was minimised in sites where infection prevention and control standards were followed, such as at Howard Springs and 'Special Health Accommodation Hotels' run by NSW Health.[704] Independent researchers told the Inquiry that there was no mechanism for common, agreed infection prevention and control standards to be applied by government and private staff throughout the quarantine process (Australian Border Force, transport, police, Australian Defence Force, health professionals and officials, hotel staff and private security guards).[705]

For example, the decision to make quarantine mandatory for airline crews required separate hotels and dedicated transport for a shorter quarantine turnaround of 24 to 72 hours. Some crew experienced full-time quarantine outside of work for the duration of 2020 and 2021.[706] Some states and territories adopted differing transport policies for drivers regarding surgical

masks or N95 masks and fit-testing. The differences between states in personal protective equipment and other infection prevention and control policies relating to vehicle cleaning and vaccine mandates were highlighted after two quarantine drivers transporting airline crew became infected in South Australia.[707] State officials told the Inquiry they want clearly defined clinical infection prevention and control guidance for future quarantine programs.[708]

We heard that there was no comprehensive cleaning advice tailored to the Victorian hotel quarantine program until 16 June 2020.[709] Independent research into hotel quarantine indicates that throughout 2021:

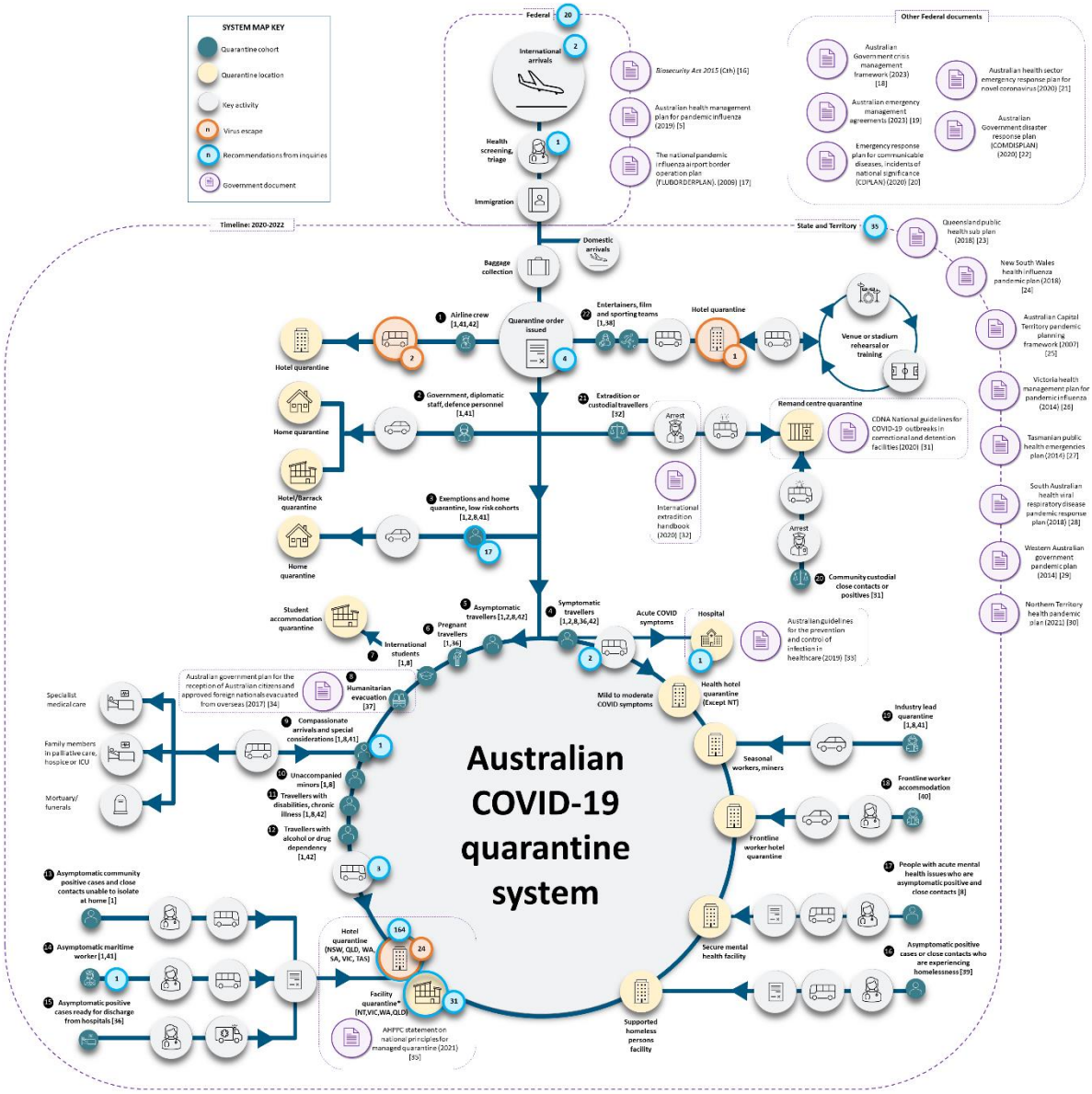
- transmission events were prevalent in environments with poor ventilation[710]
- resident to worker transmission was the most common viral escape pathway.[711]

Pre-existing pandemic plans did not consider quarantine in any detail, much less the complex pathways of entry into a managed quarantine system, or the needs of diverse groups who would quarantine, including pregnant travellers, maritime workers, humanitarian evacuees, diplomats and frontline workers.[712]

> *Dedicated quarantine facilities for essential workers (such as what occurred in Queensland through the hard work of Maritime Safety Qld and the department of Health) should have been set up close to key ports. – Maritime Industry Australia Ltd* [713]

Figure 3 presents a whole-of-system journey map for Australian quarantine, which highlights issues and complexities that emerged during the maturing of national quarantine arrangements.[714]

Figure 3: Australian quarantine journey map[715]



In response to ongoing reviews implemented by National Cabinet and the jurisdictions, some states and territories, such as Victoria, formalised government responses to the review reports and noted progress against recommended actions.[716] The Commonwealth expanded its overall quarantine capacity through the Howard Springs facility and later the Centres for National Resilience in response to these reviews.[717] However, there is currently no holistic, whole-of-system way to analyse how the full set of quarantine-related recommendations have been implemented.[718]

On the whole, review and revision of quarantine arrangements throughout the pandemic resulted in improvements. The state and territory governments reviewed and updated their quarantine arrangements informed by evolving Australian Health Protection Principal Committee advice. From 26 February 2020 to 23 May 2022, the Australian Health Protection Principal Committee made a total of 18 public consensus statements on the use and

management of quarantine arrangements.[719] These updates identified areas of emerging best practice, such as around mental health considerations, infection prevention and control standards, routine COVID-19 screening of workers, and guidance on accommodating different cohorts.[720] Quarantine arrangements in the Australian Capital Territory, for example, developed a strong emphasis on the physical and mental wellbeing of returning travellers. The Australian Capital Territory's Ragusa facility, established in September 2021, also provided larger accommodation for families to isolate together.[721]

Designs for the new Centres for National Resilience were signed off by the Chief Health Officer (or equivalent) in every state to ensure that the ventilation and waste management systems were fit for purpose.[722] Consideration was also given to infection prevention and control, including how staff would deliver food and change linen.[723] In the pandemic environment there was little consideration of designing the buildings with future or alternative uses in mind. Ensuring that infection risks were managed to very high standards and constructing the Centres for National Resilience within tight timeframes was expensive. The average cost per bed across the three sites was approximately $685,000.[724] Construction started in July 2021 on the Victorian centre, and the first beds were ready by December 2021. Overall, a 1,000-bed facility was completed in just nine months; this was accomplished by 1,200 workers working in shifts, operating under floodlights when needed to ensure 24-hour construction, seven days a week.[725]

The report of the second National Cabinet-commissioned National Review of Quarantine was delivered on 12 October 2021. Its recommendations aimed to strengthen Australia's future use of quarantine measures. The most high profile of the recommendations explained the clear need for a National Quarantine Strategy to create a risk-based framework that allows for national unity and coordination. To date, these recommendations have not been implemented.[726]

3.3.Acknowledging the differing needs of people in quarantine

Independent research and stakeholders identified that a lack of consistent quarantine approaches, including for specific types of travellers, created confusion and brought logistical and risk management challenges.[727] Participants in an Inquiry focus group said they were confused about:[728]

- where to find up-to-date, consistent and clear information – including about the range of travel routes that would result in the hotel quarantine requirements
- procedures for sourcing and securing hotel quarantine accommodation and for making complaints about negative experiences and hotel quarantine providers
- whether they could request and confirm different room arrangements, food and appliance options to meet individual needs and circumstances when in quarantine (e.g. familial and cultural requirements).

Individual accounts and independent reports have pointed out that quarantine arrangements lacked flexibility and compassion.[729] The failure of early quarantine planning and preparedness

to account for cultural differences led to discrimination and workplace tensions.[730] For example, we heard one case of a bearded Sikh chef working alone in a kitchen in a hotel quarantine site who could not shave for cultural reasons. The beard obstructed his mask and he could not properly fit it to his face. For that reason, he was stood down from his job.[731]

Focus groups, public submissions and research highlighted issues with hotel quarantine arrangements not meeting individual needs and circumstances. Issues included:

- the lack of accommodation that supported health and wellbeing needs – many noted that facilities did not offer natural light or access to fresh air[732]
- the challenges of being locked in a room with others 24/7 or in complete isolation, and the added anxiety of having security guards stationed outside the room[733]
- limited suitability of facilities for families with younger children, with small, tight rooms and little access to outdoor space[734]
- the importance of having direct and timely access to health services and other supports
- a pronounced feeling of social disconnection and reduced mental health. Many reported heightened anxiety, frustration and stress made worse by the facility's conditions[735]
- the absence or insufficiency of culturally or cohort appropriate food (e.g. for children)[736]
- the fact that these issues were intensified for vulnerable cohorts, such as people with disability or existing neurological conditions.[737]

> *Mental health was low, I was feeling distressed, isolated and alone [during hotel quarantine], at one point you lose track of time … I looked at the balcony and thought should I jump? – Focus group participant*[738]

Challenging hotel quarantine experiences

Katie was in America at the start of the pandemic due to her husband's work. However, her father became very unwell, so she and her family decided to move back to Sydney. Travelling back was easy, but on arrival her family was required to go into hotel quarantine. The extended time in a closed, cramped hotel room with no opening windows and two toddlers (one with a disability) and her husband was mentally, emotionally, relationally and physically exhausting for Katie. She had to entertain two 'overstimulated' toddlers during the day without proper sleep as her husband had to work online during the night. She was also scared and worried that she might not get to see her father as his health was deteriorating. The experience was overwhelming for her and she is still angry about the entire situation, particularly when she recalls the conditions she and her family had to live through for two weeks, as well as the 'unfriendly' and 'abrupt' way the staff at the hotel treated her and her family.[739]

Nonetheless, many people told us they understood quarantine to be a valuable and appropriate public health measure.[740] Early Australian Health Protection Principal Committee guidance and National Cabinet statements on the use of quarantine provided clarity on the

rationale for quarantine, citing the worsening global situation and epidemiological evidence linking local outbreaks to returning travellers.[741]

> *To be honest, hotel quarantine was a good way to stop people travelling without a good reason … I was glad the government brought it in. – Focus group participant*[742]

However, support for mandatory quarantine waned rapidly as Australians witnessed the greater travel freedom being experienced internationally at a time when Australia's restrictions had no clear end date. Submissions to the Inquiry and focus group participants said there was confusion about the evidence base for quarantine and why it remained in place well into 2021, even for those who had been double vaccinated.[743]

> *I'm not a fan of how it [quarantine] was handled, it was very aggressive … we had no freedom of choice or autonomy … I have less trust in government and health officials now. – Focus group member who experienced quarantine*[744]

The requirement to pay for hotel quarantine was described as unfair.[745] The significant cost of hotel quarantine had a disproportionate impact on poorer Australians, who had to balance the need to travel and be with loved ones with the unanticipated financial impacts of doing so.[746]

The Inquiry heard from many people who said home-based quarantine measures would have been better and simpler.[747] This preference is supported by findings from Commonwealth and state and territory reviews of quarantine, and by evolving best-practice advice from the Australian Health Protection Principal Committee.[748]

4. Evaluation

The national quarantine program was a rapid, pragmatic decision designed to protect Australian citizens

In deciding to rapidly implement a national quarantine program, National Cabinet demonstrated leadership and unified commitment to protect the health of Australians. There was a willingness to share responsibility between jurisdictions, and a strong commitment by numerous agencies across governments to work quickly with industry partners to make necessary arrangements. Despite a lack of clarity in roles and responsibilities, there was unprecedented national collaboration and agility to reprioritise available resources and make the program work, with extraordinary contributions by the national workforce. The Inquiry acknowledges the extraordinary efforts of all involved.

Existing pandemic plans downplayed the usefulness or likely public acceptance of quarantine as a public health measure and did not consider the range of people who would go through the system. There was consequently no agreed structure between the Australian Government and the states to fund or implement a national quarantine program, and no established processes to ensure a standardised and risk-based approach. This increased the operational and health risks associated with the rollout of a national program at the scale and within the timeframes required. The rapidity of the decision left states and territories to use their own resources in the

absence of standing mechanisms for harmonised approaches at the national level. The panel acknowledges that the use of hotels was a pragmatic decision also made by other countries – including Singapore, Taiwan and New Zealand – to use available facilities and to effectively minimise community transmission.

National guidance and coordination is critical for a robust response

Given the lack of planning for mandatory quarantine, there was no national guidance or supporting coordination structure. These would normally be managed through health ministers and health chief executives for health-related decisions with a national impact. During the initial stages this led to considerable variability between the state and territory quarantine programs.

The most critical variability was in risk management and infection prevention and control standards. Public health capability is not uniform across jurisdictions. Valuable lessons learned in one jurisdiction were not nationally disseminated. This also hindered the real-time collection and sharing of key data relating to transmission pathways in Australia. This in turn limited the ability of governments to evolve the response and reassess risk based on real-time evidence.

The use of hotels for quarantine was a creative yet high-risk approach that needed dedicated resourcing and centralised leadership, coordination and advice. Hotels are not designed to safely house large populations to reduce the risk of viral transmission. Their effective use needed to be informed by effective risk management measures, including infection prevention and control practices that would account for the movement of different people through quarantine settings.[749] The number of different groups who used hotel quarantine also highlights the need for tailored and specific pre-planning in this space. The panel confirms the need for the Australian Centre for Disease Control to play a key role in the future development of national guidelines to better support the coordinated implementation of national response measures. We suggest that Figure 2 in this chapter, which outlines the various cohorts and quarantine options used for them, would be an important input for future scenario testing led by the Australian Centre for Disease Control to further refine best practice for managed quarantine and other quarantine measures that may be contemplated in future pandemics.

The importance of centralised national guidance and coordination was made clear to National Cabinet through the Halton review of quarantine in 2021. We agree with Halton's conclusion that a risk-based National Quarantine Strategy is a critical foundation for pandemic preparedness and that in its absence there is a clear and ongoing risk of suboptimal and variable quarantine responses. Despite being recommended and agreed three years ago, there is still no National Quarantine Strategy or agreed entity at the national level to progress outstanding policy and operational components. We agree with the March 2023 Joint Committee of Public Accounts and Audit inquiry into the Department of Foreign Affairs and Trade's crisis management arrangements, which independently recommended a government response to the Halton review.[750] The importance of a quarantine strategy has not diminished, and any future use of a national or localised quarantine program is at significant risk until one is finalised. We heard from a stakeholder that without a clear plan with clear lines of authority and with the right expertise in place, the same suboptimal and variable quarantine responses will happen again.[751]

The panel heard that states and territories are likely to have greater hesitation in accepting the political, operational and financial risks associated with a future pandemic unless there is pre-agreement on key outstanding matters on quarantine management. Finalisation of a National Quarantine Strategy is a high-priority cross-cutting objective which requires the attention and agreement of First Ministers. It will benefit from close collaboration between Commonwealth agencies – including the Department of Home Affairs, the Department of Health and Aged Care, the Department of the Prime Minister and Cabinet, and the Australian Centre for Disease Control – and the states and territories. This will help to harness expertise and direct experience with national quarantine programs and to ensure that the proposed recommendations can be implemented. We consider that the First Secretaries Group, supported by the convening power and Commonwealth–state relationships of the Department of the Prime Minister and Cabinet, would be the appropriate forum to progress this work and allow for policy integration across jurisdictions and portfolios.

Clarity is needed on quarantine funding arrangements

Payment for quarantine was controversial from the perspective of travellers and remains an unresolved matter for future pandemics. States and territories bear the residual burden of costs associated with implementing quarantine arrangements. Introducing a user-pays model part-way through the pandemic was an attempt to recoup some of the costs and manage budgetary impacts. Agreement between the Commonwealth and the states and territories on funding responsibility for future use of quarantine will be needed as part of the National Quarantine Strategy.

The challenges of the hotel quarantine experience for residents and quarantine workers were compounded by the user-pays model. This model was inequitable and had a disproportionate impact on lower income Australians and, for some, prevented them from visiting loved ones who were in poor or terminal health. State governments are still pursuing unpaid debts, years after the quarantine period ended. It is noted that the Australian Government made provisions for low-income travellers. This highlights the need to explore options to better share and reduce the financial burden of hotel quarantine, particularly for people facing financial hardship.[752]

Measures should be reviewed and refined based on real-time evidence and assessment of risk

Evidence from the Australian Health Protection Principal Committee and from Commonwealth and state and territory initiated reviews informed decision-making relating to ongoing health risks and quarantine arrangements. The state and territory systems of continuous improvement informed their understanding of the broader health-related impacts associated with quarantine infection prevention and workforce risk management processes. This was important given the variability of accommodation, some of which lacked access to sunlight, fresh air, or opportunities for exercise. Mental health considerations were increasingly acknowledged to be important. Jurisdictions including New South Wales, the Australian Capital Territory and Victoria responded by modifying their standards for appropriate quarantine accommodation. Still, reports from individuals who experienced quarantine indicated that they dreaded the quarantine process more than the virus itself.

The initial decision to implement a national quarantine program was informed by health advice and was largely accepted by the public as necessary. However, its protracted use as a key intervention in the face of less restrictive approaches adopted by other countries, like the United Kingdom, undermined public trust and confidence in the measure. People doubted whether extensions to the quarantine arrangements were supported by sufficient rationale or evidence. Feedback to the panel suggests that many Australians do not believe that governments were as flexible in their use of quarantine over time as they were in establishing it – that is, rigid arrangements stayed in place for longer than the evidence suggested was effective. We share this view and agree with the public health officials who noted we went too hard for too long in maintaining quarantine and other restrictive measures.

The assumption that Australians returning from home would not adequately quarantine, without good evidence to support this, meant that quarantine for all international arrivals was based on the premise that citizens could not be trusted. This no doubt reinforced the feelings of oppression voiced by people in quarantine, and the general community push-back on what was seen as overreach by authorities. With the wisdom of hindsight, if home quarantine compliance was adequate for managing local outbreaks throughout the pandemic – and random checking by police did indicate that most were compliant in the second wave in Victoria – then hotel quarantine could have been freed up for symptomatic returnees or other arrivals who had no home to go to or who had vulnerable people at home they did not want to expose to risk of infection. Enhanced and earlier access to real-time data on the efficacy of home quarantine arrangements may have permitted more Australians to return by relieving in large part the capacity demand each international flight put on hotel quarantine. It would also have alleviated the sense of inequality, as people noted that some celebrities and sports identities were able to negotiate home quarantine.

Evidence-gathering on infection prevention and control at the borders for the entire passenger pathway from plane through quarantine should have been implemented at the outset as part of the ongoing evaluation to fine-tune the system design. This would have helped to safeguard residents, workers and the wider community through process checks on infection prevention and control measures, and to rapidly evolve the system if needed by determining how current arrangements and practices might adapt to changes to the variants that were circulating. This should extend into home quarantine options. In future there are likely to be even more technological options to support types of monitoring that are effective for assessing quarantine compliance but not intrusive. As it was, governments did not know when to switch these systems off – 'we went too hard for too long'.

The panel supports the findings of the 2020 Halton review that better informed selection of preferred accommodation facilities and alternative quarantine arrangements, such as shorter quarantine periods, should have been implemented sooner using a risk-based approach.[753] The review findings affirm the panel's view of the importance of the Australian Centre for Disease Control being authorised to expedite real-time key data sharing arrangements at the national level, as this would have enabled a more rapid de-escalation of quarantining. This evidence was not available during the pandemic.

In the course of the Inquiry, we requested quarantine-related data from several Australian Government departments that played a role in implementing quarantine. There was no single department with ownership or oversight of these data. While some went out of their way to provide a coordinated response, the data were incomplete. This fragmentation is indicative of what we heard was occurring during the pandemic. An Australian Centre for Disease Control with a whole-of-system remit for collating, analysing and disseminating real-time data and advice could have provided the data hub that is required to implement national quarantine arrangements, as well as the evidence to guide an effective and proportionate quarantine response over time.

The government has learned important lessons on capability and capacity for future quarantine responses

In establishing the Centres for National Resilience, the Commonwealth and participating state and territory governments applied key learnings from the hotel quarantine program. These facilities were designed with the latest medical advice around infection prevention and control standards, ventilation and personal protective equipment usage, and considered broader implications for mental health. Their rapid and effective design is an unambiguous success story for government and provides key foundations for pandemic preparedness.

Unfortunately the decision to construct these centres happened too late to meaningfully contribute to the COVID-19 national quarantine program. While their ongoing maintenance and usage will be an important supplement to any future quarantine arrangements and broader resilience efforts, they are not a complete solution. Centres for National Resilience have a total capacity of up to 4,000 beds. Australian Border Force data show that 330,807 returning travellers had been processed through our systems of managed quarantine by 26 August 2021.[754] The Centres for National Resilience will need to be managed alongside other infrastructure and capability to properly implement any future national quarantine and resilience programs.

Unless these facilities are used in ways that can also enable their operation as training facilities for a surge quarantine workforce, we risk these sites becoming dormant and impossible to scale up for quarantine service in a timely way. One of the key limiting considerations for quarantine facilities is access to an appropriately trained workforce.

Australia cannot implement quarantine in the same way again

Experience during the pandemic highlighted the inherent complexity and the human and economic costs of mandatory quarantine programs. These need to be weighed up in future decision-making. There needs to be pre-agreement on the circumstances that might justify quarantine, linked to the decision on international border closure. Neither can work without the other. An open border would overwhelm any quarantine system, and large numbers in isolation has flow-on effects on the economy and social functioning. Conversely, closed boarders without a quarantine system will be far less effective at keeping the virus out, especially for diseases that have long incubation periods and if people can be infectious without symptoms, making airport screening an ineffective barrier.

Experience also demonstrated that inherent risks and inefficiencies are magnified in the absence of appropriate planning and preparedness and stress-testing. Many risks cannot be mitigated without ongoing joint planning between governments and key partners. An effective national response to a pandemic requires flexibility to deal with differing health circumstances and clarity about roles and responsibilities – supported by a dedicated federal entity such as the Australian Centre for Disease Control with the authority and responsibility for providing national guidance on evidence-based quarantine systems for any such future response.

A unified approach engaging all jurisdictions and industry and community partners was pivotal in Australia's overall good results in managing the pandemic. Resolution of outstanding policy and operational matters relating to quarantine management is imperative. We note the reported reluctance of states and territories to again accept responsibility in these areas without this occurring. This is expected to be a key focus of the National Quarantine Strategy. The strategy must include consideration of alternative models of home-based and other quarantine arrangements, which were the clear preference for the majority of people. It is essential that new technologies, including those with geolocation and facial recognition features, be harnessed for monitoring isolation compliance in home-based models.

The National Quarantine Strategy must be underpinned by an operational plan that supports the broader national pandemic plans. It must document agreed escalation response triggers for a national crisis. It must also set out a de-escalation pathway to a monitoring and surveillance phase.

The government's commitment to and early establishment of the Australian Centre for Disease Control provides a significant opportunity to address key challenges relating to quarantine-based responses. We believe that the early development of national guidance to underpin the National Quarantine Strategy and inform practical implementation, in partnership with states and territories, is an urgent priority of the Australian Centre for Disease Control.

5. Learnings

- Successful utilisation of national quarantine based approaches is highly dependent on extensive planning and practised and agreed roles and responsibilities between governments. While acknowledging the need for flexibility in managing future pandemics, key outstanding matters between the national and state governments need to be addressed through the finalisation of a national pandemic plan. While the Commonwealth and states and territories banded together to implement quarantine arrangements in record time, their ongoing use desperately needed national ownership and a central coordination mechanism.
- Standardised national frameworks and real-time evidence were needed to guide decision-making for the use, modification and cessation of quarantine. This should have encompassed when, where and for how long someone should quarantine for, as well as best-practice implementation such as for infection prevention and control standards and workforce training.

- Protracted quarantine arrangements cannot be designed on the run. They require dedicated infrastructure, extensive scenario testing, established roles and responsibilities between Commonwealth and state governments, and national coordination.
- Greater clarity and supporting communications are needed around the circumstances for reopening and easing quarantine arrangements, with these being regularly updated and communicated to reflect changing circumstances.
- Data sharing and standardisation between all levels of government, with the support of the Australian Centre for Disease Control, including the travel sector, is critical to managing a national quarantine program and supporting testing and tracing regimes.
- Quarantine facilities can be successfully repurposed to assist the emergency response for other events like natural disasters. However, there must be clear guidance on how they can be quickly re-engaged to support future quarantine arrangements, and how a quarantine workforce could be trained within these facilities to ensure that the infection control benefits of the investment in these purpose-built facilities are realised.
- Quarantine arrangements should consider the specific needs of the different cohorts who will experience them. This is particularly important if home quarantine is deemed too risky and quarantine is for more than a few days, and plans should be made in consultation with community representatives so there are protocols in place ahead of the next pandemic.
- Introducing individual costs for the quarantine program was seen as unfair and lacking compassion and had disproportionate impacts on lower income Australians.

6. Actions

6.1. Immediate actions – Do in the next 12-18 months

Action 5: Develop updated health emergency planning and response arrangements in conjunction with states and territories, and key partners, including consideration of escalation and de-escalation points, real-time review and a focus on post-emergency recovery.

As part of this, develop:

- Modular operational plans for specific sectors, including high-risk settings, which can be deployed in response to a variety of hazards.

The Quarantine plan should:

- draw on recommendations from the 2021 National Review of Quarantine
- establish and regularly update best-practice guidance, informing practical implementation for quarantine facilities (including on infection prevention and control standards and changing technologies), which is informed by CDC advice.

Action 6: Develop legislative and policy frameworks to support responses in a public health emergency, including for quarantine.

The National Quarantine Strategy should:

- formalise governance arrangements around the activation of quarantine, with a focus on triggers for de-escalation and recovery
- clarify the roles and responsibilities of Commonwealth and state and territory governments, as well as industry bodies, formalising principles for cost-arrangements and workforce requirements
- identify a full set of quarantine options, including home quarantine, to limit the use of hotel quarantine and ensure that purpose-built quarantine facilities can be quickly re-engaged
- be designed closely with the Department of Health and Aged Care, the Department of Home Affairs and the Australian Centre for Disease Control, and states and territory agencies with experience operationalising quarantine arrangements during the pandemic
- account for the complex pathways and many different cohorts which the COVID-19 experience has shown us will be processed through the system
- establish culturally appropriate options for people in remote Aboriginal and Torres Strait Islander communities to quarantine on country in a national health emergency, and culturally appropriate options for culturally and linguistically diverse communities.

Health Response

Overview

When Australia's first case of COVID-19 was confirmed on 25 January 2020, only 1,320 other cases had been reported in a handful of East Asian countries.[755] By the time Australia's Governor-General declared a human biosecurity emergency for COVID-19 on 18 March 2020, 191,127 were reported to be infected worldwide.[756] By the end of 2021, this figure would be 278 million – with over five million deaths attributed to COVID-19.[757]

The health response to any pandemic is complex, but especially when the planning and preparations in place were skewed towards the expectation that the next true global outbreak with a high mortality threat would be an influenza pandemic. At the turn of the century, we were also generally considered overdue for an influenza pandemic. In 2009 the 'swine flu' (H1N1) pandemic spread rapidly from Mexico to over 200 countries and overseas territories or communities, including Australia.[758] Between 105,000 and 395,000 people are thought to have died – considerably fewer than in the 1968 H3N2 pandemic when between one million and four million were thought to have died.[759] The 2009 virus was a new strain of H1N1 – the variant responsible for the 1918 Great Flu pandemic and the 1977 Russian flu outbreak.[760]

Once the dust settled, the focus turned to pandemic preparedness. There was little public discussion about what we had learned about our state of readiness, let alone how we might respond in a future pandemic if a different pathogen were responsible. Unlike influenza where we have successful seasonal and pandemic vaccines that can be tweaked, for COVID-19, vaccine development had to start from scratch.

Before the pandemic arrived on Australian shores, stories of health systems overseas buckling under pressure started to spread, and we saw images of intensive care units overwhelmed by COVID-19 patients in countries such as Italy and the United States.[761] Australia's leaders moved quickly to assess the risk to the Australia's health system and implement strategies to ensure community transmission of the virus could be kept to levels that would not compromise heath care for pandemic-related patients and in usual service demands. Measures now synonymous with Australia's response to the pandemic – closed borders, lockdowns, physical distancing, isolation requirements, mask mandates, hand hygiene and others – emerged from this goal of aggressive suppression. The aim was to limit the spread of the virus within Australia until our health systems were reinforced and/or vaccines and treatments were available.

International comparisons today show Australia suffered fewer excess deaths per capita than most other countries, including Sweden, France and the United States.[762] The Australian Government acted rapidly to close international borders. The national effort to prevent most Australians from being infected at a rate that would have compromised critical care if needed, and the health of all Australians if the health system became overwhelmed, paid off in ways few Australians can fully understand. By holding back widespread community transmission until the vast majority of the adult population had some immunity through vaccination, far fewer Australians experienced severe COVID-19 than would have otherwise been the case. As a result, thousands fewer Australians died from COVID-19, or from other causes through suboptimal care, than would otherwise have been the case. However, there is also a view that restrictive

measures were kept in place for too long, and the broader individual, social and economic impacts came to outweigh the COVID-19 public health benefit.

The pathway to Australia's reopening was paved by what came to be known as the 'vaccine rollout'. Led by the Australian Government, this was an exercise in health logistics undertaken on a scale never before attempted. Over 20 million Australians were vaccinated against COVID-19 by November 2021.[763] This effort was made possible by countless thousands of health professionals working around the clock to keep the community safe and protected against severe COVID-19.

There were successes in our public health response, but there were also lessons we must learn ahead of a future public health emergency. The rollout, notably referred to in 2021 as the 'strollout', mostly side-stepped longstanding state and territory expertise in vaccine delivery and also excluded some health professions from efforts to vaccinate the nation.[764] These decisions added to the slow pace of vaccination and extended the time before the nation was ready to reopen. Also, there was a failure to adequately plan for vaccinating priority populations, including people living in residential disability and aged care settings.

Vaccine mandates were particularly controversial. The mandates were associated with point-in-time upticks in vaccination and were justified in critical care settings, but they helped drive vaccine scepticism and hesitancy when used more generally and contributed to frontline workforce shortfalls in areas that could least afford this at the time of opening up. These issues persist to this day, with troubling declines in vaccination for COVID-19 and other diseases across multiple population groups, including children missing out on routine childhood vaccinations.

In line with National Cabinet's National Plan to Transition Australia's National COVID-19 Response, from late 2021, the states and territories began rolling back restrictions put in place over 18 months earlier, citing high rates of vaccination. Most Australians were ready to move on and return to some form of normality with the national reopening. However, we still had the transition to community-wide transmission of the virus ahead of us. This also coincided with the arrival of the highly transmissible Omicron wave. Infection fatality rates were considerably lower for Omicron infections, and further reduced by acquired immunity, but Australia still experienced its highest mortality counts in 2022 because of the sheer number of infections – almost 90 per cent of those who died due to COVID-19 were people 70 years and older.[765]

Unfortunately, this was just the latest challenge our frontline workers faced during a pandemic that repeatedly pushed our health system to the limit. COVID-19 exposed existing fractures in the health system. Health workers were overworked and health providers understaffed before the pandemic. Public health workers had to pivot to work on COVID-19, often with extended work hours and no leave. They had to train up an inexperienced surge workforce. There were additional demands on hospitals and primary care systems battling longstanding service backlogs. Demands on our mental health system had long outpaced supply and now services faced an influx of new patients.

The pandemic caused non-COVID healthcare delays through deliberate disruptions to elective procedures and also through health workforce impacts and patients' fear of being exposed to the virus if they attended screening, or clinical or pathology services. Australia is now sicker overall and has more tired and anguished health workers trying to deal with this displaced healthcare backlog, and with the lasting health impacts of COVID-19 infections that some experienced. Impact on the health workforce, delays in care, rising costs and a greater health burden are legacy issues inextricably bound up with the pandemic itself. There is a risk the health system will further deteriorate and Australia will have fewer resources to draw upon to respond to the next health emergency than it had in 2019.

This section examines the Australian Government's management of the pandemic from the health perspective. It looks at public health measures introduced to manage the virus, and the unintended consequences of those measures. Chapter 9: Buying time examines Australia's attempts to keep the virus out of the community and aggressively stem spread in the community, and summarises lessons for the future use of non-pharmaceutical interventions. State borders are considered here, as these were tightly linked to non-pharmaceutical intervention strategies, and contributed to the risks to national cohesion, perceived and real.

Chapter 10: The path to opening up reflects on the development, regulation and use of COVID-19 vaccines, treatments and their related policies. It includes an examination of the place of mandates, the management of vaccine adverse events, the balancing of risks and benefits in a pandemic, and how the logistics of mass vaccination efforts might be better organised and planned for in the future. It also explores the management of ongoing waves and chronic impacts of the virus, including long COVID.

Chapter 11: Communicating in a crisis examines the effectiveness and public experience of government COVID-19 communication efforts. It explores the fundamental role that communication played in conveying information about the risks associated with COVID-19, explaining what authorities were doing, and advising on what Australians could do to protect themselves and others. We also consider the interdependent relationship between communications and trust, the impacts of misinformation on the response and social cohesion, and the role of trusted messengers like community helpers and experts.

Chapter 12: Broader health impacts considers key examples of broader health consequences and impacts on the health system itself and how it fared during the pandemic. The chapter focuses on aspects that could directly impact future pandemic preparedness. We also incorporate mental health impacts here as this needs to be considered as a potential direct impact from both infection and disease control measures. The pandemic and associated uncertainty and fear triggered new mental health events and exacerbated existing conditions.[766]

Timeline

- 1 January 2020: National Incident Room begins to monitor a pneumonia cluster in Wuhan, China.
- 19 January 2020: Australian Government begins communication on the 'novel coronavirus'.
- 23 January 2020: Australia's Prime Minister makes his first public comments on the 'novel coronavirus'.
- 25 January 2020: Australian Government confirms our first case of SARS-CoV-2 infection.
- 11 February 2020: World Health Organization names the disease arising from SARS-CoV-2 infection as COVID-19.
- 20 February 2020: Australian Government announces the requirement for 14-day self-isolation for all close contacts of known cases.
- 11 March 2020: Australian Government announces a $2.4 billion health package in response to COVID-19.
- 12 March 2020: Australian Health Protection Principal Committee releases a statement recommending 14 days of self-isolation for healthcare workers if they are a close contact of a confirmed case.
- 13 March 2020: Council of Australian Governments announces the National Partnership Agreement on COVID-19 Response.
- 26 March 2020: National Cabinet agrees to temporarily suspend all non-urgent elective surgeries.
- 29 March 2020: National Cabinet agrees to a nationwide lockdown.
- 29 March 2020 – States and territories implement social distancing measures, including lockdown, specific to their regions.
- 30 March 2020: Australian Government announces the expansion of Medicare-subsidised telehealth.
- 7 January 2021: Australia's COVID-19 vaccine national rollout strategy is released.
- 8 January 2021 – National Cabinet agrees mandatory use of face masks on flights and in airports.
- 22 February 2021: Australia's vaccine rollout begins.

- 23 March 2021: Therapeutic Goods Administration approves the first batches of Australian-made AstraZeneca vaccine.
- 28 June 2021: National Cabinet endorses mandatory COVID-19 vaccinations for residential aged care workers.
- 6 August 2021: National Cabinet agrees to and releases the National Plan to Transition Australia's National COVID-19 Response.
- 1 October 2021: Australian Health Protection Principal Committee recommends mandatory vaccinations for all workers in healthcare settings.
- 5 November 2021: Over 80 per cent of Australians over 16 years of aged are double vaccinated.
- 8 November 2021: Australian Government begins the vaccine booster program.
- 13 December 2021: COVID-19 Vaccination Claims Scheme opens.
- 30 December 2021: National Cabinet agrees to a standardised isolation period of 7 days regardless of vaccination status.
- 20 January 2022: Australian Health Protection Principal Committee proposes the use of rapid antigen tests (RATs).
- 12 May 2022: First Australian-made COVID-19 mRNA vaccine is given to a clinical trial patient.
- 31 August 2022: National Cabinet agrees to reduce isolation of cases from 7 to 5 days.
- 30 September 2022: National Cabinet agrees to end mandatory isolation of cases from 14 October.
- 20 October 2023: Australian Chief Medical Officer declares COVID-19 is no longer a Communicable Disease Incident of National Significance.

Chapter 9 – Buying time

1. Context

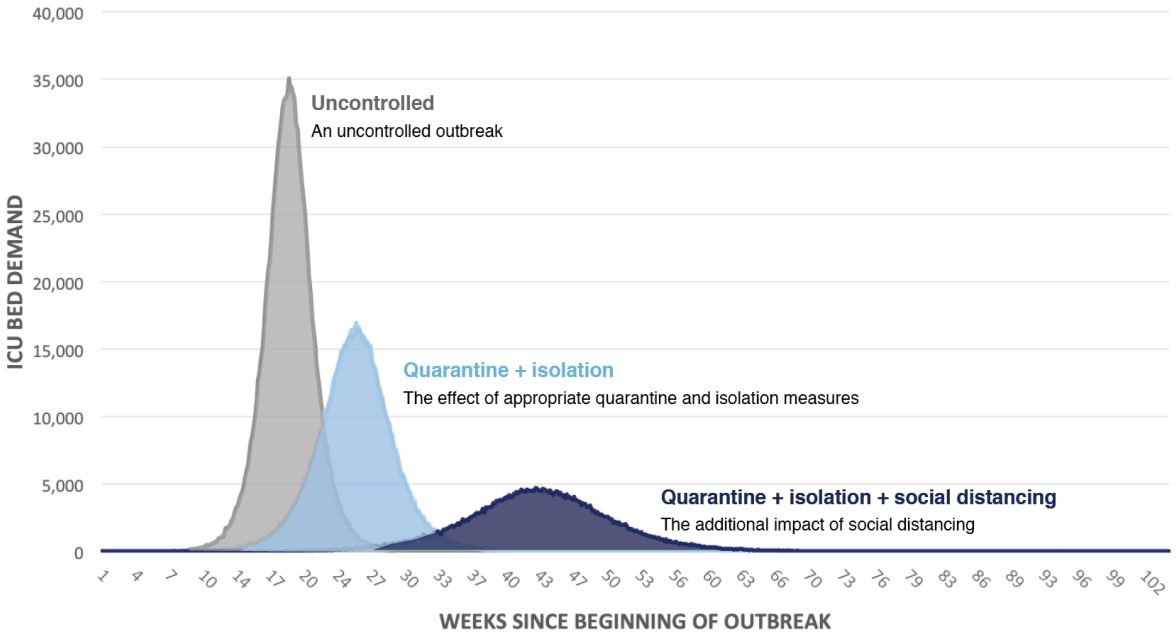
In the first two months of the COVID-19 pandemic in Australia, Commonwealth and state governments introduced a series of measures to protect against community transmission of a novel coronavirus in a population that had no existing immunity. Governments acted swiftly in an emerging information environment to introduce precautionary measures to suppress transmission until the health system and disease implications could be better understood.

These decisions were made in the context of an international environment of rapidly growing case numbers and rising mortality rates. Countries such as Italy and South Korea were reporting cases in their thousands, and China reported more than 79,000 by 1 March 2020.[767] Devastating news of overburdened health systems overseas, including in Italy and New York, quickly followed.[768] Statistical modelling was undertaken using overseas case and hospital data to estimate how the Australian health systems would cope with similar levels of community infection (see Figure 1 and Figure 2).[769] The finding was that, given the virus's combined transmissibility and disease severity, a significant reduction in population mobility could limit the number of cases with severe disease to levels where cases could access intensive care unit beds.[770]

Figure 1: Modelling parameters[771]

	Scenario 1: no mitigation	Scenario 2: quarantine and isolation	Scenario 3: quarantine, isolation and social distancing (25%)	Scenario 4: quarantine, isolation and social distancing (33%)
Infection rate	89.1%	67.5%	37.7%	11.6%
Hospitalisation rate	5.4%	4%	2.2%	0.8%
Proportion who can access ICU beds	15%	30%	80%	100%

Figure 2: Modelling COVID-19 scenarios[772]



The initial approach taken in Australia aligned with the 'precautionary principle'. Under this principle, the pandemic situation is assessed, evidence is collected and tailored measures are implemented to manage case numbers. The precautionary principle allows action to be taken before there is robust evidence regarding risk or the effectiveness of specific interventions.[773] However, the onus on decision-makers is to evaluate the situation in real time and generate and synthesise the data needed to move to a more evidence-based approach and refine their response as more becomes known about the situation. Australia's approach became known as 'flattening the curve' – slowing the infection rate – so that, even if infections could only be delayed and not avoided, case numbers would be contained to levels where those who were sick could receive optimal care. It also bought some time for therapeutic approaches to be developed and for possible vaccines to be investigated.

The initial focus on 'aggressive suppression' of community transmission of the virus recognised that closing the international borders could not guarantee the virus could be kept out of the community, even with quarantine in place. However, by mid-2020, when Victoria experienced their second outbreak following breaches at two quarantine hotels, the response escalated to zero tolerance. Some other jurisdictions followed suit when local outbreaks occurred.

It soon became clear that no control measures, including COVID-19 vaccines, could eliminate a virus that continually evolved new variants and the multiple animal reservoirs that could continue to seed the virus back into the human population made long-term global eradication impossible. Australian policies focused instead on aggressive suppression to pace the impact on the health system and preventing as much serious illness and death as possible as Australia prepared to make the inevitable transition to community-wide transmission.[774]

2. Response

The features of Australia's early pandemic response demonstrate a precautionary approach, outlined below. At a state and territory level, measures were implemented to varying degrees based on local pandemic conditions, whether the virus was circulating in the community and the level of risk of infection in the community.

2.1. Testing, tracing and isolation

Diagnostic tests for COVID-19 were developed in Australia 'within days' of the announcement on 11 January 2020 of the sequence of SARS-CoV-2.[775] On 11 February 2020 the 'Human coronavirus with pandemic potential' had been added temporarily to the National Notifiable Disease Surveillance List.[776]

This meant that, by the time the first case of COVID-19 was identified in Australia (25 January 2020), Australian laboratories had developed testing processes for the virus and the Australian and state and territory governments had activated contact-tracing processes.[777]

Self-quarantine measures were in place from 29 January 2020, initially for people who had been in contact with a confirmed case (note that people on assisted departure from Wuhan and Hubei Province in China were required to quarantine on Christmas Island or in Howard Springs: see Chapter 8: Implementing quarantine).[778] At ports of entry, incoming passengers were given information on symptoms and signs of infection, and instructions on how and when to self-quarantine.[779]

National Cabinet agreed to a mandatory self-quarantine requirement for all international arrivals starting on 15 March 2020, enforced under state and territory law.[780] The Australian Health Protection Principal Committee supported this measure, describing it 'as the most important public health measure in relation to case importation'.[781] From 28 March 2020 all incoming passengers entered managed quarantine (see Chapter 8: Implementing quarantine).[782] The Australian Health Protection Principal Committee initially described this as a 'highly precautionary approach', noting the data were 'limited and preliminary'.[783]

On 18 February 2020 the Australian Government published the Australian Health Sector Emergency Response Plan for COVID-19. The plan informed the approach to minimising disease spread while information about the virus was gathered.[784] At this time it was unclear if and when a vaccine would be developed. On 11 February 2020 the Director-General of the World Health Organization said the development of vaccines and therapeutics would take time and it could be 18 months before the first vaccines would be ready.[785]

On 21 March 2020 the Australian Health Protection Principal Committee provided further isolation guidance for people with confirmed cases of COVID-19, noting people could be released from isolation 10 days after hospital discharge or after symptoms started, as long as they had not had symptoms of acute illness for 72 hours.[786] The National Guidelines for Public Health Units were updated on 23 August 2020 extending the isolation period for cases with severe illness to at least 14 days from onset of symptoms.[787]

On 26 March 2020, the Biosecurity Determination 2020 was signed by the Minister for Health, restricting travel into remote communities within the Northern Territory, Western Australia, Queensland and South Australia to reduce the risk of spread of COVID-19 into remote communities.[788] The determination was repealed on 10 July 2020. State governments could continue emergency response to stop travel if required.[789] (See also Chapter 13: Aboriginal and Torres Strait Islander people).

In this early phase of the pandemic, Australia was able to track the virus domestically because it had 'one of the most comprehensive testing regimes in the world'.[790] Importantly, the initial widespread testing allowed for case surveillance and genomic sequencing of the virus. To support this, the Australian Government ensured there was no charge for testing for all people in Australia, regardless of Medicare status.[791]

The Public Health Laboratory Network, a standing committee of the Australian Health Protection Principal Committee and the leading network of public health laboratories, released laboratory testing guidelines from March 2020.[792] In February 2021 it released the National Testing Framework, which provided guidance on community testing but stipulated states and territories could apply the framework to fit local circumstances.[793] The framework gave information on how to identify priority groups for targeted testing in Australia, including by epidemiological zone. Later, in December 2021 and March 2022, it was revised to include additional guidance to keep up with the evolution of the evidence, and of the virus, including information on enablers and barriers to testing.

Polymerase chain reaction (PCR) tests were the most commonly used tests from early 2020 until January 2022, when rapid antigen tests (RATs) were introduced for community use. PCR tests were funded under the National Partnership on COVID-19 Response (between the Australian Government and the states and territories) and the Medicare Benefits Schedule.[794] Remote point-of-care PCR tests were also available from May 2020, ensuring real-time surveillance in remote communities.[795]

PCR tests were the reference-standard tests used due to their high accuracy in detecting the SARS-CoV-2 virus in respiratory tract samples.[796] As Australia responded to increasing case numbers in late 2021, laboratory-based PCR testing capacity became overwhelmed in several jurisdictions.[797] In this epidemiological context, guidance recommended these tests be reserved for testing of high-priority cases (for example, those at risk of severe disease).[798]

The Therapeutic Goods Administration (TGA) approved a number of RATs for supply in Australia from 1 November 2021.[799] RATs were introduced into Australia's testing regime in January 2022, following a joint statement by the Public Health Laboratory Network and the Communicable Diseases Network Australia.[800] The TGA played a key role as Australia's regulatory body for assessing therapeutic goods including COVID-19 vaccines, treatments and medical devices including in-vitro diagnostic devices (e.g. PCR assays and RATs). The approval of RATs came later in Australia than other industrialised nations in order to test the effectiveness of these devices and ensure instructions for their use in the community setting were understandable.[801]

Many Australians were able to access RATs for free under numerous Australian and state and territory government initiatives.[802] The COVID-19 Rapid Test Concessional Access Program provided up to 20 free RATs from pharmacies for eligible concession card holders.[803] RATs were also provided by the Australian Government to residential aged care facilities, Aboriginal Community Controlled Health Organisations, supported independent living disability care, GP-led respiratory clinics and the Royal Flying Doctor Service to enable additional and easy access to screening in those settings.[804]

Up to 31 December 2023 the Australian Government had funded 77.9 million COVID-19 PCR tests and around 169 million COVID-19 RATs.[805]

Contact tracing – when well-resourced and operating optimally – uses surveillance data for COVID-19 positive cases to identify and quarantine their close contacts to minimise the risk of onward transmission, should they develop the disease. Surveillance and contact-tracing data provide insight into the types and settings of exposures that lead to infections, enable mapping of infection rates across the community, and provide evidence regarding symptom and disease severity. Together, these data are used in designing and implementing disease control policies. Contact tracing was the responsibility of state and territory governments.[806] However, in April 2020 the Australian Government launched the COVIDSafe app to assist with manual state and territory tracing efforts.[807] The app was found to be ineffective.[808] Further discussion of its use and limitations is provided in Chapter 5: Trust and Human Rights.

In late 2020 National Cabinet commissioned and later endorsed a review of Australia's COVID-19 contact-tracing and outbreak management systems.[809]

The Communicable Diseases Network Australia introduced a national definition of a close contact for use by Public Health Units on 24 January 2020, with updates made via its Series of National Guidelines throughout the pandemic, including advice on isolation periods.[810] Each state and territory also had their own definition of 'close contact' under state legislation for the purposes of contact tracing from early in the pandemic. [811] Different jurisdictions had different ways of implementing contact tracing and different self-quarantine periods for close contacts.

National Cabinet reduced mandatory isolation to seven days after last exposure on 30 December 2021, following advice from the Australian Health Protection Principal Committee.[812] Mandatory isolation remained in place until 30 September 2022, when National Cabinet unanimously agreed to end the measure.[813] This decision was based on advice provided at the request of the Prime Minister from the Australian Government Chief Medical Officer, rather than a consensus statement from the Australian Health Protection Principal Committee.[814]

SARS-CoV-2 genome sequencing supported the response to the pandemic, assisting with the surveillance, tracking and tracing of cases. From 1 October 2020, the Australian Health Protection Principal Committee endorsed the use of AusTrakka to serve as Australia's national genomics surveillance and analysis platform for SARS-CoV-2.[815] AusTrakka provided a central, secure, and private online location for public health laboratories to share, store, analyse, and view aggregated national genomic data.[816] The Department of Health funded the operation of the platform from 2 June 2021.[817]

Due to the broader circulation of COVID-19 in the community in late 2021, Australia's sequencing laboratories moved from a comprehensive sequencing strategy (attempt to sequence every case) to a targeted surveillance approach, focused on surveillance and detection of variants or mutations of concern.[818] This led to the publication of the Communicable Diseases Genomics Network Sampling Strategy for SARS-CoV-2 Genomic Surveillance.[819] The strategy aimed to ensure the data collected was representative of the available confirmed cases, had the ability to identify new SARS-CoV-2 virus variant introductions, and provided reliable findings that impacted public health action.[820]

2.2.Infection prevention and control measures

From as early as March 2020, to help reduce the spread of COVID-19, the Australian public was encouraged to maintain good infection prevention and control by using measures such as hand hygiene practices and cough etiquette.[821]

On 28 January 2020 the Chief Medical Officer encouraged general practitioners coming into contact with international travellers to use personal protective equipment (PPE).[822] On 29 January 2020 the Australian Government released one million masks from the National Medical Stockpile, encouraging general practitioners and their 'patients with the relevant travel history or symptoms' to wear face masks.[823] As greater numbers of returning travellers tested positive on arrival, and further outbreaks occurred within Australia, the advice was extended to include people who provided close personal support to priority populations, including those working in Aboriginal Community Controlled Health Services, the disability sector, and aged care workers.[824] The Australian Government supported infection prevention and control education for health and aged care workers from 2020, including development of online infection prevention and control training modules.[825]

> *Surgical face masks, as we know, provide an additional physical barrier to prevent the spread of COVID-19 to older Australians receiving aged care. As we continue to reinforce, masks must be used in addition to the other measures of physical distancing and hygiene, cough and sneeze etiquette. – Deputy Chief Medical Officer, 16 July 2020*[826]

Initial advice from the Australian Government in 2020 noted there was no benefit in the general public wearing masks.[827] However, this advice progressively changed as new research showed masks could reduce the risk of an infected person transmitting the virus to others.[828] Different types of masks were recommended at different stages of the pandemic depending on availability and the emerging evidence on relative effectiveness. Effectiveness is a measure that combines the efficacy of the mask under ideal laboratory conditions, and how masks are used in everyday practice. It was the wearing of masks by the general public that made evaluating the relative effectiveness of masks very difficult to assess, and led to inconsistent findings from community-based trials. The masks used in Australia included reusable cloth face masks, single-use surgical masks and respirators (such as a P2 or N95), which the Australian Commission for Safety and Quality in Health Care had recommended for healthcare workers before the pandemic.[829]

Mask mandates for the general public were first adopted by state and territory governments. Victoria implemented the first mask mandate on 22 July 2020.[830] States and territories adopted individual approaches with varying rules on both the mandatory and recommended or voluntary use of masks – rules and exemptions were set out in state and territory public health orders. The only public mask mandates introduced at a national level were in January 2021, when National Cabinet agreed to mandatory mask wearing for passengers and crew on all flights and in all airport terminals in Australia based on Australian Health Protection Principal Committee recommendations.[831] This decision aligned with the release of World Health Organization guidance on mask use that showed the effectiveness of masks against COVID-19.[832] The national air travel mask mandate continued until 9 September 2022.[833]

2.3.Restrictions on public gatherings, social distancing and lockdowns

Throughout March 2020, following advice from the Australian Health Protection Principal Committee, National Cabinet agreed various restrictions on public gatherings and implementation of social distancing requirements, actioned under state and territory public health orders. For example, orders limited non-essential indoor gatherings of more than 100 people and introduced social distancing – keeping 1.5 metre distances between people. This resulted in the cancellation of ANZAC Day ceremonies and events a few weeks later.[834]

> *Every Australian government is focused on slowing the spread of coronavirus to save lives … Every Australian has a part to play in slowing the spread of coronavirus … All leaders reiterated the importance of Australians strictly adhering to social distancing and self isolation requirements, in particular for those who are unwell and for returned travellers. Not adhering to self isolation requirements when you are unwell puts the lives of your fellow Australians at risk. – Prime Minister Scott Morrison, 20 March 2020*[835]

By 22 March 2020, 1,765 confirmed cases, including seven deaths, had been reported in Australia.[836] National Cabinet announced widespread restrictions on social gatherings. As a result, venues such as restaurants, pubs, religious gatherings, school assemblies, and gyms and indoor sporting venues were closed.[837] These were known as Stage 1 restrictions.

Over the next week, these restrictions were progressively scaled up, culminating in Australia's first and only nationwide lockdown on 29 March 2020.[838] This lockdown included strong 'stay at home' orders and closure of non-essential businesses, in addition to the existing restrictions. It came at a time when some states and territories brought forward school holidays or switched to remote learning to keep school-aged children at home.[839] This aligned with National Cabinet advice of 27 March 2020. The 27 March advice acknowledged that 'the medical advice remains that it is safe for children to go to school', but it encouraged 'only children of workers for whom no suitable care arrangements are available at home' to attend school (see Chapter 14: Children and young people). [840] Also, during this period all people entering Australia from overseas were required to go into managed quarantine.[841] Impacts of this are explored in Chapter 7: Managing the international border and Chapter 8: Implementing quarantine.

The Prime Minister emphasised the need for people to comply with social distancing measures and advised that 'we will be living with this virus for at least six months'.[842] The Australian Health Protection Principal Committee (AHPPC) also recognised that state and territory Chief Health Officers, or equivalent, could implement local responses. This recognised that a one-size-fits-all national approach was not going to work at an operational level given variability in the distribution of outbreaks and the local health system's capability to respond.[843]

> AHPPC notes that there is no 'formula' to guide such decisions. Rather the local assessment has to be made on the current evidence and the knowledge that there is a lag time of at least 7–14 days before the real impact of additional measures will be seen on case incidence, and longer for critical care requirements and mortality. – AHPPC statement, 30 March 2020[844]

The nationwide lockdown lasted until May 2020. On 8 May National Cabinet approved the '3 Step Framework for a COVIDSafe Australia' for the easing of restrictions.[845]

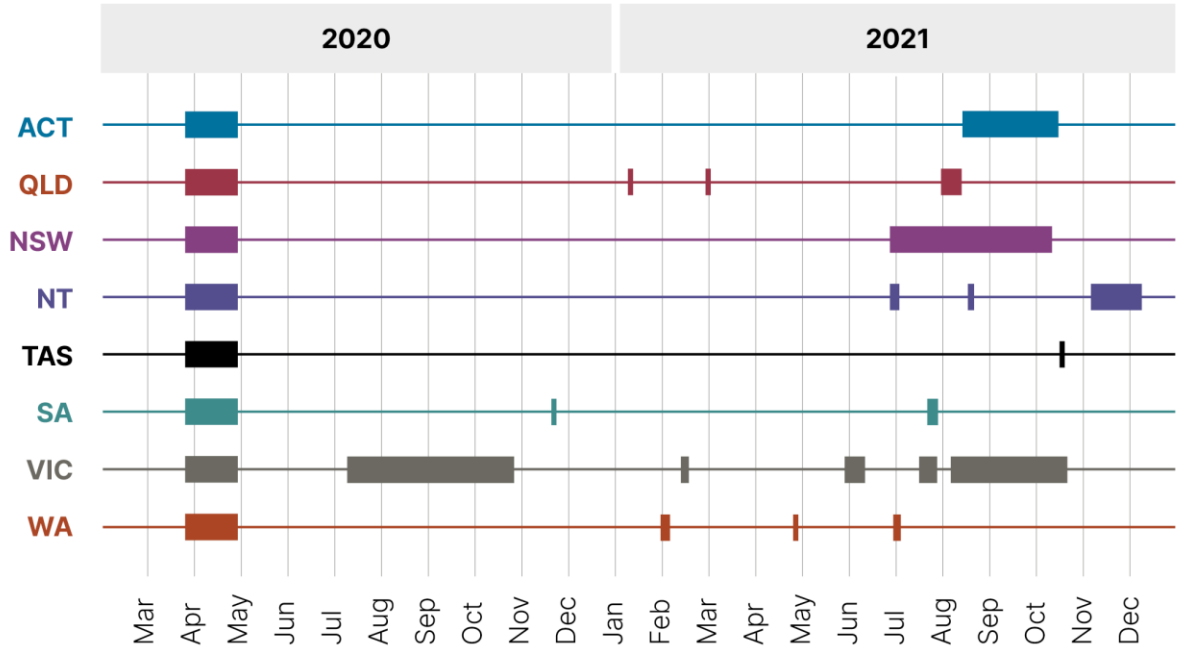
Lockdowns and social distancing measures continued to be applied on a state-by-state basis throughout the pandemic, even after the vaccine rollout had begun (see Figure 3). This included lockdowns of varying stringency and duration, with some implemented across an entire state, while others were localised, targeting particular postcodes.

Easing of all restrictions, including social distancing, was outlined in the National Plan to Transition Australia's National COVID-19 Response agreed by National Cabinet on 6 August 2021.[846] The plan set out four steps to move from pre-vaccination settings that focused on suppression of community transmission, to post-vaccination settings, prioritising preventing severe illness and death. It was informed by modelling from the Doherty Institute consortium, which forecast the vaccination thresholds needed for transitioning between phases alongside different levels of public health measures.[847]

COVID-19 'hotspots' were declared by the Australian Chief Medical Officer from 18 December 2020 for the purpose of the provision of Commonwealth support, such as PPE from the National Medical Stockpile or assistance with contact tracing.[848] These hotspots were also tied to people's ability to access some forms of economic support, such as the temporary COVID-19 Disaster Payment.[849] Economic support is explored in Chapter 20: Managing the economy.

The initial definition of a hotspot was determined in September 2020 and revised in 2021, to reflect areas where a more transmissible variant was identified in a community, combined with consideration of factors such as epidemiology, demography and mobility data.[850] Hotspots were de-listed by the Chief Medical Officer once there was evidence of decreasing community transmission and other criteria were met. In line with the National Plan to Transition Australia's National COVID-19 Response, in 2021, hotspot declarations ceased when the jurisdiction had reached an 80 per cent double-dose vaccination rate in persons aged 16 years and over.[851]

Figure 3: Timeline of COVID-19 lockdowns in Australia[852]



3. Impact

3.1. Test, trace and isolate

3.1.1. Testing

From January 2020 testing for and tracing of COVID-19 was available in Australia, and was available to the general public from March 2020. Health departments were able to collect essential data to identify cases, track their close contacts and monitor the spread of the virus in the community. These data also gave governments essential intelligence they could use to evaluate the overall effectiveness of the public health response and population-level risk of COVID-19 transmission.

> *In the absence of a vaccine or effective treatment for COVID-19, an important means to bring about a return to normal economic and community activity is rapid testing, contact tracing, isolation and outbreak management. – National Contact Tracing Review*[853]

From March 2020 the Public Health Laboratory Network, Communicable Diseases Network Australia and Australian Health Protection Principal Committee published and updated national testing guidance documents regarding who and when to test.[854] However, approaches to mandatory COVID-19 testing between jurisdictions varied, and this undermined a cohesive national approach. We heard this was particularly the case where tests were required as a prerequisite to cross interstate borders.[855]

> *We were told we needed to produce a negative test to travel interstate, they made a big deal of it and said the police were checking at the borders, but they weren't … it was very frustrating, I had to wait in line for three hours to get tested, but others didn't have to … it was so inconsistent. – Focus group participant, person from a culturally and linguistically diverse background, Brisbane*[856]

PCR tests were considered the gold standard of COVID-19 testing, but it took time for people to receive the results of their tests. For some results there were 24- to 72-hour delays.[857] Wait times were longer at peak times and in rural and remote areas, increasing the risk of disease spread if people were not as strict about their self-quarantine whilst waiting.[858] Testing capacity and capability of states also added to delays. Australia's pathology sector was more able to adapt to the challenges of the pandemic given funding support through the Medicare Benefits Schedule and the National Partnership on COVID-19 Response.[859] The establishment of drive-through testing clinics from early March 2020 was one of these adaptations. Drive-through testing was a low-contact approach that reduced the risk of disease transmission.[860]

Older Australians and people with disability told the panel they had particular challenges accessing testing services if they did not have a carer to take them to a testing site or had to queue up outside for hours to get a PCR test.[861]

The proportion of PCR tests that returned a positive result was monitored throughout the pandemic because it was a general indicator of the background infection rates in the community. On 12 May 2020 the World Health Organization recommended that the percent positive should remain below 5 per cent for at least two weeks of comprehensive surveillance and testing before governments considered reopening.[862]

Testing requirements had started to reduce in the Delta wave when case numbers peaked. They were further curtailed with the lifting of restrictions in the eastern states, where the virus was circulating and infection rates were expected to rapidly rise. Despite these preparations, the arrival of the highly transmissible Omicron variant in December 2021 saw an enormous spike in Australians requiring testing for COVID-19. It coincided with Australia's peak holiday period, and many states and territories still had testing requirements in place to allow travel to their state.[863] This spike in the volume of cases and the shorter incubation period made laboratory testing and contact tracing unfeasible, signalling the end of thorough 'test and trace'.

RATs were approved for use in high-risk settings such as aged care from late 2021.[864] In recognition of the increasing community transmission and pressure on the laboratory sector, in January 2022 the Australian Health Protection Principal Committee recommended that the community use RATs as an alternative diagnostic and screening test.[865] However, the international shortage in supply of RATs meant their introduction in this peak period did not assist the laboratory sector as much as anticipated, leaving laboratories that were performing PCR tests overwhelmed with the increased demand.[866] The RAT shortage was not aided by issues in procurement, where states and territories were competing with the Australian Government for supply.[867]

This delay to the introduction of self-testing has been described as slow and problematic, and as such did not aid the testing bottleneck that occurred over the Omicron wave.[868]

We heard from one stakeholder that the delay in approval was in part to ensure RATs were effective and instructions were clear. [869] However, they told us it was also driven by a fear of losing comprehensive testing data and the ability to conduct epidemiological analyses.[870] The use of RATs placed responsibility for testing and reporting positive results in the hands of the public, so it decreased the reliability and completeness of testing results, and did not capture the number of tests performed and the overall positivity rate.[871]

Later in the pandemic RAT supply improved. This, combined with the relative low cost, convenience and speed of results, led to their becoming the dominant testing method in Australia.[872] For low income earners, including people on income support payments, the cost of RATs was prohibitive from the start. The introduction of free RATs for concession card holders was welcomed.[873] Even so, the Australian Institute of Health and Welfare estimates Australians spent a total of $596.9 million on purchasing RATs in 2021–22 alone.[874]

The Inquiry heard that remote point-of-care testing (explored in Chapter 13: Aboriginal and Torres Strait Islander people), mobile testing in areas with potential outbreaks, and wastewater testing provided important evidence to support efforts to curb the spread of the virus.[875] COVID-19 detection in wastewater allowed public officials to target public health messaging (especially in communities where the virus was newly detected or was increasing in volume) and helped identify infection rates regardless of symptoms or testing uptake, and detect new variants on aircrafts.[876]

In the first two years of the pandemic, Australia relied on PCR tests for its surveillance of the virus, and PCR use was mostly unrestricted. Other countries went further. The United Kingdom, for example, randomly sampled the population regardless of symptom status as part of its monitoring of the virus in the community. The data gathered assisted the UK government to make more reliable estimates of infection rates across the community, and in relation to self-reported measures such as mask wearing and vaccination status.[877] The panel heard that the Australian approach over-relied on self-presentation for PCR testing or RAT self-testing for its COVID-19 surveillance, and that use of random sampling to measure underlying infection rates would be of great benefit in future.[878]

Collection of positive test data was useful to support decision-making at all levels of government.[879] It also meant that daily COVID-19 case numbers could be reported to the Australian public (see Chapter 11: Communicating in a crisis). Testing was most useful at the start of the pandemic to identify and monitor outbreaks, help suppress transmission and respond to local outbreaks.[880] Close contacts could be identified and quarantined, often before they could become infectious, to limit onward transmission. However, the effectiveness of testing waned over time as the virus became more prevalent in the community and the incubation period shortened.[881] With the arrival of the Delta wave in mid-2021, more close contacts were already infectious before they knew they had been exposed to an infectious person and could be quarantined.[882]

3.1.2. Tracing

COVID-19 tracing was done in parallel with nationwide testing efforts and was integral to Australia's suppression strategy. It helped identify priority populations where transmission rates were higher because of things like occupation, location and nature and level of social mixing. Like testing, tracing efforts varied in consistency across waves and across jurisdictions.

There were positive stories of engagement between all levels of government in this area. For example, the Department of Health funded and coordinated epidemiologists to be seconded to state and territory health departments to help analyse contact-tracing data, quality and transmission.[883] However, we also heard stories where there was not enough engagement. People with expertise wanted to help but found a closed door – there was no way they could use their training and experience to help.[884]

Some groups noted difficulties with the states' varied approaches to contact tracing.[885] For example, the definition of 'close contact' changed at different stages across the pandemic.[886]

The Australian Government launched the COVIDSafe app on 26 April 2020. The app was developed to help state and territory health officials with manual contact tracing and contribute to an automated contact tracing system that was faster and more effective and efficient.[887] The app had almost eight million registered users, but evaluations found that it created a heavier workload for contact tracers and public health staff, with no notable benefit.[888] Also, there were public fears about the privacy of information being tracked through the app. Many were concerned that law enforcement might be able to access tracing data. We heard these sentiments clearly expressed in public consultation.[889] Broader concerns around data privacy during a health emergency are discussed in Chapter 5: Trust and human rights.

Genome sequencing of the virus was predominantly organised at jurisdiction level. This allowed for targeted public health control measures and outbreak identification.[890] Stakeholders expressed support for AusTrakka, which helped achieve national surveillance of SARS-CoV-2 and demonstrated the benefit of national genomic surveillance.[891] We also heard from some stakeholders there remains a need for a long-term strategy for advancing viral genomic surveillance and consolidated guidelines to inform interoperability in a pandemic.[892] The panel heard there remains room for strengthened connectivity between different laboratory information systems, particularly between the public and private pathology sectors.[893]

Several contact tracing reviews have been conducted, including by the Victorian and Western Australian governments.[894] The National Contact Tracing Review, released in November 2020, made 22 overarching recommendations, but the status of their implementation remains unclear.[895] Not all recommendations remained relevant as systems improved, or as operations changed as Australia moved into different phases of the pandemic. However, a number of the recommendations should be implemented because they will be important during and ahead of a future health emergency. For example, public consultations have identified as critical to Australia's future health emergency capability the need to ensure sufficient surge workforce capacity in the public health sector, the importance of undertaking regular contact-tracing stress tests, and the development of an interjurisdictional data exchange pilot that would

support a level of interoperable data.[896] The data-sharing recommendation in particular was independently supported by August 2021 advice from the National COVID-19 Health and Research Advisory Committee on the need for integrated data systems.[897]

3.1.3. Isolation

Along with testing and tracing, isolation measures helped to reduce transmission of COVID-19 and limited the risk of unknown contacts, who can be harder to trace.[898] Australian research found the combination of testing, tracing and isolating, along with quarantining of close contacts, was critical in supporting the national suppression strategy before the Omicron variant emerged in November 2021.[899]

However, we heard that measures requiring individuals to isolate were in place for too long, and evidence supporting prolonged isolation after symptoms had cleared, or lengthy quarantine for those who never went on to develop an infection, was not clearly communicated to the Australian public.[900]

The need for individuals identified as close contacts to self-isolate also had a negative impact on the operations and financial viability of some businesses.[901] Impacts on businesses are explored in Chapter 20: Managing the economy. Also, we heard isolation policies had inequitable impacts, particularly for those living in poor or overcrowded housing.[902] These impacts are explored in Chapter 17: Homelessness and housing insecurity and Chapter 14: Aboriginal and Torres Strait Islander people. Isolation measures are further explored below, in section 3.3 Population-level non-pharmaceutical interventions.

3.2.Infection prevention and control

During the first six months of the pandemic, infection prevention and control practices – including hand hygiene, cough etiquette and use of PPE, including masks – were introduced in stages across Australia. PPE use in particular was first introduced in high-risk settings and later in the community in a bid to help reduce the spread of COVID-19.[903] In healthcare settings there was pre-existing experience with effective infection prevention and control use. However, that was not always the case in other high-risk settings – for example, residential disability and aged care – and rarely so in the community.[904] PPE shortages also impacted the effectiveness of infection prevention and control practices, creating challenges for Australia's pandemic response. Supply shortages are further discussed in Chapter 12: Broader health impacts and Chapter 22: Supply chains.

Participants in an Inquiry roundtable spoke of the innate challenges in delivering the level of infection prevention and control required in a pandemic in a wide range of environments, including those that are primarily designed as residences rather than clinical settings.[905] Evidence-based best-practice approaches should be designed to work in all settings.[906] The guidance available to support infection prevention and control varied in quantity and across jurisdictions.[907]

The panel overwhelmingly heard that, especially in the early days of the pandemic, workers in the care and support sector, as well as those in other high-risk settings such as hotel quarantine, received limited training or advice on how to correctly use PPE.[908] This increased the risk of exposure for the user, those they cared for, their close contacts and the wider community.

We heard in focus groups that members of the general public supported the promotion of hygiene behaviours.[909] Up to 96 per cent of Australians who responded to a national survey by the Doherty Institute in April 2020 said they were applying personal hygiene measures to protect themselves and others from COVID-19 infection.[910] At that time, in April 2020, people had a high level of awareness of the risk and consequences of COVID-19 infection.[911] However, this level of support changed over time as adherence to mask mandates diminished, particularly when the benefit of some requirements became less clear (for example, wearing masks at all times, including outdoors, when not in the company of others). As discussed in Chapter 5: Trust and human rights, a barometer study by the Department of the Prime Minister and Cabinet's Behavioural Economics Team of the Australian Government between March and June 2020 found there was a general decline in compliance with protective behaviours.[912]

Encouragement of mask use during the pandemic changed with increased transmissibility of the succession of variants, greater understanding of how COVID-19 was transmitted, and emerging evidence from studies on mask use undertaken during 2020 and 2021.[913] However, the evidence on the effectiveness of mask wearing in community settings was and still is variable. A Cochrane review published in January 2023 did not find evidence that masks were effective, and this was criticised when it was misinterpreted as evidence that they do not work.[914] The argument was that they do work; people just don't wear them properly. This highlights the importance of trialling interventions in the real world to test whether they work in practice, not just in theory.

The World Health Organization's 1 December 2020 recommendation on the use of masks was based on new, but limited, evidence of the effectiveness of masks in community settings.[915]

On 8 January 2021, based on recommendations by the Australian Health Protection Principal Committee, National Cabinet agreed on the mandatory use of masks on all flights and in airports.[916] This aligned with the recommendations on masks from the World Health Organization. Research indicates the risk of COVID-19 transmission is lower on a plane compared with other indoor spaces due to a combination of mask wearing, improved air ventilation and filtration.[917]

A 2022 international systematic review found that, while the use of masks, especially particulate filter respirators, had been shown to be effective against infection in healthcare settings, there was 'a substantial lack of evidence on the comparative effectiveness of mask types in community settings'.[918] Other studies on masks from 2015 and 2020 suggested that masks had varying levels of effectiveness in the community partly because of improper use, re-use and low mask quality (in cloth-based and some surgical masks).[919]

Mask wearing had varying levels of effectiveness for children. Victorian data showed that children aged eight to 11, who were required to wear masks under state orders, had higher infection rates than those aged five to seven, who were not required to wear masks and had previously had the same infection rates. The older children wearing masks also had higher recent vaccination uptake, so would be expected to have had lower infection rates than the younger cohort during this term.[920]

3.2.1. Mask mandates

We heard that, when states and territories began to introduce community-wide mask mandates progressively from mid-2020, there was a lack of clarity, consistency and evidence around when to wear one and why; what type to wear; and how to don, wear and remove face masks safely.[921] The implementation of mandates also varied across states throughout the pandemic.[922] This caused confusion and started to erode public trust.

> *There were many examples of inconsistencies in policies between jurisdictions which hindered the public health response. When different advice and policies were in place, such as mask mandates and venue capacity limits, the public messaging was undermined. – Australian Medical Association*[923]

Notably, the Australian Health Protection Principal Committee did not give public guidance on the role of face masks to protect individuals and the community from COVID-19 until 15 November 2021.[924] That was 10 months after National Cabinet agreed on the mandatory wearing of masks on domestic flights.[925]

Participants in Inquiry focus groups said that their decision to wear a mask or not depended on accessibility – where people could not access free masks, they were less likely to wear one.[926] The Australian Institute of Health and Welfare estimated individuals spent $223.7 million on PPE and respirators between 2019–20 and 2021–22.[927] The Inquiry's focus groups heard mask mandates did not account for those with asthma or breathing difficulties, or with a sensory disability who relied on lip reading or smell. A few participants reported feeling 'stressed', 'concerned' and 'panicked' at being 'abused' or 'yelled at' by strangers for not wearing their masks for these reasons.[928]

We heard of challenges in finding the correct mask size; and ear pain and skin irritation from extended and frequent mask wearing.[929] Many Australians experienced these challenges, but they affected those working in the care and support sector, who were required to wear them for extended periods, the most.[930]

When mask mandates were first introduced, there were not enough of the recommended N95 masks available even for healthcare and other frontline workers.[931] In healthcare settings, masks are tested to fit properly so they have the most benefit. This testing was standard practice in some countries but not in Australia.[932] Stakeholders across a range of sectors identified difficulties in accessing appropriate PPE, particularly at the start of the pandemic.[933] This experience is further covered in Chapter 12: Broader health impacts, Chapter 18: Older Australians, and Chapter 16: People with disability.

3.3.Population-level non-pharmaceutical interventions

Non-pharmaceutical interventions imposed at population level were also important in limiting COVID-19 transmission. Interventions such as restrictions on public gatherings, banning of certain activities, social distancing in public places, closing of certain venues and lockdowns were introduced intermittently from early 2020 to supplement the international border closure, and isolation, quarantine and contact tracing measures.[934]

The introduction of non-pharmaceutical interventions meant that, even with the virus being able to breach border controls, throughout 2020 Australia maintained lower reported rates of COVID-19 cases and deaths compared with other countries – for example, the United Kingdom, United States and Sweden, which did not implement the same types and levels of public health measures.[935] Up to the end of 2020, Australia had 29,118 total COVID-19 cases reported, a test positivity rate below 5 per cent and fewer deaths overall (from all causes) than expected for that year.[936]

Some told us that, for the first few months of the pandemic, the Australian Health Protection Principal Committee and National Cabinet clearly explained the purpose of isolation, lockdowns and social distancing measures, and there was a broad understanding that decisions changed because of new and changing evidence.[937] All jurisdictions were aligned in this aggressive suppression approach, and the relative consensus among National Cabinet and Australian Health Protection Principal Committee members was reflected in clear public communications. This was not the case further into the pandemic, when jurisdictional differences in approaches and communications started to become apparent (see also Chapter 4: Leading the response and Chapter 11: Communicating in a crisis).

Decisions made in the alert and suppression pandemic phases were supported by early evidence such as theoretical modelling released by the Doherty Institute on 7 April 2020. The modelling showed how non-pharmaceutical interventions such as quarantine, isolation and social distancing could work to slow the rate of transmission.[938] On 26 June 2020 the Australian Health Protection Principal Committee also released evidence on the benefits of physical distancing and person density restrictions and continued to support the policy decisions that the Australian Government and National Cabinet were making.[939]

However, as the pandemic wore on, it became less clear what evidence was being used to support the continued use of these measures. We heard in Inquiry focus groups that, while general support for social distancing measures remained, there was no clear guidance on the application of social distancing in different settings, such as schools, and a limited understanding of the rationale for specific parameters, such as attendance limits for gatherings.[940] We heard this was seen particularly from the Delta wave in 2021, when consistency of messaging went out the window, adding to public confusion and uncertainty.[941]

We heard leaders did not clearly explain the evidence that supported ongoing enforcement of measures such as prolonged isolation or lockdowns as the pandemic response progressed and vaccinations became available, particularly when in place for extended periods of time, such as in Melbourne.[942]

We heard from one stakeholder that Australia generally took an approach to non-pharmaceutical interventions where there were blanket measures, where everyone was subject to them unless they had an exemption.[943] They said this was better than the approach taken by countries such as New Zealand, where measures targeted high-risk groups or occupations rather than the entire population.[944] In some settings, both approaches were utilised – for example some outdoor ball games were permitted in Victoria during the second lockdown, whilst others were not, with no clear logic behind these decisions.[945] These approaches were based on behavioural assumptions and we heard from some that behavioural science was underutilised and under-researched in the Australian pandemic context.[946]

We heard research capability and expertise outside government was not fully leveraged to complete real-time evaluation of these measures or the general impacts of COVID-19.[947] We heard that research and modelling were being undertaken in the private sector, but there was not always a clear pathway for researchers to feed this into policy decision-making.[948]

Health and economic modelling were integrated to inform Australia's transition away from reliance on non-pharmaceutical interventions under the National Plan to Transition Australia's National COVID-19 Response; however, this did not occur until late in the pandemic.[949] This is further discussed in Chapter 20: Managing the economy.

The delay in the creation of a national exit pathway, along with the severity, uncertainty and longevity of measures, affected the mental health and wellbeing of many Australians – this was especially so for older Australians, younger people, people with disability and people with existing mental ill-health.[950] The panel also heard that people from culturally and linguistically diverse and Aboriginal and Torres Strait Islander communities were affected by the disruption of cultural practices and norms.[951] Notably, the National COVID-19 Health and Research Advisory Committee advised the Australian Government about the mental health impacts of quarantine and self-isolation in May 2020.[952] However, it is unclear whether these impacts were appropriately considered as the pandemic wore on. This is further explored in Chapter 12: Broader health impacts and the Equity section. Human rights impacts are explored in Chapter 5: Trust and human rights.

> *While public health responses including lockdowns, border closures, and strict visitation regulations in health were important, especially at the outset of the pandemic, there have been and continue to be many detrimental mental health and social impacts that continue to be acutely felt by many people, particularly those from vulnerable communities. – Australian Nursing and Midwifery Federation*[953]

During the pandemic the stringency, length and frequency of lockdowns around Australia had broader social and economic impacts as well as indirect health impacts. Support from government in the form of financial supplements such as JobKeeper and the Coronavirus Supplement supported compliance early in the pandemic, enabled people to stay home and helped limit disease transmission.[954] The role of economic measures in supporting public health measures is further discussed in Chapter 20: Managing the economy.

Some stakeholders told the panel that the level of resilience of a jurisdiction's health system had a bearing on state leaders' decision-making on lockdown measures. Where a state leader was nervous about the capacity of their public health system to manage COVID-19, lockdowns and hard border closures were more likely to be implemented.[955] However, as mentioned previously, this was not clearly communicated to the general public.

We heard that lockdowns have lost credibility with the Australian public.[956] This is particularly the case in Victoria. The city of Melbourne was kept in lockdown for 112 days in the second wave in 2020.[957] The final 30 days of that lockdown had either single-digit case numbers or zero cases reported, and most were contacts of known cases in quarantine.[958] This is one of the few examples globally of an extended COVID-19 outbreak where the virus was eliminated through the application of non-pharmaceutical interventions. For more than half of the latter part of that wave, most cases were directly linked to aged care facility outbreaks.[959] The rest of the population were kept in lockdown to reduce the risk of outbreaks spreading back into the community via workers or their household contacts.[960]

Use of statewide lockdowns where there had been no recent cases outside a capital city, rather than localised lockdowns, contributed to the loss of credibility. Advice to the Chief Medical Officer from the National COVID-19 Health and Research Advisory Committee on 30 July 2021 synthesised the benefits of localised short-term lockdowns to manage COVID-19 outbreaks.[961] South Australia successfully used a short, sharp lockdown to contain transmission after a person crossed into the state who was unknowingly infectious with the Delta variant, preventing a large outbreak (which was contained within a few chains of transmission, compared with New South Wales and Victoria, which never succeeded in getting back to zero cases).[962]

In deciding the national path to opening, National Cabinet agreed on 2 July 2021 that lockdowns were only to be used as 'a last resort'.[963] However, shortly after, stringent lockdowns were introduced in Victoria (and they were already in place in New South Wales), and they remained until vaccine targets were met and Australia began to open up.[964] All other jurisdictions apart from Tasmania also relied on lockdowns of varying length to control transmission in this period.

We heard that, in future, Australians will only have an appetite for short, sharp lockdowns, if any at all, and there would probably be decreased public compliance.[965] Some emphasised the need for established parameters for measures such as lockdowns, including de-escalation pathways.[966] The Inquiry conducted a nationally representative survey that found the top factors that would help respondents comply with future public health measures were a clear reason for restrictions and a belief they were justified.[967]

Desensitisation due to lengthy lockdowns[968]

Frederico* lives in a local government area (LGA) in Sydney that was "in constant lockdown". He was "lucky" because he managed to work from home, but his partner lost his job. They managed to make ends meet, especially with his partner qualifying to receive the JobSeeker payment for which they were very grateful. They felt "psychologically trapped" as the restrictions were very stringent. He felt that people around his area eventually broke the rules because the restrictions kept going for so long (he thought it was for around a year) and became desensitised to threats of fines. He felt that people living in the LGA were unfairly portrayed as being "bad people", were constantly chastised for breaking the rules by politicians and the media and that there was little understanding shown to "vulnerable people who needed to work". While he supported the need for local targeted lockdowns to control disease spread, he felt that when it turned into a "never ending lockdown", the effectiveness of the measure weakened.

3.3.1. Built environments

An important element of resilience and preparedness is the ability to easily modify indoor environments to manage disease transmission risk, especially in high-risk settings including hospitals, aged care, congregate living facilities, or where people have extended indoor exposure to people from outside their home, including educational settings and workplaces. In aged care residential facilities, designs that enable segments of the resident community and staff to be cohorted can allow infection prevention and control and levels of risk tolerance to be managed without employing blanket restrictions over the entire facility.

Appropriate ventilation and air management is another non-pharmaceutical intervention that needs further attention to determine its contribution to resilience against airborne disease pandemics, especially in high-risk settings such as aged care. There are efforts currently underway to determine the safety, feasibility and effectiveness of interventions to improve air quality, such as ultraviolet light and air filtering, to reduce the transmission of viruses.[969] The importance of ventilation in reducing the risk of transmission of the virus was a feature of several submissions and discussions.[970] Some stakeholders advocated for the creation of an Indoor Air Quality Taskforce that could give guidance on potential reforms to work health and safety regulations.[971]

Research commissioned by the Office of the Chief Scientist indicates that the science on ventilation as a control to help stop the spread of COVID-19 is still emerging. The systematic review suggested that, before infection control benefits can be used to stipulate codes, further research is needed to assess the viability of viruses moving through ventilation systems and the translation to impact on infection risk and health outcomes.[972]

We heard one randomised control trial conducted in New South Wales in 2023 found placement of an air purifier with a HEPA filter in residential aged care was not associated with a statistically significant reduction in risk of respiratory tract infections, but also could not rule an association out based on their data.[973] This area of research is complex and requires further investigation to properly evaluate clinical effectiveness against the opportunity costs of not

investing in other infection control measures that have already been shown to be clinically beneficial and cost-effective.[974]

The use of experts and generation of evidence during the pandemic

Governments across Australia relied on health research and modelling to assist in decision-making on the implementation of public health measures. Because of the significant demand for information and real-time analysis throughout the pandemic, the Australian Government invested early in mathematical modelling from the University of Melbourne, led by the Doherty Institute, to inform the public health response.[975] As part of this investment, experts were invited to participate in Australian Health Protection Principal Committee deliberations. The Australian Government also invested $130 million, as at December 2022, through the Medical Research Future Fund in basic, clinical and public health research.[976] Several Australian Government forums were convened to rapidly synthesise data and emerging evidence – for example:

- Rapid Research Information Forum, which was established in early 2020 and is still in operation[977]

- National COVID-19 Health and Research Advisory Committee, which operated between April 2020 and March 2022[978]

- COVID-19 Vaccines and Treatments for Australia – Science and Industry Technical Advisory Group, which operated between August 2020 and December 2023.[979]

The pandemic drove innovations in data collection and analytics, in part fuelled by the huge appetite for statistics of both decision-makers and the public. The Australian Government, in collaboration with states and territories, created new data systems such as the Critical Health Resources Information System, established on 1 May 2020.[980] This system gave a real-time view of the capacity of every intensive care unit across Australia, providing invaluable information to decision-makers.

In-house data and analytics expertise in Australian and state and territory governments were bolstered by additional capability from the private sector, including from the Quantium Group.[981] This work informed strategic and operational decisions and also provided data interpretation and visualisation to inform the public. For example, the Common Operating Picture, which commenced in August 2020, gave an infographic of the COVID-19 situation across Australia.[982]

The response to COVID-19 was the first major public health response that placed significant emphasis on health modelling. At the outset, modelling was used for 'worst case' forecasting of the possible impact on Australia's health system and the need for intervention.[983] It remained a main form of evidence behind public health measures and was often communicated alongside announcements.[984] The emphasis was on case, hospital and death counts, and then modelling. However the bulk of analytic epidemiological techniques that normally form the backbone of outbreak responses and risk assessments, and provide parameter estimates to modellers, were rarely seen.[985]

We heard there was a lack of coordination among modelling teams and research experts and inadequate strategic setting of research priorities. This led to a fragmentation of research efforts.[986] There were also significant issues with the quality, interoperability and sharing of available data for research, and this varied by jurisdiction.[987] Researchers often relied on international data that did not necessarily reflect the risk profile in Australia, particularly when data lacked sufficient detail or was obstructed by lengthy data access or ethical approval processes.[988] We heard data linkage is essential for monitoring transmission risk and the effectiveness of non-pharmaceutical interventions in place.[989] Pre-agreements on data access and ethics protocols in a crisis would enable faster development of evidence and evaluation of interventions.

Many from the research sector were critical of the Australian Government's reliance on already-engaged expertise.[990] Stakeholders at an Inquiry roundtable noted that 'if the wider modelling community was engaged earlier in the pandemic response, they could have brought a greater range of modelling expertise to the advice provided to policy makers and helped influence the data collection and accessibility needed to support modelling to meet the needs of policy makers'.[991]

We heard decision-makers and the media did not properly understand health statistics and modelling, which led to evidence being ignored or misused on occasions to defend policy decisions.[992] We heard that the lack of transparency blurred the line between politics and science.[993] Some researchers and modellers were cautious to take on work or are still suffering the track-record disruption consequences of doing so, because the government controlled the release and publication of data. This would negatively impact their research outputs and publications and, ultimately, their careers.[994]

The panel heard some of the reasons behind the reluctance to share analyses, particularly those that are sometimes described as 'quick and dirty' in the field to rapidly assess an outbreak situation to initiate a response when every hour counts.[995] The concern was that published preliminary analyses might end up being over-scrutinised and criticised out of context.[996]

Throughout the pandemic scientific experts were called upon to provide opinions on and explain the evidence behind government decisions to the general public. Due to the nature of science and the evolving evidence base in the pandemic, some experts had conflicting views on how evidence should be interpreted or applied.[997] We heard the media often highlighted areas of scientific disagreement rather than where there was consensus, contributing to public confusion and distrust.[998] The role of experts in pandemic communications is further explored in Chapter 11: Communicating in a crisis.

During the pandemic there were significant innovations and skill development in research, risk communication and modelling. It is critical these capabilities are maintained.

4. Evaluation

Australia showed agility in taking a precautionary approach and mobilising an early national response

Australia's geography gave us a natural advantage in delaying the arrival of COVID-19 in our community, and the policies brought in to buy time ahead of the introduction of vaccination or treatment undoubtedly saved many lives. The questions we must ask are of the proportionality of the response, and whether we collected sufficient data to inform, evaluate and de-escalate measures with minimum collateral damage, had the appropriate mitigations to minimise harm when unavoidable, and considered the preservation of the dignity of individuals.

Australia's response was arguably at its most coordinated and effective in the earliest stages of the pandemic. Had Australia not closed the international borders and imposed a national lockdown as quickly as we did, community spread would have overwhelmed most public health departments, which had yet to gear up to respond, and we would have been in the same situation as other countries around the world, with community-wide transmission from the outset. Non-pharmaceutical interventions held the ground until the vaccine rollout could be completed.

The quick action from research and pathology sectors to develop tests for COVID-19 also enabled early surveillance of the virus in Australia. Testing was critical in managing a virus where people could be infectious even before they developed symptoms. All levels of government are commended for ensuring COVID-19 tests remained free to the public through the acute emergency phase; and for supporting innovations such as genomics and wastewater testing in our disease surveillance infrastructure, which enabled effective tracking of the virus.

The panel also commends innovations in mobile and remote point-of-care testing. These measures played a critical role in mitigating the risk of potential outbreaks by providing rapid test results, particularly in rural and remote communities. They enabled a quick release of positive as well as negative results, enabling individuals to isolate only as long as necessary.

Varying approaches across jurisdictions and settings undermined trust in public health measures

It was necessary for states and territories to tailor responses based on the level of disease and risk in their communities. However, as the pandemic wore on, varying approaches across jurisdictions and over time caused confusion and likely reduced adherence to public health measures.

Self-quarantine rules for contacts of cases identified in contact tracing varied between jurisdictions, as did mandatory COVID-19 testing, particularly as a prerequisite to interstate travel. Travel prerequisites also placed unnecessary stress on the public health system, particularly during periods of high COVID-19 transmissibility. Worryingly they also had the potential to increase the risk of disease spreading across borders, as well people who were getting a test to travel (including those who had been shielding themselves from exposure in the lead-up to travel) were exposed to symptomatic individuals also waiting to test at that same

testing site. Nationally agreed testing, tracing and isolating principles, including identification of what determines an appropriate level of testing under pandemic conditions, need to be in place before the next pandemic to optimise the use of testing, increase national consistency, and manage the burden on pathology services.

Mask mandates were also applied inconsistently. The reason behind their enforcement was not clearly communicated to the community, particularly when people were requested to wear masks outside at all times. The UK population-based REACT-1 studies found lower infection rates among those who reported wearing masks, but we also heard that in public communications there was a lack of clarity and evidence on their efficacy, and this affected adherence.[999] This was also true as jurisdictions transitioned away from public health orders if changes in exposure risk, or risk from infection, were not clearly communicated.

Another critical gap in Australia's pandemic response was the lack of consistent national guidance on the appropriate use of infection prevention and control in both health and community settings – in particular, guidance on the use of PPE. In quarantine settings, the absence of appropriate training for staff on the use of infection prevention and control was a significant vulnerability. Also, in healthcare settings, the absence of nationally consistent guidelines limited the capacity for workforce mobility and the ability to redeploy staff in a crisis.[1000] Pre-prepared living guidelines that can be rapidly adapted for a particular infectious disease, and infection prevention and control training in high-risk settings, form the first line of defence against disease transmission.

Perceived effectiveness of public health measures was undermined by a lack of clear and consistent communication

Changing evidence is a challenge for policymakers and the public. The evidence for many interventions, such as social distancing and lockdowns, was not developed at the beginning of the pandemic. Knowledge about the virus evolved as time went on. The characteristics of the virus itself also changed as successive variants emerged with different levels of infectiousness and immune escape properties, and these were studied in detail, documented and factored into the response. This level of evaluation was not seen for non-pharmaceutical interventions.

As Australia moved into aggressive suppression in the wait for a vaccine, there was no communication of non-pharmaceutical intervention evaluations in the Australian context, and only limited evidence updates on their use in the community overseas. Also, there were no adjustments to control measures to suggest systematic evaluation was occurring behind the scenes. Effectiveness was inferred from overall reported case numbers, but this is a very limited approach to evaluation and did not reveal which particular non-pharmaceutical interventions were effective and whether the stringency settings were right. The lack of real-time measurement of unintended impacts, including on health, mental health, education and economic security, meant these could not be considered by decision-makers, and therefore there was no ongoing monitoring of proportionality of responses.

While other countries became more nuanced in their response, some Australian jurisdictions tended to escalate and broaden measures over time. Interventions such as lockdowns must

only be used as a last resort, not as a frontline disease control measure. Clear national guidance is needed on when such restrictive measures are indicated, and triggers for escalation and de-escalation. It became clear that factors including concerns over health department capacity and capability were behind some decisions on harsh measures, but this was not communicated to the public, undermining trust in the information that was being shared by government. It is understandable to not want to add to public anxiety by announcing weaknesses in the public health response, but it does not pay to underestimate the media's and the public's ability to see through 'smoke and mirrors'.

Some have said that some rules (curfew and 5 km limits being the most controversial) were implemented so that adherence to other social isolation measures could be policed.[1001] However, these measures were packaged together with other public health measures, leading to doubts about the validity of all measures being proposed when evidence could not be procured to defend measures when questioned.

Assumptions were also made about human behaviour and social needs that were neither evidence-based nor evaluated in real time. For example, it was thought that people would find it easier to remember to put a mask on as soon as they left their house rather than remember to carry it with them and put it on when entering a public indoor space, and this was what led to a rule on wearing masks outside. Real-time evaluation that goes beyond case counts and population-level data modelling is essential to guide non-pharmaceutical interventions used in pandemics to ensure they are used effectively without introducing extra burden and inconvenience that may not alter infection risk but may reduce overall adherence. Behavioural science must have a more prominent advisory role in future pandemics.

It also became hard to understand how interventions could be evidence based when they differed across state borders where pandemic conditions were similar. Public trust is vital during a pandemic, and misinformation can quickly fill the void where there is limited sharing of evidence[1002] (see also Chapter 5: Trust and human rights).

A more complete picture of the dynamics of the virus could have been achieved using a more targeted approach to gathering epidemiological data in the community, akin to the REACT-1 surveys in the United Kingdom.[1003] This would generate more detailed insights into predictors of infection, asymptomatic carriage, disease severity, disease persistence, and death, as well as testing and non-pharmaceutical intervention adherence. Such approaches would generate more reliable parameters for statistical modelling, and provide the essential real-time data for evaluating interventions, and monitoring for unintended adverse events.

The use of genomics to assist in outbreak investigations was a great advance, although at times where the relatedness of cases was of great public interest to help understand the dynamics driving an extended lockdown, for example, genomic information was either not reported or not helpful. We also did not hear of its use in monitoring trends beyond the successions of variants in the community. Genomics has the potential to assist in determining whether new variants are more likely to cause severe disease – for example, if found to be over-represented in people in hospital compared with the general community. This was the first time genomics

have been used at scale, and we are only scratching the surface of how they might contribute to future pandemic responses. It is important that advisory structures integrate this technical expertise to maintain and extend this capability.

Australia's response to the pandemic would have been better supported with a stronger, more established evidence base, equipped with near real-time national surveillance data and data linkage to generate intelligence for evidence-based policy decisions and ongoing evaluation of measures. To achieve this, research and surveillance infrastructure, as well as data linkage capability, must also be strengthened for actionable insights into broader health, social and economic impacts of public health measures. The Australian Centre for Disease Control has a critical role to play in consolidating and coordinating the multiple threads of research, modelling and data analytics and evidence synthesis needed in a pandemic (see COVID-19 Response Inquiry Report Summary – Australian Centre for Disease Control).

As we saw in COVID-19, jurisdictions had different experiences of the virus, and a state with no virus circulating will be looking to others that do to learn what works and what does not. With good quality enhanced surveillance data in a pandemic, models can take what is being learned in real time from one state and apply this to the transmission potential profile of another so that they can understand how an outbreak could play out in their community.

There were significant evidence limitations during the pandemic that must be addressed ahead of a future public health emergency. Relying largely on international evidence to inform our policy decisions is not good enough. There was also insufficient leveraging and coordination of the wider research community across Australia.

Public trust would have been improved if there had been greater interpretation and public communication of evidence that supported decision-making. Transparent advice and a trusted and respected source of information for both health practitioners and the wider public would have been of great value.

More broadly there is a role for the Australian Centre for Disease Control to play in increasing Australia's health data literacy. It is important to help media, industry and the general public to understand the sometimes tenuous relationship between testing and case counts, or what hospital counts actually mean. This is particularly relevant in a pandemic because changes in testing practices can lead to changes in case reporting that can be misleading. For example, providing RATs to families played an important role in building confidence to send kids back to school, but it meant school children were testing more systematically and infection detection rates went up, including mild infections that would otherwise go undetected. This can create the illusion that infection rates are rising when it is really the detection rate that is changing.

Non-pharmaceutical interventions came with individual and system-level impacts

Although non-pharmaceutical interventions helped suppress community transmission, they also carried notable social, economic and personal costs. The extended duration of many measures and uncertainty about end dates further exacerbated the negative impacts. This was true at the

individual level, and also at system level where employers and business owners were left guessing when significant restrictions might ease.

The delay in the procurement and implementation of RATs also carried system-level impacts by slowing the easing of testing burden on a strained pathology sector. The Australian Government must prioritise the evaluation and approval of self-tests as soon as practicable in a future health emergency.

Public health interventions were not always equitable in design, and their impacts were invariably inequitable. Efforts were made to support access to testing for all Australians, particularly for people with disability and older Australians, but there were often too few tests to meet their needs for self-testing and screening visitors and carers. People found it difficult to access general health care and support services that had a negative test threshold for entry. Once the free test allowance was used, basic services could become inaccessible if paying for additional tests was unaffordable. Measures such as mask wearing also had inequitable impacts because of the economic costs, the ability to hear and be heard, and other disruptions to social interaction. These impacts undermine the adherence to measures, highlighting the need to ensure such measures are implemented sparingly.

Isolation and quarantine arrangements, social isolation requirements, lockdowns, border closures and other public health measures affected the mental health and wellbeing of all Australians, but they had disproportionate effects on some priority populations and on the viability of businesses. For many, such as children and people with existing mental health issues, it is very likely these impacts will be felt for some time. It is clear these impacts were not appropriately considered given these measures continued to be applied once the risk–benefit balance had shifted and proportionality was harder to argue. This must not be repeated in a future health emergency.

Noting the challenges non-pharmaceutical interventions pose to individuals and communities – especially the more stringent measures such as lockdowns – it is critical that active consideration is given to whether the interventions are proportionate or remain so. They must be recognised and protected as a finite resource to be preserved for times of greatest need.

In the course of this Inquiry, we sought out data and analyses that would tell the story of who was at greatest risk of infection and, of these, who most often ended up in hospital or died, and how this varied across the priority populations and across the phases of the pandemic – that is, if there were barriers to access to health information, health care, vaccines and antivirals, or other forms of preventable disadvantage in particular population segments in the pandemic response that we could learn from. Detailed data and analyses were not available by population segment, which shows how much work is yet to be done to build essential data linkage and real-time evidence synthesis capability.

A common response to the question of overall effectiveness of the measures discussed in this chapter, and the proportionality of pandemic policy, is to say Australia's COVID-19 outcomes (cases, hospitalisations and deaths) were not that bad and therefore did not warrant such stringent approaches. However, Australia only experienced these outcomes because these

measures were in place. When determining whether interventions were proportionate at the time, we should not add the modified outcomes into the risk equation; rather we need to balance them against the outcomes that we would have experienced without those interventions in place. Retrospective modelling to show what we avoided is limited, and has mainly focused on vaccine effectiveness. Modelling exercises using Australian data would help Australians appreciate how their efforts, and the overall response, paid off. We lost too many lives, but we also saved thousands, and this needs to be understood as we reflect on how we did.

The precautionary principle sat behind the rapid decisions to close the international border and enter lockdown. By not waiting on evidence, Australia kept the option open to follow a path of suppression and avoid community-wide transmission until people could be vaccinated and the health system could cope. However, we became locked in to this way of operating. The precautionary principle should not be applied for extended periods of time. While initially beneficial, prolonged use of an approach that is light on evidence, and does not fully evaluate interventions to ensure they are proportionate, has significant impact on their longevity as effective disease controls, and on trust in government. By staying under the cover of the precautionary principle rather than meeting evidence obligations, governments risk exacerbating the uneven distribution of benefit and harm across different population groups.

5. Learnings

- Australia was largely successful in holding the virus at the border for the better part of two years.
- The transition to community-wide transmission was delayed in Australia and was a different experience for us as a low-infection, highly vaccinated country, compared to the countries we were relying heavily on for epidemiological evidence. Country-specific data is critical to ensure relevance to our circumstances.
- The stronger our own surveillance, data linkage and dedicated real-time evaluation is, the better Australia can navigate the various phases of a pandemic.
- Early introduction of non-pharmaceutical interventions at the start of a pandemic can help curb disease spread and protect Australia's health system. However, what we still do not know is whether we had the stringency, scope and duration of these interventions right, and whether the same disease control outcomes could have been achieved with fewer negative consequences.
- Stringent non-pharmaceutical interventions, especially lockdowns and school closures, must be recognised and preserved as a finite resource for only the most judicious use. There was uncertainty about when to switch off, or step down, non-pharmaceutical interventions. Decision trees need to balance purpose, effectiveness, equity and proportionality.

- Given the significant and varied direct and indirect impacts of public health measures, the use of these measures must be built on evidence and constantly evaluated, especially in a protracted health emergency.
- There is a need for improved and consistent real-time data sharing between the Australian, state and territory health agencies, and analysis and synthesis of these data to ensure evidence-based policy decisions can be are made.
- There is a hunger for health data in a public health emergency but the Australian public is naïve on its complexities. A trusted and respected source of truth on the evidence underpinning public health measures is needed to ensure clear communication to government, healthcare professionals, the media and the general public.
- Testing and tracing regimes play an integral role in managing closed borders and in suppression strategies, but will not be feasible or effective in all situations.
- National cohesion in approaches employed, including consistency of testing and tracing protocols, rules and capability will improve the systematised collection and sharing of timely, comparable data.
- Infection prevention and control can be an effective tool to manage virus spread; however, clear guidance must be provided to ensure all Australians can access information on how to appropriately enact it.

6. Actions

6.1. Immediate actions – Do in the next 12–18 months

Action 7: Finalise establishment of the Australian Centre for Disease Control (CDC) and give priority to the following functions for systemic preparedness to become trusted and authoritative on risk assessment and communication, and a national repository of communicable disease intelligence capability and advice.

The CDC must:

- Build foundations for a national communicable disease data integration system, enabled for equity and high-priority population identification and data interrogation, with pre-agreements on data sharing, including:
    - Finalising an evidence strategy and key priorities to drive optimal collection, synthesis and use of data and evidence, address data gaps and develop linkages to public health workforce capability data. This would include:
        - identifying inconsistencies and gaps in shared data with the states and territories to prioritise for national surveillance data linkage, and upgrading existing datasets by improving data consistency and enabling data linkage readiness (see Action 11)

        - establishing technical advisory groups that bring together technical expertise as required to contribute to preparation of pandemic guidelines and rapid research-gap advice; advise on developments in their fields that should be incorporated in future pandemic detection and response strategies; assist in designing and reviewing pandemic exercises; and advise on national technical capacity and training needs. This can rapidly contribute additional expertise in a crisis
        - finalising work underway to establish clear guardrails for managing privacy and enabling routine real-time access to linked, granular data.
    - Publishing a report on progress against key priorities identified in this data strategy.
- Commence upgrade to a next-generation world-leading public health surveillance system, including:
    - commencing establishment of new comprehensive surveillance infrastructure that incorporates wastewater surveillance to facilitate disease detection and monitoring, risk assessment, national data sharing, and operating with state and territory systems to provide national updates on notifiable diseases
    - developing a plan to improve at-risk cohort data collection and linkages to ensure cohorts are visible in an emergency and responses can be appropriately tailored
    - ensuring captured surveillance data meet the analytical needs of public health responders and support rapid research and real-time evaluation
    - drafting enhanced surveillance protocols for potential use in pandemic settings, including for proactive community screening and for the cohort of first cases to monitor for persistent symptoms resulting from infection
    - enhancing early warning surveillance capability and related modelling to inform procurement planning for the National Medical Stockpile (to be undertaken by the Department of Health and Aged Care)
    - confirming linkages with New Zealand health authorities and other regional partners, and agreeing to near real-time data and intelligence sharing with them and other regional partners.
- Establish an evidence synthesis and public communications function, including:
    - support for both business-as-usual communication activity and crisis communications in a public health emergency
    - working with the Department of Health and Aged Care, NEMA and the Department of the Prime Minister and Cabinet to develop a national communication strategy for use in national health emergencies (see Action 19)

    - making communication a focus for technical advisory group input, drawing from public and private channels to provide risk communication data synthesis and behavioural and social science expertise
    - in-house expertise in evidence synthesis and communication.
- Build foundations of in-house behavioural insights capability, including:
    - mapping existing behavioural insights functions across the Australian Government with the Behavioural Economics Team of the Australia Government
    - working with experts to develop a fully scoped and costed business case for an in-house behavioural insights capability.
- Establish structures including technical advisory committees to engage with academic experts and community partners, including:
    - public reporting on work to support research and intelligence exchange with research institutes in Australia and abroad, including behavioural research, private scientists, and peak health industry bodies.

Action 11: Improve data collection, sharing, linkage, and analytic capability to enable an effective, targeted and proportionate response in a national health emergency.

This should include:

- Improvements to data collection and pre-established data linkage platforms, including:
    - delivering actionable insights regarding optimal emergency response design to ensure emergency responses can be appropriately designed, tailored and adjusted through real-time evaluation of both intended outcomes and broader impacts.
- Expanded capability in Australian Government departments to collate and synthesise economic and health data to inform decision-making, including:
    - bolstering health departments at all levels of government with public health data analytic expertise to better inform policy decisions
    - translating health statistics and information for the wider health community and general public, helping to build health data literacy particularly in pandemic settings
    - leveraging research across academia and research institutions through Australian Centre for Disease Control (CDC) technical advisory groups in key methods areas
    - coordinating and resourcing training programs in partnership with states and territories and research institutions to address gaps in applied public health

analytic and evidence synthesis expertise identified within and across jurisdictions

    - planning for how Treasury and the CDC will work together to integrate health and economic data and analysis.

- Finalising work underway to establish clear guardrails for managing data security and privacy and enabling routine access to linked and granular health data, and establishing pre-agreements and processes for the sharing of health, economic, social and other critical data for a public health emergency, including:
    - ensuring rapid mobilisation of real-time evidence gathering and evaluation
    - sharing within the Australian Government, between the Commonwealth and states and territories and with relevant sectors
    - finalising agreements by the CDC on the sharing of health data between the Commonwealth and the states and territories (also see Action 7)
    - prioritising key health data on Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities, people with disability and children and young people.

Action 16: Develop and agree principles for the transparent release of advice that informs decision-making in a public health emergency.

- National Cabinet (and other key decision-making bodies) should be more transparent in disclosing the expert advice that underpins their decisions, and the other multi-sectoral factors that must necessarily influence policy decisions.
- This should include the rationale for why decisions are being made that result in significant reduction of freedoms.
- Principles should be developed in partnership with science communication experts to ensure consideration is given to how evidence and advice can be easily interpreted given the inherent complexities and nuances.

Action 19: Develop a communication strategy for use in national health emergencies that ensures Australians, including those in priority populations, families and industries, have the information they need to manage their social, work and family lives.

The strategy should:

- be informed by behavioural science and risk communication expertise.

6.2.Medium-term actions – Do prior to the next national health emergency

Action 21: Build emergency management and response capability including through regular health emergency exercises with all levels of government, interfacing with community representatives, key sectors and a broad range of departments.

Lead by the Department of Health and Aged Care, this should include:

- exercises and stress tests for testing and contact tracing, including the utilisation of genomic surveillance across jurisdictions and analytic epidemiology capability.

Action 23: Progress development of the Australian Centre for Disease Control in line with its initial progress review and to include additional functions to map and enhance national pandemic detection and response capability.

This should include:

- agreeing standardised case definitions and reporting requirements across jurisdictions
- linking datasets prioritising residential aged care, the National Disability Insurance Scheme (NDIS), the Australian Bureau of Statistics, the Australian Taxation Office and the Department of Social Services
- undertaking pandemic response capability mapping and coordinating national training programs with jurisdictions to address capacity gaps
- acting on recommendations arising from scenario testing and post-incident reviews it has facilitated following health emergencies and through this Inquiry
- establishing a library of living guidelines for high-risk clinical, residential and occupational settings and health professions that can be readily adapted for a new health emergency. This should include nationally agreed testing and tracing principles. These guidelines should be developed in partnership with:
    - the Department of Health and Aged Care, states and territories and relevant professional bodies
    - the NDIS Quality and Safeguards Commission in relation to disability settings
- embedding behavioural insights capability to assess, refine and enhance the effectiveness of pandemic responses
- drawing on national health workforce trend data to inform advice on pandemic readiness of the health system. This would include oversight of national surge workforce capabilities and gaps to be mapped and ready to be operationalised in a future emergency response
- developing dedicated ethical guidelines and processes for national health emergencies to enable rapid review in a changed risk context and enable real-time crisis-related research, overseen by the National Health and Medical Research Council.

Chapter 10 – The path to opening up

1. Context

In Australia, in late January 2020, SARS-CoV-2 was first isolated at the Victorian Infectious Diseases Reference Laboratory (VIDRL) at the Peter Doherty Institute for Infection and Immunity, the first laboratory outside of China to do so. VIDRL shared the isolated virus with other Australian laboratories, the World Health Organization and other countries, to enable the development, validation and verification of diagnostic tests and vaccines for COVID-19. [1004]

The Australian Government's mid-2021 pathway out of the pandemic, the National Plan to Transition Australia's National COVID-19 Response, focused on maximising vaccine coverage before reopening the economy and Australia's borders.[1005] The government aimed to progressively reduce significant restrictions as vaccine and treatment options became available.

Access to vaccines was phased, prioritising those most at risk of infection and those most vulnerable if infected. Government policy encouraged people to vaccinate by using equitable measures such as subsidised access to vaccines and treatments and punitive measures such as vaccine mandates. In some jurisdictions, this included a staged reopening of non-essential venues. During the vaccine rollout phase of the pandemic, it was not as easy to control transmission using the test, trace, isolate and quarantine and non-pharmaceutical interventions measures of the initial phases. New 'variants of concern' emerged that were more transmissible and had shorter incubation periods, meaning contacts of a case were more likely to be already infectious themselves before the original case was reported.[1006] Also, the measures we had used were no longer as effective – fatigue for public health rules led to lower levels of adherence. Despite this, the total number of COVID-19 infections before and during the vaccine rollout remained low by international standards.[1007]

By the second half of 2021, when vaccines progressively became available to all Australians, millions of Australians had endured a year or more of restricted personal liberties and limited social contact. The initial hope was that the new vaccines and treatments could deliver the silver bullet, defeat the virus and return life to normal. However, this did not happen. The virus continued to evolve, and it was quickly discovered that immunity, whether vaccine-induced or from infection, diminished after a few months.[1008] Also, by 2020, longer term symptoms were being reported in more severe COVID-19 cases. It became clear that COVID-19 may have both an acute and chronic disease profile with differing health, diagnosis, treatment and management challenges.

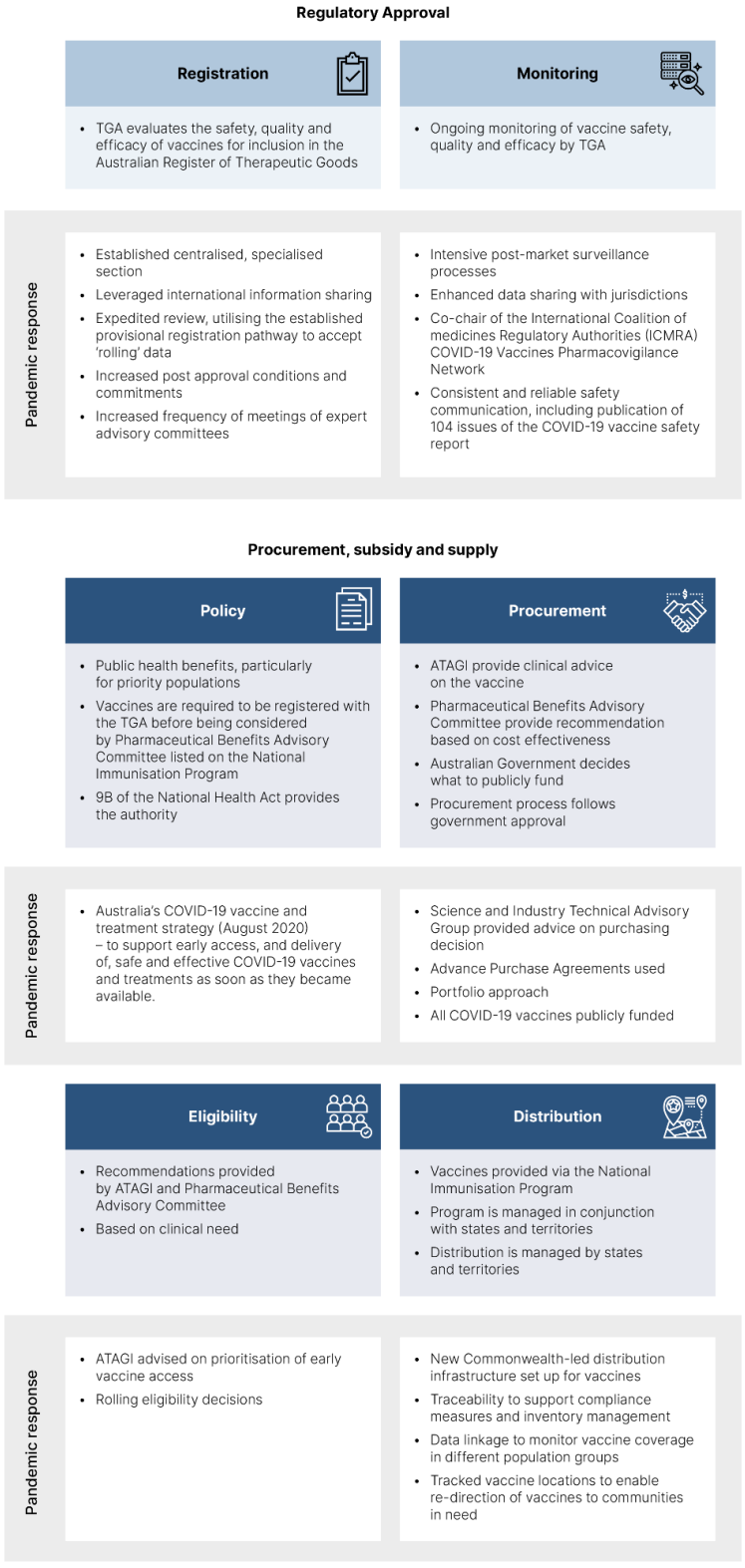
2. Response

2.1. Development and procurement of vaccines

On 12 January 2020 China published the genetic sequence of the COVID-19 virus.[1009] This enabled biotech organisations and pharmaceutical companies to develop vaccines using existing technology. At the outset, it was uncertain whether a vaccine against severe disease

and death from COVID-19 could be produced and, if it could, how long the manufacture and approval process would take.[1010]

Figure 1: Functions and advisory committees supporting the regulation, procurement, distribution and supply of COVID-19 vaccines in Australia[1011]



A variety of vaccine candidates were developed throughout 2020. Most required two spaced doses for the primary course. By mid-2020, several candidates entered clinical trials for effectiveness against severe COVID-19 infection.[1012] Countries started to enter Advanced Purchasing Agreements (APAs) with major vaccine manufacturers. From August 2020 Australia began negotiating APAs with several manufacturers, including AstraZeneca, Pfizer and Moderna, committing to a 'diverse global portfolio of investments'.[1013] Figure 1 shows the functions and advisory committees that supported the Australian Government to regulate, procure, distribute and supply COVID-19 vaccines to the eligible Australian public.

Two of the vaccines explored for purchase under the COVID-19 Vaccine and Treatment Strategy – the University of Queensland vaccine and AstraZeneca – had the potential to be manufactured in Australia.[1014] Phase 1 clinical trials of the University of Queensland vaccine in October 2020 produced false positive test results for human immunodeficiency virus (HIV) (because its technology used parts of an HIV protein, not because there was any risk of HIV to the recipient).[1015] Therefore, the University of Queensland vaccine did not proceed, under advice from the Science and Industry Technical Advisory Group.[1016] AstraZeneca went on to be manufactured domestically.[1017]

Informed by the newly established Science and Industry Technical Advisory Group and under the general guidance of the COVID-19 Vaccine and Treatment Strategy, Australia signed multiple APAs with five vaccine manufacturers from September 2020 to May 2021.[1018] Australia signed APAs several months later than comparator countries – Australia had relied on public health measures to suppress community transmission while other countries with major outbreaks secured earlier vaccine supply. For example, in July 2020, the United States, the United Kingdom and Japan all signed APAs with vaccine manufacturer Pfizer for 100 million, 20 million and 120 million doses of COVID-19 vaccines respectively.[1019] Australia committed to 10 million doses in November 2020.[1020] In March 2021 the then Prime Minister and the then Secretary of the Department of Health, Professor Brendan Murphy, publicly defended the slower arrival of vaccines into Australia by saying the vaccine rollout was not a race.[1021]

During this time, Australia's favoured vaccines were in different stages of clinical trials. In late November 2020 the AstraZeneca vaccine was in phase 3 trials and showing 90 per cent efficacy in preventing COVID-19 disease after one dose.[1022] The Novavax vaccine was in phase 2 and 3 trials and was known to prevent infection in rhesus monkeys, and Pfizer had announced its vaccine was 95 per cent effective against COVID-19 illness after phase 3 trials.[1023] At this time, there were more than 212 vaccine candidates being trialled globally.[1024]

Between early 2021 and early 2022 the Therapeutic Goods Administration (TGA) evaluated real-time data of trial outcomes when assessing provisional applications for the vaccines from AstraZeneca, Pfizer, Moderna and Novavax.[1025] The average evaluation time for provisional approval of COVID-19 vaccines was 55 days (the legislated time frame is 255 working days). The TGA achieved this in part by working closely with international regulators in places where the vaccines had been given emergency authorisations and were already being delivered to the wider community. This allowed Australia to also benefit from international real-world evidence of the safety and quality of the vaccines.[1026] Figure 1 also shows the regulatory role of the TGA

and the functions used to rapidly approve and extensively monitor the safety, quality and efficacy of COVID-19 vaccines in the pandemic.

Vaccine manufacturers had shortened the time required to determine vaccine effectiveness by conducting larger trials than usual in populations where the virus was circulating at high rates. They were able to rapidly accumulate infection outcome data in both vaccine and control trial arms and encourage high levels of participation in trials, which also allowed less common vaccine reactions to be detected. The Australian Technical Advisory Group on Immunisation (ATAGI) continually updated their advice to government on prioritisation of groups that were most at risk from COVID-19 infection and made recommendations around use of specific vaccines.[1027]

Ancestral strains were the dominant COVID-19 variants during the development of the first vaccines. Alpha and subsequent other variants of concern were already circulating globally while phase 3 trials were underway. However, when most Australians were vaccinated, the dominant variants were Delta and then Omicron. While COVID-19 vaccines were approved for preventing serious disease and death due to COVID-19 illness, researchers and manufacturers found that vaccines were less effective in protecting against infection as the virus evolved, and there was less effect in reducing onwards transmission.[1028] However, it should also be noted that overall transmission decreases when infection rates are lowered in vaccinated individuals, whether or not breakthrough infections are contagious.[1029]

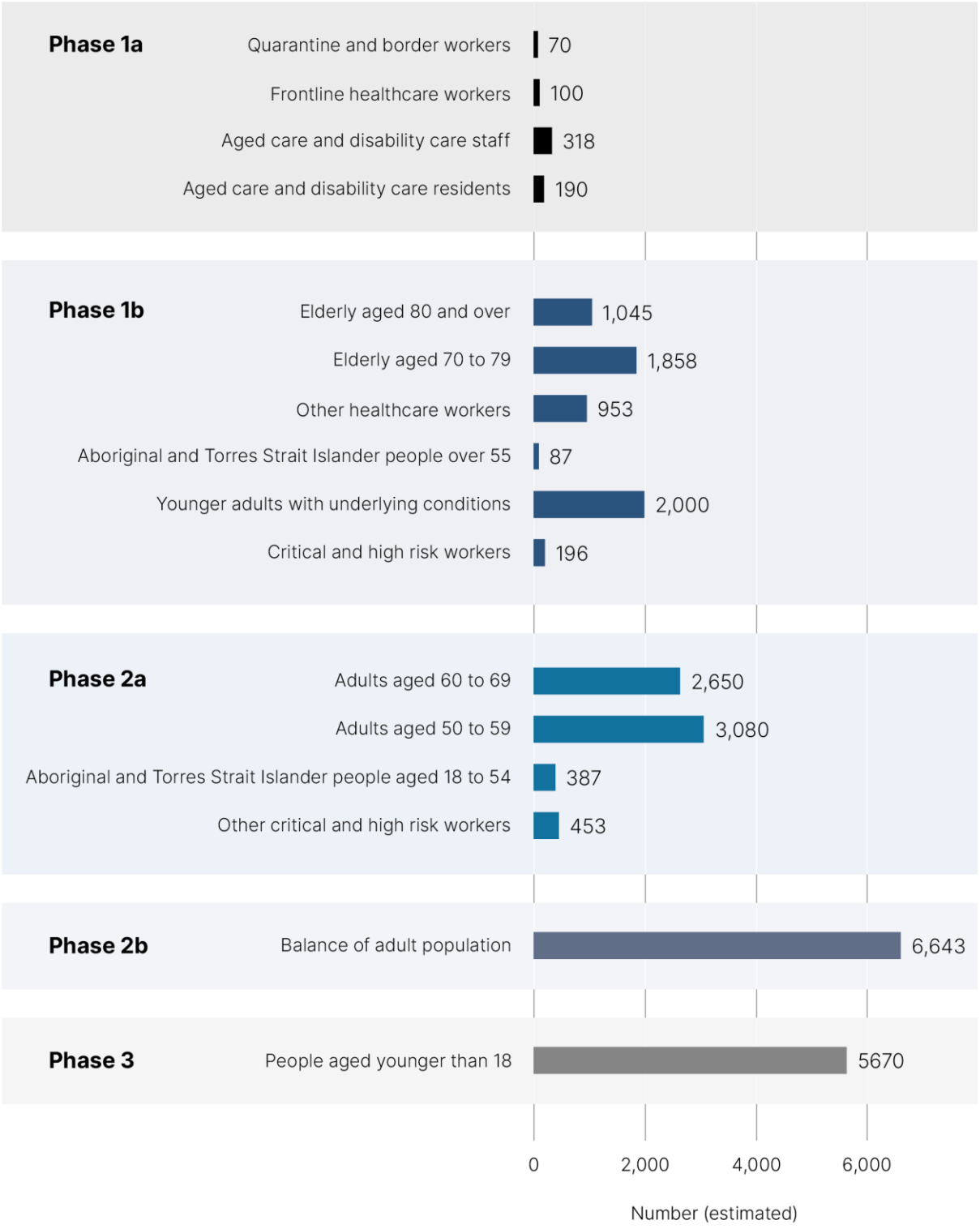
2.2.The vaccine rollout

On 28 December 2020 the then Minister for Health, the Hon Greg Hunt MP, announced that the government aimed to fully vaccinate the population against COVID-19 by the end of October 2021.[1030] The vaccine was to be free, universal and entirely voluntary. This announcement signalled what would be known as the 'vaccine rollout' in Australia. The United States had begun their vaccination efforts two weeks earlier, on 14 December 2020.[1031]

In November 2020 the government began to plan the rollout with the states and territories.[1032] A series of jurisdictional agreements to implement the vaccine rollout were negotiated and finalised by February 2021.

Australia's COVID-19 vaccine national rollout strategy was published on 7 January 2021.[1033] It set out guiding principles, including a three-phase approach starting with priority populations in line with ATAGI's advice of November 2020 (Figure 2).[1034] This phased approach was needed because the supply of vaccines would not meet community demand. Groups most at risk of exposure, hospitalisation and death were prioritised for vaccination.[1035] Figure 2 outlines the initial Department of Health phased approach and the estimated population for each phase, noting aged care residents were subsequently prioritised for vaccination over people with disability.[1036] Appearing before the Disability Royal Commission on 17 May 2021 the then Associate Secretary of the Department of Health, Caroline Edwards, noted 'I did not make a decision to deprioritise disability, I made a decision to save the people most at risk of disease and death'.[1037]

Figure 2: Estimated population size of eligible groups by vaccine rollout phases[1038]



The vaccine rollout commenced on 22 February 2021, supported by the rollout strategy.[1039] Early planning for the rollout focused on the near term, with less detail provided for longer term implementation through to October 2021. Vaccine usage modelling and delivery schedules for the rollout occurred throughout mid-2021.[1040]

More than 20 million Australians were estimated to need vaccination in a short space of time, so a broad number of distribution channels were needed.[1041] Under the National Immunisation Program, the Australian Government buys vaccines while the states and territories deliver vaccines to the people. This time it was different. The Australian Government led the purchase and delivery of the COVID-19 vaccine. We heard the decision to take a different approach was driven by the need to vaccinate the population quickly and at a scale never before attempted, and the National Immunisation Program was not able to take on the mass vaccination approach needed.[1042] Some stakeholders said it was a political decision – the Commonwealth wanted to be seen as leading on the issue.[1043]

The rollout was delivered largely through primary care.[1044] There was a heavy focus on general practice as the point of immunisation, in addition to state-run mass vaccination clinics. Aboriginal Community Controlled Health Services delivered vaccines to many Aboriginal and Torres Strait Islander people. Private providers played an important role in administering the vaccine, with Aspen Medical, HealthCare Australia and Sonic HealthCare providing staff to Commonwealth vaccination hubs and in-reach services.[1045] The Royal Flying Doctor Service was engaged under contract to distribute vaccines to selected rural and remote areas.[1046] Figure 3 shows the administration channels used in the rollout and identifies the level of government responsible. The Inquiry sought data from the Department of Health and Aged Care outlining the number of vaccines delivered via each of these channels; however, they were not able to provide this information by the given deadline.

Figure 3: Vaccine administration channels

Administration channel	Responsible government	Date of commencement
Commonwealth Vaccination Clinics	Australian	February 2021
In-reach	Australian	February 2021
Hospital hubs	State and territory	February 2021
General practice	Australian	March 2021
Aboriginal Controlled Community Health Organisations	Australian	March 2021
Mass vaccination hubs	State and territory	April 2021
Community hubs	State and territory	SA: April 2021 VIC: April 2021 WA: April 2021 NSW: May 2021 ACT: June 2021 QLD: June 2021

Administration channel	Responsible government	Date of commencement
Royal Flying Doctor Service	Australian	May 2021
Community pharmacies	Australian	August 2021

There were around 13,500 sites where people could be vaccinated at some time throughout the pandemic.[1047] Logistics were complicated for mRNA vaccines because they required stringent cold-chain storage infrastructure and had to be distributed in small, multi-dose vials. Also, there was a shortage of low dead space syringes, designed to minimise wastage of fluid.[1048] To support this network to store and administer COVID-19 vaccines, in January 2021 the Department of Health partnered with the Australian College of Nursing to develop and deliver training modules for all vaccine administration providers. These training programs ran from February 2021 to 30 September 2023, enrolling 219,000 people nationally.[1049]

The rollout had a slow start. Several compounding factors contributed to this. For example, initially there was a heavily reliance on one vaccine, AstraZeneca, which comprised 80 per cent of allocated doses to sites over the first 12 weeks of the rollout.[1050] Australia had pre-purchased substantially more AstraZeneca vaccine than other options and had also ensured that it could be domestically manufactured, so there was almost three times more AstraZeneca on hand than Pfizer.[1051] After international reports of very rare, serious side-effects from the AstraZeneca vaccine appeared in March 2021, the rollout was recalibrated towards favouring the mRNA vaccines (Pfizer and later Moderna) for younger adults.[1052] Concerns over the use of AstraZeneca for those aged under 40 were voiced publicly by Queensland's Chief Health Officer in June 2020.[1053] There was limited supply of alternative vaccines available at this time.[1054] This was the first of seven eligibility changes made to the vaccines between 22 April and 11 August 2021.[1055]

Throughout this period and for the rest of the vaccine rollout, the Australian Government was responsible for transporting COVID-19 vaccines to the states for local storage and administration. Distribution had to be managed in a way that tried to match local demand and to minimise wastage, such as with unopened vials expiring on the shelf. Existing distribution arrangements had to be supplemented through March and April 2021, particularly to assist in-reach delivery to residential aged care.[1056]

As the vaccine rollout matured and issues emerged delivering into critical areas like aged care facilities, the Australian Government called on the logistical expertise of the Department of Defence to support the Department of Health. Operation COVID Shield commenced on 8 June 2021.[1057] The Prime Minister directed Lt General John Frewen to take 'direct operational control across numerous government departments for the direction of the national (COVID) vaccination program'.[1058]

> *I think that very direct Command and Control structure that has proved to be so effective in the past will add a further dimension and assistance as we step up in this next phase. – Prime Minister Scott Morrison, 4 June 2021*[1059]

The Operation COVID Shield National COVID Vaccine Campaign Plan, released on 3 August 2021, was a key milestone.[1060] It established the first set of publicly communicated goals, targets and milestones for the rollout. It also instigated regular public reporting of vaccination progress against these targets.

At the same time, the Australian, state and territory governments instituted reforms to expand the number of health professionals who could administer COVID-19 vaccines – for example, allied health workers, Aboriginal Health Practitioners, pharmacists, practising nurses and other professions could administer vaccines through 2021 and 2022.[1061] Primary Health Networks assisted with local-level actions targeting hard-to-reach communities.[1062] From late 2021 the Australian Government instituted the Vaccine Administration Partners Program to assist with COVID-19 vaccination in employment and community settings.[1063]

The rollout became markedly more effective over time. In April 2021, 600,000 Australians were vaccinated with two doses.[1064] By 2 November 2021 Australia had reached its stated goal of 80 per cent of the adult population double vaccinated.[1065] There were several key factors that contributed to this improvement:

- The Commonwealth and states and territories linked data systems to identify areas of poor vaccine coverage. This helped them to better direct outreach programs and divert existing vaccine stock, which was limited until later in 2021.
- Vaccine supply and distribution pressures eased in mid-2021.
- Vaccination delivery points increased from around 4,000 in March 2021 to over 10,000 by November 2021 as supply of COVID vaccines increased from approximately five million in April 2021 to almost 90 million in December 2021.[1066]

Informed by the issues seen with COVID-19 vaccine access and supply, in March 2022 the Australian Government and US biotech company Moderna reached a 10-year agreement to build an mRNA vaccine facility in Victoria.[1067] The new facility is expected to manufacture up to 100 million vaccine doses a year in Australia from 2024.

2.3.Vaccine mandates

National Cabinet agreed to national COVID-19 safe workplace principles in April 2020.[1068] Safe Work Australia was given responsibility for being the national information hub for these principles.[1069] From April 2020 Safe Work Australia published guidance to aged care, health and later other employers, highlighting their responsibility to minimise the risks of COVID-19 in the workplace as far as is reasonably practicable.[1070] This included implementing vaccination mandates where relevant.[1071]

In June 2021 Australia became one of the first countries to mandate COVID-19 vaccination – National Cabinet endorsed the introduction of mandatory COVID-19 vaccinations for workers in residential aged care facilities, with limited exceptions, effective 17 September 2021.[1072]

The publicly stated rationale for this policy was emerging evidence showing the effectiveness of COVID-19 vaccines in reducing transmission and protecting against severe illness and death;

and the consequences of infection in this high-risk population.[1073] There was also evidence on the need to protect workers in high-risk settings and for interventions to increase vaccine uptake among these workers.[1074]

On 9 July 2021 National Cabinet agreed to advice from the Australian Health Protection Principal Committee that COVID-19 vaccination should be encouraged for all disability support workers and should be mandated for residential disability support workers by 31 October 2021 following the Australian Health Protection Principal Committee's consideration of the evidence on risk in a range of disability settings.[1075] National Cabinet also agreed to the Australian Health Protection Principal Committee's advice that vaccination in sectors with high mobility, such as aviation, resources and freight, should be encouraged.

On 6 August 2021 National Cabinet announced it had received a briefing from the Solicitor-General on the use of vaccinations in the workplace.[1076] National Cabinet noted businesses' legal obligation to keep their workplaces safe by minimising exposure to COVID-19 and that, where there was no state or territory public health order, decisions to require COVID-19 vaccinations for employees were a matter for individual businesses, taking into account their circumstances and obligations under safety, anti-discrimination and privacy laws.[1077]

On 1 October 2021 National Cabinet noted the Australian Health Protection Principal Committee's recommendation of mandatory vaccinations for all workers in healthcare settings.[1078] On 10 November 2021, after further consideration of the evidence, the Australian Health Protection Principal Committee extended their advice for disability workers, and recommended mandatory vaccination of disability workers who were providing intensive supports to National Disability Insurance Scheme (NDIS) participants as well as for in-home and community aged care workers.[1079]

As part of jurisdictional efforts under the national plan, from September 2021 state and territory governments implemented their own vaccine mandates.[1080] Over time, vaccine mandates expanded to include booster doses. The mandates were enacted through public health orders and under the direction of their Chief Health Officers (or similar officials).

State-level vaccine mandates were applied to more workplaces than had been initially agreed by National Cabinet. Other affected workplaces included construction, education and correctional and detention facilities.[1081] This led to the creation of temporary vaccine economies, where employment across many critical sectors was tied to immunisation, and different levels of general restrictions applied according to vaccination status. There were also unintended complications from these 'shadow mandates' where, in Victoria for example, unvaccinated teenagers could not go to a café with their vaccinated parents.[1082]

The vaccine mandates that resulted from Australian Health Protection Principal Committee advice and National Cabinet decisions were designed to reduce the risk of serious illness, hospitalisation and fatality in high-risk groups, and to protect critical workforces. They would also help ensure the nation's health system could manage COVID-19 and other infectious diseases once significant restrictions were lifted, as part of the National Plan to Transition Australia's National COVID-19 Response.[1083]

2.4. Indemnity

On 13 December 2021 the Australian Government established the COVID-19 Vaccine Claims Scheme for those who suffered moderate to significant harm following the administration of a COVID-19 vaccine.[1084] The scheme provided financial support and was intended to bolster public confidence in the vaccination program.

The Australian Government acknowledged that, while serious adverse reactions to COVID-19 vaccines were rare, there should be a safety net to support those affected.[1085] This was the first vaccine claims scheme introduced in Australia.

To be eligible for compensation, a claimant must have suffered an eligible clinical condition and received hospital treatment for it. The threshold for accessing the scheme was suffering at least $1,000 in losses, such as through out-of-pocket medical costs or lost wages. All claimants had to supply a medical report from a doctor linking their condition to the vaccination.[1086]

The government gave COVID-19 vaccine manufacturers an indemnity covering certain liabilities that could result from the use of their vaccine.[1087]

2.5.COVID-19 treatments

From early 2020 potential COVID-19 treatment candidates began to appear.[1088] The TGA assessed the safety and efficacy of chloroquine and hydroxychloroquine and found they had no clinical benefit. Noting a rise in 'off-label' use and risks of adverse events, the TGA limited the prescription of these medicines on 24 March 2020.[1089] Similar restrictions were placed on ivermectin in August 2021.[1090]

Australia signed APAs with multiple treatment manufacturers. The first treatment for COVID-19, Veklury®, was granted provisional approval by the TGA on 10 July 2020.[1091] By the third quarter of 2021, the TGA had granted provisional approval for the first monoclonal antibody treatment. These treatments, such as Xevudy®, target the SARS-CoV-2 spike protein.[1092] Monoclonal antibody treatments were particularly important for the immunocompromised, who would not respond as well to vaccination and therefore were more vulnerable to infection.

In 2022 the Australian Government listed two oral antiviral treatments on the Pharmaceutical Benefits Scheme (PBS): Lageviro® on 1 March and Paxlovid® on 1 May.[1093] These treatments were used to help fight the coronavirus infection, reducing risk of hospitalisation and death.[1094] As at 31 December 2023 over 1.2 million PBS prescriptions for these treatments had been dispensed.[1095] From February 2022 to 30 April 2024, the National Medical Stockpile deployed a total of 1,073,908 COVID-19 treatments (including Veklury®, Sotrovimab, Ronapreve, Paxlovid®, Lagevrio® and Evusheld® to state and territory governments, residential aged care homes, Aboriginal Community Controlled Health Services, the Royal Flying Doctor Service and the Department of Foreign Affairs and Trade.[1096]

Antivirals were successfully trialled in people at risk of serious illness, but evidence is still emerging about the effectiveness of these treatments for those with milder illness and in protecting against long COVID.[1097] For those with complex underlying conditions, there were

also significant contraindications. In response, the Commonwealth subsidised longer telehealth consultations so that doctors could properly assess a patient's underlying conditions before prescribing.[1098]

As the Australian Government's portfolio of vaccines and treatments matured throughout 2021 and 2022, the Minister for Health and Aged Care commissioned an independent review of COVID-19 Vaccine and Treatment Purchasing and Procurement.[1099] The review was finalised on 28 February 2023.[1100] It made eight recommendations to government to improve ongoing supply and security of COVID-19 vaccines and treatments. All recommendations were accepted by government.[1101]

2.6.Reopening Australia

On 6 August 2021 National Cabinet agreed to the National Plan to Transition Australia's National COVID-19 Response.[1102] The plan set out a phased approach to reopening the economy, easing significant restrictions and returning life to normal which would begin in earnest once Australia hit 80 per cent vaccination among eligible people.[1103] It was informed by modelling from the Doherty Institute and the Treasury.

When Australia reached 80 per cent vaccination of eligible people in late 2021, the transition out of significant restrictive public health measures began. Guided by the National Plan to Transition Australia's National COVID-19 Response, the jurisdictions took their own pathways towards easing into community-wide transmission, guided by local vaccination coverage and assessments of the strength of their respective health systems. New South Wales was the first to reopen, from 11 October 2021, with the other states and territories following suit over the following months.[1104]

To increase the capacity of the health system to respond to reopening, in November 2021 the Australian Government announced $32 billion in additional Commonwealth and state and territory health funding.[1105] This funding focused on extending COVID-19 specific measures, including for General Practitioner Respiratory Clinics, private hospital guarantees and aged care in-reach programs. Media announcements from leading health officials, including the Chief Medical Officer, reinforced the strength of state and territory health systems to support the national reopening and cited the protective factor of high levels of vaccination within the Australian population.[1106]

Australia's reopening coincided with the Omicron wave in Australia. This was the most transmissible wave of the virus so far, but it was less virulent, with fewer cases requiring hospitalisation.[1107] As much of Australia was now fully vaccinated with an initial course of vaccine, focus turned to promotion of booster shots to protect against ongoing severe disease.[1108]

In this environment, Australia's understanding of 'living with COVID-19' evolved to include managing ongoing waves and chronic impacts of the virus, including long COVID.

Long COVID

During the pandemic a collection of post-viral conditions, commonly known as long COVID (or post-acute sequelae of COVID-19 (PASC)) began to emerge. Lingering impacts of diseases like COVID-19 are common, and infectious disease experts have been reporting on post-viral infections for more than a century, from as early as the 1918 influenza pandemic.[1109] However, our systems were not prepared to capture data early to track the rise of long COVID and have the evidence at hand to prepare an effective response.

What is long COVID?

Long COVID was identified in early 2020, when it was recognised that some people may experience a wide range of presentations and symptoms for several months after the acute phase of COVID-19.[1110] Australia accepted the World Health Organization definition of 'post-COVID-19 condition' (long COVID) as the continuation or development of new COVID-19 symptoms three months after initial infection, with these symptoms lasting for at least two months, that are not explained by an alternative diagnosis.[1111]

Long COVID patient presentation can vary greatly, with more than 200 symptoms recognised in literature (none which are unique to long COVID).[1112] As in other chronic conditions, symptoms can be episodic and may fluctuate and/or relapse over time, making diagnosis, management and assessment of prevalence more challenging.

More robust research is required to understand the true prevalence of long COVID in Australia. This is particularly important given Australia's experience of long COVID may be different to that experienced internationally, due to factors that are unique to our context. Most of Australia's SARS-CoV-2 infections were of the Omicron variant and occurred in a highly vaccinated population, with many individuals having received a primary COVID-19 vaccination course (two doses) and some a booster dose, prior to initial infection. This contrasts with the experience internationally, where significant waves of Alpha and Delta variant infection occurred prior to widespread vaccine and booster availability.

In 2022, the Australian Institute for Health and Welfare estimated that five to 10 per cent of COVID-19 cases may develop long COVID.[1113] However, these estimates are based on limited data capturing self-reported symptoms, including one recent Australian cohort study conducted on people infected between January and May 2020 (before there was vaccination available) finding around five per cent of individuals who had an acute COVID-19 infection still had symptoms three months following infection.[1114] Prevalence estimates from Victoria range from 0.17 per cent to 4.4 per cent in adults, and are lower among vaccinated adults who were infected with the Omicron variant (0.09 per cent for non-hospitalised and 1.9 per cent for hospitalised adults).[1115]

It is clear from studies in Australia and overseas that both vaccination against COVID-19 and infection with the Omicron variant (compared to earlier variants) is associated with a reduced risk of long COVID.[1116] This indicates that Australia's COVID-19 strategy, which focused on the national vaccination rollout and availability of antiviral treatments, played an important role in

reducing the incidence and severity of COVID-19 infection, and through this the number of people who develop long COVID.

In contrast to adults, current evidence suggests that long COVID symptoms are rare in children and adolescents; however, long COVID in young people is poorly understood and requires further research to understand its risk and impact on this cohort.[1117]

How is long COVID managed?

There is still uncertainty about the disease mechanisms and pathways for diagnosis and effective treatment of long COVID in Australia. Measures that protect against COVID-19 and subsequent complications, such as long COVID, remain in place. These include vaccination, personal protective behaviours and COVID-19 oral antiviral treatments for eligible people.

There is evidence which suggests that COVID-19 vaccines may reduce the risk of long COVID symptoms in adults, but it is less clear if vaccines offer similar protection for children and adolescents given the lower risk.[1118] Limitations in data collection during the pandemic, including the poor case definition and diagnostic challenges of long COVID, make it difficult for experts to fully assess the protective impact of vaccines.[1119] Further studies are required to determine the effectiveness of COVID-19 vaccination in reducing the risk of long COVID.

On 19 April 2023, the House of Representatives Standing Committee on Health, Aged Care and Sport, as part of its Inquiry into Long COVID and Repeated COVID Infections, published its final report, *Sick and tired: casting a long shadow*.[1120] The Committee made nine recommendations, which focused on strengthening primary care services, improving COVID-19 vaccination communications, educational support for healthcare providers, and a national research program.

As part of the recommendations, the Committee recognised the chronic nature of long COVID as well as the need for a multidisciplinary primary-care based approach. The Australian Government accepted seven recommendations in full or in principle and noted two recommendations.[1121]

Many states and territories have established long COVID clinics since early 2022, and some submissions to our Inquiry advocated for more funding for long COVID clinics.[1122] The Long COVID Inquiry found that clinics were useful in reducing pressure on GPs and improving practitioner expertise, but concluded there were issues with enabling patients' access to the clinics, very long wait lists and not enough evidence on long COVID to identify appropriate service models.[1123]

The National Health Reform Agreement (NHRA) supports states and territories by providing funding for the cost of delivering public health and hospital services, including for long COVID. Under the NHRA, states and territories are responsible for how they allocate Commonwealth funding contributions for the delivery of public health and hospital services. During the pandemic, some jurisdictions allocated funding to establish long COVID clinics whilst others did not.[1124]

Australians with long COVID are currently supported by existing primary care and mental health services, including Medicare subsidised general practitioner consultations, multidisciplinary support through chronic disease management plans, and mental health services.[1125] There are additional resources available online which provide information and advice on long COVID. The Healthdirect website provides advice on long COVID symptoms, risk factors and treatment, as well as links to helpful resources and support from trusted information partners.[1126]

In late 2021, the Department of Health contracted the Royal Australian College of General Practitioners (RACGP) to develop guidance materials for health practitioners and long COVID patients.[1127] These are publicly available on the RACGP website.

The Long COVID Inquiry report acknowledged these guidance materials but noted the concerns raised by academics and medical professionals regarding the confusion about, and under-education on, long COVID in Australia, and the need for improved public health messaging on its risks to individuals.[1128] People with long COVID who attended our Inquiry's focus group told us they felt helpless and unable to effectively manage their condition as their health professionals were unaware of how to appropriately manage and address their complex symptoms.[1129]

Many doctors and specialists were dismissive and this was very stressful … We need GPs to be trained to be alert for the symptoms of long COVID so that people can get timely support. – Individual submission[1130]

The panel heard of the lingering social, economic and health impacts of long COVID.[1131] People with long COVID feel neglected by government, and identify a lack of messaging around its existence.[1132] Individuals with long COVID have spoken about its economic cost, many noting symptoms have disrupted their ability to work, resulting in a loss of income.[1133] The Department of Health and Aged Care also noted that the long-term psychological and cognitive impacts of long COVID will contribute to a growing demand for mental health support.[1134]

I'm always sick now, I've gained weight and developed pretty bad anxiety. I would cry every day for six months and started feeling like I should just die. I honestly wanted to die; it was excruciating. – Focus group participant with long COVID, Melbourne[1135]

The need for additional research into long COVID was recognised early in the pandemic. Advice provided to the Chief Medical Officer from the National COVID-19 Research and Advisory Committee in November 2020 noted the lack of evidence on long COVID and the need for 'ongoing research … to understand the long term sequelae of COVID-19'.[1136] The Long COVID Inquiry also identified additional research as a significant area of need and, as part of its response to the report, the Australian Government made a $50 million commitment over five years from 2023–24 from the Medical Research Future Fund for research into long COVID.[1137] The funding for long COVID research is provided through the Medical Research Future Fund Post-Acute Sequelae of COVID-19 Research Plan and will ensure investment focuses on research most likely to improve patient outcomes and healthcare experiences.[1138]

In June 2024, the Australian Government provided $14.5 million in funding to 12 projects to improve our understanding of the impacts of long COVID.[1139] These independent research projects have a primary care focus and include a living evidence review of international clinical trials, identification of patient and clinician treatment priorities, and development of clinical trial protocols.[1140] Continued investment into long COVID builds on existing knowledge, improves clinical care and guidance, and enables ongoing research in priority areas such as understanding disease mechanisms and pathways for diagnosis and effective treatment of long COVID.

3. Impact

3.1. Procurement and regulation of vaccines and treatments

Australia's procurement of vaccines was initially delayed and limited. It meant that where other nations had a demand-side problem, Australia had a supply-side problem over various stages of the rollout.[1141] The panel heard from some stakeholders that pharmaceutical companies were able to supply the volume of vaccines that government requested, but it was also noted that other countries were advantaged by having liability schemes and protections in place that supported the end-to-end vaccine development process.[1142] However, some suggested associated delays allowed Australia to gather more overseas data to assess vaccine effectiveness and safety.[1143] One stakeholder noted other countries were more flexible and moved faster than Australia to secure vaccines.[1144]

These procurement delays ultimately affected the timing of the vaccine rollout and prolonged restrictive public health measures that had by then been in place for over a year. This meant our staged reopening occurred months later than it otherwise could have, with a direct economic cost estimated at $31 billion.[1145] There were also unforeseen health consequences to this timing, because it meant we transitioned to 'living with COVID-19' as the Omicron variants became prevalent in the community. This led to our highest ever number of case numbers and deaths from COVID-19, particularly among vulnerable populations and groups less likely or as yet unable to be vaccinated.[1146]

The panel heard praise for the Science and Industry Technical Advisory Group's role as a logical, evidence-based, professional and cohesive group that provided government expert advice on the selection of vaccines.[1147] It advised that Australia take a portfolio approach, and the Australian Government acted swiftly on this advice.

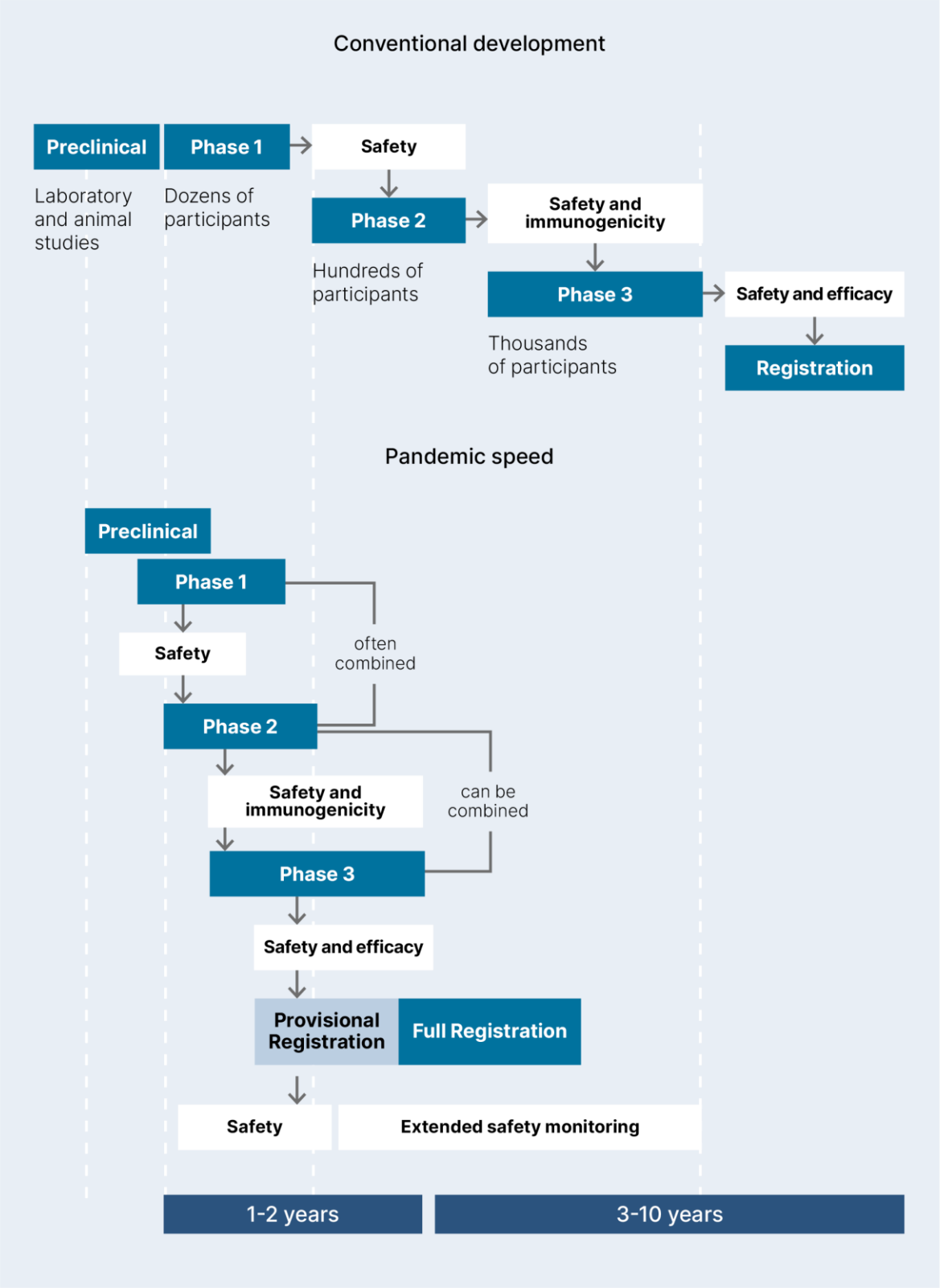
In line with key findings from Professor Jane Halton's 2022 review of COVID-19 vaccine and treatment procurement, stakeholders commended Australia's portfolio approach to vaccines for giving Australians flexibility in choice of vaccine as more supply was secured.[1148] Some stakeholders noted that countries need redundancies in their vaccine strategies when dealing with a novel virus and that broad-based engagement with manufacturers and a purposeful portfolio approach to vaccines is more effective than a focus on local technology and manufacturing.[1149] One stakeholder noted the Commonwealth went after multiple vaccine candidates, which was of benefit when there were later issues with the AstraZeneca vaccine.[1150]

The portfolio approach allowed us to be less reliant on the use of AstraZeneca once complications emerged. However, some have suggested that this was an over-reaction to the actual risk posed by the vaccine. Fuelled by high-profile criticism, including from senior Queensland Government figures, this significantly undermined public confidence in the safety of vaccines.[1151] Independent Australian research conducted in July and August 2021 found an overwhelming preference for Pfizer compared to AstraZeneca. [1152] It is likely recommendations from ATAGI during this period also contributed to this preference. [1153] At this time, Australia also did not have adequate reserves of Pfizer onshore, meaning the vaccine rollout suffered further intermittent shortages in supply.[1154]

Stakeholders also commended the government for innovations in vaccines and treatment regulation.[1155] The panel heard the TGA met the challenges of the pandemic, balancing speed of assessment with clinical rigour.[1156] Unlike counterparts in Europe and America, the TGA did not exercise Emergency Use Authorisations for COVID-19 vaccines (which authorise the use of unapproved medical products to be used in an emergency to treat life-threatening illnesses) but provided provisional approval pathways to COVID-19 vaccine candidates.

The benefit of early vaccine availability outweighed the risk of waiting for additional data, although we worked from more robust clinical observations than those countries utilising emergency authorisation.[1157] Manufacturers described this pathway as flexible and collaborative, as it enabled them to provide rolling submissions and supply the necessary minimum standard of data (on outcomes of clinical trials and vaccines' performance in different countries) as it became available. This meant the TGA could fast-track assessments without compromising the usual stringent data requirements and analytic processes that underpin approvals.[1158] The more serious adverse events identified globally after the vaccine rollout began were too rare to be detected, even in large-scale trials.[1159] Figure 4 compares the conventional pathway to register vaccines outside of a pandemic and during the pandemic.[1160]

Figure 4: Conventional and pandemic vaccine development pathways[1161]



However, many individual submissions to the Inquiry were highly sceptical of the efficacy of the TGA process in assessing the safety of the vaccines.[1162] Some stakeholders and members of public are divided as to the efficacy and safety of Australia's assessment process for COVID-19 vaccines and treatments.[1163]

> *Products released under 'Provisional Approval' cannot be considered fully evaluated. … it is premature to declare such drugs 'safe and effective', and the use of these agents needs to be constantly under review in light of emerging safety data to reassess the risk versus any perceived benefit.* – Submission 717[1164]

The divided opinions on the thoroughness of the vaccine review process and the safety of vaccines approved under this process remain, reflected in and reinforced by ongoing campaigns in social media. Vaccine adverse event data are difficult to interpret in the context of a pandemic, especially where new vaccine technologies are used, both of which contribute to an elevated level of anxiety in the community. High rates of reporting of vaccine reactions continue to be promoted as indicators of vaccine failure, even though these are mainly short term self-resolving reactions, and we have no comparable vaccine rollout data to compare with.[1165] Fear of the vaccines kept just under five per cent of the eligible adult population from being vaccinated, and for some this cost them their employment if in an occupation where vaccine mandates were in place. Others who were reluctant to have the vaccine but who complied with mandates were vaccinated under duress and this can also increase the severity of vaccine reactions, acting to confirm their fears.[1166] It is not unreasonable to expect some people to choose not to be vaccinated, and this needs to be accommodated in vaccine and disease control policies. What was unusual in COVID-19 was aiming for a global adult vaccine rollout in a short period of time, and the proportion of the population who fluctuated in their vaccine intent, leading to unprecedented public discussion and information-seeking on vaccines. Misinformation on vaccines was rife, and would also have played a role (see Chapter 11: Communicating in a crisis).

Australia's lack of onshore manufacturing capability for vaccines other than AstraZeneca left us reliant on international providers and supply chains when issues with this treatment emerged. Supply chain impacts are explored in Chapter 22: Supply chains. In 2022 Moderna finalised a 10-year partnership with the Australian and Victorian governments to build a domestic mRNA manufacturing facility, due to be completed by late 2024.[1167] Sovereign manufacturing capability can provide greater security of supply in a crisis, but it is not a silver bullet. Manufacturers will still need to honour international supply commitments that keep local production facilities viable between pandemics, and vaccine and treatment production is complex and reliant on international supply of inputs.[1168] It is also difficult to know if the mRNA platform will be the most effective against future pandemic pathogens.[1169]

We heard from one stakeholder that vaccine indemnities were critical to Australia securing contracts with vaccine suppliers, providing vaccine manufacturers certain liabilities that could result from the use of their vaccine.[1170] In their absence, there would have been significant delays in securing commitments to supply or refusal from manufacturers to supply vaccines in

Australia. Indemnities are a common element of agreements with vaccine manufacturers internationally.[1171]

3.2.The vaccine rollout

3.2.1. Logistics and planning

The Australian Government invested over $18 billion in vaccine and COVID-19 treatment supply during the pandemic and delivered the first mass population-level national vaccination rollout in Australian history.[1172] It was not without its challenges.

We heard from some stakeholders that the government's decision to work outside of established immunisation networks was a political one.[1173] Many stakeholders said that in a future emergency it would be better to use the National Immunisation Program.[1174] Cold-storage requirements were also a logistical challenge, which some states were not able to meet. However, we heard the vaccine rollout did not always recognise, or plan for, jurisdictional differences in geography, demographics and capability; or adequately use local networks.[1175] For example, Tasmania has a highly dispersed population and delivery of vaccines through primary care was not the best method of distribution.[1176] The vaccine rollout was most successful when it was operationalised regionally and grounded in local knowledge, relationships and tailored responses.[1177]

The panel heard that some health professions are experiencing post-pandemic moral distress – for example, because they felt they were underutilised in the vaccine rollout.[1178] This includes nurses and nurse practitioners operating independently who ordinarily deliver in-reach vaccination and other services for priority groups.[1179]

> *[restrictions on COVID-19 vaccine administration] impeded patient access to vaccination services solely provided by Nurse Practitioners … This constraint included the inability to conduct home visits or provide services in the wider community, such as to patient residences or aged care facilities. – Australian College of Nurse Practitioners*[1180]

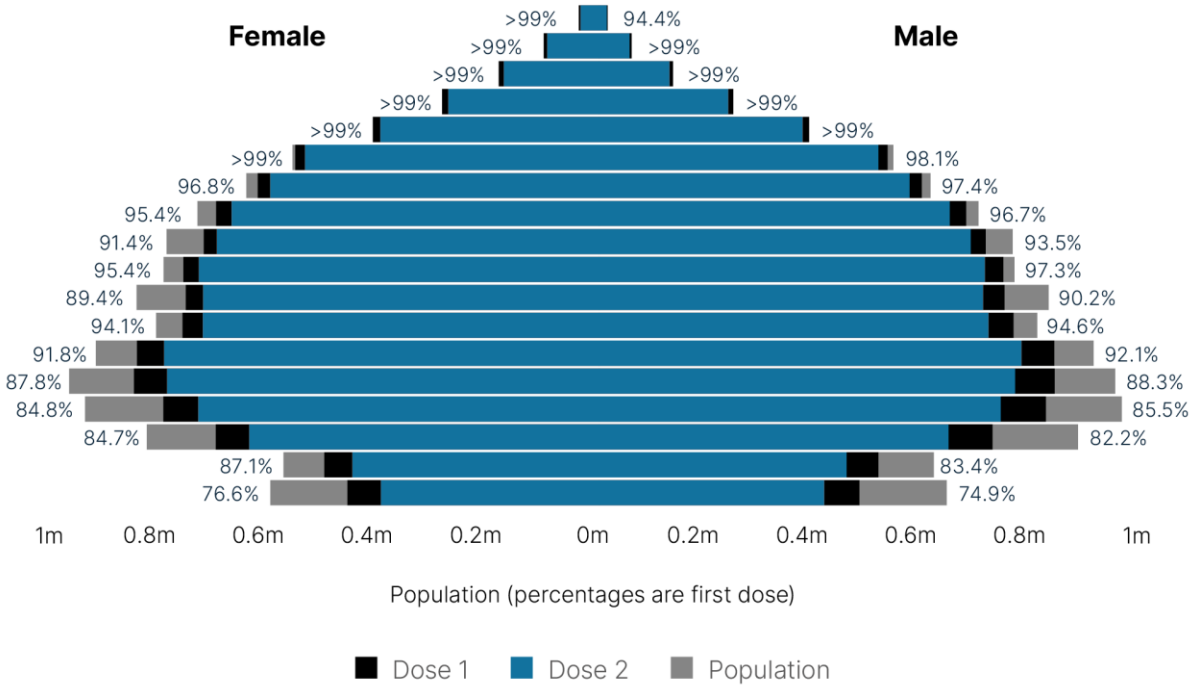
As at September 2024, nurses, particularly nurse practitioners, are able to administer vaccines under the National Immunisation Program but cannot be directly renumerated for administering COVID-19 vaccines.[1181] Also, they need to be supervised by a GP when they do administer the vaccine. This has impacted the financial viability of some nurse-led clinics.[1182]

Pharmacists were able to administer COVID-19 vaccines from August 2021 (while pharmacists in America were vaccinating people from December 2020).[1183] As at July 2024, pharmacists had administered 16.6 per cent of all vaccines since the beginning of the Australian rollout and were administering around 40 per cent of all COVID vaccines each week.[1184]

> *… the leveraging of allied health professionals, such as Community Pharmacists, could have enhanced the efficiency of the response. – WentWest (Western Sydney Primary Health Network)*[1185]

While it took time, stakeholders praised the collaborative efforts of government, union groups, industry bodies and regulatory agencies that enabled changes to the scope of practice of health practitioners – including Aboriginal Health Practitioners and allied health workers – to ensure they could deliver vaccines during the pandemic.[1186] These changes improved patient access to care and alleviated service delivery bottlenecks in primary care settings.[1187] These issues are discussed further in Chapter 12: Broader health impacts. Figure 5 shows the cumulative administration of vaccines through to the end of November 2021.[1188]

Figure 5: Cumulative vaccine doses administered as at 29 November 2021[1189]



Vaccine Clinic Finder

The Vaccine Clinic Finder was an online booking tool which operated from 2021 to 2023. It was an initiative of the Department of Health and was managed by Healthdirect Australia.

Millions of Australians used the Vaccine Clinic Finder to book a COVID-19 vaccine appointment. At its peak, the Vaccine Clinic Finder listed more than 9,600 sites across Australia where people could be vaccinated. The tool was made available in 16 languages. The listings were regularly updated to include features such as whether individual sites were wheelchair accessible or offered low-sensory environments, and whether walk-in appointments were available.[1190]

Primary Health Networks gave the Australian Government a link to communities and facilitated interfaces between primary care and hard-to-reach communities, including aged care, culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander people, people experiencing homelessness and rural communities.[1191] The success of Primary Health Networks varied by geography, with rural Primary Health Networks that cover disparately populated communities needing the most support.[1192] Some stakeholders noted that a lot of Primary

Health Network success depended on relationships and knowing local organisations.[1193] While these were critical, formal relationships would have been better.[1194]

We heard positive comments on the supporting role played by private organisations, including Aspen Medical and HealthCare Australia, in assisting with the vaccine rollout and providing in-reach services.[1195] However we also heard private providers were not always well connected with services or the community, and there would have been benefit in allowing these providers to deliver other immunisations, such as influenza.[1196] Stakeholders were unequivocal in their praise for the Royal Flying Doctor Service, which helped to deliver vaccines in rural and remote areas, and highlighted their trusted, longstanding relationships in these communities as being critical to their success.[1197] Royal Flying Doctor Service expertise was critical for engaging these communities, noting the absence of a dedicated vaccine rollout plan to do so. However, domestic border closures impacted the timely movement of the Royal Flying Doctor Service workforce in border regions and caused delays in their provision of care.[1198]

Role of Royal Flying Doctor Service in rural communities

During our Inquiry, we heard a striking example that shows the importance of trust in community outreach. A nurse from the Royal Flying Doctor Service was working in a new community in the Northern Territory, speaking to residents at a local event. During the event, a man approached her and asked a number of questions about COVID-19 vaccines. The next day he returned with a whole football team, all ready to be vaccinated. The man was the local football coach and had been asking questions of the nurse on their behalf, gathering information and building a trusted relationship.[1199]

In its planning, the Australian Government determined the volume of vaccines to be delivered to states and territories based on perceived need given current outbreak context. This approach was understandable, but it led to tension between the Australian Government and some state and territory counterparts.[1200] Attendees at an Inquiry roundtable said that modelling could be better used for more nuanced vaccine rollout planning under limited supply conditions.[1201]

3.2.2. Prioritisation

Because Australia's vaccine supply was limited, a phased approach to the vaccine rollout was needed.[1202] ATAGI identified priority groups that were most at risk of COVID-19, using several risk factors – for example, those who had a higher risk of severe illness and death; those who had an increased risk of exposure and transmission to others; and those working in critical services.[1203] The panel heard this advice was accurate, but evidence has shown that future prioritisation advice could consider the risk profile of a broader population base – for example, people living in lower socio-economic areas with high levels of communal living were hit badly in the Delta wave before they were fully vaccinated.[1204]

Overall communication and transparency about prioritisation decisions was inadequate and caused confusion across all priority groups the Inquiry heard from. Attendees at one Inquiry roundtable told us there is an ongoing need for vaccination prioritisation for those who work

alongside people at high risk of severe COVID-19, including disability support workers and social care workers, as well as family and informal carers.[1205]

Rollout plans for aged care, Aboriginal and Torres Strait Islander people and culturally and linguistically diverse communities were not finalised until February 2021 – more than a month after the rollout started.[1206] A plan for people with disability was never published. The rollout to people with disability was slow, particularly in the initial phase. The panel heard that people with disability felt ignored, deprioritised and abandoned, and that government underestimated the complexity of delivering vaccines to people with disability in a range of settings.[1207] Further detail on the experience of the vaccination rollout for people with disability is in Chapter 16: People with disability.

Vaccination rates of some priority populations consistently lagged behind the general population for the entire vaccine rollout. For example, by 21 November 2021, 81 per cent of those with low English language proficiency had received at least one dose of vaccine compared with 91 per cent of the general population aged 12 and over.[1208] Only 72 per cent of the eligible Aboriginal and Torres Strait Islander population was double vaccinated by 31 December 2021 (at the start of the Omicron wave) compared with 97 per cent of the non-Indigenous population – despite Aboriginal and Torres Strait Islander people being prioritised in phases 1b and 2a.[1209]

Unfortunately, these lower rates of vaccination may have resulted in more severe disease among some populations as Australia transitioned to living with the virus from December 2021 to June 2022.[1210] During the Delta wave, between 16 June and 14 December 2021, Aboriginal and Torres Strait Islander people were 1.2 times more likely, than the general population to be admitted to an intensive care unit with COVID-19.[1211] These rates increased to 2.2 times more likely in the first wave of the Omicron, from 15 December 2021 to 28 February 2022. Culturally and linguistically diverse people were also more likely to be admitted to intensive care in the first wave of Omicron compared to the general population. This included people born overseas (1.9 times higher), those with low English proficiency (3.2 times higher) and those who speak a language other than English (2.5 times higher).[1212]

We have heard there was a range of barriers to vaccination that contributed to lower vaccine uptake among priority groups.[1213] These issues are explored further for each group in the Equity section. However, they can largely be characterised by a failure to understand and plan for the complexity of rolling out vaccines to priority groups with diverse circumstances and needs and by a lack of tailored communication, which contributed to lower trust and vaccine hesitancy.[1214]

> *They labelled us as high risk, so we had to be guinea pigs to test it … I felt discriminated against. – First Nations focus group participant, Cairns*[1215]

3.2.3. Vaccine information and communication

ATAGI came under significant pressure during the pandemic. In the face of a quickly evolving virus it was constantly getting new intelligence about the safety of the vaccines, and this drove ongoing changes to eligibility. The fast pace of change and the complexity of the information

being communicated challenged many different stakeholders. We heard from one stakeholder that the ATAGI advice was hard to operationalise at times due to the specificity of some identified priority groups.[1216]

ATAGI also traditionally focused on vaccine distribution based on individual risk from disease.[1217] In this pandemic that included risk of exposure (frontline workers) as well as risk of serious disease from infection (the elderly or immunocompromised). However, prioritising vaccination rates at population level can also be an effective disease control measure. Hotspots where outbreaks repeatedly seed and where the virus spreads most quickly indicate the groups we should also prioritise for vaccine access. This not only protects the groups who are most likely to bear the brunt of the next wave, but also reduces the accelerator effect these groups play in epidemic dynamics, and so also reduces the risk to surrounding communities.[1218] ATAGI advice needs to extend early on in a pandemic into population-level disease control strategies.

Additionally, one stakeholder told us ATAGI had a conservative frame of reference when considering the benefits and harms of vaccines.[1219] For example, in the case of AstraZeneca, ATAGI's advice was based on balancing risk from infection calculated for low community transmission rates, as they were at the time, against the risk of adverse reactions to the vaccine, which were extremely rare but significant reactions that could be fatal.[1220] The risk comparison would look very different when there were high levels of infection across the community. The rise in numbers with severe illness and deaths due to COVID-19 would have cast the very low risks from vaccine in a different light, meaning the benefits of vaccines vastly outweighed the harms, and this could have led to earlier decisions to reopen access to AstraZeneca for younger adults, allowing more of the population to be vaccinated and protected earlier in the Delta wave given constraints on accessing other vaccine options.[1221]

Several stakeholders also raised issues around the timing of the release of vaccine eligibility advice, especially for changes to eligibility for the AstraZeneca vaccine, as well as the delivery of booster doses.[1222] The panel heard the timing did not allow for coordinated public messaging with the states and territories.[1223] We heard there was a lack of credible and reliable information around vaccines and supply available to private providers.[1224] At an Inquiry roundtable, GPs said they felt they were often the last to know of changes, and this undermined their relationships with patients.[1225] The panel heard of the efforts being made on the ground to manage this complex communication environment, including from the Primary Health Networks. One stakeholder reflected that there would be new guidance every single day to share with their professional network.[1226] GPs were sending information on vaccine stock to each other through a WhatsApp chat.[1227] They felt in no way prepared to participate in the emergency response.

As eligibility for COVID-19 vaccines was refined over time, public criticism arose around booster shots not being made widely available to children.[1228] Some parents were confused and anxious about why the booster doses were available for children in the United States but not in Australia.

Some of the communication challenges at this time appear to have contributed to recent increases in vaccine hesitancy in Australia. Focus groups conducted by the Inquiry found

increased vaccine hesitancy across all groups driven by information gaps (especially for culturally and linguistically diverse communities), misconceptions about number of required doses and potential risks, contradictory information about vaccines, and the removal of the AstraZeneca vaccine from circulation.[1229] Gaps in communications tailored to priority populations also contributed to lower uptake and trust in the vaccine. Further discussion on the Commonwealth's COVID-era communication strategies are discussed in Chapter 11: Communicating in a crisis. Communication strategies for priority populations are discussed in the Equity section.

> *We didn't have any translations … sometimes there's no word in my language for English words so I had to use Google translate … especially about vaccination and medical terminology. – International student focus group participant, Western Australia*[1230]

Other government attempts to streamline information on vaccines for the general population were well handled. Forums and webinars led by the Department of Health were praised.[1231] These channels provided peak bodies, academics, health practitioners and advocates with timely and factual information, allowing them to ask questions of key decision-makers such as ATAGI members, and assisted in countering misinformation.

3.2.4. COVID Shield

The vaccine rollout did improve over time. Most stakeholders commended the operational support the Department of Health received from the Department of Defence under Operation COVID Shield.[1232] Some stakeholders suggested that Operation COVID Shield was more for show, to offset negative media coverage on the perceived slowness of the rollout.[1233] The panel heard the command and control structure provided by Operation COVID Shield brought a greater level of policy coordination, greater precision in data capture, and more streamlined engagement with private providers.[1234] It also brought a direct line of communication to the Prime Minister.[1235]

Under COVID Shield, the public was given data on the consistent progress being made against key metrics. This was essential to improving confidence in the rollout over time.[1236] The focus groups and public survey conducted by the Inquiry highlight that Australians are more receptive to public health messaging and preventive measures when the evidence and rationale are clearly and honestly explained.[1237] We heard that several criteria helped to facilitate these achievements:[1238]

- making the early determination that communications and public sentiment were critical to the success of the vaccine rollout
- building public and stakeholder engagement on a platform of accountability and transparency
- establishing dedicated assessment cells to focus on vaccine supply, demand and uptake analytics

- working to streamline fragmented data-reporting systems which were initially all different for incident reporting, testing and vaccination booking
- relying on well-established and trusted expertise, such as with the Royal Flying Doctor Service, to ensure vaccine delivery to rural and remote areas.

3.2.5. Vaccine mandates

Australia's success in immunising more than 90 per cent of the eligible population by the end of 2021 was characterised by a number of policies designed to encourage uptake, including vaccine mandates linked to occupation. Vaccine mandates are not new. They were around in 1853 when the British Government made smallpox vaccination compulsory for children.[1239] They were also business as usual for healthcare workers in critical settings such as aged and disability care in the lead-up to the pandemic.[1240]

When National Cabinet decided to mandate vaccination against COVID-19 for workers in residential aged care and disability facilities, there was concern about the practical, ethical, legal and human rights implications.[1241] However, this was a targeted mandate designed to protect people living and working in the most high-risk settings at a time when only 10 per cent of staff were fully vaccinated. Most Australians agreed with this approach at the time.[1242] Once vaccine mandates were used in a less occupation-targeted way, such as through the introduction of vaccine passports in Victoria and New South Wales, public opinion dropped.[1243]

The mandates did not universally drive vaccination adherence, particularly among Aboriginal and Torres Strait Islander Australians. Research indicates that mandates appear to have reduced the motivation of some people to be vaccinated for COVID-19 and other communicable diseases and led to ongoing reluctance to vaccinate.[1244] This may lead to negative health impacts.

There has been much public debate around whether the restriction of individual liberty underpinning vaccine mandates was justified by the public health outcomes they helped to achieve. One former state leader defended the use of vaccine mandates as a public health measure, asserting that they helped ensure high levels of immunisation and allowed the state to be prepared for when the virus did emerge.[1245] In contrast, former New South Wales Premier Dominic Perrottet said in his valedictory speech to the New South Wales Parliament on 6 August 2024 that the strict enforcement of vaccine mandates was wrong.

> *Health officials and governments were acting with the right intentions to stop the spread, but if the impact of vaccines on transmission was limited at best, as it is now mostly accepted, the law should have left more room for respect of freedom. Vaccines saved lives but, ultimately, mandates were wrong. People's personal choices should not have cost them their jobs. – The Hon Dominic Perrottet*[1246]

Securing vaccines and making them accessible and affordable for Australians was publicly understood as a proactive, necessary and a positive initiative. However, broad opposition to vaccine mandates is one of the clearest findings from focus groups and surveys conducted by

the Inquiry.[1247] Mandates were described as a heavy-handed and controlling response which lacked scientific justification.[1248] People could not understand why vaccines were being mandated for people who were at low risk of being exposed to or of having severe COVID-19.[1249]

> *My mum is from the Czech Republic … she came here to escape the communists and had the same feeling she had back then … I'm not against the vaccine but there needs to be a choice. – Focus group participant with a disability, Parramatta*[1250]

Public advice was at times inconsistent with advice received by and from medical practitioners, causing confusion and promoting scepticism. It also resulted in often low levels of understanding of medical and public health advice among individuals. The changing science compounded confusion, as more evidence emerged around vaccine effectiveness against infection for new variants, on extremely rare side-effects becoming apparent, and on the protection the vaccine provided against the risk of passing the virus on to others if infected.

As part of state and territory pathways to reopen their economies, the general public had to demonstrate proof of vaccination or exemption status to access a range of services, including air travel, pubs and recreation facilities.[1251] These measures were intended to address community transmission in the adjustment to living with COVID-19 phase, but they further antagonised vaccine-hesitant members of the public and those concerned about infringement of personal liberty.[1252]

People felt their right to choose was taken away. These feelings were pronounced within groups that had been previously disempowered by government decisions – for example, Aboriginal and Torres Strait Islander people and people who have been in prison.[1253] The introduction of vaccine mandates occurred concurrently with increases in vaccination rates among the general population but caused some people to choose not to be vaccinated.[1254]

> *I wasn't worried about the vaccine itself … the mandate was an issue, different people have different reasons to not take it. – Focus group participant, international student, Western Australia*[1255]

The panel is mindful of challenges to vaccine mandates that have recently made their way through state court systems – for example, in Queensland, which found their use for police officers was unlawful.[1256] The courts are best placed to litigate the legalities of the way vaccine mandates were implemented during the pandemic. Our analysis speaks only to contemporary medical justifications and their subsequent social impacts.

Impact of vaccine mandates[1257]

Charlie was in jail during part of the COVID-19 pandemic and was concerned about getting the vaccine. He had heard about the potential side-effects and was sceptical about the amount of research that had been done to prove its safety, given the short period over which it was developed. However, he reported that, if he did not get it, he would have been placed in a more isolated, higher security area with other prisoners he considered to be more dangerous,

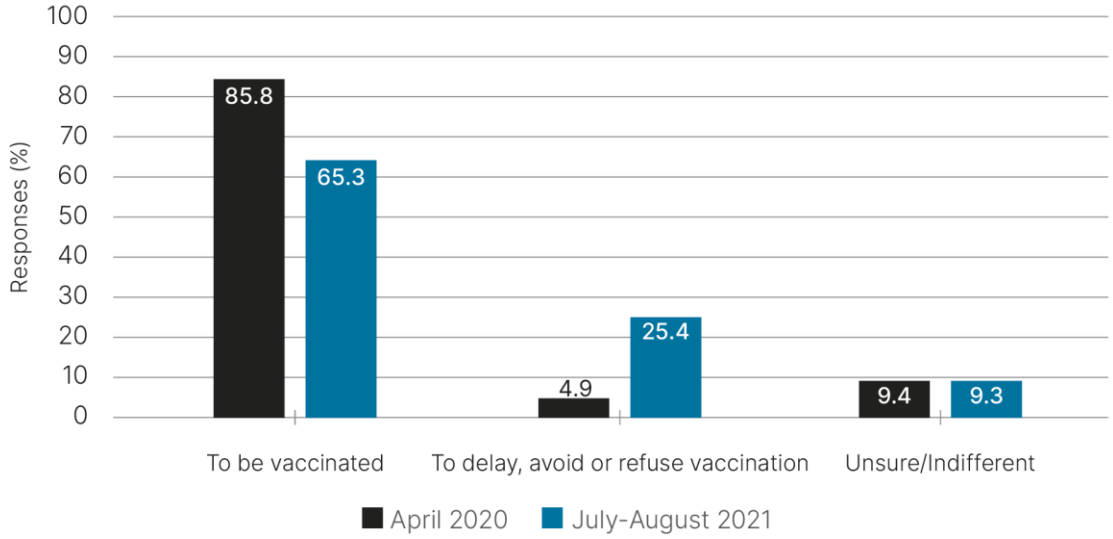
potentially putting his life at risk. As such, he felt that he was threatened into getting the vaccine.

After being released from jail, he spoke to his other friends about the vaccine. Charlie and his friends were young men and lived in Darwin, where they felt that the risk from COVID-19 was low and the risk of getting the vaccine seemed unknown and potentially high. His friends reported also feeling 'forced' into being vaccinated, as not being vaccinated would have meant that they would be unable to work and financially support themselves.

They wondered why there was such a strong push for them to be vaccinated. Charlie became increasingly concerned about the government's motives for 'pushing vaccinations' and became substantially less trusting of government decision-making, not only in relation to COVID-19 but also more broadly.

Australian Government actions taken after the pandemic, including the withdrawal of the AstraZeneca vaccine from circulation, have confirmed these views.[1258] The Inquiry heard that vaccine hesitancy is linked to a growing distrust in government and medical science and a reduction in social licence to implement such policies if required in future.[1259] Figure 6 shows overall declining vaccine intention for COVID-19 vaccines between April 2020 and July and August 2021.

Figure 6: Intention to receive a COVID-19 vaccine, 2020–2021[1260]



Note: Chart presents data from a nationally representative survey of adults in Australia. Results for 2020 include participants aged 18 to 90 years old. Results for 2021 include participants aged 18 to 49 years old.

Vaccine mandates had a mixed impact on the broader health system. There was a high level of compliance in the health sector, and vaccine mandates were a factor in addressing community transmission and minimising risk of the health system being overwhelmed.[1261] However, there were some critical workers, including nurses, who left the profession because of the mandates.[1262]

> *I resigned because I could not follow Ahpra's mandated compliance with the narrative that the Covid vaccine is necessary, safe and effective … Ahpra needs to*

be bought under a federal law so it cannot force health professionals to practice unsafely. Health practitioners should never be silenced nor coerced to perform any procedure by a governing regulatory body. – Submission 1353[1263]

Individual submissions to the Inquiry underscore the impacts that vaccine mandates had on other workers. We heard many stories of how teachers, tradespeople, disability and aged care workers and others were fired from their jobs for objecting to being vaccinated against COVID-19, including on health, moral or religious grounds.[1264] The ongoing requirement to remain up to date with booster doses meant that some who had adverse reactions to the initial vaccination and were reluctant to receive a further dose have been fired.[1265] We also heard that there was a lack of national discussion and approach on the use and implementation of vaccine mandates.[1266]

3.3.Data, vaccine effectiveness and safety

3.3.1. Data and vaccine effectiveness

The Department of Health and Aged Care told the Inquiry it used data integration as a key tool to help understand the progress of the vaccine rollout as well as changes in the virus as it evolved. This included establishing track and trace capability for COVID-19 vaccines; weekly linking of data from the Australian Immunisation Record, Medicare Benefits Schedule and Pharmaceutical Benefits Scheme into the Person Linked Integrated Data Asset; rapid linkage of population-level data by creating a national single COVID-19 database, the COVID-19 Register; and establishment of strong data-sharing relationships with jurisdictions, other departments and providers, enabling the timely integration of data.[1267]

These data innovations helped drive research to understand the effectiveness of the vaccine. For example, in October 2022 the Department of Health and Aged Care commissioned research from the National Centre for Immunisation Research and Surveillance focused on approximately 3.8 million people aged 65 years and over – almost the entire Australian population in that age group, including those in residential aged care. It found that, in the first half of 2022, COVID-19 vaccination and boosters were effective in protecting against death from COVID-19 by up to 93 per cent compared with those who were unvaccinated. Vaccine effectiveness wanes over time, but the effectiveness of boosters remained above 50 per cent six months after receipt.[1268]

Independent research shows that unvaccinated individuals aged 50 and over had 11.2 times greater mortality rate than those who were fully vaccinated with two doses and received a booster dose.[1269] It is estimated that the vaccine rollout saved 21,250 lives in New South Wales alone. Without the vaccine rollout, six times as many people in New South Wales would have died.[1270] Delaying most primary infections until after mass vaccination meant we had far fewer deaths than countries that took a different approach, like Canada and Denmark.[1271] By 30 December 2021, when 80 per cent of eligible Australians had received two doses of COVID-19 vaccine, Australia had nine COVID-19 deaths per 100,000 population, while Canada had 77 and

Denmark had 55.[1272] This equates to eight times the number of COVID-19 associated deaths if the Canadian death rate were applied to the Australian population.

3.3.2. COVID-19 Vaccine Claims Scheme and vaccine safety

The COVID-19 Vaccine Claims Scheme came into effect at the end of the vaccine rollout.[1273] As at 31 March 2024, 4,282 claims have been lodged with 3,522 claims finalised – of which only 324 were paid out.[1274] The Inquiry received many submissions that voiced concern over a lack of transparency, fairness and accessibility of the scheme process, with some submitting upwards of 1,000 pages of paperwork and waiting hundreds of days for responses.[1275] Many applicants felt they were rejected due to unfair technicalities, where the list of adverse events covered under the scheme was narrow and inflexible.[1276] Independent research from the University of New South Wales reinforces these findings, describing the scheme as a case study in administrative burden which was designed to limit government responsibility and financial exposure.[1277]

> *… we are confident in stating that fewer than 1% of Australians harmed by these vaccines have been compensated – i.e. more than 99% have been abandoned by their government. – COVERSE*[1278]

Up-to-date safety reporting from the TGA highlights that adverse events are rare.[1279] The reporting rate of adverse events from COVID-19 vaccines to 29 October 2023 was two per 1,000 doses.[1280] One recent study, using population data on 46 million adults in the United Kingdom – nearly the whole adult population of England – found the incidence of heart attacks and strokes was lower after COVID-19 vaccination than before or without vaccination.[1281]

Submissions, focus groups and surveys presented to the Inquiry showed a broad and deepening scepticism about the safety of COVID-19 and other vaccines. However, a nationally representative survey conducted by the Inquiry found that most respondents (59 per cent) viewed the safety and efficacy of the vaccine as important, but almost half (43 per cent) rated the federal government's communications on vaccine safety and efficacy as poor.[1282] Many respondents self-reported reactions or had heard firsthand accounts of health episodes people associated with adverse side-effects from vaccines at rates much higher than those of documented vaccine-related medical episodes or the rare reactions seen in large controlled clinical studies.[1283] Statistics from a survey conducted by the National Centre for Immunisation Research and Surveillance show 43.7 per cent of participants in their AusVaxSafety report had at least one adverse event, but only 0.9 per cent reported visiting a GP or emergency department.[1284]

> *[There was] ongoing vilification of alternative opinions about the safety and efficacy of the Covid-19 vaccines and government responses to the pandemic. Only the official government narrative on these matters seemed to be allowed to be vented. GPs were being threatened by Ahpra to be deregistered if they would speak a different opinion. This is a dangerous development as it severely diminishes the trust I can have in my own GP. – Submission 948*[1285]

Other Australians grew sceptical of COVID-19 vaccines after becoming repeatedly sick with the virus even after booster doses (while adults who were not vaccinated reported only having mild symptoms with COVID). Others were anxious about the newness of the vaccines and the rapidity with which they were produced. Sceptical groups perceived this as suggesting a lack of testing and clinical rigour.[1286] One stakeholder told the Inquiry this view demonstrates a lack of understanding of and trust in science that needs to be addressed.[1287] More exploration of this topic is provided in Chapter 5: Trust and human rights.

Using personal anecdotal evidence of vaccine effectiveness[1288]

When COVID-19 vaccinations became available, Mikey* trusted the advice of his support coordinator, his doctor and his family and got three COVID-19 vaccines plus the booster vaccine. Mikey thought that the vaccines would help to prevent him from getting COVID-19. However, he became unwell with the virus four times after getting vaccinated. This led him to become highly sceptical about whether the vaccines actually worked. He reported that he had seen 'conspiracy theories' about the vaccines being harmful. He didn't believe these, but he did feel that vaccines were not as effective as they had been made out to be by government and the media. In hindsight, he felt that the vaccine rollout had been rushed and that it was unfair to 'take away the choice of a person' when it had not protected him from COVID-19 in the end.

The Inquiry heard many personal stories from the pandemic, including on the use of COVID-19 vaccines. Some of these were profoundly tragic. These may not stand out against whole of population safety figures, but we are thankful for the time and bravery of those who came forward to share their stories of injury following vaccination. It also highlighted the trauma and uncertainty many families went through when an awful incident was thought to be the result of a vaccine but could not be proved or firmly demonstrated as such.

3.4. Declining rates of vaccination

Public health experts and priority cohort representatives were aligned in expressing concern around post-pandemic declining vaccination rates, particularly among at-risk populations, for both COVID-19 and other serious illnesses.[1289] Recent reports indicate that, in some areas in Queensland, for example, only around 80 per cent of children are vaccinated against polio.[1290] Figure 7 demonstrates how stark the COVID-19 vaccination decline has been among older Australians.[1291] Doses administered in 2021 largely represents the two-dose primary course of COVID-19 vaccination, and some third doses, with the booster program commencing November 2021.[1292] From 2022, doses administered were primarily boosters.

Figure 7: Vaccination doses administered to 65 years and older between 2021 and 2024[1293]

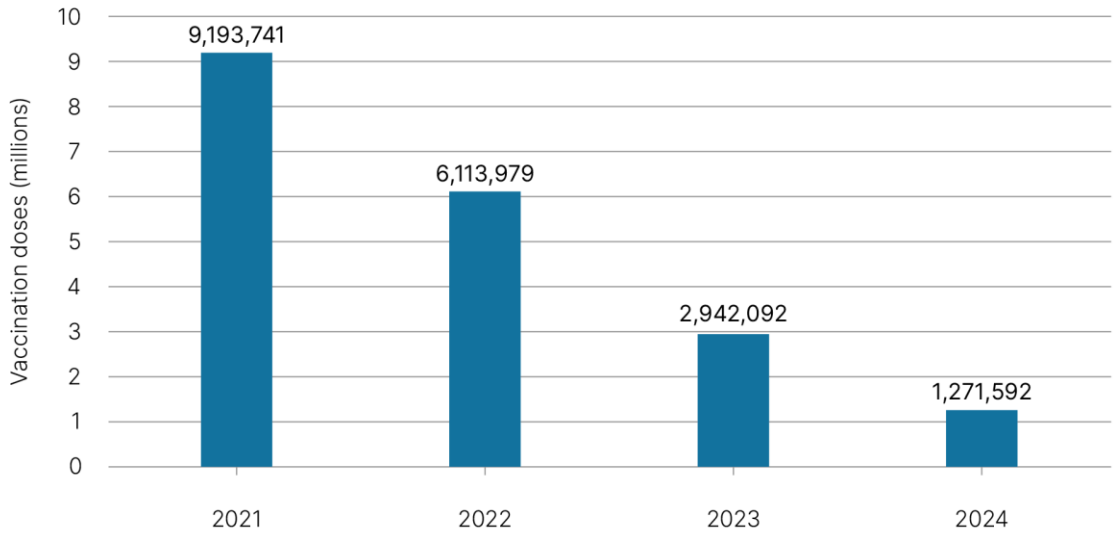
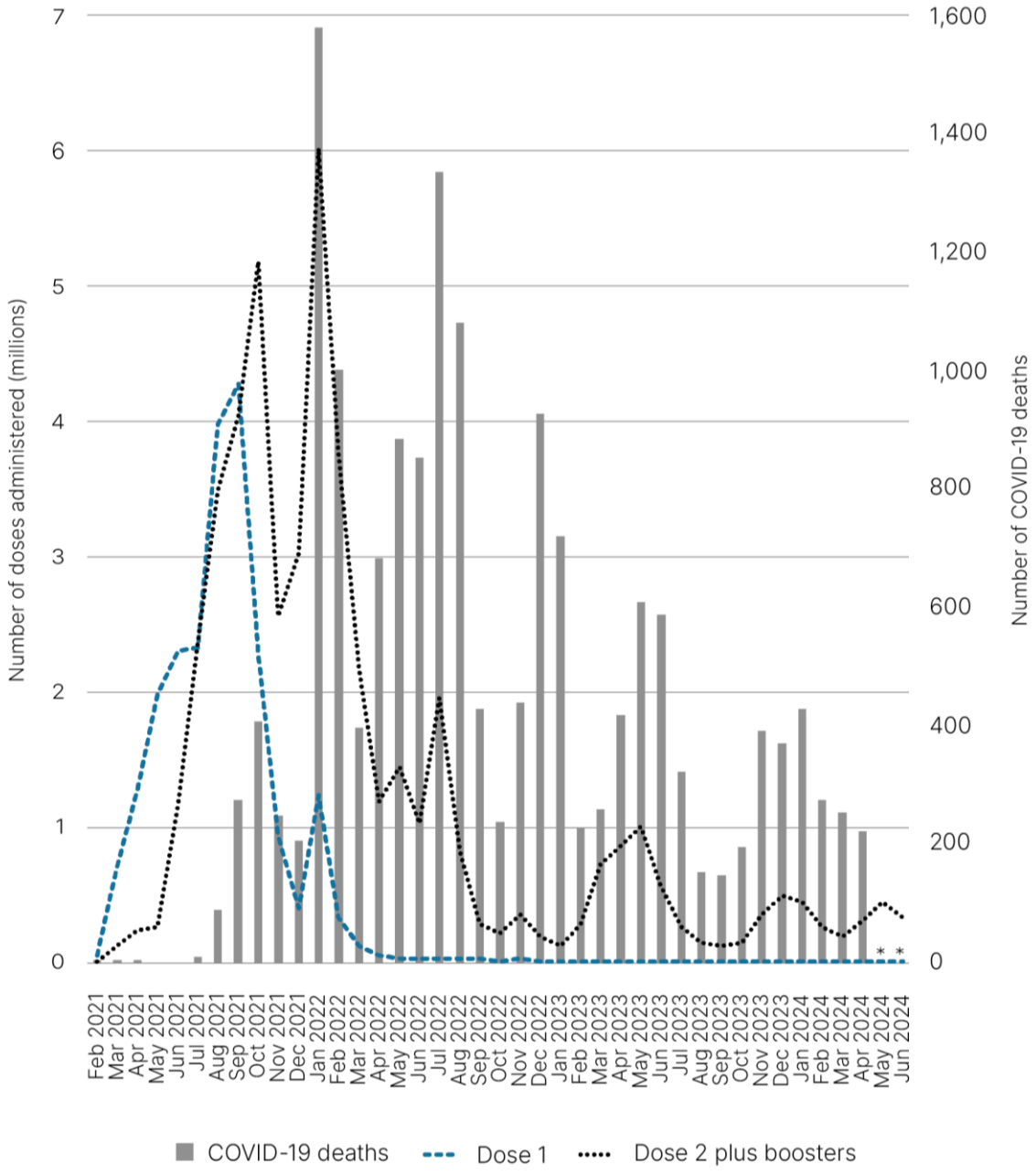


Figure 8 demonstrates the declining overall trajectory of COVID-19 vaccinations in Australia since February 2021.[1294]

Figure 8: Vaccine doses administered (LHS) and the number of COVID-19 deaths (RHS) between February 2021 and June 2024



Note: Data on vaccine doses was provided by the Department of Health and Aged Care. Data on COVID-19 deaths is sourced from the Australian Bureau of Statistics. The asterisk (*) denotes where COVID-19 deaths have not yet been reported.

Vaccination rates are generally lowest in non-English-speaking communities and areas where there are high levels of socio-economic disadvantage. As at November 2023, people in high-

risk groups (people aged 65 or older or with two or more conditions that are high risk for COVID) who are not proficient in English are 60 per cent less likely to be vaccinated for COVID.[1295] Those living in very remote areas are 35 per cent less likely to be vaccinated for COVID.[1296] Unfortunately, early data from the Australian Bureau of Statistics shows people born overseas were almost three times as likely to have died from COVID-19. People born in the Middle East were 10 times more likely to have died with COVID-19 (see Chapter 15: Culturally and linguistically diverse communities).[1297]

At the winter peak of 2023, 2.5 million people aged 65 and over were not up to date with their COVID-19 vaccination.[1298] This trend is not unique to COVID-19 – there are pronounced declines in vaccination rates for many other diseases. Less than half of people in their 70s were vaccinated for shingles; and one in five were vaccinated for pneumococcal disease.[1299] Many of these groups have worse overall health outcomes to start with.[1300] Poorer access to vaccines compounds the risk of severe illness among those who need improved access most. These issues are compounded by a lack of accountable government targets for the adult vaccine population and poor reporting on vaccine disparities.[1301]

3.5.Treatments

COVID-19 antiviral treatments were an important part of Australia's response to the COVID-19 pandemic, especially to support the immunocompromised and those for whom vaccination was not medically recommended. Independent research on the use of COVID-19 antivirals in Victoria provides promising data for their effective use for vaccinated individuals aged 70 and over.[1302] Treatment with Paxlovid® was associated with a 73 per cent reduction in the risk of death. Treatment with Lagevrio® was associated with a 55 per cent reduction in the risk of death. Cases treated within one day of diagnoses had a 61 per cent reduction in the risk of death, while those treated within four or more days only had a 33 per cent reduction in the risk of death.[1303] These findings were at odds with clinical trial data and there was some debate about effectiveness in people at different levels of disease risk. However, recent results from the PANORAMIC trial also found benefit from Lagevrio® in a vaccinated population where people treated for acute COVID-19 experienced fewer and less severe COVID-19 symptoms, accessed health care less often, and took less time off work compared with those not given the treatment.[1304] The differences were small though, and large numbers would need to be treated to see the benefit.

While antiviral usage was important, we heard there was a lack of transparency about what treatments were being held in the National Medical Stockpile and who they were being distributed to.[1305] This meant pharmaceutical companies did not know whether their products were being appropriately distributed and prescribed, and this impacted ongoing reviews of their effectiveness and safety. We also heard there was a lack of data linkage between the states and territories and the Australian Government to understand who was accessing antivirals.[1306]

Pharmacists noted that the high demand for non-approved COVID-19 treatments, such as ivermectin and hydroxychloroquine, risked supply disruptions for people who are prescribed

these drugs, and demand should have been better managed by regulators.[1307] Another health expert told the panel only a very small number of Australians are prescribed ivermectin (which is used to treat tropical diseases such as scabies).[1308] Supply for those users could have been protected by other means rather than restricting off-label use of ivermectin for COVID-19, an action that may have only served to further fuel conspiracy theories.[1309] While it was shown to have no clinical effect against COVID-19, it was also a safe drug and restricting access fuelled distrust of government.

Unfortunately, many Australians are struggling to get access to antivirals after getting sick with COVID-19.[1310] Those living in rural areas were 37 per cent less likely to get access than those living in cities, and Indigenous Australians were nearly 25 per cent less likely to get them despite being nearly 70 per cent more likely to die from COVID-19.[1311] The difference within cities is stark, with those aged over 70 in Sydney's affluent Eastern suburbs being nearly twice as likely to receive access as those living in some Western suburbs.[1312]

3.6.Reopening Australia

The reopening of Australia coincided with the first and second Omicron waves of December 2021 to July 2022, leading to the highest number of COVID-19 cases and deaths during the pandemic. The largest number of COVID-19 associated deaths peaked in January (1,828) and July (1,759) of 2022.[1313] Each of these spikes exceeded the total number of deaths recorded during the Delta wave (1,396), and the total number of deaths during Omicron was almost four times higher than that recorded across the two years of the pandemic.[1314]

The highest number of deaths during this period occurred in New South Wales and Victoria. New South Wales went from having six deaths during the pandemic's second wave between June and November 2020 to 3,009 during Omicron in 2022.[1315] Those aged 70 and over during Omicron (up to September 2022) accounted for almost 90 per cent of total deaths.[1316] Some of highest numbers of COVID-19 associated deaths during Omicron were among those born in the Middle East, southern and eastern Europe and north-west Europe.[1317]

Representatives of older Australians and people with disability in particular told the Inquiry of the fear they experienced at the sudden transition to opening up. They said they felt public health measures, including isolation and mask wearing, which had helped to keep them safe, were dismantled too quickly. Some said working from home and online education options also ceased and they stopped attending because campuses were not accessible or safe for them.[1318]

While the use of restrictive non-pharmaceutical interventions went on for too long and was undermined by a lack of clearly communicated scientific evidence, we heard that the pathway to reopening happened too suddenly.[1319] Australia's rolling back of significant restrictions occurred at a time when a particularly transmissible strain of the virus was circulating. Key stakeholders were clear that greater care should have been taken to protect vulnerable populations, especially older Australians, Aboriginal and Torres Strait Islander people and people with disability, once the economy reopened.[1320]

4. Evaluation

Planning and preparedness helps enable a swift pandemic response

To develop, approve and roll out COVID-19 vaccines and treatments swiftly, governments, industry, the health and care sector, the community and experts had to work closely, innovatively and at a speed and scale not attempted before. Outcomes were smoothest where an existing process was in place and used.

Provisional approval by the TGA was in place before the pandemic for assessing vaccines and treatments and this ensured the agency could work at pace while maintaining clinical rigour.[1321] Its assessment was aided by the early adoption of vaccines overseas, as it could evaluate international data on their safety and efficacy. This was only possible because Australia was trailing behind in its rollout; however, having this process in place did enable consistent and close collaboration between regulators and manufacturers, ensuring critical lines of communication remained ongoing.

The Australian and state and territory governments worked with private providers and industry to hit an 80 per cent vaccination rate against COVID-19 by November 2021. The significance of this achievement, as an unprecedented logistical exercise and a case of rapidly protecting the health of Australians, cannot be overstated. Had this not been done, tens of thousands more Australians would have become critically ill or died of the virus and a potentially overwhelming burden would have been placed on our primary care and hospital systems.[1322] This was very close to the target and date set at the outset of the vaccine rollout, but it was not a smooth road.

To achieve this outcome, the Australian Government had established a different way of rolling out the COVID-19 vaccine, and setting up a new network took time. The existing infrastructure within the National Immunisation Program could have been better leveraged in collaboration with the states and territories. Similarly, the speed and efficiency of the national vaccination effort would have been assisted by having processes in place to ensure the widest range of health professionals could assist in the effort from day one, including ensuring equitable remuneration across providers. The successful role the Royal Flying Doctor Service played in vaccinating rural and regional communities underlines the importance of utilising ongoing, trusted relationships when providing life-saving care during an emergency.

Early decision-making for the vaccine rollout underestimated the delivery and size of the exercise. Too great a logistical burden was placed on the Department of Health at a time when their capability was already under pressure managing other critical aspects of the health response.[1323] Preparing for similar mass immunisation efforts should include detailed pre-planning with states and territories and consider delivery approaches that leverage existing distribution structures, and include in-reach services to the aged care and disability sectors. Data collection and monitoring structures are now improved with the establishment of the whole-of-life immunisation register, the Australian Immunisation Register, but need to be nimble in a pandemic to monitor variation in uptake across the community in real time during an accelerated rollout. We heard many positive accounts of how Operation COVID Shield

improved data capture, public reporting and decision-making, but there are difficulties involved in changing operational roles and responsibilities mid-stream.

Centralised planning capabilities are not prevalent across the Australian Public Service. Where Defence or the National Emergency Management Agency is engaged to help, it is best done in a planning and advisory capacity in the first instance. Their experience in contingency planning is invaluable, especially when provided to agencies that do not specialise in operational capability. The most significant value they can add during a massive logistical effort like the vaccine rollout is during this early stage, ensuring challenges and solutions are properly captured.

Unfortunately, there was lack of planning to provide for the safety of vulnerable populations once Australia hit high rates of vaccination and reopened. While the National Plan to Transition Australia's National COVID-19 Response identified measures that would be rolled back with reopening, it did not identify how vulnerable populations would be protected in the inevitable increase in viral transmission. The increase in COVID-19 case numbers and deaths, particularly among older Australians, and the fear that some people felt during the fast transition to opening up, highlights the need for clear de-escalation pathways that are informed by ongoing monitoring and risk assessment.

Innovations in data sharing and linkage are critical to maintain going forward

The need for data-informed policy and operations as well as public thirst for data during the vaccine rollout led to improvements in data capture, sharing and linkages across the Australian and state and territory governments and industry. This critical work was enabled where there were interoperable data systems in place or where these linked systems could be swiftly enabled. The pandemic created the will to make this happen and overcame previously entrenched barriers to data sharing. Unfortunately, our ability to link immunisation data to local government area, age and other key demographic characteristics, including being part of a priority group, has regressed since the pandemic.[1324] Retaining a focus on ongoing data collection and interoperability is critical; there is merit in these arrangements being pre-agreed between jurisdictions hardwired into the appropriate plans.

These data innovations eventually generated vital evidence that helped keep Australians safe. They enabled sharing of data to provide up-to-date, granular but de-identified information on coverage, effectiveness and safety of vaccines and treatments. For the vaccine rollout, they enabled data analysis down to the level of a specific town or region, which helped in the accurate and timely delivery of vaccines. In some cases they provided the necessary evidence to drive targeted strategies to improve rates of coverage among populations at high risk of COVID-19. Timely sharing of this data was key to its utility.

Evidence-based approaches were most effective in keeping Australian safe during the pandemic – for example, linking COVID-19 case numbers and vaccination rates in aged care helped to prioritise vaccine supply and surge workforce support. But there are many more data points across Australia's health system that need to be linked to provide the evidence required to ensure a more equitable response to a health emergency across Australia. The Australian

Centre for Disease Control will play a critical role in this space, facilitating a nationally integrated communicable disease dataset across Australia's health system.

In contrast to advances made in data collection during the rollout, there was inadequate preparation to monitor the longer term impacts of COVID-19 even though these conditions are relatively common. There remain large gaps in our knowledge about long COVID, and about vaccine effectiveness in preventing long COVID. Identifying control groups early in the pandemic would have helped to address potential evidence gaps in advance. Established data linkages would have allowed for early monitoring and analysis of long COVID and supported the translation of evidence into clear public health messaging.

Clear communication of scientific information is required to maintain public confidence

Much of the available official information about the COVID-19 vaccines and treatments was complex, subject to rapid change and not always timely or well targeted. This undermined relationships between government and the health sector and also undermined public confidence in the safety of the vaccines. Patient access to COVID-19 treatments also suffered. Greater national coordination and clarity was needed to give frontline workers certainty as to when treatments could be prescribed and how their patients could access them.

The speed at which new evidence was being received by experts and the desire for new information meant that communication was delivered at rapid pace, and many members of the public were for the first time consuming scientific information. It did not help that the public did not always know who to trust and who had an authoritative voice. It is clear that lack of a trusted voice affected public trust in vaccines and treatments. This must be addressed as a priority well ahead of a future public health emergency. The government's webinars and public forums were recognised as a success, as they provided critical vaccine information. This underscores the importance of having clear and consistent lines of communication in an emergency. These pathways of engagement help to clear away confusion and combat misinformation. Where there is a void of timely information, scepticism will fill it (see Chapter 11: Communicating in a crisis).

The COVID-19 Vaccine Claims Scheme was intended to address emerging vaccine hesitancy and give primary care providers certainty. However, it arrived too late in the pandemic and was undermined by profoundly negative user experiences around slowness and difficulty of access. We are mindful of international research that reinforces how establishing fair and accessible vaccine claims schemes is fundamental to maintaining public health and overall confidence in vaccination, especially in a pandemic.[1325] Noting persistent and rising rates of vaccine scepticism since the pandemic, we encourage a formal review of the scheme so governments can understand how similar processes could be streamlined and made more transparent in future.

Lessons must be learnt from the unintended consequences of vaccine mandates

Vaccine mandates are common practice in high-risk settings such as in aged care, but their justification for use in general population settings eroded trust during the COVID-19 pandemic. Rapid movements of multiple variants of concern through the community had led to increases

in population level immunity. This made the difference between the vaccinated and unvaccinated marginal in terms of risk infection to themselves and others. An evidence-based pathway was needed for rolling back the use of vaccine mandates as key conditions were met, especially as they impacted critical industries and workers. Where restrictive measures remain in place without clear justification, or longer than the original justification suggested, scepticism is reinforced.

Vaccine mandates have been associated with broader declines in public trust in government and medical science since the pandemic.[1326] Mandates were among the least preferred and understood measures taken during the pandemic.[1327] Australians now fear the politicisation of medical science and are placing their trust in local healthcare providers instead of government leaders and media.[1328]

General vaccine hesitancy and scepticism has increased around the world since the pandemic.[1329] The declines are most pronounced among at-risk cohorts who would benefit most from vaccination.[1330] These trends will lead to a high risk for future health emergencies. We support recent Commonwealth efforts, working with the National Aboriginal Community Controlled Heath Organisation, to improve uptake of vaccines among Aboriginal and Torres Strait Islander people. However, much more work needs to be done to reverse ongoing declines in vaccination rates across Australia. Any future use of vaccine mandates must be carefully balanced against their tendency to erode social licence, increase vaccine hesitancy and work against the goal of improving vaccination for certain groups.

5. Learnings

- The portfolio approach to vaccine procurement was justified given the uncertain operating environment posed by the pandemic. Early reliance on the AstraZeneca vaccine (and the subsequent issues with the vaccine) suggests future efforts might better distribute supply between different brands.
- Australia's health technology approvals process worked well to ensure rigour and safety and enable timely access to life-saving COVID-19 vaccines and treatments.
- The risk equation for vaccine safety and efficacy will change during a pandemic, especially where vaccines are approved through a provisional pathway. This creates a balance between sharing the most up-to-date information and overwhelming the public and providers and, if mismanaged, can undermine public trust.
- The vaccine rollout started slowly due to supply constraints and the need to establish new delivery and storage mechanisms. It improved over time as vaccine stock and sites increased, outreach programs were established across jurisdictions, and decision-making and data reporting were improved under Operation COVID Shield.
- The Department of Health was tasked with delivering the vaccine rollout at a time when its capabilities and workforce were under intense pressure. Its speciality is in policy design and advice, with logistical expertise sitting with the states and territories.

Planning capability is more readily provided by emergency management agencies or the Department of Defence.

- The vaccine rollout did not fully leverage Australia's world-class healthcare workforce or existing vaccination delivery systems. The breadth of expertise of nurses, pharmacists, Aboriginal Health Workers and other health workers should be more appropriately drawn on from the outset of a health crisis to support logistical efforts.
- Despite COVID-19 vaccination rates improving for the general population over 2021, there were particular challenges meeting targets for vaccination among priority cohorts. This resulted from a lack of pre-planning and tailored outreach programs for these cohorts.
- Vaccine mandates were a controversial tool that accelerated vaccine uptake and helped achieve the target under the national plan for reopening. However, they contributed to distrust in government, increased vaccine hesitancy and carried profound social and economic costs for those who could not or decided not to get vaccinated.
- Vaccination rates for many diseases, including COVID-19, have fallen since the pandemic, with vaccine fatigue and increased anti-vaccine misinformation being key drivers. An unvaccinated population increases vulnerability to co-occurring outbreaks that would overrun the healthcare system.
- There was no contingency in pandemic planning for surveillance for long-term sequelae, or measures that should ideally be put in place at the outset to capture cases and controls to monitor for early indications of longer term disease consequences – persistent symptoms, altered risk for developing other conditions, or exacerbation of pre-existing conditions. The standing up of cohorts of first cases and clinical trial platforms, supported by funding, pre-approved data and ethics protocols, is critical to developing an evidence base in a crisis.

6. Actions

6.1. Immediate actions – Do in the next 12–18 months

Action 2: Review the COVID-19 Vaccine Claims Scheme, with a view to informing the future use of similar indemnity schemes in a national health emergency for a wider profile of vaccines and treatments.

The COVID-19 Vaccine Claims Scheme review should:

- examine barriers to access for the vaccine scheme based on feedback from the public, users and primary care providers, and links between the scheme and vaccine hesitancy
- consider international research on vaccines claims schemes and their relation to public health and confidence in vaccination
- include findings of how future processes could be improved.

Action 7: Finalise establishment of the Australian Centre for Disease Control (CDC) and give priority to the following functions for systemic preparedness to become trusted and authoritative on risk assessment and communication, and a national repository of communicable disease intelligence capability and advice.

The CDC must:

- Commence upgrade to a next-generation world-leading public health surveillance system, including:
    - commencing establishment of new comprehensive surveillance infrastructure that incorporates wastewater surveillance to facilitate disease detection and monitoring, risk assessment, national data sharing, and operating with state and territory systems to provide national updates on notifiable diseases
    - developing a plan to improve at-risk cohort data collection and linkages to ensure cohorts are visible in an emergency and responses can be appropriately tailored
    - ensuring captured surveillance data meet the analytical needs of public health responders and support rapid research and real-time evaluation
    - drafting enhanced surveillance protocols for potential use in pandemic settings, including for proactive community screening and for the cohort of first cases to monitor for persistent symptoms resulting from infection
    - enhancing early warning surveillance capability and related modelling to inform procurement planning for the National Medical Stockpile (to be undertaken by the Department of Health and Aged Care)
    - confirming linkages with New Zealand health authorities and other regional partners, and agreeing to near real-time data and intelligence sharing with them and other regional partners.

Action 9: Agree and document the responsibilities of the Commonwealth Government, state and territory government and key partners in a national health emergency. This should include escalation (and de-escalation) triggers for National Cabinet's activation and operating principles to enhance national coordination and maintain public confidence and trust.

This should include:

- greater clarification of roles and responsibilities, including around key areas of shared or intersecting responsibility such as vaccine distribution in a national health emergency.

Action 11: Improve data collection, sharing, linkage, and analytic capability to enable an effective, targeted and proportionate response in a national health emergency.

This should include:

- Improvements to data collection and pre-established data linkage platforms, including:
    - delivering actionable insights regarding optimal emergency response design to ensure emergency responses can be appropriately designed, tailored and adjusted through real-time evaluation of both intended outcomes and broader impacts.
- Expanded capability in Australian Government departments to collate and synthesise economic and health data to inform decision-making, including:
    - translating health statistics and information for the wider health community and general public, helping to build health data literacy particularly in pandemic settings
    - leveraging research across academia and research institutions through Australian Centre for Disease Control (CDC) technical advisory groups in key methods areas.
- Finalising work underway to establish clear guardrails for managing data security and privacy and enabling routine access to linked and granular health data, and establishing pre-agreements and processes for the sharing of health, economic, social and other critical data for a public health emergency, including:
    - ensuring rapid mobilisation of real-time evidence gathering and evaluation
    - sharing within the Australian Government, between the Commonwealth and states and territories and with relevant sectors
    - finalising agreements by the CDC on the sharing of health data between the Commonwealth and the states and territories (also see Action 7)
    - prioritising key health data on Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities, people with disability and children and young people.

Action 13: Agree nationally consistent reforms to allow health professionals to work to their full training and experience.

Options outlined in the independent Scope of Practice Review should be prioritised, including harmonising existing legislation and regulation which govern what services pharmacists can provide.

In addition, these reforms should include:

- simplifying and streamlining the legal basis under which Aboriginal and Torres Strait Islander Health Practitioners are able to administer medications
- supporting nurse-led clinics to work independently and be remunerated equitably for services provided that are commensurate with those of a GP, such as for vaccination
- streamlining legislative changes made during the pandemic to engage the broadest possible range of health professionals in ongoing immunisation efforts.

Action 17: Develop a national strategy to rebuild community trust in vaccines and improve vaccination rates.

As part of this:

- Health Ministers should urgently agree a strategy for addressing the broad decline in COVID-19 vaccination, especially among priority cohorts, with a view to formalising policy responsibility to improve these vaccination rates by target dates
- There should be an emphasis on lifting early childhood vaccination rates for other communicable diseases to pre-pandemic levels.

Action 19: Develop a communication strategy for use in national health emergencies that ensures Australians, including those in priority populations, families and industries, have the information they need to manage their social, work and family lives.

The strategy should:

- create a central public health emergency communications hub that serves as a single source where the Australian public can find integrated information about the emergency response around the country
- be informed by behavioural science and risk communication expertise
- proactively seek to ensure consistency of messaging between levels of government, providing supporting rationale and evidence for different approaches
- leverage existing communication channels through professional bodies, unions, local government and advocacy groups
- meet the diverse needs of communities across Australia, including through co-design
- include mechanisms to coordinate and consolidate communications, considering the timing and frequency of announcements

- include a strategy for addressing the harms arising from misinformation and disinformation, which incorporates:
    - information environment and ongoing narrative monitoring to combat misinformation
    - transparent engagement with social media companies
    - promotion and coordination of policies to increase the resilience of the information environment
    - partnership between government and trusted organisations, experts, media, and other influencers to pre-bunk and debunk misinformation.

6.2.Medium-term actions – Do prior to the next national health emergency

Action 23: Progress development of the Australian Centre for Disease Control in line with its initial progress review and to include additional functions to map and enhance national pandemic detection and response capability.

This should include:

- developing dedicated ethical guidelines and processes for national health emergencies to enable rapid review in a changed risk context and enable real-time crisis-related research, overseen by the National Health and Medical Research Council.

Action 25: Continue to invest in monitoring and evaluating the long-term impacts of COVID-19, including long COVID and vaccination adverse events, mental health, particularly in children and young people, and educational outcomes.

- Where evidence from ongoing monitoring and evaluation shows long-term impacts of the COVID-19 pandemic continue to be seen, governments must ensure policies and programs in place are tailored to actively address the impacts
- Evidence collected from ongoing monitoring and evaluation should inform plans and responses to future public health emergencies in order to mitigate similar long-term impacts.

Chapter 11 – Communicating in a crisis

1. Context

During a health emergency, communication helps build confidence and trust in the crisis response, improves public understanding and engagement, and alleviates fear.[1331] Communication also acts as a tool to engage and encourage people to take an active role to slow the spread of the virus. Most people wanted to stay safe and help others stay safe during the COVID-19 pandemic. Communication was a crucial part of supporting them to do this.

The ability to communicate information clearly, honestly, empathetically and responsively can mean the difference between successful mitigation of some of the most harmful aspects of a pandemic, and an irreversible loss of trust and greater spread of the virus. If communication fails, everything else government does to manage the pandemic is put at risk.

Effective communication is a two-way process that delivers clear messages via appropriate platforms, tailored for diverse audiences, affirmed by trusted people, and providing an avenue to hear from communities.[1332] Trust is inextricably linked with communication; this includes trust in the people delivering the message, trust that the policy decisions are evidence based and balanced and made for the good of the community, trust that the health system is fit for the task, and trust in governance. The long-term success of the overall emergency response depends on developing and maintaining trust with the public.

COVID-19 was the first significant global communicable disease challenge in the era of widespread social media use.[1333] Before COVID-19, digital technologies and social media platforms were rapidly changing the way people accessed news and information.[1334] With traditional news readership declining, there has been widespread closure of newsrooms and an increasing number of 'news deserts' – locations that have little to no local news coverage.[1335]

Many Australians spent extended periods under 'stay at home' orders, which led to an increase in use of the internet.[1336] In this environment it was hard for people to find reliable information as well as work out what was true or false and what action they needed to take to protect themselves and others. Over time, Australians began to engage less with COVID-19 news and sought to minimise stress by avoiding information about the pandemic.[1337]

As public health crises become more complex and multifaceted, there is greater reliance on effective communication. Australia's COVID-19 experience showed that future pandemic communication must be effective in situations of considerable uncertainty and fear, changing evidence and evolving pathogen and risk settings. Communication also needs to be able to manage conflicting messages, conflicting opinions among experts, differing information needs across diverse communities and industry sectors, changing levels of trust and resilience and a more active climate of misinformation and disinformation.

2. Response

Whole-of-government communication arrangements are set out in Australia's communicable disease plans, including the February 2020 COVID-19 Plan (see Chapter 3: Planning and preparedness).[1338] Under these arrangements, the Australian Government had responsibility for developing and coordinating national public communications and communications to the health sector, the primary care sector and at international borders. State and territory governments had responsibility for public communications about the situation and approach within their jurisdiction.

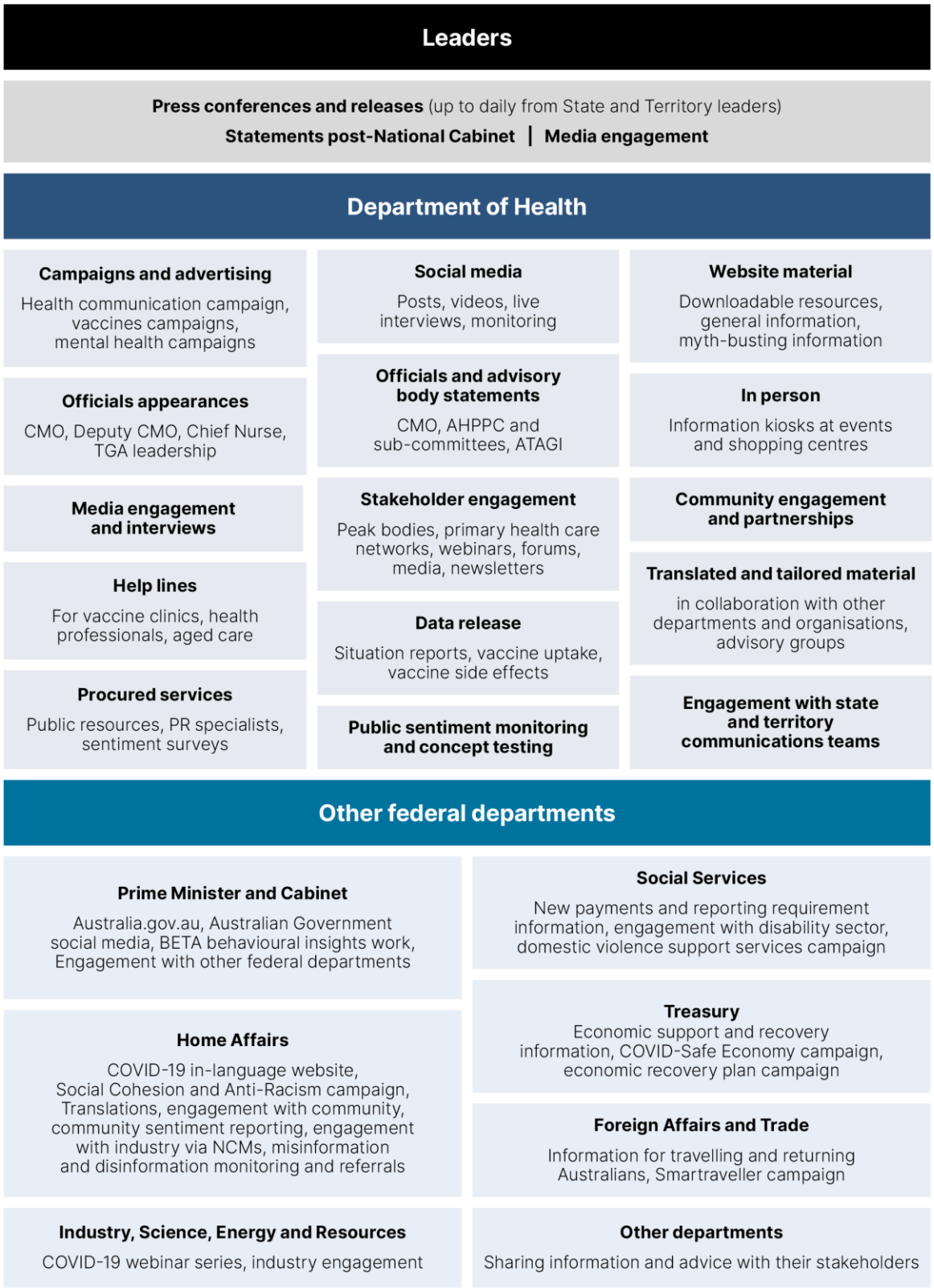
The COVID-19 plan emphasised principles of openness and transparency, accuracy, two-way communication, use of existing channels, consistent clear messages, timeliness, communication with vulnerable populations, flexibility and use of a wide range of methods to reach a broad audience.[1339]

Australians engaged with communications in various ways that changed over time depending on:

- individual circumstances and information needs (for example, people who were medically at risk or were essential workers sought specific information to suit their needs)
- how credible and trusted they found the source
- availability and accessibility of information provided through official channels.

People had multiple sources of information. Australian Government communications included messages from leaders and federal departments. Communication activities from departments ranged from campaigns to information provided from sources including officials, expert advisory bodies, and partnerships with institutions, the health sector, and community groups (Figure 1).

Figure 1: Australian Government COVID-19 communication activities



The most accessed sources of information during COVID-19 were:[1340]

- media coverage, which partially drew on information from government sources (63 per cent of Australians used media as a source for their information about COVID-19)
- government (federal and state and territory) departmental websites, including Health.gov.au and Australia.gov.au (41 per cent of Australians sought information from these sources)
- press releases and conferences by the Prime Minister (35 per cent), and First Ministers (46 per cent)
- conferences from health officials (including the Chief Medical Officer, Chief Nursing and Midwifery Officer, Therapeutic Goods Administration leadership and deputy Chief Medical Officers) (42 per cent)
- social media posts from official government sources (21 per cent)
- people also reported engaging with information from their workplaces, schools and from family, friends, and support workers.[1341]

2.1. Communication activities in each pandemic phase

The focus of Australian Government communication activities and messaging changed over the course of the pandemic. This reflected the evolving risk situation and government interventions. This section provides an overview of the key Australian Government messages in each phase. While not exhaustive, it illustrates the scope and complexity of communications in a changing pandemic environment.

2.1.1. Alert phase (January–April 2020)

Reports of the 'novel coronavirus', as it was then called, emerged in early 2020. Little was known about the virus at the time. It was seen as a predominantly 'overseas' issue, with media reports and social media posts discussing rising numbers of international cases. The first messages from Australian leaders and the Chief Medical Officer began in late January 2020.[1342] They focused on factual statements about the disease and its possible impacts on Australia.[1343] Messaging emphasised that the Australian Government was following the public health and medical advice and assuring and commending the public and institutions.[1344]

Once National Cabinet was established in March 2020, it was the primary decision-making forum for national measures. Decisions of National Cabinet were communicated by the Prime Minister through press conferences and media releases.[1345] Major decisions made by National Cabinet included restrictions on gathering size and other social distancing measures, international travel restrictions, self-isolation for arrivals, and advice for 'at-risk' groups.[1346]

To provide context for these decisions, messaging focused on the need to 'slow the spread' and 'flatten the curve'.[1347] The public was advised that measures could stay in place for the medium term because we would be 'living with this virus for at least six months'.[1348]

Australian Health Protection Principal Committee statements gave updates on the virus and disease and provided further information on some of their recommendations to government on issues such as travel restrictions, isolation requirements for returning travellers and testing for healthcare workers.[1349] Following the establishment of National Cabinet, Australian Health Protection Principal Committee statements provided further background on health information and advice to complement National Cabinet's decision announcements.

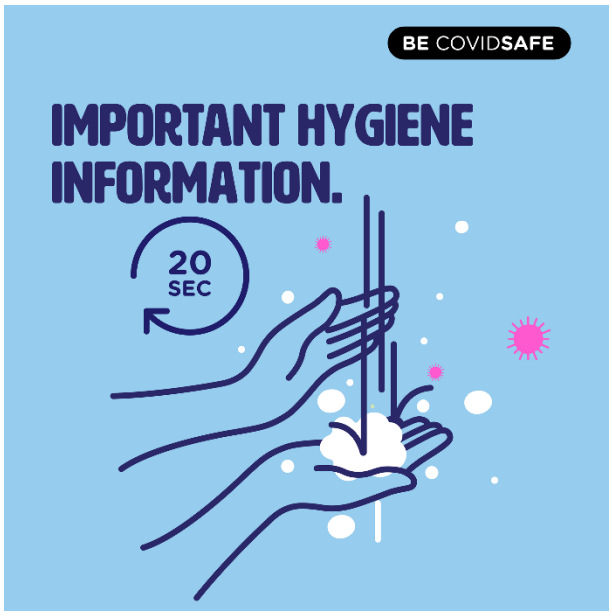
The Australian Government Department of Health rolled out the first national communications health campaign in mid-March 2020.[1350] The campaign's focus was on hand hygiene, support for at-risk groups and COVID-19 testing information for Australians returning from overseas.[1351] This was soon followed with information about enhanced social distancing measures and other protective behaviours (Figure 2).

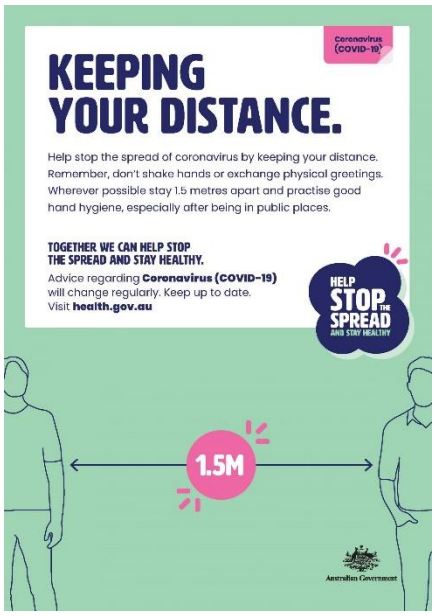
By March 2020 the first Australian COVID-19 related death was reported and community cases increased, leading to Australia's first wide-scale multi-state lockdown. As a result, public health communications needed to be scaled up substantially to respond to the crisis and address the level of fear and uncertainty in the community. There was a rapid expansion of communication channels out of government, an increase in messaging frequency and a staffing surge into communications areas, particularly into the Department of Health.[1352]

The pandemic quickly escalated into an economic and whole-of-society crisis. Media and National Cabinet statements expanded to cover economic and social issues, including the introduction of economic measures to support households and businesses.[1353]

In April 2020 the Department of Health launched a daily infographic (used across media, social media and online) on the COVID-19 situation in Australia, including counts of tests, cases, hospitalisations and deaths.[1354] This was just one of many trackers released publicly by governments and other parties, including academic institutions and media organisations. The public looked to these sources frequently (and official sources and the media often referenced them daily) as a way of knowing whether sacrifices being made were 'flattening the curve', and for clues on when measures like lockdowns might end. Jurisdictions and agencies used different methods to determine and convey COVID-19 data, for example hospitalisations could include any positive test or only COVID-19 admissions, and the trackers that combined these data were difficult to compare and interpret.[1355]

Figure 2: Social Distancing and Hygiene (Alert phase) communication samples[1356]





2.1.2. Suppression Phase (May 2020 – January 2021)

In this phase, announcements following National Cabinet meetings used the catchphrase 'Save lives and save livelihoods'. State and territory government messaging focused on how National Cabinet decisions would be implemented in their jurisdictions. It also covered other locally imposed public health measures, including 'stay at home orders', travel restrictions, work arrangements, restrictions on aged care facility visiting and internal and international border closures. Because pandemic response settings were different in each state and territory, there was different health messaging across the country (see Chapter 9: Buying time).

Attention on state and territory leaders increased as they implemented specific local measures in response to disease oubreaks around the country. First Ministers and Chief Health Officers held press conferences up to daily, giving updates on case numbers and changes to health measures. During the second wave from July 2020, which mostly affected Victoria, the then Victorian Premier was the most prominent Australian politician in the media, holding COVID-19 press conferences on 120 consecutive days.[1357] The journalists covering COVID-19 were more often political reporters than health reporters.

Australian Government departments were also producing messages for the general public on the economic and other support measures. The Department of the Prime Minister and Cabinet engaged regularly with other agencies to build and improve consistency in communications across the Australian Government and communicated these through Australia.gov.au.

2.1.3. Vaccine rollout phase (February 2021 – November 2021)

On 22 February 2021 the first COVID-19 vaccine dose was given in Australia. This was the start of the vaccine rollout phase. It lasted until national vaccine coverage of eligible Australians over 16 years reached 80 per cent in November 2021.[1358] In this phase, the public profiles of the Australian Technical Advisory Group on Immunisation (ATAGI) and the Therapeutic Goods

Adminstration (TGA) significantly expanded and their acronymed names came into everyday use. However, it is unclear how many people fully understood their roles or responsibilities, and ATAGI spokespeople did not have a strong media presence.

The TGA released regulatory updates on issues such as vaccine approvals and ongoing safety and adverse event information.[1359] The mainstream media often picked up on these reports, especially if they were to do with a death. The general public did not have a good understanding of vaccine adverse event reporting and causation investigations, and this left them more vulnerable to misinformation.

ATAGI's publicly available advice included clinical recommendations; advice for vaccine usage, including on prioritisation and eligibility; and statements and weekly meeting updates.[1360] It also produced comprehensive clinical advice documents for vaccine providers as well as vaccine information, safety information and shared decision-making guides for the general public.[1361] Its advice was mostly used to inform the Minister for Health and Australian immunisation providers, but there was significant public attention on and media coverage of their statements and advice about the COVID-19 vaccine rollout (see Chapter 10: The path to opening up).[1362]

In this phase the Department of Health developed a specific communications strategy with the tagline 'Safe, Effective, Free'. Messaging was increasingly informed by surveys and research, advisory groups, and community and expert stakeholders.[1363] The early stages of the strategy focused on vaccine purchasing agreement announcements, the regulatory approval process, and safety and efficacy of the vaccines.[1364] In later stages messaging that actively promoted vaccination was introduced as access widened. The final stage focused on addressing barriers to vaccination and encouraging people to complete their dosing schedule. [1365]

The communication approach shifted in mid-2021 with the establishment of Operation COVID Shield. COVID Shield communications focused on the 20 per cent of the population who were uncertain about vaccination and introduced greater transparency on the progress of the rollout.[1366] When Operation COVID Shield began it supported a significant increase of publicly available information. This included daily COVID-19 vaccine dose number reports, with more detailed breakdowns by age, sex, jurisdiction, vaccine brand, administration site and eventually doses delivered to at-risk priority groups.[1367]

In January 2021 the Australian Government launched a series of regular COVID-19 vaccine forums bringing together government officials, scientists and researchers, including experts, prominent in the media to share information. These forums enabled discussion on the vaccine rollout and helped ensure information in the public domain was well informed. This included information regarding vaccine evidence, the rollout, and communcation challenges.[1368] The forums were jointly hosted by the Department of Health (National Health and Medical Research Council), ATAGI and the National COVID-19 Health and Research Advisory Committee.

2.1.4. Recovery phase (November 2021 to present)

In late 2021, as vaccination targets were met and Australia started to shift into the transition/recovery phase, messaging focused on boosters for eligible groups, rapid antigen tests (RATs), changing testing requirements and arrangements, and antiviral treatments. The Department of Health progressively scaled back its daily updates to the current combined vaccine, treatment and case and outbreak trends report, which give monthly updates on cases; deaths; hospital, aged care and disability impacts; vaccinations; and treatment information.[1369]

The current approach to COVID-19 communications is set out in the National COVID-19 Health Management Plan for 2023. This plan includes key objectives of 'Informed community, informed choices' and 'No one left behind'. It aims to increase community education and engagement (particularly to maximise vaccination, treatment uptake and community protection) and provide additional supports to those most at risk of severe COVID-19. The plan outlines that messaging should continue about the COVID-19 vaccine program, treatments and preventive behaviours and also informs people about ongoing impacts of COVID-19, including long COVID.[1370]

2.2.Tailored and two-way communication

The government's approach to communications was to prioritise messages in an accessible, inclusive way to maximise engagement and reduce the need for tailoring.[1371] Over time, the government began to use multi-channel, integrated approaches to communicating with specific parts of the community and developed written material and other messaging that was designed or adapted for different populations.[1372] Further information is available in the Equity section.

The Department of Health sought to improve communications with priority populations – including people with disability, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities, and older Australians – after those communities reported concerns about previous communications.[1373] Throughout 2020 and into 2021 newly established advisory groups within the Department of Health set up communications working groups and advised the department on the development of tailored communications for these groups.[1374] As discussed in the Equity section, some of these groups have an ongoing role post-pandemic and have expanded to advise on health outside of COVID-19.[1375]

The government also increasingly worked with community organisations and trusted 'voices'. It created partnerships with community leaders and helpers[1376] to tailor resources and drive grassroots campaigns, provided flexible funding to community organisations, and produced videos featuring health professionals and carers.[1377]

The government produced key health and vaccine information in 85 languages other than English,[1378] partnered with media organisations to develop video content in language, and created audio and video materials in up to 15 Indigenous languages.[1379] Closed captioning and Auslan interpreters were used during Department of Health updates and media briefings, as well as at leaders' press conferences.[1380]

Media organisations were important in reaching specific audiences. Community broadcasters and local news organisations served as a vital information source for people in regional and remote Australia; Aboriginal and Torres Strait Islander people; culturally and linguistically diverse and youth communities; and older Australians.[1381] SBS provided in-language online video resources and simultaneous interpretation of media conferences into key languages.[1382] Aboriginal and Torres Strait Islander media teams assisted with translations into Indigenous languages and delivered content relevant to those communities.[1383]

Australian government departments were responsible for communication and information sharing with stakeholders within their areas of responsibility. The Department of Health distributed messaging through medical colleges and associations, the National Aboriginal Community Controlled Health Organisation, community and representative organisations, aged care facilities and private sector health providers. It also distributed information through forums and released online statements and guidance documents.[1384]

The Department of the Prime Minister and Cabinet acted as a central point within the Australian Government for sharing of information. It shared Department of Health information with other agencies, and those agencies then shared it with the sectors or industries for which they held policy or regulatory responsibility.[1385] The National Coordination Mechanism was also used for information sharing across the Australian Government, states and territories, industry bodies and the private sector (see Section 4: Preparedness, governance and leadership).[1386]

2.3.Information guiding public health communications

Australian and state and territory government departments did surveys, media analyses and research on information needs and how people were percieving communications on COVID-19.[1387] These were sources of feedback on how Australians were responding and felt about the crisis. They also provided important feedback on the efficacy of measures. For example, the Department of the Prime Minister and Cabinet behavioural science team researched Australians' behaviours to support government communications and policy design of health measures, the vaccine rollout and information needs of businesses and industry.[1388]

In the pre-vaccine phase, the Department of Health set up a large, bespoke survey and social media monitoring. This informed communications and advertising efforts, assisted the Australian Health Protection Principal Committee to understand the impacts of and adherence to COVID-19 measures, and eventually informed the vaccine rollout communications strategy and logistics.[1389]

Jurisdictions carried out similar analysis. The New South Wales Department of Customer Service used its central data analysis and customer insights capability and direct engagement with key communities to inform decision-making and communications efforts. Throughout the pandemic it shared the data it collected, including health and economic inputs and information received directly from priority populations, across the New South Wales Government, providing feedback on the efficacy of communications and health measures and assisting with adapting the response. For example, its data helped to shape different types of messaging for different people in different locations, encouraging them to adhere to public health measures and

increasing intention to vaccinate. The department collated data from a variety of sources, including an ongoing COVID-19 sentiment survey.[1390]

2.4. Addressing misinformation and disinformation

Health has long been an area where misinformation is rife, and it is a target for well-established and coordinated disinformation campaigns.[1391] Accordingly, measures to address misinformation and disinformation were factored into the Australian Government's health communication strategy from the start.[1392] The aim was to build community understanding to inoculate against false and misleading content and to counter false narratives as they occurred.

Australian Government departments increased their social media presence to provide people with easy access to official information, to help mitigate the risks of information voids. It promoted its official messaging and responded to comments on social media. For example, the Department of Health received over 50,000 comments per month at the peak of the pandemic.[1393] The department actively addressed misinformation, misconceptions and rumours using proactive posts and statements and through the 'Is it true' page on its website.[1394]

The Australian National Clinical Evidence Taskforce was set up to investigate which treatments were backed up by evidence and provided advice to clinicians and government. This served as an authoritative source of information and assisted in countering misinformation and confusion.[1395]

The Department of Home Affairs led an interdepartmental committee that shared information on misinformation, disinformation and violent extremism.[1396] The department also monitored social media content for harmful misinformation and disinformation. Where it found this type of content, it asked social media companies to review it against their terms of service policies. Between 16 March 2020 and 18 May 2023 the department referred 4,726 social media posts to social media companies. Social media companies took action on 3,098 of those posts to either remove them or limit their reach.[1397]

During COVID-19 the major social media companies introduced specific terms of service policies, algorithm changes and third-party fact-checking organisations to limit harmful content about the pandemic.[1398]

In December 2019, the Australian Government requested that major digital platforms in Australia develop a voluntary code of practice to address online disinformation and news quality concerns.[1399] In 2021 the Digital Industry Group released its voluntary Australian Code of Practice on Disinformation and Misinformation (the DIGI Code). The DIGI Code, which was updated in December 2022, seeks to reduce the risk of online misinformation causing harm to Australians. The Australian Communications and Media Authority oversees the operation of the DIGI Code, though it currently has no formal enforcement powers. There are currently nine signatories to the DIGI Code: Adobe, Apple, Meta, Google, Legitimate, Microsoft, Redbubble, TikTok and Twitch, which have committed to some safeguards against online disinformation and misinformation.[1400]

3. Impact

3.1. Early communications needed to build understanding and promote action

People valued the clear information from government during the alert phase

In early 2020, initial uncertainty about what was happening quickly turned into a massive amount of data, media and commentary.[1401] Once numbers of cases and deaths started to rise in Australia, people increasingly sought out more information. This demand was met with an overwhelming volume of information from many sources.

By mid-March 2020, 80 per cent of news was related to COVID-19.[1402] Information of varying quality spread quickly and widely on social media and digital services. Amongst this noise, governments competed to provide official information to the public that was clear and digestable.

As expected in a pandemic situation, information about the virus, the disease, the situation in Australia and internationally, the effectiveness of measures and how the public were responding to them was constantly changing. The panel was told that everything changed so fast, minute by minute and hour by hour.[1403] Rapidly changing, uncertain and complicated circumstances meant it was often challenging to provide clear information. This made information difficult to absorb and understand.[1404]

Some stakeholders expressed the view that although the information enviroment was challenging, communication was viewed as successful, particularly in the alert phase.[1405] Australians were told to 'stay at home', 'slow the spread', and 'flatten the curve'.[1406] Health experts and the media used engaging graphics to explain complex scientific concepts and describe virus transmissibility so that Australians could understand more about the virus and how effectively the government's approaches were driving down case numbers.

Figure 5: Chief Medical Officer demonstrating health measures 'flattening the curve'[1407]

The Inquiry's community input survey found that most people agreed the Australian Government helped them understand COVID-19 (73 per cent agree).[1408] Another report found people thought the government had explained what they could do (81 per cent agree).[1409] At the peak of the pandemic (2020–2021), people agreed government information was easy to access (77 per cent), was clear and easy to understand (73 per cent), was up to date (73 per cent) and was provided at the right time (64 per cent); and people thought they were given enough information on what to do to protect themselves (COVID-safe messages) (65 per cent).[1410]

Delays and some confusion were, however, a feature of early communications. There were some criticisms that messaging from leaders to the public was slow and inconsistent at times. While the health sector was ramping up to respond, early government communications to the general public were limited, which meant in many cases they lacked the knowledge required to understand the upcoming rapidly changing technical information and prepare for what was to come.[1411]

There was some mixed messaging by leaders and in the media, particularly about social distancing and attendance at major events such as the football and Formula 1.[1412] However, messages progressively became clear, calm and directive. They followed risk communication principles, emphasising reassurance and acknowledging uncertainty. The most impactful communications followed a structure of 'what we know, what we don't know, and when we'll know more'.[1413]

Fear drove some communications, undermining effectiveness as the pandemic wore on

International reports of high death rates and overwhelmed hospitals and morgues led to intense fear. We heard the Australian Government generally attempted to avoid using fear to promote compliance.[1414] However we also heard that some communications used 'scare tactics', blame, or a castigating or aggressive tone.[1415] For example, some felt that media was focused on 'outing' people who were primary cases in outbreaks; some government messaging was seen as patronising; and, a New South Wales advertisement featured a woman in a hospital bed struggling to breathe.[1416]

There were examples where the government used more empathetic messaging. This includes the Australian Health Protection Principal Committee statement in February 2020 calling out racism and xenophobia and highlighting that public health measures were recommended to contain the virus, not to isolate communities from the support and care they need.[1417]

The Inquiry's community input survey report and other research outlines that people thought the government response to the pandemic (and therefore communications on measures) were appropriate at the time.[1418] This support remained high up to February 2021 (up to 80 per cent agreeing) but has declined since. Some people reported negative experience with COVID-19 information, becoming increasingly distrustful and thinking the content was biased towards 'the government agenda'.[1419] In some instances, this caused people to seek information from their social networks and alternative sources online.

An overload on information contributed to confusion and fatigue

The Inquiry's focus groups reported that as the pandemic progressed, the general public became increasingly confused and frustrated by the overwhelming amount of information and the government's approach to communication.[1420] We heard that despite efforts from government some found information relating to the pandemic overly detailed and complex.

The initial success in controlling COVID-19 was followed by a drop in public enthusiasm for 'controlling the spread'. Success meant that the perceived risks of community spread reduced with relatively few Australians having direct experience of infection. Pandemic fatigue set in when it became clear that the pandemic would last some time and there would be a long period of uncertainty, stress, despair and grief. [1421] As the levels of interest, trust and confidence dropped, the government found it challenging to maintain engagement and motivate people through communications.[1422]

How communications were perceived was heavily influenced by what was being messaged and whether people agreed with it, the public's engagement, and their levels of trust in both the government making the decisions and the person delivering the message.

3.2.Coordination and consistency

> *The pandemic saw government and public health officials trying to understand, convey and adjust to the immediate threat of COVID-19 and the evolving evidence and research. Coordinating and communicating a clear and consistent message during this crisis was not always successful, with states and territories often using different sources thereby providing different health advice – Queensland Nurses and Midwives' Union.[1423]*

The speed of information made consistency difficult

Evidence and public health orders changed quickly, sometimes daily. While advice was intended to be responsive to rapidly changing circumstances, information being released so quickly created confusion.[1424] Advice was sometimes seen as inconsistent and contradictory.

New public health orders would often start from the day of announcement and not always be accompanied by detailed information to explain what was different and why, and what it meant for families, workplaces and industry sectors.[1425] In some jurisdictions they started on a Friday afternoon, making it virtually impossible to make changes to rostering and other working or family arrangements.[1426] In particular, people found it difficult to keep up with changing rules about lockdowns, close contacts and domestic border closures.[1427] This was particularly true for businesses that operated across state borders, including aged care and food and grocery providers.

Different approaches undermined national consistency in communication

Australia's federated system made nationally consistent and coordinated communication even more difficult. Frequent and rapidly implemented changes to advice that were simultaneously

communicated from multiple levels of government added to the already overwhelming information environment. Communication struggled to keep up with the speed at which things were changing.

Some of the most confusing information scenarios occurred because there were differing approaches around the country. Conflicting messaging from the Australian Government and state and territory governments added to confusion. For example, we heard the different approaches to schooling between the Australian Government and state and territory governments caused significant confusion among representative bodies, school boards, principals, teachers, parents and students.[1428] The Australian Government was not able or willing to explain why approaches diverged. It was often not clear to the public what the objective or rationale for response measures was and the reasons why there were differing approaches.

Participants in the Inquiry's survey rated the Australian Government's communication performance most negatively in relation to the reasoning behind different rules and restrictions in different regions (43 per cent) and state border closures and the reasons behind different rules for different restrictions across the country (51 per cent).[1429]

Coordination assisted in bringing consistency

We heard that National Cabinet communications were most effective when there was an agreed communications strategy with high-level summary points. This type of communication assisted each state and territory to then tailor localised advice.[1430] However, this did not always occur. We heard that, on several occasions after National Cabinet meetings, the Prime Minister announced decisions that states and territories did not consider were the same as those agreed at the meeting.[1431]

Australian Government officials were also hearing outcomes from National Cabinet at the same time as the public.[1432] The Prime Minister's press conferences were rapidly translated into public material, but there was little opportunity to provide further background and explain the basis for decisions or how they would be implemented; or to align Australian Government, state and territory communications. We heard this made coordinated implementation of National Cabinet decisions challenging.

The timing of announcements was identified by many to be important to strengthen alignment and consistency between national and state communications, and for messaging to be supported by expert voices to assist in translation. We heard that although Australia.gov.au was a central hub of information, communication could have been more coordinated across Australian Government departments and with other levels of government.[1433] Our research indicates people wanted a clear, central source of live information that provided straightforward guidance about what to do and why.[1434] Industry groups told us it was very difficult to get advice directly from public health officials to assist them to interpret and implement key measures.

Mainstream media played an important role

We heard that people were tuning into leaders' press conferences every day, but the media had a role to explain all the comments leaders made. Without the media, that 'sense-making' role would have been missing.[1435] Media organisations told us they viewed themselves as having a key role in identifying what was important, credible and relevant and then helping their audience make sense of that information.[1436] Despite their resources they found it difficult to grapple with changing information.[1437]

We heard that political leaders were more willing to directly brief journalists on complex information.[1438] The Department of Health also expanded its media engagement, holding media briefings and daily press conferences where spokespeople took questions from journalists and provided background information.[1439] Despite this, we heard criticism that government departments retained 'normal' risk-averse ways of operating when engaging with media, with limited transparency and slow responses.[1440] Differing views may be indicative of the fast-paced demands of the crisis operating environment. From some departments we heard it was not always an advantage to rely on media reporting.[1441]

3.3.Trusted sources and science communication

Experts played a critical role in keeping the public informed but a lack of transparency undermined trust

The most trusted sources of COVID-19 information in Australia were scientists and health experts (85 per cent), state/territory governments (67 per cent) and the federal government (66 per cent).[1442] From the outset, leaders emphasised that they were 'following the advice of medical experts'.[1443] However, some believed political leaders 'hid' behind experts to justify tough or unpopular decisions.[1444]

We heard there was a reluctance to acknowledge uncertainty and explain where there were unknowns when making decisions, particularly from political leaders.[1445] Some experts were then placed in the firing line when they could not provide sound scientific bases for particular measures (such as curfews or travel limits).[1446] However, we also heard that experts thought there were extraordinary opportunities to better engage the public, particularly to build understanding and maintain trust in situations where there was uncertainty and reliance on emerging evidence, or where evidence and decisions were contested.[1447]

We heard there were unintended impacts of confidentiality constraints on communication from experts. Confidentiality limited sharing of advice between national expert technical advisory groups, which impacted coordination of their public communications.[1448] It also meant there were fewer experts available to explain complex advice through the media or other channels.

People who did not always have the required expertise or contextual knowledge of government-held data or decision-making stepped into those information voids to provide commentary.[1449] We heard that across the pandemic, but particularly during the vaccine rollout (see 3.4 Vaccination communications impact), there was a large amount of conflicting information being shared with the public, including different views expressed by people seen as

health experts. There was a proliferation of 'armchair experts', including reputable scientists who were providing opinions outside their areas of expertise. This confused members of the public who found it hard to identify which 'expert' was qualified to comment.[1450]

The panel heard views that there was not enough transparency of data and expert advice that was informing government decision-making. Specific concerns were raised regarding the limited transparency of meeting minutes and advice from important advisory groups including the Australian Health Protection Principal Committee and ATAGI.[1451] Stakeholders told the Inquiry that the Australian Health Protection Principal Committee as Australia's peak health advisory group was no longer transparent and its advice was not visible.[1452] Because generally only high-level outcomes were shared, there was limited insight into how decisions were made and how different considerations were weighted to get to the final advice.[1453]

The panel heard differing views on whether all data should be made publicly available in every instance because there are risks involved in releasing raw information without analysis or context.[1454] Transparency is needed for trust, but sometimes it can work against other principles of good communication, such as accuracy. We heard that transparency, without ensuring information is understandable and accessible, is problematic and does not improve trust or promote positive health behaviours.[1455]

3.4. Vaccination communications impact

Communications during the vaccination phase were some of the most criticised, despite following a communciations strategy that was comprehensively informed by research, advisory groups, and community and expert stakeholders.[1456]

Vaccine messaging was affected by the changing risk and trust situation; a breakdown between Australian and state and territory governments; and increasing levels of misinformation and disinformation circulating widely on social media and other channels, even before COVID-19 vaccines were available.

Initial communication strategy matched the slow vaccine rollout

Strong calls to action were not initally used. Instead, the approach focused on factual and reassuring messages on vaccine safety. This approach was informed by consumer research and was intended to avoid creating demand for a vaccine the government could not (at that stage) supply quickly.[1457] Despite some hesitancy, surveys up to April 2021 indicated that the intention to vaccinate was over 70 per cent and increasing as more information about international vaccination programs became available, and confidence in the Australian program was rising.[1458]

Changing advice caused confusion and undermined confidence in the vaccines

There was significant attention on communications coming from ATAGI, as the pre-eminent Australian advisory group on immunisation, and the TGA, as Australia's medicine regulator. Pre-existing terms of reference and confidentiality constraints prevented advisory group members from publicly commenting on their advice outside of published statements. During COVID-19,

the co-chairs of ATAGI were appointed spokespeople, but they were not present at annoucements of changes to the rollout in response to their advice. Some thought this was a problem because nuance in their advice was lost when communicated to the media by others.[1459]

One of the most confusing aspects for the public to navigate related to changes to the vaccine rollout in response to a very rare but serious side-effect of the AstraZeneca COVID-19 vaccine. ATAGI advice to change eligibility by age was responsive to international evidence, but it had a profound impact on Australia's vaccine rollout. On multiple occasions, a rush by government to announce changes to the rollout in response to ATAGI's advice created communication and implementation challenges. There were two instances where press conferences by the Prime Minister and health department officials were held to announce changes, without first informing vaccine providers.[1460]

The situation itself was complex. It was difficult for the experts, let alone the public, to balance the risks of the effects of COVID-19 with side-effects of the vaccine, especially as most of Australia was yet to experience the full effects of the virus. This was heavily debated publicly by people with varying degrees of health expertise, and by politicians, leading to further confusion and distrust.

Organised anti-vaccination groups stepped up their counter-messaging. Complexity was also worsened by some of the carefully chosen language being used, with subtle differences in meaning between terms (such as 'preferential use', 'consider' and 'recommend') being lost.

At this time, Australia was in the enviable position of having virtually zero community transmission. However, it was known that the next wave could occur at any time. That came in June 2021 with the start of the Delta wave. This highly transmissible and deadlier variant changed the risk environment and led to another round of changing vaccine recommendations. This was again complicated by public disagreements, including between governments and with ATAGI.[1461] By June 2021 intention to vaccinate had decreased to its lowest level.[1462]

In response, the Department of Health adjusted its communications. It placed an even stronger focus on vaccine safety; tailored messaging to people over 50 years who were particularly affected by the AstraZeneca changes; and addressed barriers to vaccination.[1463]

The further reset that came with Operation COVID Shield was associated with an expansion of data transparency. It was accompanied by the first major campaign directly encouraging people to be vaccinated. However, there was some criticism at the time that it was an ineffective call to action that did not create a strong emotional pull. It was also noted as being alienating for some, especially people from culturally and linguistically diverse communities coming from countries with a background of conflict.[1464] While 'Arm yourself' was adapted to 'Protect yourself' for culturally and linguistically diverse and Aboriginal and Torres Strait Islander audiences,[1465] most would have still been exposed to the original version in mainstream media.

Figure 3: First phase of the Operation COVID Shield campaign – 'Arm yourself' (June 2021).

By November 2021 the COVID-19 vaccine rollout had met and quickly surpassed its 80 per cent vaccinated target, which allowed for the easing of restrictions. However, concerns remained regarding contradictory messages on safety, perceptions of overstated vaccine effectiveness claims, and less tolerance and understanding of evolving evidence, when compared with earlier phases of the pandemic.

3.5.Misinformation and disinformation

Misinformation and disinformation, particularly within the context of a deadly health emergency, are significant issues. Misinformation about COVID-19, the response, vaccines and treatments was very prevalent, with serious consequences.[1466] By the end of the vaccine rollout phase, most adult Australians (82 per cent) had come across misinformation about COVID-19.[1467] Most of this misinformation imitated or contested scientific and health messages, particularly in relation to COVID-19 vaccines, where misinformation and disinformation was spreading even before vaccines were available.

False and misleading content gave rise to harms including a reduced willingness to be vaccinated or increasing risky behaviour such as using dangerous alternative therapies, or taking ineffective treatments not backed by science, such as hydroxychloroquine and ivermectin.[1468]

Opportunists and scams also became a problem during COVID-19. The Australian Competition and Consumer Commission estimates that Australians lost a record $851 million in scams in 2020.[1469] Between 2020 and 2023 Scamwatch received over 6,415 reports mentioning the coronavirus, with more than $9.8 million in losses.[1470] Opportunists capitalised on massive interest and an environment of fear. As early as March 2020 the TGA was already seeing some

people take advantage of the pandemic by advertising products that claimed to prevent or cure COVID-19. A very public case was legal action by the TGA against Pete Evans' 'subtle energy revitalisation platform', resulting in a fine of $25,200 for false advertising.[1471] While the product was removed, it had already contributed to the misinformation and misleading information contributing to public confusion.

There were also increases in online harassment, bullying, and extremist content.[1472] In Australia, there were instances of threats directed at health experts, media, officials, and politicians during lockdowns and the vaccine rollout, and incitement to violence. We heard concern that experts were silenced by online vitriol and this could affect their willingness to publicly engage in a future crises.[1473] There have been warnings that extremist groups have 'exploited' anger at COVID-19 policies to radicalise Australians into believing conspiracy theories and adopting white supremacist and other radical ideologies.[1474]

Social media presented fresh challenges

Social media expands access to information of varying quality and feeds people curated content, which can reduce the diversity of information people are exposed to.[1475] However, social media is not the only place where misinformation exists, and we saw examples of unsubstantiated claims made in traditional media.[1476] Social media and media more generally could be vectors for misinformation, or useful in addressing it. Some media organisations, for example, played a vital role in identifying information gaps and proactively addressing misinformation.[1477] Social media and online forums also had a positive function in providing places where experts could rapidly share credible information and research with their peer networks and the public.

It is difficult to quantify the impact of the government's approach to addressing misinformation and disinformation. Misinformation kept evolving, so the approach to addressing it needed to adapt. Government did work to stay engaged and responsive to this changing situation. These efforts ranged from pushing out communications to prevent or fill information gaps, through to working with community groups and leaders to tailor information to respond to specific narratives circulating in those communities.[1478]

Some people viewed the approach taken to refer content to social media platforms for review against their terms of service as controversial or government censorship. We have heard that efforts to address misinformation and disinformation should be as transparent as possible, and informed by the public.

Vaccine adverse event reporting and causation investigations are complicated, and this left the public confused and more vulnerable to misinformation.[1479] People struggled to make sense of the reporting, as very few had previously looked at these data for other vaccines and most did not how the system worked, or changes to the system. There were no previous equivalent data to compare with where new vaccines had been rolled out on this scale, or under the same level of public scrutiny. Organised anti-vaccination groups took advantage of the confusion, claiming all adverse reports, particularly deaths, were vaccine-related. In the year of the rollout, Australia had fewer deaths than in 2020, and many fewer than were expected. [1480]

3.6.Tailored messaging for priority populations

Communication for priority groups were less effective

Communication activities for priority groups were less effective than general communications campaigns, particularly regarding vaccination.[1481] We heard that government communications were often not considered accessible, timely or tailored to the diverse requirements of priority populations.[1482] This was despite efforts to provide accessible and inclusive information.

We heard there were initial delays in developing appropriately tailored messaging, delivering messaging using trusted voices and feeding back the community experience of communications and the measures.[1483] Several advisory groups were established and consulted on communications for priority populations. While these advisory groups played a key role, in some instances they were established too late, with the void already filled through informal channels, often including international media sources or family and friends overseas.[1484]

This exposed a lack of planning and knowledge within government on how to effectively engage and communicate with different parts of Australia's population.[1485]

Lack of tailored communication undermines public health objectives

The Inquiry heard that a lack of tailored communications made it difficult for some groups to understand and comply with public health directions and increased confusion and anxiety.[1486] Some groups felt forgotten and left behind in the response. We also heard that the public officials and experts did not reflect the cross-section of the community.[1487] Information vacuums led some groups to turn to informal information sources and left space for misinformation to flourish.[1488]

Communications were most successful when they were interpreted and disseminated by trusted voices and community organisations.[1489] This leveraged their understanding of groups' needs and preferred information channels and was helped when government also provided clear advice in plain English that could be translated, tailored and disseminated. The government also developed unbranded templates (such as social media tiles and newsletters) that organisations could utilise, and these were also successful.[1490] Flexible funding from government enabled tailored communications activities, but we heard some organisations performed significant amounts of work developing messaging relevant to their communities and disseminating official information without additional funding.[1491]

Communication needs are ongoing

The panel heard that people still want ongoing communication about COVID-19.[1492] This is particularly the case for people with disability or other people at greater medical risk from COVID-19. People told us that they feel abandoned by the abrupt shift in focus away from COVID-19 and the associated reduction in information.[1493]

> *Participants expressed confusion and loss of confidence in why COVID-19 information rapidly came to a standstill. They were unsure if the Government was taking it seriously, and why there were so many rules imposed in hindsight, which*

> *changed so often and stopped so drastically. - University of Western Australia, Bilya Marlee School of Indigenous Studies*[1494]

4. Evaluation

Plans need to be coordinated and flexible to address changing circumstances

> *It's difficult to quantify or characterise the sheer scale and complexity of public communication requirements from the earliest days of the pandemic to today – Cochrane Australia and the Centre for Health Communication and Participation.*[1495]

The importance of communication to minimise harm was identified early in the pandemic, along with the need for agility to adapt to the various phases of the pandemic and associated changes in knowledge, risk and trust. There were positive aspects to the government's early communications approach: messaging was timely and clear, experts were brought in to strengthen credibility and engagement, and communication approaches were innovative. However, government communications were slow to adapt over the course of the crisis, did not explain the health orders and related frequent changes to rules or exemptions, and were not responsive to community sentiment. We heard that collectively this caused frustrations, heightened tensions and increased the likelihood of people turning off from government communications or going to other information sources.

The panel concludes that there were deficiencies and opportunities for improvement in future national communication strategies. Coordination and information-sharing mechanisms must be able to provide individuals, businesses and communities clear explanations about 'what this means for me and why'. Without this, governments run the risk of diluting the effectiveness of measures and eroding goodwill. Early engagement with community-based organisations, community leaders and local government was shown to be key to both shaping and communicating health measures relevant to the local communities. This applies equally in the business sector.

As COVID-19 wore on, there was greater questioning of the rationale underpinning the governments' response, specifically the duration, severity and broad application of response measures. Confusion about significant changes in the goals of the national response contributed to this reduced confidence.

People perceived there were inconsistencies between the national strategy of aggressive suppression (as agreed by National Cabinet) and the approaches employed by some states (e.g., COVID-zero). Later, when there was a change in national position toward living with the virus, communication failed to bring the public along; in fact communication fell away at this critical time.

When pushed to defend the evidence behind differing measures across jurisdictions, some governments moved towards catastrophising the situation – talking of the deaths that had to be prevented, and the damage the virus could do. This polarised government communications about the level of risk, which were challenging to address.

Governments must reconsider broader communications planning and implementation for future pandemic responses to better coordinate with state and territory approaches – they cannot work in isolation. This is especially important when there are major shifts in pandemic management or when there are perceived inconsistencies in the approach across jurisdictions. A major goal of national and state communication should be to proactively identify and respond to differences in public health measures and explain the rationale.

The panel acknowleges that efforts made by the Department of Health and the Department of the Prime Minister and Cabinet helped coordinate messaging and sharing of information through a central portal with links to federal and state and territory information. However, they were not sufficient to deliver a cohesive and timely national communications approach and did not meet the expectations of industry and community sectors, and the general public.

The panel considers the frequency and timing of National Cabinet decisions minimised the opportunity for health officials and sectoral lead agencies to be made aware of and prepare supporting material. Inconsistent or delayed responses to requests for greater transparency or more detail relevant to their specific circumstances resulted in increased criticism of government and impacted trust.

While the government's communications capability and capacity improved over time, the broad effectiveness of the communications varied and, in the absence of post-action reviews, it is difficult to assess the efficacy of individual strategies and their contribution to health outcomes. Real-time evaluation needs to be a priority going forward given the very rapid nature of change in a pandemic.

Vaccine communication weakness

The comunication challenges around vaccines were significant, and the government's approach added confusion to what is already a complicated topic. This could have been better managed with leadership, and a clearer role for ATAGI in the communication of vaccine-associated risks. ATAGI could have been better supported by communications experts. This may have helped maintain greater confidence in its changing advice, both with the public and within government. The consequence of this poor communication was to undermine broader trust in the vaccine rollout.

There are immediate and longer-term consequences of the challenges surrounding communication on vaccination. Inconsistency in messaging among governments and experts impacted the vaccine rollout. Concerns about very rare but serious side-effects also had a significant impact on slowing the vaccine rollout just when community transmission and hospitalisations were on the rise. This pandemic legacy of a loss of trust in vaccines within an active and entrenched vaccine misinformation and disinformation environment is having a continued effect on Australian vaccination rates, including COVID-19 boosters and non-COVID-19 vaccines.

Communication strategies do need to take into account the sensitivities of vaccine-related severe reactions and loss of life, and how to communicate the risk in a balanced way to the public. This must be taken into account in communication plans, including specific approaches

that deal with complex health data, their limitations and their meaning – including case counts, hospitalisations, deaths, excess deaths and vaccine adverse events.

Tailored communications

As highlighted in the Equity section, there was significant need for and benefit in tailoring communications for priority populations. The government's initial communications relied heavily on a universal communication approach. We recognise that starting with broadly accessible, simple messages has a place, and that tailoring communications for groups and individuals can take time; however, too often initial messages were not simple, accessible or meaningful for all audiences.

There were occasions when messaging was unsuitable for some groups. For example, the 'Arm yourself' campaign was confronting for some, particularly people coming from war-torn backgrounds. The message was modified for some groups, but the original message continued to roll out in a national campaign, which was visible to all.

Communication for priority groups improved over the course of the pandemic. Advisory groups were a good example of mechanisms for community-informed design that improve the speed and relevance of messaging as well as maintain relationships and a two-way flow of information. These supported the development of innovative and cohort-engaging communication at the community level. These trusted communication pathways were very powerful and particularly important as broader trust diminished. In going forward, governments need to engage early and resource these functions.

Several national and state and territory agencies successfully deployed behavioural science approaches in tandem with direct feedback from communities. A particular standout to the panel was the combination of data integration and direct community feedback undertaken by the New South Wales Government. These systems produce powerful insights but take time, resourcing and cooperation to build and are key foundations for pandemic preparedness.

Transparency and trust

The high level of adherence to public health measures was an encouraging feature of the pandemic and requires further examination of the role of communication in achieving it. Political leaders, health experts, and journalists often worked together in innovative collaborations to deliver information about the pandemic for Australian audiences. However, much of this work was not coordinated by government and was based on voluntary efforts. A key lesson of the pandemic was the importance of testing the traditional emergency management communication strategies to enhance our preparedness.

However, there were instances where the government actively placed limits on experts and advisory groups engaging fully with the public. Examples of this included Australian Health Protection Principal Committee advice being subject to Cabinet confidentiality requirements, and barriers to ATAGI explaining their advice. At a point when there was significant public attention on these groups, this only fuelled distrust and allowed commentary by everyone except the experts best placed to explain. The pandemic highlighted the need to have highly

nuanced advice and evidence communicated to the public by the people who best understand it, supported by communication experts.

Misinformation and disinformation

There is work underway to address misinformation and disinformation. During the pandemic the focus was on proactive communication to counter misinformation, including by establishing credible sources of information and trying to avoid major information voids. However, there are a range of other tools and evidence-based approaches that could be more often deployed in a crisis, such as countering narratives as they occur, and deterrence measures. These need to be supported by longer-term community resilience building activities that protect against harm to individuals and wider society.

The panel welcomes initiatives to address misinformation and disinformation through literacy building, proactive communications, and regulatory approaches. These are important longer-term initiatives to build societal resilience. The panel considers that if we do not rebuild confidence in the government's approach, including through effective communications, the next pandemic will have vastly different consequences.

5. Learnings

- A different approach is essential for communicating in a protracted health emergency that is jointly supported and relies heavily on maintaining public confidence and trust.
- A joint communication approach between levels of government is needed to ensure national consistency in overarching messaging while maintaining sufficent flexibility to communicate the rationales behind different approaches by states and territories.
- No media or communication approach can fully insulate the public from the impact of our leaders voicing different views, but there is a need for proactive strategies to address perceived inconsistencies and for greater transparency about the evidence that underpins differing approaches.
- The strategy should agree on a common approach including using shared terminology, communicating regularly at predictable times, identifying a lead authoritative source, having consistently presented information available on a central portal, and using shared branding and multiple media.
- Communities must be embedded in the local emergency governance structures, decision-making processes, and communications.
- Trusted messengers can effectively share guidance in a public health emergency and connect their communities with people able to explain what it means to them.
- Vaccine messaging on safety, efficacy and eligbility works best when presented with clear risk assessment information that supports individuals in their decisions on vaccine uptake. Online risk calculators are useful and should be set up as soon as a vaccine is developed, and updated as risks or evidence change.

- Vaccine communications need to align the targeting and timing of messaging with vaccine access. A phased approach to rollout should give attention to all cohorts across the phases, preparing them for when they are eligible. There are risks in leaving information voids for particular cohorts, and also in messaging encouraging people to vaccinate now when supply is not available to meet demand.
- Coordinated communications are required where states and territories have differing prioritisation for vaccine access, based on the risks associated with specific populations and settings.
- Effective risk communication is a two-way process, between decision-makers and the public. While difficult in a fast-moving crisis, it is critically important to receive input and ongoing feedback from community members, experts and priority populations to understand their needs and how messages are being received, and refine approaches accordingly. Behavioural science has an important role to play in a crisis through optimising the behavioural impact of communications.
- Government must actively manage the overwhelming flow of government information in crises, including the frequency, speed and complexity of changes.
- Government must maintain in-house communication capability and build systems for more efficient sharing of intelligence, resources and expertise across all government levels and with industry and academia to reflect rapidly changing communication challenges and the need for more dynamic and bespoke approaches.
- Involvement of content experts and communication experts (e.g., in risk communication, behavioural science, misinformation) should be prioritised when creating evidence-based risk communication strategies and sharing information about the crisis and rationale for measures.
- Communication strategies need to be shaped around an understanding of current levels of trust in governments, institutions and experts. This needs to be assessed throughout an emergency to determine the most effective communication pathways and messaging.
- There is significant merit in utilising key health experts to communicate the underlying evidence and rationale for key decisions, rather than requiring political leaders to navigate this complexity. Where possible, underlying public health advice should be made available to maximise public trust.
- Misinformation and disinformation needs to be actively addressed, using a range of tools and strategies across prevention (including resilience building), reaction (to counter narratives as they occur) and adaption (recovery and deterrence).
- The Department of Health and Aged Care should leverage primary health care networks and primary care providers to disseminate information, given their trusted status, local knowledge and extensive community networks.

- Government must ensure information releases are adequately explained so that technical complexity, uncertainty in the data, lack of nuance or unclear impacts of other non-health considerations are not barriers to understanding.
- Technical advisory bodies require specialist communication supports during a national health emergency.
- Effective approaches are those that are well designed, follow established principles, incorporate new evidence-based techniques, and are delivered in ways that meet the needs of the audience.

6. Actions

6.1. Immediate actions – Do in the next 12–18 months

Action 7: Finalise establishment of the Australian Centre for Disease Control (CDC) and give priority to the following functions for systemic preparedness to become trusted and authoritative on risk assessment and communication, and a national repository of communicable disease intelligence capability and advice.

The CDC must:

- Establish an evidence synthesis and public communications function, including:
    - support for both business-as-usual communication activity and crisis communications in a public health emergency
    - working with the Department of Health and Aged Care, NEMA and the Department of the Prime Minister and Cabinet to develop a national communication strategy for use in national health emergencies (see Action 19)
    - making communication a focus for technical advisory group input, drawing from public and private channels to provide risk communication data synthesis and behavioural and social science expertise
    - in-house expertise in evidence synthesis and communication.

Action 16: Develop and agree principles for the transparent release of advice that informs decision-making in a public health emergency.

- Principles should be developed in partnership with science communication experts to ensure consideration is given to how evidence and advice can be easily interpreted given the inherent complexities and nuances.

Action 19: Develop a communication strategy for use in national health emergencies that ensures Australians, including those in priority populations, families and industries, have the information they need to manage their social, work and family lives.

The strategy should:

- create a central public health emergency communications hub that serves as a single source where the Australian public can find integrated information about the emergency response around the country
- be informed by behavioural science and risk communication expertise
- proactively seek to ensure consistency of messaging between levels of government, providing supporting rationale and evidence for different approaches
- leverage existing communication channels through professional bodies, unions, local government and advocacy groups
- meet the diverse needs of communities across Australia, including through co-design
- include mechanisms to coordinate and consolidate communications, considering the timing and frequency of announcements
- include a strategy for addressing the harms arising from misinformation and disinformation, which incorporates:
    - information environment and ongoing narrative monitoring to combat misinformation
    - transparent engagement with social media companies
    - promotion and coordination of policies to increase the resilience of the information environment
    - partnership between government and trusted organisations, experts, media, and other influencers to pre-bunk and debunk misinformation
- build on the principles of crisis and risk communications and have clear communication goals, including:
    - being timely, transparent, empathetic and consistent, promoting action and effectively communicating risk to foster trust
    - being inclusive, addressing inequities in accessing information, and supporting two-way communication
    - reflecting an evidence-based approach relevant for the contemporary information and media environment

    - embedding ongoing evaluation practices to ensure communication activities are effective, are appropriate, and are meeting the diverse needs of the Australian public

- account for the distinct communications preferences and requirements of priority populations – including:
    - reflecting the key role of community and representative organisations in communicating with priority populations, including Aboriginal and Torres Strait Islander community organisations; peak bodies for children, young people and education providers; culturally and linguistically diverse community organisations; Disability Representative Organisations; peak bodies for older Australians; and community service providers
    - funding community and representative organisations to tailor and disseminate communications through appropriate channels and trusted voices
    - providing plain English messaging to community organisations for tailoring in a timely manner.

Chapter 12 – Broader health impacts

1. Context

Australia's passage through the acute emergency response and transition into the tail of the pandemic was shaped by the underlying capability in public health and the resilience and broader capacity of the health system. Australia's healthcare system is one of the best in the world based on its provision of universal access to high-quality services.[1496] However, uncertainty on how the system would cope under the strain of high numbers of people with severe COVID-19 disease was a key driver of early policy decisions. The pandemic had broader direct and indirect impacts on health care that would challenge both individuals and the health system, including in relation to mental health, disruptions to normal care, access to elective surgery, chronic disease management, and disease screening.

2. Response

In the first quarter of 2020 there were high levels of uncertainty about the virus that causes COVID-19 and how it might impact our health systems. From March 2020 the Australian Government, in partnership with the states and territories, began to implement measures to mitigate the direct and indirect impacts on the health system and progressively increased or adapted these measures as knowledge and understanding of COVID-19 increased. These measures are discussed below.

2.1. Financial support to the health system to manage pandemic impacts

On 13 March 2020 Australian Government leaders agreed, through the National Partnership on COVID-19 Response, they had 'joint responsibility to act to protect the Australian community by ensuring that the health system can respond effectively to the outbreak of Novel Coronavirus'.[1497] The National Partnership on COVID-19 Response was the way the Australian Government rapidly provided financial assistance to the states and territories to assist with additional costs they incurred in their health systems during the pandemic. In announcing the National Partnership on COVID-19 Response, leaders noted the 50:50 shared funding deal would 'ensure the capacity of the health system to effectively assess, diagnose and treat people with coronavirus in a way that minimises the spread of the virus in the community and protects our most vulnerable'.[1498]

A key measure introduced under the National Partnership on COVID-19 Response was the Private Hospital Viability Guarantee. In the face of pauses to elective surgery, the guarantee ensured the viability of private hospitals in return for private hospital beds and, at times, workforce to supplement the public hospital COVID-19 response.[1499]

The National Partnership on COVID-19 Response accounted for almost a quarter of Australian Government health spending over 2019–2024 ($14.26 billion).[1500] It operated alongside the National Health Reform Agreement, through which public hospital funding is ordinarily delivered.[1501]

2.2.Managing impacts on mental health

The Australian Government recognised early on that there was potential for mental health effects from the pandemic and associated public health measures. On 11 March 2020 it announced that people in home isolation or quarantine because of COVID-19, as well as some specified patient groups, could receive Medicare-funded mental health support through telehealth.[1502] The support was temporarily expanded on the Medicare Benefits Schedule[1503].[1504]

On 29 March 2020, a day ahead of the Prime Minister's announcement of the first national lockdown, the Australian Government announced that all Australians were able to receive mental health support provided through the Medicare Benefits Schedule via telehealth, and it is now a permanent Medicare Benefits Schedule item.[1505] This announcement also included funding for targeted mental health services commissioned by Primary Health Networks, additional funding to crisis lines, and the creation of the Coronavirus Mental Wellbeing Support Service, which provided free 24/7 mental health support.[1506]

On 13 May 2020 the Australian Government appointed a Deputy Chief Medical Officer for Mental Health within the Department of Health.[1507] Their role was to promote the importance and interconnectedness of mental health within the broader health system. During the pandemic, the Deputy Chief Medical Officer for Mental Health attended many Australian Health Protection Principal Committee meetings and weekly briefings with the Prime Minister.[1508]

On 15 May 2020 National Cabinet endorsed the National Mental Health and Wellbeing Pandemic Response Plan and the allocation of $48.1 million in Australian Government funding.[1509] The plan was developed by the National Mental Health Commission and the Victorian and New South Wales governments and informed by all nine jurisdictions and key sector stakeholders. It was the primary policy guiding the mental health response to the pandemic. Improvement of evidence collection on the mental health impacts of COVID-19 was one of its key priorities. From mid-2020 the Australian Institute for Health and Welfare coordinated integrated data sharing between the Australian and state and territory governments on the use of mental health services and from various crisis helplines.[1510]

In August 2020 the Australian Government enabled people in areas with lockdown restrictions to access 10 additional individual psychological therapy sessions under the Better Access initiative.[1511] Eligibility for the additional sessions was expanded to all Australians from October 2020 until December 2022.[1512] The additional sessions ceased, as planned, on 31 December 2022. An independent evaluation found that the number of new people accessing treatment decreased when the additional sessions were in place and those who needed support the most were missing out.[1513]

The Primary Health Networks played a key role in supporting the establishment of HeadtoHelp and Head to Health integrated care hubs.[1514] Twenty-six hubs were established to provide no-cost mental health supports in areas experiencing prolonged lockdowns. The first clinics opened in Victoria in September 2020 (HeadtoHelp).[1515] Clinics later opened in New South Wales and the Australian Capital Territory (Head to Health pop-up clinics).[1516] The clinics were to

cater for a 'missing middle' of individuals with mental ill-health considered too severe for GPs but not severe enough for acute mental health units.[1517]

2.3.Managing impacts on access to health care

On 11 March 2020 the Australian Government announced a $2.4 billion health plan to boost the capacity of the health system to ensure people could access essential care in a way that reduced the risks of spreading COVID-19.[1518] Measures under this package included funding for the National Coronavirus Helpline, the creation of General Practitioner Respiratory Clinics, and rapid acceleration of the introduction of digital health services such as telehealth and e-prescribing:

- Between 2002 and 2019 medical practitioners could bill Medicare for the delivery of 130 telehealth services. By 28 May 2020 this had rapidly increased to 281 telehealth services.[1519]
- E-prescribing was intended to start in 2022 but was fast-tracked to May 2020. From March 2020 to 31 December 2023, over 191 million e-prescriptions were issued by more than 78,000 prescribers.[1520]

The first General Practitioner Respiratory Clinics opened from 21 March 2020. They were assisted by Primary Health Networks, which identified locations and supported their operations.[1521] This was the first time a primary care clinic-based model had been used in Australia – influenza clinics are usually affiliated with hospitals.[1522] General Practitioner Respiratory Clinics aimed to direct patients with mild to moderate respiratory illness away from GPs and public hospitals and instead to 'an environment specifically designed to maximise infection prevention and control in order to protect the general practice workforce and other patients, and preserve access to regular services'.[1523] Treatment was provided at no cost, including for those ineligible for Medicare.[1524] The General Practitioner Respiratory Clinics program ran until February 2023. At its peak, there were 150 General Practitioner Respiratory Clinics across Australia.[1525]

The National Coronavirus Helpline was available 24 hours a day, seven days a week. It assisted COVID-positive patients in accessing information and support.[1526] In October 2021, the Australian Government invested an additional $180 million in measures through a Living with COVID package to support and strengthen primary care as Australia began reopening.[1527] This included a Living with COVID service operated by Healthdirect which supplemented the National Coronavirus Helpline from January 2022.[1528] This service supported COVID-positive individuals with mild to moderate symptoms to self-manage their illness by seeking care through their GP, online through Healthdirect, or a combination of both.[1529] It supplemented the work of states and territories, which had implemented digital first connections with people who tested positive for COVID-19.

The Living with COVID package also supported Commonwealth-funded Primary Health Networks to work with primary, community and acute hospital providers in their regions to

develop COVID Positive Pathways, providing an integrated model of care for COVID-positive patients.[1530]

Some public health measures directly affected people's access to health care. Elective surgeries and cancer screening were paused so that public and private health services could focus on COVID-19 response measures, including tracing and vaccinations, and to help preserve the availability of personal protective equipment (PPE).[1531] National Cabinet agreed to restrict elective surgeries between 26 March and 29 April 2020 when only Category 1 or 2 surgeries (which require admission within 30 or 90 days) could be performed.[1532] Further restrictions were applied on a state-by-state basis as the pandemic continued through 2020–22.

State and territory governments restricted cancer-screening programs throughout 2020–21. For example, the BreastScreen program was paused for various periods in both New South Wales and Victoria.[1533] The National Bowel and Cervical Cancer Screening Programs were less impacted by the pandemic – bowel screening could continue because screening tests are home delivered.[1534]

2.4. Managing impacts on our health workers

In Australia, the responsibility for health workforce planning and most regulation is shared by the Australian and state and territory governments.[1535] Most health workers are employed by states, territories and private providers.

In 2020 Australia's 642,000 registered health workers, (including 105,000 medical practitioners, 350,000 nurses and midwives, 166,000 allied health professionals and others) came under immense strain.[1536] The Australian, state and territory governments introduced a range of measures to widen the pool of workers and extend the scope of practice of the existing available health workforce. For example:

- the Australian Health Practitioner Regulation Agency and its National Boards (representing each registered health profession) established a pandemic sub-register in April 2020 for retired or non-practising medical staff who were willing to assist with workforce gaps. At the height of the pandemic, the register contained the details of 40,000 eligible health workers (doctors, nurses, midwives and pharmacists)[1537]
- throughout 2020–2022, changes to legislation in states and territories allowed many health workers to work to, or closer to, the full scope of practice in which they are educated, competent to perform and permitted to perform by law. These changes enabled Aboriginal and Torres Strait Islander Health Practitioners, midwives, dentists, oral health therapists, occupational therapists and, in some jurisdictions, nursing students to administer COVID-19 vaccines[1538]
- as part of the scope of practice changes, private and public health providers rapidly upskilled health workers. The Australian Government funded 2,000 registered nurses to complete Authorised Nurse Immuniser training and administer COVID-19 vaccines without supervision.[1539] Some private hospital providers designed in-house training so that nurses could be redeployed into aged care settings in under two weeks.[1540]

Private healthcare providers and peak bodies worked alongside Australian and state and territory governments to develop policies to manage the growing fatigue and distress of health and aged care workers during the pandemic. For example, they made ongoing face-to-face support available, provided free access to digital mental health services, and developed national frameworks and guidance to specifically support the wellbeing of healthcare providers.[1541]

The mobility and growth of the health workforce was constrained by domestic and international travel restrictions and costs associated with quarantine. In response, the Australian Government gave international medical and nursing students exemptions to work restrictions and increased funding for locum placements (for temporary doctors) from two to 12 weeks.[1542] State and territory governments gave health workers exemptions to border restrictions, and the Department of Home Affairs helped prioritise visa applications for health workers.[1543]

2.4.1. National Medical Stockpile

A critical part of ensuring Australia's health workforce was safe and able to provide care was ensuring they had sufficient medical supplies such as PPE. The National Medical Stockpile had a role in distributing PPE to health workers throughout the pandemic. The National Medical Stockpile operates under advice of the Australian Health Protection Committee but is managed by the Department of Health and Aged Care. It usually provides supplementary medical and other equipment supplies to state and territory government reserves. During the pandemic, the Department of Industry, Science, Energy and Resources assisted the Department of Health in procuring medical supplies for the National Medical Stockpile.[1544] This included monitoring, reporting and addressing supply chain issues for medical supplies, as well as providing logistical support and grant funding to domestic manufacturers.[1545] See also Chapter 22: Supply chains.

At various points in the pandemic, starting on 29 January 2020, the National Medical Stockpile's consumer base incrementally expanded to include GPs and other frontline health workers, residential aged care facilities, Aboriginal Community Controlled Health Services, the Royal Flying Doctor Service, private and public pathology labs, some National Disability Insurance Scheme providers, and clinicians employed by the Australian Defence Force and private hospitals.[1546] Some of the servicing of these consumers was done with the assistance of Primary Health Networks.[1547] Global supply chain shortages affected the National Medical Stockpile's ability to provide sufficient medical supplies to its expanded consumer base and led to situations where the National Medical Stockpile was competing with states and territories for supplies.[1548]

Given the massive global demand for medical supplies, which are generally sourced offshore, the National Medical Stockpile took a 'more is better' procurement approach.[1549] Between February 2020 and February 2021 the National Medical Stockpile awarded 44 suppliers 53 contracts and procured over $2.83 billion worth of medical supplies.[1550] This meant deployments to identified consumers increased from an average of 10 deployments a year to states and territories to 260,000 deployments over the course of the pandemic.[1551]

3. Impact

3.1. Mental health measures

The pandemic, and the measures introduced to manage the spread of the virus, had a significant impact on the mental health and wellbeing of many Australians. Issues such as prolonged isolation and loss of social contact, fear of contracting COVID-19, increased uncertainty, loss of routine, financial stress and disruptions to health services affected people's wellbeing and exacerbated existing system-level strain. [1552]

According to the National Health Survey, the percentage of people experiencing high or very high psychological distress across the community increased from 10.8 per cent in 2011 to 13 per cent in 2017 and 14.3 per cent in 2022.[1553] In parallel, there has been an increase in the estimated unmet need for psychosocial supports, with 2022–23 estimates finding 230,500 people with severe mental illness were not receiving the psychosocial support they need. [1554] This far exceeds the Productivity Commission's 2019–20 estimate of 154,000 people.[1555]

> *The mental health system was in crisis before the pandemic hit; COVID-19 exacerbated pre-existing issues. Australian communities are experiencing a process of rolling recoveries from one emergency to the next (extreme weather events and the pandemic), with resulting cumulative trauma. – Mental Health Roundtable*[1556]

The Inquiry heard mental health impacts were particularly severe for some because of the nature of their work.[1557] Also, some already experienced higher rates of mental ill-health and inequities in accessing support services. For example:

- essential workers across many sectors bore the brunt of the pandemic, with significant impacts on their mental health. We heard essential workers experienced greater risk of exposure to the virus, separation from family, increased workloads and emotional strain from seeing the impact of the pandemic up close[1558]
- Aboriginal and Torres Strait Islander people who were affected by the pandemic 'were more likely to experience mental disorders and harmful substance use'.[1559] This was compounded by disruption of cultural practices – in particular, those related to grieving – because of lockdowns or border closures[1560]
- the pandemic had significant negative impacts on the social and emotional development of children and young people – 41 per cent of respondents to a 2022 Australian Human Rights Commission national survey of children and young people reported the pandemic had a negative impact on their wellbeing.[1561] The Lancet Psychiatry Commission on youth mental health found young people have experienced disproportionately poorer mental health outcomes since the pandemic[1562]
- many culturally and linguistically diverse communities experienced mental health impacts stemming from disruptions of cultural norms, increased racism, limited access to financial supports, and international border closures.[1563] Inaccessibility and lack of

awareness of support services, as well as stigma around help-seeking, were key concerns.[1564]

- people with disability overwhelmingly reported feeling afraid and forgotten in the pandemic response.[1565] They become increasingly isolated, with significant impacts on their mental health.[1566] Rates of psychological distress among people with disability were higher than in the general population (29 per cent compared with 17 per cent in 2021)[1567]
- isolation was a significant issue for older Australians. We heard visitation restrictions in residential aged care had a significant impact, with residents experiencing increased distress, loneliness and cognitive decline[1568]
- mental ill-health is an underlying issue among regional, rural and remote communities, with suicide rates up to 40 per cent higher than in urban areas.[1569] This was exacerbated by challenges accessing services during the pandemic, including due to border closures[1570]
- women suffered from higher incidence of psychological distress than men, in part because of increased burden of caring responsibilities during lockdowns.[1571] Data from the National Study of Mental Health and Wellbeing conducted over 2020–2022 found females experienced higher rates of 12-month mental disorders, anxiety disorders and affective disorders.[1572]

Overwhelmingly, we heard the mental health impacts from the pandemic will not fully be known for some time, particularly for children and young people.[1573] This has been echoed in many state and territory reviews of the pandemic responses.[1574] The mental health impacts on these populations are considered in further detail in the Equity section.

The panel heard that the response to the pandemic prioritised population-level physical health and did not adequately consider the mental health impacts of protracted wide-ranging and coercive measures.[1575] The Deputy Chief Medical Officer for Mental Health attended almost every meeting of the Australian Health Protection Principal Committee, but we heard from some that mental health was peripheral to their discussions, as it was a struggle for the Australian Health Protection Principal Committee to deal with the entirety of the response.[1576] We heard that before changes were made to public health legislation in 2021, the Victorian Government was unable to take into account other matters, such as mental health or economic considerations, when making a pandemic order.[1577] Peak bodies note that future responses to public health emergencies would benefit from more active consideration of mental health risks and access to mental health treatment and supports.[1578]

While the additional funding and focus on mental health was welcomed, the panel heard from some that it was not clear how the National Mental Health and Wellbeing Pandemic Plan helped to drive improvements to the mental health of Australians during the pandemic.[1579] It was unclear how the plan linked with other related pandemic plans or how it helped drive action across states and territories.[1580]

The panel heard that pandemic-era measures – particularly multidisciplinary integrated care hubs and increased access to free mental health support – improved the quality of and general access to mental health supports during and after the pandemic and reached underserviced sectors of the community.[1581]

Participants at an Inquiry roundtable said delivery of mental health support through telehealth is not a solution for everyone – it does not suit many people with complex mental health needs, people experiencing poverty or people without existing relationships with a service.[1582] There are also challenges in providing continuity of clinical support and multidisciplinary approaches through telehealth.[1583] Submissions noted that online services are effective as a supplementary service offer and help address workforce gaps, particularly outside of metropolitan areas.[1584]

Inquiry roundtable participants said there is a need for closer integration and coordination with local health services, as well as family/informal carers, when delivering mental health services in general, including through telehealth and online supports.[1585] These stakeholders emphasised the importance of ensuring future responses consider the role of informal carers and support them appropriately, because the mental health of individuals who are most reliant on support from family members or carers – as well as those family members or carers – was significantly affected during the pandemic.[1586]

> *Family carers provided more hours and more complex support during the pandemic, many without the assistance of financial, practical or social resources. The additional stresses resulting from inadequate support during the pandemic resulted in family carers feeling isolated, overwhelmed, distressed, financially vulnerable, fearful – and in some cases, experiencing thoughts of suicide. – Mental Health Australia*[1587]

A number of reviews have identified that income support measures such as JobKeeper were critical in supporting the mental health of many Australians. Research from the University of Sydney's Brain and Mind Centre found that 'employment programs [primarily JobKeeper and JobSeeker] (were) the single most effective strategy for mitigating the adverse mental health impacts of the COVID-19 crisis'.[1588] Further detail on the impact of financial supports can be found in Chapter 21: Supporting households and businesses.

Peak bodies and academics say that one marker of success of Australia's pandemic response was that the national suicide rate did not increase at the time, despite the expectation that it would.[1589] However, existing research draws links between suicide and post-disaster situations, with studies finding rates of suicide increase during the first three years after natural disasters.[1590]

During and since the pandemic there has been an increase in the prevalence and severity of eating disorders.[1591] Trends in Australia and overseas show that healthcare is increasingly being used for issues related to eating disorders, particularly when stay-at-home orders were active.[1592] This impact was most prominent among children and adolescents, as discussed in Chapter 14: Children and young people.

We heard the pandemic was a catalyst for improvements in mental health data collection, linkages and sharing.[1593] However, we also heard improvements in this space are needed to ensure that services are efficient, equitable and accessible and that the long-term impacts of the pandemic on mental health are understood.[1594] Stakeholders emphasised the need for access to real-time mental health data to identify areas that need additional support in a future public health emergency.[1595]

3.2.Delivery of care

Primary care (especially that delivered by GPs and pharmacists) is the first point of entry into the health system for many people seeking health care and advice. This was no different during the pandemic. In fact, we heard there was greater demand on primary care during the pandemic as access to emergency departments was less readily available and/or discouraged.[1596] The panel heard primary care workers showed a remarkable level of commitment, resilience and flexibility.

Inquiry roundtable participants pointed out the essential role of the primary care sector in supporting people to engage with and trust public health advice, particularly in rural and remote communities.[1597] Multidisciplinary models of primary care were of particular benefit to rural and remote communities, where delivery of health care is complex.[1598]

Peak bodies and service providers emphasised the need for primary care practitioners to be better engaged in emergency planning at a regional level given their knowledge about communities' needs and services.[1599] This aligns with recommendations from the Royal Commission into National Natural Disaster Arrangements, which notes the importance of primary healthcare providers being involved in ongoing disaster management.[1600]

> *The Aboriginal Community Controlled Health Sector must be recognised as an essential partner in emergency health responses. This includes being formally included in response plans, recognised as shared decision makers, trusted through timely and accurate data sharing, and financially resourced to do the operational work of the response that the Sector is better-placed than government agencies to do. – Aboriginal Health Council of Western Australia*[1601]

Stakeholders told us Primary Health Networks have a critical role to play in supporting a strong public health response at the regional and local levels.[1602] The panel heard from some that the maturity and the capacity of Primary Health Networks to support and actively lead and engage in the pandemic response varied across regions.[1603] We heard Primary Health Networks were exceptional where they had previous experiences in emergency management responses and had collaborative relationships with local hospitals and frontline workers.[1604] However, those that cover a large geographical footprint in particular struggled to achieve this level of success.[1605] Stakeholders underscored the importance of better integrating the primary care and acute systems in non-pandemic times by improving collaboration and data sharing between Primary Health Networks and state Local Health Districts (known also as Local Health Networks or Hospital and Health Services).[1606] The panel also heard the Primary Health

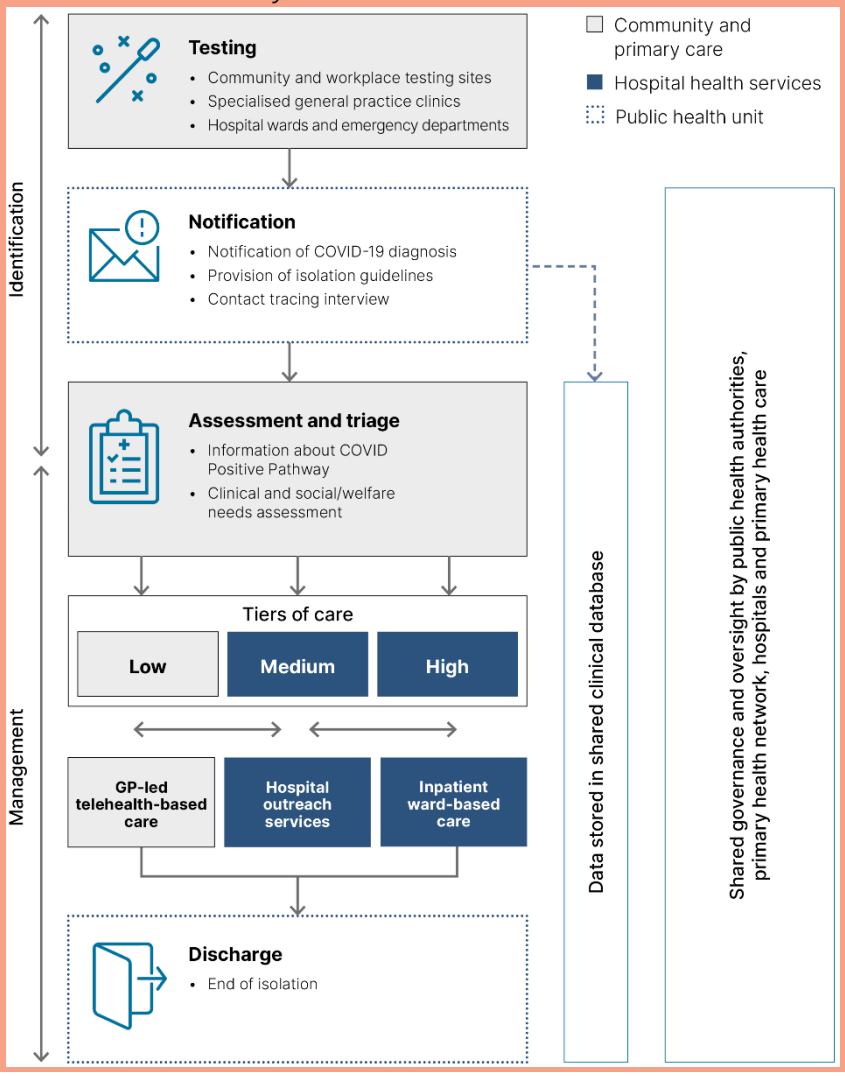
Networks need to be adequately funded to support emergency responses and the transition/recovery period.[1607]

Integrated COVID-19 pathways, North Western Melbourne Primary Health Network[1608]

During the second wave of COVID-19 in Victoria, the North Western Primary Health Network helped to develop and pilot the COVID Positive Pathway (Figure 1) – a collaboration between public health authorities, primary care practices, Primary Health Networks and hospital services to minimise community transmission and enable timely and appropriate care transitions for deteriorating patients. It supported COVID-positive patients to isolate at home, providing multidisciplinary and holistic support – for example, assisting people to access food and other basic supplies.

Of the 1,392 people who were referred to the pathway, approximately 80 per cent of those with COVID-19 were supported through primary care channels, ensuring hospital services were reserved for those with more severe illness or risk factors for disease progression.[1609]

Figure 1: The COVID Positive Pathway[1610]



Interviews and submissions said that the rapid establishment of General Practitioner Respiratory Clinics – supported by Primary Health Networks and Local Health Districts – was a key success of the pandemic response because it meant people with respiratory symptoms could be tested and treated in isolation.[1611] Around 95 per cent of Australians lived within a half-hour drive of a General Practitioner Respiratory Clinic.[1612] The General Practitioner Respiratory Clinics program ran from March 2020 to February 2023, servicing people from 2,540 postcodes nationally and delivering more than 3.5 million consultations for patients with respiratory symptoms.[1613] An academic review of the program in 2022 noted the clinics needed rigorous infection prevention and control measures and had the potential to fragment care, but they addressed a service gap in communities and improved the integration of GPs within the broader health response.[1614]

The General Practitioner Respiratory Clinics also played an important role in the collection of surveillance data. Inquiry roundtable participants emphasised primary care data are underutilised and could be an important part of the pandemic surveillance system.[1615]

Stakeholders also praised the role of Healthdirect in providing support to Australians through the National COVID Hotline and through their Living with COVID service. An independent evaluation of Healthdirect's Living with COVID service found it was a scalable model for patient triage, effectively connecting patients to primary care channels.[1616] This meant non-acute cases were kept out of hospitals, resulting in a lower chance of disease transmission and keeping beds free for those who most needed them.

On the whole, submissions to the Inquiry noted telehealth was beneficial in keeping people connected to health care during the pandemic.[1617] The Department of Health and Aged Care advised that, since March 2020, 185 million Medicare Benefits Schedule telehealth services had been delivered to more than 20 million patients by more than 100,000 health practitioners.[1618] The panel heard of the positive impact it had in connecting patients with clinicians across borders at times when border crossing was restricted; and how it assisted delivery of health care in poorly serviced areas, such as in rural and remote Australia.[1619]

Healthcare workers identified challenges with delivering care through telehealth. For example, there were problems relating to:

- the logistics of coordinating multidisciplinary consultations
- developing relationships virtually
- identifying patient discomfort and distress.[1620]

Also, the panel heard that a lack of appropriate clinical guidance on delivery of telehealth and other service innovations meant there were gaps in ensuring standards of safety were maintained.[1621]

However, the benefits of telehealth were not evenly felt. The panel heard some people faced barriers in accessing digital health services. Those with low digital literacy, including older Australians, did not gain as much benefit.[1622] The same can be said for people who speak languages other than English, those with complex mental health needs and those without easy access to internet, reception or relevant devices.[1623] Stakeholders, particularly those in the

primary care sector, emphasised the importance of ensuring digital health services are supplementary to face-to-face consultations, not a replacement for them.[1624]

Some raised specific concerns about the impacts of pausing elective surgery. They questioned the scale and the duration of closures. A number of stakeholders emphasised that the pause to elective surgery, coupled with staffing pressure and bed shortages, have exacerbated pre-pandemic backlogs.[1625] In 2022–2023, patient wait times were at their highest level in 20 years, with nearly 10 per cent of patients waiting over 12 months for elective surgery.[1626]
The panel heard from one stakeholder that decisions to pause elective surgeries did not take proper account of workforce availability and capacity within private hospitals. These facilities could have continued surgery services while maintaining proper infection control.[1627]
Stakeholders said there was insufficient government consultation with the private sector, which performs around 60 per cent of elective surgeries. More consultation may have helped to alleviate the issues being faced.[1628]

Nonetheless, we heard that the support provided under the Private Hospitals Viability Guarantee was vital to the sustainability of the sector. It provided for the potential use of critical resources such as private hospital facilities and workforce to support the broader public health system during the pandemic.[1629] Some private providers felt the Private Hospitals Viability Guarantee did not provide a robust level of financial assistance to private hospitals[1630] – the Australian Bureau of Statistics shows only 30 per cent of the private hospital sector profited in 2021, down from 80 per cent in 2019.[1631] However, others reaffirmed the Private Hospitals Viability Guarantee's invaluable role in supporting the broader health system, with private hospitals accommodating residential aged care residents during COVID-19 outbreaks, for example.[1632]

> *The completion of the Private Hospitals Partnership and Viability Guarantee, at the same time as bringing Telehealth online, was arguably the single most important decision in maintaining health system capacity and indeed building health system capacity at a time when both the Primary Care and Private Hospital systems were facing the threats to continuity of service that were evident in Italy, Spain, and parts of the United States. – Professor the Hon Greg Hunt*[1633]

During the pandemic, states and territories placed restrictions on various preventive health programs, including cancer-screening programs. This may also have longer-term impacts. Between 2020 and 2022 there were 163,595 and 158,211 fewer cancer-related diagnostic procedures, based on 2017 to 2019 trends.[1634] The Department of Health and Aged Care notes the national cervical and bowel cancer screening programs had flexibility to deal with pandemic disruptions thanks to the home delivery of screening tests and enabling GPs to issue program kits directly to patients through telehealth.[1635] Screening services recovered to normal levels quickly, but pandemic-related disruptions such as a worker redeployment to COVID-19-related care still affected their usage.[1636]

Independent modelling from Australian researchers anticipates an additional 234 cases and 1,186 deaths from colorectal cancer through to 2030 because of COVID-era disruptions to screening services.[1637] Other long-term effects are likely to emerge. Recent screening

participation is a strong indicator of future screening behaviour, meaning those who missed screening due to the pandemic are less likely to return to it now.[1638] Fortunately, the research shows that even a modest increase to services can effectively manage patient backlogs and mitigate the long-term impacts of the pandemic on cancer mortality.[1639]

The impacts of public health measures and health workforce shortages resulted in a disruption to primary care for many communities. We have heard there has been a drop-off in planned periodic health prevention checks.[1640] Australian Bureau of Statistics research shows that in the 2020–21 financial year almost 10 per cent of people aged 15 and over reported having delayed or not used primary care due to COVID-19.[1641] This in turn affected the number of non-COVID pathology tests people were completing, with analysis by the Continuity of Care Collaboration highlighting declining trends in pathology testing uptake at the beginning of the pandemic.[1642]

Longer-term impacts are now being seen, particularly in rural and remote areas, where an increased prevalence of underlying chronic conditions and poor health infrastructure existed before the pandemic.[1643] The Royal Flying Doctor Service has reported an upward trend in aeromedical retrievals, with data in 2022–23 translating to 101 retrievals every day compared with 91 a day in 2021–22.[1644] We heard greater focus on prevention of chronic disease and managing the health system for equity will better prepare us for future health emergencies.[1645]

3.3.Health workforce

The pandemic amplified existing pressures on health workers and directly affected the mobility of and access to interstate and international workforces, which form a key part of the national health delivery system. Between 2020 and 2022 the annual growth rate in the number of medical practitioners declined from 3.2 per cent, compared with a 3.6 per cent growth between 2013 and 2019.[1646]

Australian Institute of Health and Welfare data show that overseas-trained primary care workers comprise an increasingly larger part of Australia's workforce – 34.4 per cent of general practice specialists in 2013 and 42 per cent in 2022 are overseas trained.[1647] Census data from 2021 show that 40 per cent of registered nurses and aged and disability carer workers were born overseas.[1648] Rural, regional and remote communities are particularly reliant on overseas workers.[1649,1650] The Department of Health and Aged Care submission to the Inquiry indicates the fragility of this reliance during a pandemic. The Visas for GPs Program saw a 30 per cent year-on-year drop in the number of Health Workforce Certificates issued for overseas doctors to work in the primary health care system in 2020–21 compared with 2019–20.[1651] We are pleased to note that these levels have since improved, with 4,699 overseas doctors registering to work in Australia in the first 10 months of the 2023 financial year – a marked increase from 2,991 brought in throughout 2018.[1652]

We note that the government's National Medical Workforce Strategy 2021–2031 recognises COVID-era challenges for Australia's medical workforce, and identifies ongoing and sustainable changes made in response to the pandemic. [1653]

The Australian Government's *2023 Skills Priority List: key findings report* identified shortfalls in 82 per cent of health professional occupations in that year.[1654] Both public and private health providers told the Inquiry they are struggling to recruit – only 44 per cent of vacancies are being filled in 2023. This is down from 60 per cent in 2022.[1655] Workforce data from the Australian Institute of Health and Welfare indicate a decrease in suitable applicants per vacancy from 2.5 in 2020 to 1.3 in 2022.[1656] Rural and regional areas of Australia are particularly affected by recruitment and retention issues. In 2022, 44,930 people did not have access to GP services within 60 minutes' drive of their home.[1657]

> *In the health sector, COVID-19 exposed the faults in a fractured, under-supported and underinvested workforce, which made the impacts of the pandemic much worse than they could have been. – Health Services Union*[1658]

The stress of working at the pandemic frontline over a long period negatively impacted the mental health and wellbeing of many health workers.[1659] This is a well-established national and global issue. Levels of stress, anxiety, fatigue and occupational burnout reported by health staff increased significantly during the pandemic.[1660] We consistently heard that high workloads, limited socialisation and the impact of furloughing all contributed to this trend.[1661]

Uncertainty of access to PPE, particularly at the start of the pandemic, contributed to work-related stress. One stakeholder recalled receiving PPE stock from the National Medical Stockpile that was unusable because it was noncompliant with quality guidelines.[1662]

In December 2020 the Australian National Audit Office reviewed the operations of the National Medical Stockpile. It found the National Medical Stockpile's pre-pandemic procurement planning was partially effective and that more should have been done to ensure sufficient reserves of PPE and critical medical supplies.[1663] An independent review in September 2022 also recommended the priority development of new mechanisms to manage National Medical Stockpile stock in a pandemic to enable transparency.[1664] At various points of the pandemic the states and territories were competing with each other and the Australian Government for supplies of PPE and RATs.[1665] Public submissions and Inquiry roundtables were clear that Australia should ensure sovereign manufacturing capability for PPE to better prepare for a future public health emergency and reduce reliance on international supply chains.[1666] See also Chapter 22: Supply chains.

Health and care sector stakeholders called for greater clarity on what stock is held in the National Medical Stockpile and who is able to access it in an emergency.[1667] Some nurses and allied health professionals said they felt they were not prioritised for access to the National Medical Stockpile's PPE reserves when other frontline workers were.[1668] Access to PPE was also said to be the biggest obstacle in general practice, with some staff reusing PPE or having to buy N95 masks from Bunnings early in the pandemic.[1669] These concerns were shared by residential aged care and disability service providers, who said they felt they got what they could from the National Medical Stockpile, not what they should.[1670] We heard from one stakeholder the experience of accessing PPE from National Medical Stockpile supplies was variable and often reliant on existing relationships.[1671]

The furloughing of health staff who had come into contact with COVID-19 and were at risk of incubating the virus, in line with Australian Health Protection Principal Committee advice and state and territory public health orders, significantly impacted health system capacity and strained the delivery of health services.[1672] Furloughing of staff also impacted critical care settings, including in residential aged and disability settings, which had high rates of exposure to COVID-19.[1673] Workers who were required to undergo 14-day exclusions from work suffered impacts from feelings of job insecurity and fear of infecting family.[1674] Chapter 23: Workers and workplaces and Chapter 20: Managing the economy during the pandemic further explore pandemic impacts on workers, including the supports made available to them during this period. Furloughing issues had compounded for 18 months by the time requirements were changed in late 2021. We heard concerns from some that furloughing decisions were not sufficiently amended based on emerging research and evidence.[1675]

> *It's the workforce and furloughing, which remains the principle national challenge at this point in time. – Minister for Health and Aged Care, the Hon Greg Hunt MP, January 2022*[1676]

The pandemic had significant impacts on health and wellbeing and staff retention. The panel heard that frontline workers pushed themselves to breaking point, working overtime in the most confronting and challenging of environments.[1677] Department of Health and Aged Care data indicate that more than 117,000 nurses left the workforce between 2020 and 2022, compared with 97,745 nurses leaving the workforce between 2018 and 2020.[1678] NSW Health reported an increase in rates of part-time hours worked, attrition and use of sick leave among health workers since the pandemic.[1679] Data provided to the Inquiry by the Australian Health Regulation Protection Agency show that the number of practitioners applying for non-practising registration has increased across all professions, and there has been an increase in the number of practitioners not renewing their registration at all across many professions from 2018 to 2023.[1680]

Workforce pressures have had flow-on impacts to patient access to primary care. The Australian Bureau of Statistics patient wellbeing survey found the number of people waiting more than 24 hours for emergency GP care and those waiting an 'unacceptable' amount of time for a standard GP appointment almost doubled between 2019 and 2023.[1681] Seven per cent of people delayed or did not seek GP care in 2022 due to cost – an increase from 3.5 per cent in 2021.[1682] The panel heard that the distribution of these stresses to the health system is uneven – it hit hardest in areas such as regional and rural Australia, where worker shortages were already acute.[1683]

> *We are seeing consequences of these shortages in reduced screening rates for cancer, health checks and immunisations – these issues are worst in areas with the greatest workforce shortages. – National Aboriginal Community Controlled Health Organisation*[1684]

The Inquiry heard that Commonwealth and state and territory governments worked collaboratively with unions, industry bodies and regulatory agencies to address the existing

workforce challenges. The panel heard that the use of retired clinicians and streamlined processes that enabled retired medical staff to quickly return to the workforce resulted in a modest increase to workforce capacity.[1685] Many stakeholders told the panel that allowing qualified health professionals to work to their full training and experience alleviated workforce shortages and generally improved patient access to life-saving care.[1686] The panel also heard that, if these reforms had been in place 10 years ago, the impact of the pandemic on the health workforce and on patients would not have been as great.[1687] Participants at an Inquiry roundtable said they had high regard for medical students who were elevated to new medical assistant roles, as it helped alleviate workforce shortages.[1688] Independent research into the use of these new roles during COVID-19 found feedback was overwhelmingly positive from both the students and heads of units, and that the workload of junior doctors decreased as a result.[1689] One stakeholder told us that many students, particularly in allied health, nursing and midwifery fields, had longer placements in rural and remote communities as a result of pandemic restrictions, and that this was beneficial for both the students and the communities.[1690]

> *Aboriginal and Torres Strait Islander Health Practitioners and the RFDS [Royal Flying Doctor Service] played a vital role in the vaccination program during the pandemic. The utilisation of these health practitioners to provide vaccination in communities was key to the high uptake and protection of Aboriginal and Torres Strait Islander communities, particularly in remote areas. – National Rural Health Alliance*[1691]

The panel heard that private and public health providers helped to rapidly train and upskill an array of health workers to help fill critical gaps across the system.[1692] For example, requirements for onsite nurse training in infection prevention and control were introduced in 2020 in line with recommendations of the Royal Commission into Aged Care Quality and Safety.[1693] Some private hospital providers also designed in-house training so that nurses could be redeployed into aged care settings in under two weeks.[1694]

National COVID-19 Clinical Evidence Taskforce

From April 2020 to 31 December 2022 the Australian Government funded the development of COVID-19 clinical guidelines through the National Clinical Evidence Taskforce. The guidelines supported the 'clinical management of patients with suspected or confirmed COVID-19 infection across primary, acute and critical care settings'.[1695] During the pandemic and up to 30 May 2023, 134 updates were made to the guidelines to ensure they reflected emerging global evidence, with 23 clinical flowcharts developed to support clinical management of COVID-19.[1696]

We heard from some stakeholders these guidelines were useful in supporting the health workforce to provide appropriate care to patients with confirmed or suspected COVID-19 infection. They noted these guidelines were good practice and could be mirrored in non-pandemic times to ensure the health workforce is operating from best available evidence.[1697]

Allowing health practitioners to provide broader levels of care in their communities is shown to offer broader benefits beyond the COVID-19 pandemic. Issues papers released by the 2023–

2024 Independent Scope of Practice Review Unleashing the Potential of our Health Workforce, show that barriers preventing health professionals working to their full training and experience reduce worker mobility and retention, restrict patient access to care, and diminish overall productivity.[1698] Australia's overall health system response to the pandemic was strongest when the full breadth of our world-class health workforce was leveraged. Concerns were expressed about the speed and scale of change.

Some argue the scope of practice changes during the pandemic did not go far enough.[1699] The panel heard that Aboriginal Health Practitioners were invaluable for delivering COVID-19 vaccines and should have been used to administer other vaccines and prescribe antivirals.[1700] Participants at an Inquiry roundtable spoke of moral distress that some health professionals suffered because they felt unable to contribute to the pandemic response to the level that their experience and capacity would allow.[1701] Nurses especially felt as though they were waiting on the sidelines, particularly in the vaccine rollout.[1702] This is explored further in Chapter 10: Path to opening up. Stakeholders at an Inquiry roundtable said that nurses were supported to deliver COVID-19 vaccines at state-run mass vaccination centres, but much more could be done to help nurse-led clinics work independently and be financially viable at the national level.[1703]

> *The continuing failure of the healthcare system to utilise nurses and midwives to their full scope of practice is limiting consumer access to evidence-based, cost-efficient nurse and midwife-led models of care. – Queensland Nurses Union*[1704]

Other submissions said the pandemic-era scope of practice changes exposed unfavourable inconsistencies. For example, pharmacists are able to deliver COVID-19 vaccines across Australia, but their ability to deliver other vaccines, such as the vaccine for shingles, varies across the states and territories.[1705]

> *Each jurisdiction has its own scope of practice for pharmacists with clear inconsistencies. This results in equity of access and presents challenges in training and the quality use of medicines. This is particularly difficult with evolving practice which is common in pandemic response. The scope of practice for vaccinations demonstrates current fragmentation within the system. – GSK Pharmaceuticals*[1706]

Allied health professionals told the Inquiry they felt their contribution was deprioritised during the pandemic.[1707] Allied health workers were heard to be key leaders and members of multidisciplinary teams in some areas. But they were not considered essential workers early in the pandemic or in remote areas where biosecurity measures were put in place.[1708] This left gaps in mental health and other key services. The Office of the National Rural Health Commissioner notes, anecdotally, that the oversight has resulted in numerous allied health practitioners leaving the healthcare sector.[1709]

> *With the lack of support from the government, allied health workers felt it was not worth staying in the sector and that it was not worth putting up with years of costly study to then receive minimal recognition of efforts during COVID-19. – Health Services Union*[1710]

Both public and private health providers said they found it difficult to plan and manage their existing workforce in response to the pandemic's rapidly changing priorities and operational requirements.[1711] There was no holistic, system-wide view of the healthcare workforce that analyses levels of training, accreditations and skills gaps. This type of system would have allowed providers to better match capabilities to needs.

The current Independent Scope of Practice Review explores this as a broader system-wide problem, suggesting a National Skills and Capability Framework and Matrix in response.[1712] We support this idea, noting it would present a detailed system-wide view of the full range of skills, competencies and capabilities required of the health workforce mapped to professions, occupations and qualifications.

We heard the public health workforce played a critical role during the pandemic – for example, in supporting contact tracing efforts, providing advice through committees such as the COVID-19 Series of National Guidelines Working Group, and supporting health literacy and promotion more broadly.[1713] As discussed in Chapter 9: Buying time, we relied on public health workers to be expert voices in health communications, sharing opinions on and explaining the evidence behind government decisions to the general public.

> *The COVID-19 pandemic has underscored the importance of a well-prepared and adaptable public health workforce to manage the complexity of contemporary public health emergencies. – National Centre for Epidemiology and Population Health, Australian National University*[1714]

Stakeholders told us of the need to maintain and strengthen the public health workforce in non-pandemic times to ensure there is a greater pool to draw from in a future public health emergency. They noted a lack of regulation of public health workers made it difficult to identify and recruit appropriate expertise during the pandemic. This meant public health roles in the pandemic were often filled by general health workers, government officers or Defence Force personnel.[1715]

The capability of the public health workforce is not evenly spread across states and territories. We heard there is a need to ensure health departments at all levels of government are bolstered with public health expertise to better inform policy decisions.[1716]

Participants at an Inquiry roundtable told us there has been no specific investment from any level of government directly in public health since the pandemic, even though leadership recognises the need to expand training for the public health workforce.[1717] There are concerns about the impacts of budgetary pressures in the acute sector and the potential risks this may have on the retention of the public health workforce.

4. Evaluation

Leadership across governments and the health system was critical

Acting through National Cabinet, governments were able to rapidly agree and support a shared financial responsibility for the pandemic-related healthcare costs. This was a key foundation of the pandemic response. It was critical in building unity, collaboration and trust when it was most needed across jurisdictions and within the broader sector to ensure the rate and scale of change that was needed to meet the anticipated demands of the pandemic. A notable driver was the National Partnership on COVID-19 Response, which enabled rapid financial supports to be provided for both COVID-19-related efforts and ongoing health service delivery. This was key in driving mitigation efforts to curtail transmission. It also prioritised ongoing access to health care during the pandemic and its transition. As discussed in Chapter 4: Leading the response, the rapid authorisation through National Cabinet, supported by the Council of Federal Financial Relations, was a key enabler of these supports and was a stellar example of leadership and agility. Throughout the Inquiry there was a strong recognition of the critical role of this early decision in Australia's management of the pandemic response.

Innovation in healthcare delivery was built upon strong foundations

A well-resourced and resilient health system is a key foundation to pandemic preparedness. The speed with which innovation was introduced into the delivery of primary health care is a testament to the many people across governments, the health care sector, professional bodies and academic bodies who worked together to make it happen. The move to delivery of care through telehealth and e-prescribing, and the rapid establishment of General Practitioner Respiratory Clinics and mental health HeadtoHelp hubs helped to ensure continued access to health care and support, reduce transmission of the virus and ensure there was access to the limited number of intensive care hospital beds for those who were severely ill.

New delivery models could be quickly assembled because they could be built on existing structures and relationships. Telehealth and e-prescribing services could be fast-tracked because they were in the pipeline before the pandemic, while General Practitioner Respiratory Clinics and HeadtoHelp hubs could be stood up rapidly due to the existing relationships between government, Primary Health Networks, Local Health Districts and primary care providers. These examples of innovation emphasise that a strong and forward-looking health system is better placed to withstand future shocks.

Programs including COVID Positive Pathways and the Living with COVID program were game changing in providing fully integrated approaches to care. Such approaches have significant utility in the support of chronic care and warrant further development based on pandemic experiences.

The pandemic experience reaffirmed the need to ensure that the needs of priority populations are proactively considered in the design and implementation of public health measures and the associated changes to service delivery models. Influential relationships were built at the national level between the Department of Health and key cohort advisory groups. These are strong foundations for future preparedness and need to be maintained to inform future health program design and delivery.

The response had unintended consequences that we must learn from

The pandemic response required the significant redeployment of workforce and restrictions on health service delivery and access to care. The panel heard of the challenging decisions that health services were required to make in building intensive care unit capacity, resourcing contact tracing, carrying out vaccination and quarantine, redesigning service models and ensuring the safety of patients and workforce to prepare for COVID-19.

In many instances the impacts of some of these changes were unavoidable, but they are now becoming more apparent. For example, the panel heard specific concerns about the rapid decision to halt elective surgery, the impacts on surgical waiting lists and access to care, and the missed opportunities of not considering broader health impacts and further exploring other more targeted options, including the utilisation of private health services. With the wisdom of hindsight, this experience highlights the importance of considering broader health impacts in the development of public health measures to minimise harm. Similarly, the impacts on health prevention programs are now better understood.

The Australian Government has announced commitments to address some of these issues, including $40.7 million over three years in the 2022–23 Budget to help reverse the decline in screening and early detection of cancer that occurred during the pandemic.[1718] We note the mid-term review of the National Health Reform Agreement recommended a recovery plan be agreed for the remainder of the current agreement to address ongoing impacts of COVID-19, including the elective surgery backlog. We welcome the recognition of this significant issue and urge resolution of these matters. The National Health Reform Agreement is due for renewal in 2025. That may also be an appropriate opportunity to address the inequities in regional, rural and remote communities that were amplified as a result of the pandemic.[1719]

Pandemic planning must take a more holistic approach and consider the broader health ecosystem, including the private sector. Joint planning and exercising prior to the pandemic would have assisted in better defining the role and fair remuneration of private providers. The rapid establishment of the Private Hospitals Viability Guarantee demonstrated the Australian Government's recognition of the need for this; however, a more suitable framework is required to further develop pandemic preparedness.

The panel notes the significant reforms in primary care since the pandemic – for example, the establishment of Medicare Urgent Care Clinics across Australia. These reforms will potentially be of benefit in a future public health emergency because they could reduce pressure on hospitals and emergency departments.

Ensuring the health and wellbeing of health workers is essential

The key foundations to future pandemic planning and preparedness must be built in tandem with critical workforce planning that prioritises health, wellbeing and safety. It was consistently acknowledged throughout this Inquiry that the effectiveness of the pandemic response was built on the efforts and commitment of people rather than systems or plans. We all owe them our thanks.

The key concerns of the workforce are highlighted throughout the report. One concern was the confusion, fear and lack of coherence around access to suitable PPE. The panel heard this should not happen in future pandemic incidents, noting the shared responsibilities of governments in this area.

At a national level, there needs to be a better prepared response from the National Medical Stockpile. We acknowledge the agility the Australian Government showed in rapidly expanding access to the National Medical Stockpile consumer base and procuring hundreds of millions of units of medical supplies from 2020. However, there was a clear lack of agreed planning for the utilisation and understanding of the capacity of the National Medical Stockpile in a health emergency. This resulted in a lack of clarity of roles and responsibilities, ad hoc development of procurement and distribution approaches during the pandemic and insufficient and inappropriate PPE supplies. This left many health workers vulnerable to COVID-19. We support the findings and recommendations of the 2021 Australian National Audit Office and the 2022 Halton review on National Medical Stockpile preparedness.[1720]

Expansions to scope of practice in the pandemic showed agility and were critical in reducing workforce pressures during the pandemic. Having regard to the legislative and regulatory base underpinning the national health workforce, through the Australian Health Practitioner Regulation Agency, further opportunities could be pursued to enhance the harmonisation on changes to scope for practice. We support recent jurisdictional efforts to strengthen the role that registered nurses, midwives and pharmacists can play in administering vaccines, including for COVID-19.[1721] We note that the Independent Scope of Practice Review which is currently underway, will consider nationally consistent reforms to allow health professionals to work to their full training and experience.[1722] The benefits of multidisciplinary models of care in alleviating workforce pressures were also highlighted in the pandemic, particularly in rural and remote communities. Allied health professionals played a critical role in the delivery of this care. It is vital they are classified as essential workers.

Furloughing was a key measure to protect patient and workforce safety. Furloughing of healthcare workers for 14 days recognised that people were infectious before they developed symptoms. It also allowed positive test results to return from the laboratory and acknowledged the variable incubation periods of the virus. Early in the pandemic, it was clear that the risk of healthcare workers being at work when infectious (particularly when healthy adults could still be infectious after seven days) was far greater than the risk of having insufficient healthcare workers available to treat people. However, this must be regularly looked at and monitored throughout a pandemic to see if and when this risk changes. In a future pandemic, furloughing may be managed differently, particularly if the infectious period does not precede symptoms or if less invasive regular testing is an option to allow people to work until they are unwell or a risk to others.

The lack of a unified whole-of-system single source of health workforce data affected the Australian Government's ability to forecast and plan based on supply and demand, leaving workers under-resourced and ineffectively surged. The lack of visibility of a nationally coordinated assessment of Australia's health workforce capacity and capability makes it difficult

for government to identify training and skills gaps, assist in reprioritising public and private health workers in both regular and health emergency settings, and provide for a more collaborative and national approach to health workforce planning and training. This includes public health workforce capacity and capability, which should be guided by and align with the World Health Organization's *Global competency and outcomes framework for the essential public health functions*.[1723] The Australian Centre for Disease Control, in collaboration with the Department of Health and Aged Care and the newly established Medical Workforce Advisory Collaboration, should lead this work (See COVID-19 Response Inquiry Report Summary – Australian Centre for Disease Control).

We acknowledge the critical workforce strategies, including the National Medical Workforce Strategy and the National Nursing Workforce Strategy, to build a sustainable, highly trained health workforce, noting important work is already underway between government and key sector stakeholders.[1724]

Embedding the primary care sector into pandemic planning and future responses

A strong primary care response is a key component of future pandemic planning and responses. Australia's primary care sector continues to manage the after-effects of COVID-19. In many communities it played a key role in supporting ongoing access to care. Established relationships between health workers and their community were invaluable to the effective delivery of care and advice. It is encouraging to see the National Medical Workforce Strategy 2021–2031, the Primary Health Care 10 Year Plan and the National Health Reform Agreement Roadmap all working towards a strengthened health workforce, emphasising the need for better coordinated and patient-focused care.[1725]
Where primary care representatives, including from the Aboriginal Community Controlled Health Sector, were involved in emergency planning, there were better outcomes. Better integration of primary care into emergency planning and preparedness frameworks was a recommendation of the 2020 Royal Commission into National Natural Disaster Arrangements.[1726] We understand the Australian Government is working to address this recommendation, including through providing funding to Primary Health Networks from 1 July 2025 to develop and maintain the capability to engage in jurisdictional emergency planning.

Primary Health Networks are well placed to play a key role in emergency planning, noting their existing relationships across the community, as well as a role in assessing community needs and commissioning services to address critical gaps. Primary Health Networks need to play a much larger role in a future pandemic. However, they must be flexibly funded to do so and support innovations in primary care delivery.

Australian Government investment in mental health services during the pandemic – including in national data collection, additional supports to crisis services, the establishment of integrated care hubs and digital initiatives – helped mitigate harm. It also demonstrated the benefit of collaboration between governments, Primary Health Networks and the health sector. The panel strongly welcomes the continued rollout of innovative models of integrated care across Australia through the Medicare Mental Health Centre model and the Head to Health Kids model, and the Australian Government's investment of $71.7 million in funding over four years

from 2024–25 to Primary Health Networks to design and deliver multidisciplinary care for people with severe or complex needs in primary care settings.[1727]

Australian governments were aware of the risk of mental health impacts of the pandemic response and were early to act on these concerns. However, it is not clear how these risk factors were actively considered in public health decision-making. As discussed in Chapter 9: Buying time, some of these decisions had detrimental impacts on the mental health of many Australians. It was encouraging to see amendments to public health legislation in Victoria in 2021 that allowed government to consider other matters, including social and economic considerations, when making public health orders. Active consideration of broader impacts, such as effects on mental health, in decision-making would minimise unintended consequences (see Chapter 4: Leading the response).

We know the mental health impacts of the COVID-19 pandemic will continue to be felt by many Australians for some time. Further research and longer-term data collection that gives us a whole-of-system view of mental health in Australia would help us to understand the extent to which mental health impacts persist, particularly for at-risk groups such as children and young people. Linking this data through the use of unique identifiers would assist in monitoring and evaluating these impacts. This becomes even more critical as the mental health impacts of COVID-19 compound with other stresses such as cost-of-living pressures, global conflict and climate change.

The importance of dedicating planning and resourcing to the transition and recovery phase following COVID-19 and future pandemics cannot be understated. Without appropriate supports, the impacts of a pandemic will be felt more acutely and for longer.

5. Learnings

- A strong and resilient health system and a healthy population is the best way to prepare for a future health emergency. Pre-existing structural issues will be exacerbated in a crisis and will lead to longer-term impacts.
- Leveraging the full skillset of qualified health professionals (including nurses, pharmacists, and Aboriginal health workers) and supporting multidisciplinary team care will help address workforce shortages, reduce service delays, improve access to care and put our healthcare system in a better position to address future health emergencies.
- Australia's health workforce was prepared to go above and beyond to meet the challenges of a health emergency – their effort and commitment was critical to the effectiveness of Australia's pandemic response. Measures must be in place before, during and after a future pandemic which ensure the mental and physical wellbeing of Australia's health workforce is supported.
- Decisions on furloughing staff following exposure need to balance immediate risk of transmission against the broader health consequences of worker shortfalls.

- Primary care is often people's first point of entry to the health system. Resourcing the primary care sector and innovating the delivery of health services in an equitable way helps safeguard the care of patients during pandemics.
- At the onset of a public health emergency response, governments must seek and incorporate advice about the broader health impacts, including mental health implications, of proposed measures.
- Greater planning and understanding about the role, priorities and capacity of the National Medical Stockpile in future pandemic incidents is needed ahead of a health emergency to ensure better protection for Australians, for our health sector and for essential health and social care providers.

6. Actions

6.1. Immediate actions – Do in the next 12–18 months

Action 1: Address critical gaps in health recovery from the COVID-19 pandemic, including prioritising greater investment in mental health support for children and young people and a COVID catch-up strategy in response to a decline in the delivery of key health prevention measures.

Prioritise additional mental health funding and investment in services for children and young people, to help manage the ongoing mental health impacts of the pandemic on this cohort.

Health Ministers should coordinate a 'COVID Catch-up' strategy in response to a decline in the delivery of elective surgery and cancer screenings, including:

- a national plan to reduce the elective surgery backlog, in consultation with the private and public hospital sectors
- additional funding and an implementation strategy to re-engage regional, rural and remote and other high-risk populations in preventive care to help address undiagnosed cases of cancer, diabetes and other illnesses.

Action 6: Develop legislative and policy frameworks to support responses in a public health emergency, including for the National Medical Stockpile.

The National Medical Stockpile plan should:

- address the recommendations from both the 2021 Australian National Audit Office audit and the 2022 Halton Review on National Medical Stockpile preparedness.

Action 7: Finalise establishment of the Australian Centre for Disease Control (CDC) and give priority to the following functions for systemic preparedness to become trusted and authoritative on risk assessment and communication, and a national repository of communicable disease intelligence capability and advice.

The CDC must:

- Build foundations for a national communicable disease data integration system, enabled for equity and high-priority population identification and data interrogation, with pre-agreements on data sharing, including:
    - Finalising an evidence strategy and key priorities to drive optimal collection, synthesis and use of data and evidence, address data gaps and develop linkages to public health workforce capability data.
- Commence upgrade to a next-generation world-leading public health surveillance system, including:
    - enhancing early warning surveillance capability and related modelling to inform procurement planning for the National Medical Stockpile (to be undertaken by the Department of Health and Aged Care).
- Conduct biennial reviews of Australia's overall pandemic preparedness in partnership with NEMA, including:
    - summaries of new pandemic exercises held to date
    - detailed reporting on local and national incidents with advice on system strengths and weaknesses
    - recommendations for system improvement
    - a preliminary view of how many public and private health workers might need to be deployed in response to different pandemic scenarios, as informed by an assessment of national capacity
    - mapping of national technical public health pandemic response and research capability to identify skills gaps and coordinate and resource training programs in partnership with the Department of Health and Aged Care and states and territories
    - reporting to the Health Minister and National Cabinet prior to tabling in the Australian Parliament.

Action 11: Improve data collection, sharing, linkage, and analytic capability to enable an effective, targeted and proportionate response in a national health emergency.

This should include:

- Improvements to data collection and pre-established data linkage platforms, including:
    - delivering actionable insights regarding optimal emergency response design to ensure emergency responses can be appropriately designed, tailored and adjusted through real-time evaluation of both intended outcomes and broader impacts.
- Expanded capability in Australian Government departments to collate and synthesise economic and health data to inform decision-making, including:
    - bolstering health departments at all levels of government with public health data analytic expertise to better inform policy decisions
    - coordinating and resourcing training programs in partnership with states and territories and research institutions to address gaps in applied public health analytic and evidence synthesis expertise identified within and across jurisdictions.
- Finalising work underway to establish clear guardrails for managing data security and privacy and enabling routine access to linked and granular health data, and establishing pre-agreements and processes for the sharing of health, economic, social and other critical data for a public health emergency, including:
    - ensuring rapid mobilisation of real-time evidence gathering and evaluation
    - sharing within the Australian Government, between the Commonwealth and states and territories and with relevant sectors
    - finalising agreements by the CDC on the sharing of health data between the Commonwealth and the states and territories (also see Action 7)
    - prioritising key health data on Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities, people with disability and children and young people.

6.2.Medium-term actions – Do prior to the next national health emergency

Action 23: Progress development of the Australian Centre for Disease Control in line with its initial progress review and to include additional functions to map and enhance national pandemic detection and response capability.

This should include:

- drawing on national health workforce trend data to inform advice on pandemic readiness of the health system. This would include oversight of national surge workforce capabilities and gaps to be mapped and ready to be operationalised in a future emergency response.

Action 25: Continue to invest in monitoring and evaluating the long-term impacts of COVID-19, including long COVID and vaccination adverse events, mental health, particularly in children and young people, and educational outcomes.

- Where evidence from ongoing monitoring and evaluation shows long-term impacts of the COVID-19 pandemic continue to be seen, governments must ensure policies and programs in place are tailored to actively address the impacts.
- Evidence collected from ongoing monitoring and evaluation should inform plans and responses to future public health emergencies in order to mitigate similar long-term impacts.

Equity

Overview

Any comprehensive pandemic plan and response must take into account the many different experiences and challenges that various population groups face. The panel heard evidence that, while the COVID-19 pandemic had a substantial impact across the population, there were particular groups that experienced unique challenges and disproportionate impacts from public health measures.

Some groups faced heightened risks because of pre-existing disparities in health and economic outcomes and inequities in access to health care and other government services. For some people, their experience of the pandemic was further shaped by intersecting layers of discrimination, inequity and disadvantage.

During the Inquiry, we heard from individuals, community organisations, peak bodies and government representatives who described the diverse experiences of their communities and the people they serve.

In this section, we explore the experiences of groups that were recognised as being at greatest risk during the COVID-19 pandemic or are likely to be disproportionately affected during a future pandemic. These groups are:

- Aboriginal and Torres Strait Islander people
- children and young people
- culturally and linguistically diverse communities
- people with disability
- people experiencing homelessness or housing insecurity
- older Australians
- women.

This does not cover all groups. The experiences of other groups, for example casual workers and international students, also feature in the relevant sections of this report. There are also positive lessons to learn from these groups. Communities demonstrated remarkable resilience, innovation and solidarity throughout the COVID-19 pandemic. Community organisations quickly mobilised to provide vital wraparound supports, filling gaps and delivering services. We heard many organisations provided much-needed food relief, tailored information, outreach services, mental health supports and advocacy. Flexible funding to organisations enabled people to develop tailored solutions for their locations.

This section explores the enablers, challenges and lessons learnt from the pandemic response. The response for priority populations was slow in some instances but was improved by engagement and partnerships between the community sector and government, mostly through official advisory bodies established during the pandemic, as well as informal networks. Genuine

engagement in the design and implementation of tailored responses contributed to improved outcomes, and in some sectors response measures were innovative and effective.

Supports worked well for some priority populations, but the benefits were not felt evenly – for example, telehealth was transformative for some and enhanced the access to services, but it was less effective for people without adequate internet access or digital literacy. The benefits of some response measures were dampened by implementation challenges. For example, most people appreciated the government's recognition of priority populations in the vaccine rollout, but a lack of planning and tailored communications contributed to delays.

Other response measures exacerbated existing inequities or created new challenges for some populations. The immediate health response for the general population was prioritised, and this created some unintended impacts. For example, children experienced fewer direct health impacts, but the enduring consequences of disrupted education and developmental opportunities need to be understood and managed.

A lack of coordination and clarity of roles and responsibilities across government contributed to delays in the development of tailored responses for priority populations. Data for some priority populations were not systematically collected, linked or shared. The invisibility of priority populations in the population-level data that was available challenged the tracking of interventions and measurement of impacts, intended and otherwise, and the development of tailored responses and effective communications. Risk communication was especially challenging given the wide range of understandings and concerns in the most impacted populations. Some groups' prior lived experiences affected trust in government or influenced which people they considered to be trusted leaders within their community.

For many, public health measures increased social isolation, exacerbated mental health issues, reduced access to essential services and support networks and impacted cultural practices. Movement restrictions in remote communities prevented attendance at important cultural events. Visitation restrictions in residential aged care contributed to loneliness, physical and cognitive decline, and reduced oversight of care for older Australians. Work from home orders impacted single parents who had to work and supervise home-schooling. Stay-at-home orders increased the risks of family, domestic and sexual violence.

The rapid transition out of pandemic settings, end of pandemic-era supports and lack of consideration of ongoing health risks was particularly difficult for priority populations. We heard some people felt safer at the height of the pandemic, when preventive health measures provided a degree of protection.

The COVID-19 pandemic showed the need for systemic changes to address underlying inequities before any future public health emergency. Priority populations all have different experiences and needs. There is a clear need for government responses to be developed in advance, be informed by genuine consultation, and be tailored to reflect diverse and often complex needs. Once a crisis is upon us, it will be too late to establish these forums, programs and policies and access key data.

Timeline

- 25 January 2020: First COVID-19 case in Australia.
- 18 February 2020: Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19) released.
- 5 March 2020: Aboriginal and Torres Strait Islander Advisory Group on COVID-19 established.
- 11 March 2020: COVID-19 declared a worldwide pandemic by the World Health Organization.
- 13 March 2020: Communicable Diseases Network Australia National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia released.
- 17 March 2020: Australian Health Protection Principal Committee published first guidance on risks in schools and early childhood education and care.
- 23 March 2020: Coronavirus Economic Response Package Omnibus Bill 2020, containing eight bills to respond to the economic impacts of the coronavirus, passed both houses.
- 26 March 2020: Determination under the *Biosecurity Act 2015* (Cth) restricted travel into some remote Aboriginal and Torres Strait Islander communities.
- 29 March 2020: National Cabinet announced agreement on six-month moratorium on evictions.
- 29 March 2020: Coronavirus Domestic Violence Support Package announced.
- 30 March 2020: Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19): Management Plan for Aboriginal and Torres Strait Islander Populations published.
- 3 April 2020: Advisory Committee on Health Emergency Response to Coronavirus (COVID-19) for People with Disability established.
- 6 April 2020: Free early childhood education and care period commences.
- 17 April 2020: Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19): Management and Operational Plan for People with Disability released.
- 12 July 2020: Free early childhood education and care period concluded.
- 27 July 2020: Victorian Aged Care Response Centre established.
- 21 August 2020: National Aged Care Emergency Response began.
- 21 August 2020: Aged Care Advisory Group established.

- 30 September 2020: National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (Including COVID-19 and Influenza) in Residential Care Facilities released.
- 12 November 2020: Visitation Guidelines for Residential Aged Care Facilities released.
- 30 November 2020: Updated National COVID-19 Aged Care Plan released.
- 8 December 2020: Culturally and Linguistically Diverse Communities COVID-19 Health Advisory Group established.
- 13 February 2021: COVID-19 Vaccination Program – Culturally and Linguistically Diverse Communities Implementation Plan released.
- 22 February 2021: Phase 1a of vaccine rollout commenced.
- 9 March 2021: COVID-19 Vaccination Program Implementation Plan for Aboriginal and Torres Strait Islander Peoples released.
- 24 November 2021: National Aged Care Advisory Council established.
- 24 December 2021: Aged Care Council of Elders established.
- 13 December 2022: National COVID-19 Health Management Plan for 2023 released.
- 16 October 2023: Office of the Inspector-General of Aged Care established.

Chapter 13 – Aboriginal and Torres Strait Islander people

1. Context

In any public health emergency, Aboriginal and Torres Strait Islander people face higher risks because of interrelated factors such as inequities in service provision, social determinants of health and high burden of chronic disease.[1728] The results of this inequity have been seen in other health emergencies, such as the 2009 H1N1 influenza pandemic, so from early 2020 there was significant concern that COVID-19 could have a catastrophic impact on Aboriginal and Torres Strait Islander communities.[1729] There was also an awareness that a tailored response would be needed to address the risks to Aboriginal and Torres Strait Islander communities.[1730]

Despite initial fears and research showing 59 per cent of Aboriginal and Torres Strait Islander adults have a higher risk of severe illness from COVID-19 due to ongoing health inequities,[1731] in the first 18 months of the pandemic, Aboriginal and Torres Strait Islander people seemed to fare better than non-Indigenous Australians and other Indigenous populations globally.[1732] During this period there were no reported Aboriginal and Torres Strait Islander deaths from COVID-19 and the virus was prevented from spreading in communities.[1733] This was in large part due to biosecurity measures, initially called for by the community-controlled sector.

This Inquiry heard and received data showing this positive early result was largely the result of a rapid community-led response aligned with the Closing the Gap Priority Reforms. The response built upon existing governance structures and relationships that enabled effective and genuine collaboration between governments and the community-controlled sector enabled. A rapidly mobilised and tailored response was made possible because of existing trusted relationships, effective planning, coordination and consultation, and flexible funding to the community-controlled sector.

However, we also heard about issues that specifically impacted Aboriginal and Torres Strait Islander communities and the sustainability of the response. For example, it was difficult for people to isolate in overcrowded housing, there were significant challenges in the vaccination rollout and with access to PPE, response measures were not always culturally sensitive, and COVID-19 spread rapidly following the lifting of restrictions.

2. Planning, coordination and engagement

2.1. Response

During the pandemic, governments and the community-controlled health sector shared responsibilities for the Aboriginal and Torres Strait Islander COVID-19 response:[1734]

- The Australian Government was responsible for implementing the Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19): Management Plan

for Aboriginal and Torres Strait Islander Populations (Management Plan) in partnership with jurisdictions and the community-controlled health sector.

- States and territories were responsible for day-to-day management of the pandemic response and mainstream health services.
- Aboriginal and Torres Strait Islander Community Controlled Health Services were responsible for developing response plans to deliver primary health care to Aboriginal and Torres Strait Islander people, supported by the National Aboriginal Community Controlled Health Organisation.
- Primary Health Networks were responsible for coordinating the GP Respiratory Clinics rollout and PPE distribution. They also had a broader role in coordinating and commissioning primary care and mental health services.

In consultation with community, the Australian Government developed a number of Aboriginal and Torres Strait Islander specific plans to respond to the COVID-19 pandemic, including:

- the Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19): Management Plan for Aboriginal and Torres Strait Islander Populations (30 March 2020)[1735]
- the Communicable Diseases Network Australia National Guidance for Remote Aboriginal and Torres Strait Islander Communities for COVID-19 (20 April 2020)[1736]
- the Communicable Diseases Network Australia National Guidance for Urban and Regional Aboriginal and Torres Strait Islander Communities (10 December 2020)[1737]
- the COVID-19 Vaccination Program Implementation Plan: Aboriginal and Torres Strait Islander Peoples (9 March 2021).[1738]

The Australian Government commissioned modelling by the University of Melbourne and the Kirby Institute which helped inform National Guidance and response strategies in remote communities.[1739]

The Aboriginal and Torres Strait Islander Advisory Group on COVID-19 (Advisory Group) was the primary mechanism for consultation and coordination across governments, the community-controlled health sector and public health experts. The Advisory Group was co-convened by the National Aboriginal Community Controlled Health Organisation and the Department of Health and utilised pre-existing relationships in its work. It first met on 6 March 2020.[1740]

On 17 October 2022, the Advisory Group became the National Aboriginal and Torres Strait Islander Health Protection subcommittee of the Australian Health Protection Principal Committee. The subcommittees remit also expanded beyond COVID-19, to include Aboriginal and Torres Strait Islander health protection matters and relevant health outcomes of the National Agreement on Closing the Gap.

The Advisory Group helped to coordinate responses, develop and implement plans and response measures and share information from networks of community service providers. It

also helped to develop national guidelines - for example, the National Guidelines for COVID-19 Outbreaks in Correctional and Detention Facilities and the Vaccination Program Implementation Plan.[1741]

The Australian Government provided funding to support the Aboriginal and Torres Strait Islander response to COVID-19. This funding was largely provided to the National Aboriginal Community Controlled Health Organisation to distribute to Aboriginal and Torres Strait Islander Community Controlled Health Services. The funding was used for planning and preparedness, the primary health response, vaccination rollout activities and community supports.[1742] The National Indigenous Australian Agency also administered funds under the Indigenous Advancement Strategy and provided additional funding packages to Aboriginal and Torres Strait Islander businesses and communities to enable continuity of critical service delivery.[1743]

The Australian Government response was developed using local knowledge, data and evidence gathered by National Indigenous Australians Agency regional offices - for example, information on impacts of travel restrictions on regional and remote communities. From June 2020, the Department of Health's National Incident Centre produced informal reporting for the Advisory Group on Aboriginal and Torres Strait Islander case numbers. From 6 September 2021, weekly Aboriginal and Torres Strait Islander epidemiology updates were produced. Drawing on the National Notifiable Diseases Surveillance System, the reports documented cases, geographic distribution, age, hospitalisation and intensive care unit admissions, mortality, source of acquisition and vaccination status.[1744]

2.2.Impact

The effectiveness of the pandemic response for Aboriginal and Torres Strait Islander people was the result of an explicitly community-led response.[1745] The Inquiry heard that Closing the Gap Priority Reform Areas were embedded into all aspects of the response. There was a focus on shared planning and decision-making, centring the community-controlled sector, improving accessibility of mainstream services, and sharing data.[1746]

The government responded to requests from the National Aboriginal Community Controlled Health Organisation and other community organisations to manage travel into remote communities. We heard that delayed virus transmission in rural and remote Aboriginal and Torres Strait Islander communities can be attributed to the rapid implementation of public health measures and entry restrictions employed under the *Biosecurity Act 2015* (Cth).

The early development of the Management Plan was critical. It meant that roles and responsibilities across all levels of government, the community-controlled health sector and the wider health system were clearly established from the outset.[1747] Early action meant plans and initial measures were in place to delay virus transmission and allow sufficient time to build workforce capacity.[1748]

> *By the time Australia had its first COVID-19 case, our community controlled health sector and local community leaders had already begun making decisions – National Aboriginal Community Controlled Health Organisation*[1749]

Effective collaboration and coordination among governments and between governments and the community-controlled health sector was critical, and the Advisory Group was a successful enabling mechanism.[1750] The Inquiry heard that the Advisory Group's success was due to its rapid mobilisation, the inclusion of both government and community representatives with significant expertise, and access to decision-makers.[1751] The existence of longstanding structures such as the Health Chief Executives Forum (formerly the Australian Health Ministers Advisory Council) and strong relationships at the ministerial level also meant efforts could be coordinated between all levels of government.[1752]

We heard that the effectiveness of cross-jurisdictional coordination varied during the pandemic. For example, there were issues in the distribution of vaccinations to Aboriginal and Torres Strait Islander Community Controlled Health Services. This was partly because of a lack of coordination and understanding between the Australian Government and states and territories.[1753] However, when there were outbreaks in Aboriginal and Torres Strait Islander communities, we heard that the response involved coordination of efforts between the state and territory governments, the Australian Government and the community-controlled health sector.[1754]

Cross-jurisdictional coordination was particularly critical for Aboriginal and Torres Strait Islander communities that cover multiple states and territories - for example, the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Lands across the borders of South Australia, Western Australia and the Northern Territory.[1755] A tristate coordination mechanism, with representatives from the Australian Government, each state and territory, police and health experts, was established to coordinate the pandemic response.[1756] Community organisations were not included until later in the response,[1757] but the approach showed that cross-jurisdictional coordination can be effective when the right players are included.

Better outcomes were seen where communities were included in planning and decision-making. Their involvement ensured the evolving needs of community were identified and addressed quickly.[1758] For example, when Aboriginal and Torres Strait Islander Community Controlled Health Services were finding it difficult to access PPE early in the pandemic, the National Aboriginal Community Controlled Health Organisation worked successfully with the Department of Health to make sure they had adequate supply.[1759] Stakeholders have spoken of the genuine willingness of the department to work with community, but we heard this was often because there were already well-established relationships with key individuals.[1760] Some community organisations also felt the high-level government response was at times disconnected from needs on the ground, and there was a need to strengthen coordination:[1761]

> *With contextual knowledge of community, ACCHOs [Aboriginal Community Controlled Health Organisations] were the most equipped to provide correct and relevant information to facilitate informed decision making. – South Australian Health and Medical Research Institute*[1762]

Aboriginal and Torres Strait Islander Community Controlled Health Services played a central role in developing and delivering local community responses.[1763] The Inquiry heard that funding

flexibility allowed for responses that were tailored to communities and responsive to changing local needs.[1764] Flexible funding allowed services to develop public health messaging that was tailored to their communities' circumstances and disseminated through appropriate channels. They were also able to design local initiatives to lift vaccination rates.[1765] We heard from stakeholders that some grants were narrow in scope, so they could not be used to fund crucial health and social supports such as mental health and food security.[1766]

We heard longstanding barriers to data sharing were easier to remove during the pandemic. The Advisory Group was able to use data to make informed decisions - for example, it was able to identify specific communities that faced vaccine rollout challenges and respond accordingly.[1767] However, some stakeholders said they were concerned that data sharing models made possible in the pandemic are no longer in place.[1768]

Accounts about the early period of the pandemic were largely positive, but we heard some criticism of the effectiveness of the response during the transition/recovery phase. For example, as emergency settings were lifted from November 2021 onwards, we heard from a stakeholder that some pandemic plans were abandoned. Testing, tracing, isolating and quarantining procedures were discarded or transferred from governments to Aboriginal and Torres Strait Islander Community Controlled Health Services without formal negotiation.[1769] This coincided with the emergence of the Omicron variant and had significant impacts.

In the period 16 June 2021 to 14 December 2021 Aboriginal and Torres Strait Islander people were 1.2 times more likely than the general population to be admitted to intensive care with COVID-19 pneumonitis.[1770] This increased when borders reopened and Aboriginal and Torres Strait Islander people were 2.2 times more likely than the general population to be admitted to intensive care with COVID-19 pneumonitis.[1771]

Mortality data reflect similar trends, with Aboriginal and Torres Strait Islander people 1.3 times more likely to die from COVID-19 than the general population in the period 16 June 2021 to 14 December 2021 and two times more likely after the reopening of borders.

3. Access to information

3.1. Response

During the pandemic, governments and the community sector all worked to ensure Aboriginal and Torres Strait Islander people received targeted and appropriate information. The Department of Health's communications were informed by the Advisory Group and its Communications Working Group.[1772] Key activities included:

- engaging Aboriginal and Torres Strait Islander organisations to develop culturally appropriate materials[1773]
- publishing websites with information, audio and video materials in 15 Indigenous languages[1774]

- distributing a fortnightly newsletter to community stakeholders and providing updates and templates for local adaptation[1775]
- adapting mainstream COVID-19 vaccine communications materials to Aboriginal and Torres Strait Islander communities - for example, the mainstream 'Arm Yourself' campaign was adapted as the 'Protect Yourself' campaign (Figure 1)[1776]
- producing videos featuring health workers and community leaders promoting vaccination[1777]
- partnering with Aboriginal and Torres Strait Islander media organisations to deliver fact-checked vaccine messaging in both English and Aboriginal and Torres Strait Islander languages[1778]
- working with local Elders, religious leaders and Aboriginal Community Controlled Health Services to disseminate fact-based information to combat misinformation campaigns[1779]
- providing funding to the community-controlled health sector to develop tailored resources and communications campaigns specific to local circumstances and requirements.[1780]

Figure 1: 'Protect Yourself' COVID-19 vaccination campaign material[1781]

3.2.Impact

Some stakeholders criticised government communications with Aboriginal and Torres Strait Islander communities. They noted there was an overreliance on translating or adapting general communications campaigns, when community-led approaches should have been prioritised and supported. Governments were often slow to communicate, and there was not enough early and proactive communications.[1782]

Vaccine communications were particularly ineffective. The Australian National Audit Office report on the rollout found that 31 per cent of Aboriginal and Torres Strait Islander people recalled seeing vaccine campaign materials in December 2021, compared with 49 per cent of all Australians.[1783] Because communications were delayed and ineffective, some people turned to other information sources. The delay also allowed time for misinformation to spread.[1784] The Australian Government attempted to combat this, but we heard its communications were not always effective in doing so.[1785]

Concerns were raised about the framing of messaging. Some Aboriginal and Torres Strait Islander focus group participants that said that some people had difficulty with the formats of some information, and the use of fear-based tactics in some messaging had negative mental health impacts.[1786] The shift of messaging from 'stop COVID' to 'live with COVID' also caused confusion and impacted vaccine uptake:[1787]

> *Use more visuals, than words … it was all too wordy and First Nations people don't like that … how do you expect us to understand that? – Focus group participant, Cairns*[1788]

The Department of Health's most valuable contribution to Aboriginal and Torres Strait Islander communications was seen to be the provision of flexible funding, up-to-date information and templates to community organisations.[1789] The community-controlled sector was able to use those things to develop tailored communications that recognised the diversity within and across communities.[1790] Stakeholders agreed there cannot be a national message for all Aboriginal and Torres Strait Islander people. For example, different communications were needed in different locations - 38 per cent of Aboriginal and Torres Strait Islander people live in major cities, 44 per cent live in regional areas and 17 per cent live in remote areas.[1791] Communications materials need to be tailored to local circumstances and delivered through local channels.

Aboriginal and Torres Strait Islander Community Controlled Health Services, some Primary Health Networks and other Aboriginal and Torres Strait Islander community organisations played a vital and successful role in developing tailored resources. We heard that a range of resources were developed - for example, posters, Facebook posts, radio promotions, video clips and Easy Read fact sheets,[1792] as well as materials designed to counter misinformation.[1793] These resources were disseminated by local Elders, Aboriginal and Torres Strait Islander Community Controlled Health Services, local radio, community Facebook groups and other channels.[1794] We heard examples of local radio incorporating community services into their programming. For

example, some broadcasted church and funeral services when there were travel restrictions in place.[1795]

> *While content was based on official government requirements, the messages themselves were much more engaging and community focused emphasising cultural values and personalised - Aboriginal Health Council of Western Australia*[1796]

However, not all communities felt information reached them. Some Aboriginal and Torres Strait Islander focus group participants reported they did not receive enough information through trusted sources.[1797]

4. Experiences of the health response

The government's response to the COVID-19 pandemic included a range of initiatives specific to Aboriginal and Torres Strait Islander communities, in addition to responses for all Australians (see Chapter 9: Buying time, Chapter 10: The path to opening up, Chapter 12: Broader health impacts and Chapter 21: Supporting households and businesses).

4.1. Response

The public health response to COVID-19 included a range of initiatives specific to Aboriginal and Torres Strait Islander communities, in addition to health responses for all Australians (see Chapter 9: Buying time, Chapter 10: The path to opening up and Chapter 12: Broader health impacts).

4.1.1. Vaccine rollout

Aboriginal and Torres Strait Islander people were recognised as a priority group for vaccination. All Aboriginal and Torres Strait Islander people 18 years and over were included in Phase 1b or Phase 2a.[1798] The initial target was for 80 per cent of Aboriginal and Torres Strait Islander people to receive at least one dose by 31 October 2021.[1799] A specific Aboriginal and Torres Strait Islander Peoples Implementation Plan was published on 9 March 2021.[1800]

Several initiatives were implemented to support the rollout:

- Aboriginal and Torres Strait Islander Community Controlled Health Services were the primary channel for administering vaccinations.[1801] The Royal Flying Doctor Service also administered vaccines to remote communities.[1802]
- The scope of practice for Aboriginal Health Practitioners was expanded nationally to include administering COVID-19 vaccinations.[1803] From September 2021, Aboriginal and Torres Strait Islander Community Controlled Health Services were able to access additional workforce under the Vaccine Administration Partners Program.[1804]
- The Australian Government implemented a 'surge plan' in September 2021 under Operation COVID Shield to accelerate the rollout in 30 identified regions.[1805] Funding

vaccine liaison officers and community engagement activities were deployed as part of the operation.

- A range of tailored communications activities were implemented (see Section 3.1).

4.1.2. Broader health response

- Following early community-level action to prevent COVID-19 outbreaks, National Cabinet agreed to restrictions in remote communities, put in place through the *Emergency Requirements for Remote Communities Determination* under subsection 477(1) of the *Biosecurity Act 2015* (Cth). From 26 March 2020, the determination restricted movement to or from some remote communities. Exemptions were in place only for essential services or medical treatment.[1806] This measure was called for by the community-controlled sector and informed by consultation with states, territories and land councils.
- Early in the pandemic, positive or suspected COVID-19 cases in remote communities who were unable to safely isolate were evacuated to prevent outbreaks. The Royal Flying Doctor Service conducted aeromedical retrievals.[1807]
- Funding was directed to support planning, preparedness and outbreak management activities, such as mobile respiratory clinics and PPE delivery, in remote communities.[1808]
- As part of the national GP Respiratory Clinics program, 23 Aboriginal and Torres Strait Islander Community Controlled Health Services were able to operate as respiratory clinics.[1809]
- The Royal Flying Doctor Service delivered supplies and mobile GP clinics in remote communities.[1810]
- COVID-19 antiviral medications were distributed from the National Medical Stockpile directly to Aboriginal and Torres Strait Islander Community Controlled Health Services.[1811]
- Aboriginal and Torres Strait Islander Community Controlled Health Services were funded to facilitate culturally safe access to COVID-19 testing.[1812]
- Under the COVID-19 Point-of-Care Testing Program, existing point-of-care testing models were expanded. In 2020, in remote communities, 86 testing sites were established to deliver test results rapidly in situ.[1813]
- The National Indigenous Critical Response Service expanded mental health and suicide support available via phone and online.[1814]

4.2. Impact

4.2.1. Vaccine rollout

A number of initiatives assisted the vaccine rollout to Aboriginal and Torres Strait Islander people:

- Delivery: Aboriginal and Torres Strait Islander Community Controlled Health Services put in place walk-in, static, pop-up and mobile outreach vaccination clinics so that Aboriginal and Torres Strait Islander people in as many areas as possible could easily access services.[1815] The introduction of vaccine liaison officers helped bridge gaps in service delivery.[1816]
- Workforce: The expansion of the scope of practice for Aboriginal Health Practitioners, use of the Royal Flying Doctor Service in remote communities and the Vaccine Administration Partner Program were all effective in increasing the vaccination workforce.[1817]
- Outreach: Culturally appropriate public messaging around vaccinations developed by Aboriginal and Torres Strait Islander Community Controlled Health Services was considered effective.[1818] Aboriginal and Torres Strait Islander Community Controlled Health Services staff were available to address community members' questions and concerns face to face, and this helped boost vaccine uptake.[1819]

However, we also heard about a number of barriers to effective rollout of the vaccine:

- Delivery: Many Aboriginal and Torres Strait Islander people were not able to use online registration processes for large vaccine clinics, particularly those in urban areas.[1820]
- Workforce: The benefits of the Vaccine Administration Partners Program diminished over time.[1821]
- Supply: Some service providers, particularly in remote communities, said they had difficulty in accessing and storing vaccinations because of the specific storage requirements of the Pfizer vaccine, including the need to administer the vaccine within seven days.[1822] Delays in supplying Aboriginal and Torres Strait Islander Community Controlled Health Services with mRNA vaccines recommended for people under 60 years of age resulted in significant limitations on vaccinations for the majority of Aboriginal and Torres Strait Islander people in the initial phases of the rollout.[1823] These issues were eventually resolved, but they had an impact on initial uptake.
- Hesitancy: A number of factors contributed to vaccine hesitancy. For example, there was longstanding mistrust of government;[1824] reliance on AstraZeneca in the initial Aboriginal and Torres Strait Islander rollout, contributing to fear of side effects;[1825] limited early community transmission, resulting in a lack of urgency about getting vaccinated;[1826] delays to family decision-making given family members were separated into different rollout phases;[1827] prevalence of religious-based misinformation campaigns targeted at Aboriginal and Torres Strait Islander people;[1828] and insufficient

funding and capacity for Aboriginal and Torres Strait Islander Community Controlled Health Services to undertake adequate face-to-face outreach.[1829]

We heard from a stakeholder that there was a missed opportunity to increase the scope for the Royal Flying Doctor Service and Vaccine Administration Partners Program to deliver other immunisations, such as influenza, when in remote communities.[1830]

The Australian National Audit Office found vaccination uptake for Aboriginal and Torres Strait Islander people lagged behind targets and broader population rates, particularly in 2021.[1831] In September 2021, in response to low vaccine uptake, National Cabinet endorsed plans to accelerate vaccinations for Aboriginal and Torres Strait Islander people with an initial 30 priority areas identified. The government funded and worked with the Aboriginal and Torres Strait Islander health sector to prioritise vaccinating Aboriginal and Torres Strait Islander people through culturally appropriate local and community led initiatives.

When restrictions began to ease on 1 November 2021, vaccination rates were considerably lower for Aboriginal and Torres Strait Islander people. The Australian National Audit Office found initial national vaccine rollout targets for Aboriginal and Torres Strait Islander people were not met, and 72 per cent of the eligible Aboriginal and Torres Strait Islander population was double vaccinated by 31 December 2021 compared with 97 per cent of the non-Indigenous population.[1832] From March 2022 80 per cent of eligible Aboriginal and Torres Strait Islander people were vaccinated.[1833]

4.2.2. Broader health response

The speed with which movement restrictions for remote communities came into place helped delay the transmission of COVID-19.[1834] However, the practicalities of implementation and cultural issues were not adequately considered.[1835] For example, while movement restrictions were designed to stop people bringing COVID-19 from outside communities, we heard the restrictions:

- did not always stop people moving between remote communities and would not have necessarily been effective against a more transmissible virus[1836]
- stopped some people travelling for urgent medical care, as it would mean being away from their community for two weeks or longer.[1837] Where people did travel for medical care, they were often placed in inappropriate quarantine accommodation after being released from hospital[1838]
- resulted in a reduction of some external services to communities, increasing the burden for Aboriginal health workers and Aboriginal and Torres Strait Islander Community Controlled Health Services staff living and working in community[1839]
- contributed to a perception that COVID-19 was not a risk, negatively impacting vaccine uptake[1840]
- impacted cultural practices and social and emotional wellbeing (see Section 4.2.3).

We heard positive feedback from stakeholders on the community-controlled health sector's continued delivery of comprehensive primary care services to Aboriginal and Torres Strait Islander people throughout the pandemic, despite persistent workforce shortages (see Chapter 12: Broader health impacts).[1841] The GP Respiratory Clinics model was reflected on positively, although the funding application process was burdensome for Aboriginal and Torres Strait Islander Community Controlled Health Services.[1842]

Stakeholders praised the decision to distribute antivirals from the National Medical Stockpile directly to Aboriginal and Torres Strait Islander Community Controlled Health Services because it meant treatments could be provided faster.[1843] However, we heard the Department of Health underestimated the number of cases that would present at services, particularly during the Delta and Omicron outbreaks. Stakeholders raised that as a result, these services were poorly equipped in terms of appropriate PPE and rapid antigen tests at critical times in the pandemic.[1844]

The Point-of-Care Testing Program was successful, delivering results within 45 minutes where previously results had taken up to 10 days.[1845] An independent review estimated it prevented up to 122,000 infections.[1846] It also reduced the number of suspected cases that had to be evacuated while waiting for results.[1847] The infrastructure has provided ongoing benefits for testing for other priority infections.[1848]

The introduction of MBS items to support telehealth increased access to primary and allied health care for many Aboriginal and Torres Strait Islander people.[1849] However, its benefits were not shared equally because inequities in health and digital literacy and access to technology and internet meant not everyone could take advantage of it.

The pandemic had a significant impact on the mental health and social and emotional wellbeing of many Aboriginal and Torres Strait Islander people. It also exacerbated existing inequities in access to support services. While there is limited national data,[1850] a range of studies indicate Aboriginal and Torres Strait Islander people experienced compounding mental health impacts and greater decline in mental health and wellbeing.[1851] For example, a Healing Foundation study on the impact on Stolen Generation survivors found that during the pandemic 75 per cent of respondents reported a decline in mental health and wellbeing and 66 per cent reported decreased ability to cope with stress.[1852] We heard that telehealth made mental health services more accessible for some,[1853] but in remote communities access to mental health support workers was limited because of movement restrictions.[1854] A lack of flexibility in some grant funding meant it could not be spent on activities to support people with mental health concerns.[1855]

4.2.3. Design of health measures

The Inquiry heard that the health response to the pandemic was prioritised over social determinants of health. Although this is not new, it had a significant impact on outcomes for Aboriginal and Torres Strait Islander people.[1856] For example, we heard that some grant funding could be used for health-related activities but not for activities to address food insecurity.[1857]

> *How social determinants affected Aboriginal and Torres Strait Islander people was not adequately considered in the pandemic response. – Aboriginal Medical Services Alliance Northern Territory*[1858]

We heard the community sector provided significant wraparound support to Aboriginal and Torres Strait Islander people to fill this gap in the broader health response. For example, Aboriginal and Torres Strait Islander Community Controlled Health Services undertook work outside their primary care remit, such as delivering food packages and supporting people to access government services.[1859] This was often done rapidly without funding in place.[1860] Similarly, Inner Sydney Empowered Communities brought together 13 Aboriginal and Torres Strait Islander organisations to develop a comprehensive response plan covering health, food security, education and social and emotional wellbeing support.[1861]

Housing is a key determinant of outcomes in a health emergency. This was a particular concern for stakeholders. Rates of overcrowding and insecure housing are consistently higher for Aboriginal and Torres Strait Islander people than the national average.[1862] Aboriginal and Torres Strait Islander households are also larger and more often multi-family.[1863] These challenges made it difficult for some Aboriginal and Torres Strait Islander people to isolate, undermining the efficacy of public health measures.[1864]

The Inquiry heard there were concerns about the remote community retrievals and quarantine measures that were introduced during the response. Most quarantine facilities were not considered culturally safe.[1865] Stakeholders said there were issues with communication between health providers, people not having family nearby and disconnection from country.[1866] Local solutions such as the COVID on Country program in the Northern Territory were more culturally appropriate.[1867] However, these models were not implemented more widely in a timely way.[1868]

Ultimately, overcrowding and inadequate local quarantine options 'exacerbated the spread of COVID-1919' in Aboriginal and Torres Strait Islander communities in the vaccine rollout and transition/recovery phases.[1869] This played out in Wilcannia, New South Wales. As early as March 2020, the Maari Ma Aboriginal Health Corporation warned governments of the risks from overcrowding and urged them to establish local isolation facilities.[1870] Governments did not take action, and within 10 days in August 2021, Wilcannia had the highest transmission rate in New South Wales.[1871] Measures to support local isolation were only implemented after the outbreak received widespread attention.[1872]

> *In Wilcannia, people were forced to isolate in tents to avoid spreading the virus to Elders and other vulnerable family members. Yet, there was an ongoing reluctance to invest in quarantine, and particularly in community-led quarantine facilities. - National Aboriginal Community Controlled Health Organisation*[1873]

Many stakeholders noted that the cultural impacts of response measures were not adequately taken into consideration. In particular, movement restrictions impacted Aboriginal and Torres Strait Islander communities by stopping people visiting family and attending to cultural practices, such as Sorry Business.[1874] We also heard concerns about a lack of cultural safety in

mainstream health services, such as the COVID-19 Care@Home programs delivered by jurisdictions.[1875]

> *There needs to be sympathy with funerals, especially in Indigenous communities. When one person dies it affects all of us, we all feel it … it was an attack on our culture, community and our way of life - Focus group participant, Melbourne*[1876]

> *The health system was culturally inappropriate … I asked the midwife if I can have my partner here and she said no [crying] … we're in 2024 and I still live with that trauma now – Focus group participant, Cairns*[1877]

We also heard concerns about the cultural impacts for Aboriginal and Torres Strait Islander people who were incarcerated during the pandemic. This is of particular relevance to Aboriginal and Torres Strait Islander people given their over-representation in the prison system. Aboriginal and Torres Strait Islander people account for over 30 per cent of all incarcerated Australians.[1878] Due to pandemic restrictions, Aboriginal and Torres Strait Islander people who were incarcerated were restricted from attending critical cultural practices, such as Sorry Business. Also, there were fewer transfer requests approved for those wanting to move to a prison closer to their community and country.[1879] This had a significant impact on the mental health of people who were incarcerated, as well as their families and communities.[1880] We heard from one stakeholder that, in some cases, where people were on remand or had committed minor offences, it may have been beneficial to grant periods of leave.[1881] For further detail on the criminal justice system, see Chapter 5: Trust and human rights.

Aboriginal and Torres Strait Islander people experienced the enforcement of public health measures differently. That was particularly the case for those people who had experienced the policing of their movements.[1882] Fines for noncompliance with restrictions disproportionately impacted Aboriginal and Torres Strait Islander people. In New South Wales, fines were 'disproportionately issued to marginalised groups, including Aboriginal and Torres Strait Islander children'.[1883] Between April 2021 and March 2022, 2.5 per cent of child penalty notice recipients were issued to Aboriginal children.[1884] For further detail on the enforcement of public health orders, see Chapter 5: Trust and human rights.

5. Evaluation

Systemic inequities mean Aboriginal and Torres Strait Islander people are likely to be at risk in a future pandemic. Strong foundations in planning and early mitigation action are required

Aboriginal and Torres Strait Islander people experience widespread and well-documented health inequities and socio-economic disadvantage - for example, inequity in access to health care, education, housing and employment; and a high burden of chronic disease. These disadvantages contribute to increased risk during any health emergency.

During the 2009 H1N1 influenza pandemic, the rate of death from the virus was 5 times higher for Aboriginal and Torres Strait Islander people.[1885] The risks to Aboriginal and Torres Strait Islander people were not recognised, and this had serious impacts for the community.[1886]

Governments learned from these outcomes, and the result was that, from the outset of the COVID-19 pandemic, it was acknowledged that Aboriginal and Torres Strait Islander people were 'at a higher risk from morbidity and mortality during a pandemic and for more rapid spread of disease'.[1887]

The early prioritisation of Aboriginal and Torres Strait Islander people was demonstrated by rapid community action and planning, the early development of the Management Plan, and the restriction of travel into remote communities. These strategies helped delay transmission, bought time to build workforce capacity and contributed to better health outcomes, particularly in the first 18 months of the pandemic.

Understanding the risks to Aboriginal and Torres Strait Islander people, particularly those living in remote communities, and developing specific strategies to mitigate risks and minimise harms will enable early and targeted action and an equitable response.

Tailored responses require effective planning, coordination and data sharing

The most successful response measures were those that were tailored to specific Aboriginal and Torres Strait Islander communities. The Aboriginal and Torres Strait Islander COVID-19 Point-of-Care Testing Program successfully addressed the challenges of testing in remote communities, and an independent evaluation recommended it should be continued in response to other infectious diseases in remote communities.[1888] Local responses were also reported to be more successful when Aboriginal and Torres Strait Islander leaders and health entities had previously been actively involved in planning and delivery for other emergencies and were familiar with local challenges and capacities of partner agencies.[1889] Planning for future pandemics should consider and respond to specific circumstances of Aboriginal and Torres Strait Islander communities and leverage the broader emergency management processes at state and regional levels.

The response demonstrated the importance of effective coordination and collaboration between different levels of government and the community sector. Existing relationships - those among the community-controlled health sector, between the sector and the Department of Health, and between jurisdictions through high-level and local governance structures - were critical.[1890] These relationships need to be reflected in response structures so that the broader capacity of the Australian Government Crisis Management Framework is hardwired into planning for a protracted health emergency response. The Advisory Group in particular was successful in bringing together stakeholders. It demonstrated how the needs and experiences of an at-risk cohort can be effectively integrated into decision-making processes even during a rapidly changing health emergency.

The panel strongly supports the decision to make the Advisory Group a permanent subcommittee of the Australian Health Protection Committee as the National Aboriginal and Torres Strait Islander Health Protection subcommittee, with its remit expanded to other health issues. This is a positive development. This will ensure that Aboriginal and Torres Strait Islander voices are embedded in planning for and responding to future crises and that coordination between sectors and jurisdictions is adequately supported. The new subcommittee should also

be able to advise the newly formed Australian Centre for Disease Control. This high-level governance must be coupled with effective coordination of national and local level planning and response activities.

Better evidence collection and sharing are key to enhancing pandemic preparedness. During the COVID-19 pandemic, both community and government partners consistently reported delays in sharing of data and associated negative impacts. However, we also heard that improved cross-jurisdictional coordination and collaboration eventually led to reductions in barriers to data sharing. This was a vital element in supporting rapid tailored response measures.[1891] We are concerned by reports that these improvements have been reversed since the height of the pandemic. We urge all jurisdictions to urgently collaborate on the sharing of key health data. All jurisdictions should agree in advance on access to all key datasets for relevant government and community partners during a health emergency. Collection of necessary data must also be a priority focus. We welcome initiatives underway to improve data collection, such as work on measuring Aboriginal and Torres Strait Islander social and emotional wellbeing and mental health.[1892] This must be done in line with Indigenous Data Sovereignty and Governance principles such as the recent Framework for Governance of Indigenous Data (May 2024). The Framework aims to provide Aboriginal and Torres Strait Islander people greater agency over how their data are governed within the Australian Public Service (APS) so government-held data better reflect their priorities and aspirations; and provides guidance to the APS in improving governance practices for data related to Aboriginal and Torres Strait Islander people.[1893]

Community-led responses are essential to supporting Aboriginal and Torres Strait Islander people

The strength of the Aboriginal and Torres Strait Islander response lies in the effective role Aboriginal and Torres Strait Islander leaders and organisations were able to play and the recognition by governments of the importance of shared decision-making and genuine engagement and relationships with community. Aboriginal and Torres Strait Islander Community Controlled Health Services were able to develop effective local plans and measures that responded to the needs of their communities - from the design and dissemination of communications to the delivery of tailored health and vaccination services. Effective feedback loops between the community-controlled sector and government were also essential. For example, issues with PPE access for Aboriginal and Torres Strait Islander Community Controlled Health Services were only resolved when the Department of Health negotiated directly with the sector.[1894]

The availability of flexible funding was key in supporting agile, rapid and targeted responses by Aboriginal and Torres Strait Islander Community Controlled Health Services and other community services. However, we heard there are persistent limitations on grant and procurement processes for some programs. Also, some grants were not sufficiently flexible, and this led to delays and shortfalls in funding for mental health supports and food relief. In a rapidly evolving crisis, funding needs to be flexible to allow an agile, community-led response. There is benefit in devolving emergency funding decisions to regional offices and Primary

Health Networks, because they have greater awareness of local requirements and community service providers can be given the flexibility to respond rapidly. A rapid audit could be conducted after the fact so that the need for transparency and accountability is balanced with the ability to quickly redeploy funds where necessary during a crisis.

Planning for and responses to a future pandemic must be carried out in line with the Closing the Gap Priority Reforms. Future planning and responses must also emphasise the role of the community-controlled sector and the need for genuine co-design, formal partnerships and shared decision-making. They should build on the objective of the National Aboriginal and Torres Strait Islander Health Plan 2021-2031 for disaster and pandemic planning, preparedness and recovery to embed mechanisms for Aboriginal and Torres Strait Islander leadership and surge capacity for the community-controlled health sector during crises.[1895]

Tailored and community-led communications are most effective

During the pandemic the Australian Government developed a range of communications for Aboriginal and Torres Strait Islander people. However, we consistently heard that the most effective communications were those that were tailored by community organisations and shared through local channels and trusted voices. Government support was most useful where it provided resources and up-to-date health information to local organisations and flexible funding to undertake communications activities or where it partnered with community leaders.

In a future pandemic, the community-controlled health sector should have responsibility for and funding to tailor and deliver public health communications to Aboriginal and Torres Strait Islander people, with clear links into broader government communications activities. The focus for governments should be on collection, integration and synthesis of key data; provision of access to flexible funding; and provision of accurate information that connects the sector and other community organisations and sources.

Responses must consider social determinants and cultural factors

The COVID-19 response showed the impact that inequities in social determinants of health have on the outcomes for Aboriginal and Torres Strait Islander people in a public health emergency and the challenges that are involved in trying to address systemic issues during a crisis. Ongoing work is needed to address entrenched inequities under the National Agreement on Closing the Gap so that preparedness and resilience during crises are enhanced.

For example, overcrowding in some Aboriginal and Torres Strait Islander communities impacted people's ability to safely isolate. While mitigation strategies such as remote evacuation and retrievals were introduced, they were often inadequate or inappropriate. Greater investment in secure housing for Aboriginal and Torres Strait Islander people (such as the March 2024 announcement of $4 billion for housing for remote communities in the Northern Territory[1896]) will improve preparedness for future pandemics. In parallel, governments need to invest in emergency facilities to address gaps, including culturally appropriate regional quarantine facilities.

Cultural factors and the different ways Aboriginal and Torres Strait Islander people experience public health measures need to be considered when designing and implementing pandemic responses. The inquiry heard many examples of initiatives designed in consultation with community that sought to prioritise cultural safety, but these were often too slow to be introduced and were not universal. Some restrictions – particularly on movement between communities – had a particular impact on cultural practices, social and emotional wellbeing and mental health. There needs to be recognition of the risks for Aboriginal and Torres Strait Islander people who are incarcerated during a pandemic, including being held away from country and without visits from family and social supports. In future pandemics, these considerations must be balanced in the development of public health measures and enabled through effective consultation with community.

6. Learnings

- Aboriginal and Torres Strait Islander people are likely to be at risk in future pandemics due to longstanding health inequities and socioeconomic disadvantages. Engagement in planning and preparedness and proactive action is essential to minimise transmission and mortality in Aboriginal and Torres Strait Islander communities.
- The community-controlled health sector and other Aboriginal and Torres Strait Islander organisations play a critical role in designing and delivering services for Aboriginal and Torres Strait Islander people. In line with the National Agreement on Closing the Gap, genuine partnership between government and the sector is essential for planning and responding to future public health emergencies.
- Flexible funding to community organisations, including the community-controlled health sector, enables agile and tailored local responses during a health emergency.
- Collection and cross-jurisdictional sharing of data in line with Indigenous Data Sovereignty and Indigenous Data Governance principles needs to be pre-agreed to ensure tailored responses.
- Aboriginal and Torres Strait Islander community organisations and trusted voices are best placed to tailor and disseminate culturally appropriate and effective communications to Aboriginal and Torres Strait Islander people. Government should clearly define roles and responsibilities for communications and prioritise supporting organisations to perform this role, including with resourcing.
- Effective mitigation strategies must be included in pandemic plans to address systemic health inequities and social health determinants. Overcrowding and food insecurity must be addressed to reduce the risks to Aboriginal and Torres Strait Islander people in a public health emergency, and community-based quarantine facilities should be established to mitigate risks of transmission in rural and remote communities.
- Pandemic response measures should take into consideration implications for cultural practices and the social and emotional wellbeing of Aboriginal and Torres Strait Islander

people. This should include specific strategies to ensure the cultural safety of Aboriginal and Torres Strait Islander people in settings such as the criminal justice system or quarantine during a pandemic.

- Effective engagement with Aboriginal and Torres Strait Islander people at the regional and local government level in emergency planning is critical to leverage whole-of-government responses.

7. Actions

7.1. Immediate actions – Do in the next 12–18 months

Action 5: Develop updated health emergency planning and response arrangements in conjunction with states and territories, and key partners, including consideration of escalation and de-escalation points, real-time review and a focus on post-emergency recovery.

As part of this, develop management plans for priority populations under the National Communicable Disease Plan, including for Aboriginal and Torres Strait Islander people.

- The Management Plan for Aboriginal and Torres Strait Islander people should include co-designing strategies to mitigate the risk of a virus spreading to remote Aboriginal and Torres Strait Islander communities, limiting the impact of pandemic response measures on cultural practices, and ensuring culturally appropriate delivery of vaccination and healthcare services. This plan should be aligned with the Closing the Gap Priority Reform Areas and make explicit the central role of the community-controlled sector in responding to a pandemic.

Action 6: Develop legislative and policy frameworks to support responses in a public health emergency, including for quarantine.

- The National Quarantine Strategy should establish culturally appropriate options for people in remote Aboriginal and Torres Strait Islander communities to quarantine on country in a national health emergency.

Action 8: Establish mechanisms for National Cabinet to receive additional integrated expert advice for a whole-of-society emergency, including advice on social, human rights, economic and broader health impacts (including mental health considerations), as well as specific impacts on priority populations.

- In parallel with making decisions based on key public health advice, National Cabinet should consider the differential impacts of a pandemic across the population and economy. This must include considering and mitigating unintended consequences, and seek to minimise negative impacts on broader health, mental health, educational, equity, economic and social outcomes.
- Human rights considerations should be embedded into National Cabinet's decision-making processes, particularly where measures are intended to significantly restrict rights and freedoms.

- This might include mechanisms for a national health emergency that allow expert advice to be sought from the Australian Human Rights Commissioner and other commissioners (e.g. National Children's Commissioner) to support better understanding of the broader impacts of their decisions on human rights and priority populations.

Action 11: Improve data collection, sharing, linkage, and analytic capability to enable an effective, targeted and proportionate response in a national health emergency.

This should include:

- improvements to data collection and pre-established data linkage platforms, including enhanced data collection for Aboriginal and Torres Strait Islander people in line with Indigenous Data Sovereignty and Indigenous Data Governance principles
- finalising work underway to establish clear guardrails for managing data security and privacy and enabling routine access to linked and granular health data, and establishing pre-agreements and processes for the sharing of health, economic, social and other critical data for a public health emergency. Key health data on Aboriginal and Torres Strait Islander people should be prioritised.

Action 14: Embed flexibility in Australian Government grant and procurement arrangements to support the rapid delivery of funding and services in a national health emergency, for instance to meet urgent community needs and support populations most at risk.

This should include:

- funding mechanisms that allow organisations to rapidly develop and deliver solutions tailored to their communities
- funding to Aboriginal and Torres Strait Islander community service providers and the community-controlled health sector during a national health emergency.

Action 15: Ensure there are appropriate coordination and communication pathways in place with industry, unions, primary care stakeholders, local government, the community sector, priority populations and community representatives on issues related to public health emergencies. Structures should be maintained outside of an emergency, and be used to provide effective feedback loops on the shaping and delivery of response measures in a national health emergency.

- Build and maintain engagement mechanisms outside of an emergency with the community sector.
- Maintain and build on effective structures that were established before or during the COVID-19 pandemic, including those with priority populations such as Aboriginal and Torres Strait Islander people.
- Consult these groups on the development and updating of pandemic plans, and ensure they participate in stress-testing exercises.

- Ensure there are clear mechanisms to feed into decision-making processes in an emergency, and genuinely engage relevant bodies in pandemic preparedness activities and responses to future emergencies.
- Utilise these structures in national health emergencies to provide effective feedback loops on the delivery of response measures.

Action 18: Proactively address populations most at risk and consider existing inequities in access to services (health and non-health) and other social determinants of health in pandemic management plans and responses, identifying where additional support or alternative approaches are required to support an emergency response with consideration for health, social and economic factors.

- All plans and response measures should have an equity lens applied, including for health, social, human rights and economic factors (see Action 1).

Action 19: Develop a communication strategy for use in national health emergencies that ensures Australians, including those in priority populations, families and industries, have the information they need to manage their social, work and family lives.

The strategy should account for the distinct communications preferences and requirements of priority populations – including:

- reflecting the key role of community and representative organisations in communicating with priority populations, including Aboriginal and Torres Strait Islander community organisations
- funding community and representative organisations to tailor and disseminate communications through appropriate channels and trusted voices
- providing plain English messaging to community organisations for tailoring in a timely manner.

Chapter 14 – Children and young people

1. Context

Children and young people are considered a vulnerable group during pandemics. Many viruses, including influenza, result in more severe illness and higher probability of death in children, especially infants, than adults.[1897] In addition, children and young people's development is negatively affected by several factors that arise with pandemics - for example, parental illness and death, financial hardships, restrictive public health measures, disrupted routines and lack of social contact. In the short term, these factors can lead to anxiety, depression, aggression, fear and grief. Over the long-term, direct and indirect impacts of pandemics can contribute to mental health disorders, poor academic performance and education outcomes, and persistent socio-economic disadvantages.

In the early stages of the COVID-19 pandemic, there was widespread community concern and uncertainty about the potential impacts of the virus on children. Evidence quickly emerged that children and young people were less susceptible to the direct health impacts of the virus, and they had significantly lower risk of serious illness and mortality.[1898] Despite this, many parents withdrew their children from school and early childhood education and care (ECEC) settings to protect them from exposure.

The Inquiry heard how the COVID-19 pandemic and associated public health orders affected educational experiences, mental health and wellbeing, child development and in some instances oversight of child welfare and safety.[1899] Some children and young people experienced more significant impacts with pre-existing inequities exacerbated.[1900] There is also evidence of a worrying decline in early childhood vaccination rates in the aftermath of the COVID-19 pandemic.

We must learn how the COVID-19 pandemic and the response affected children and young people so we can ensure that, in future, responses to public health emergencies take into account the unique risks, vulnerabilities and experiences of children and young people.

2. Planning, coordination and engagement

2.1. Response

All levels of government had roles and responsibilities in the pandemic response that related to children. For example, the Australian Health Protection Principal Committee, chaired by the Commonwealth's Chief Medical Officer and comprising all state and territory Chief Health Officers, was the primary advisory body on health issues, including on children and young people.[1901] State and territory governments were responsible for decisions related to public health orders that impacted children and young people. The Australian Government held primary responsibility for ECEC, while state and territory governments were responsible for decisions around school closures.[1902]

However, there was no national framework guiding the response for children until January 2022, when the Australian Government published the National Framework for Managing COVID-19 in Schools and Early Childhood Education and Care.[1903] The Framework set out principles for limiting the impact of COVID-19 on children during the transition/recovery phase. For example, it stated that ECEC services are essential and should remain open wherever possible, particularly for vulnerable children and children of essential workers.[1904]

The Australian Government did not establish an advisory body to assist in the response for children as it did for other population groups. However, some other newly established advisory bodies included members with expertise on the experience of children and young people. For example, representatives from the Royal Children's Hospital and the Multicultural Youth Advocacy Network were included on the Culturally and Linguistically Diverse Communities COVID-19 Health Advisory Group when it was established in December 2020.[1905] The Australian Technical Advisory Group on Immunisation also included members with expertise in paediatrics.[1906]

The first National Children's Commissioner commenced in 2013.[1907] The role of the National Children's Commissioner, situated within the Australian Human Rights Commission, is to promote and advocate for the human rights of all children in Australia.[1908] The National Children's Commissioner's work complements the work performed by equivalent positions in all state and territories. During the COVID-19 pandemic, the Australian Human Rights Commission and the National Children's Commissioner conducted a number of projects related to the impacts of the pandemic on children and young people, with a focus on mental health and wellbeing.[1909] The position of National Children's Commissioner was vacant between 24 March 2020 and 5 November 2020. The National Children's Commissioner did not sit on any health advisory bodies during the pandemic.

In 2020 the Australian Government also restored funding for the Australian Youth Affairs Coalition because it recognised the need for a peak body to share information and coordinate responses for young people.[1910]

2.2.Impact

The Inquiry heard from many stakeholders that a focus on the health impacts for the broader population at all levels of government meant that the indirect impacts of response measures on children and young people were not prioritised. We heard that pandemic response measures did not take a holistic view of health and wellbeing, and came at the expense of considering the unique needs of children and young people or their 'education, emotional, cognitive and physical development'.[1911]

For example, state and territory governments introduced restrictions for settings ranging from school to playgrounds despite evidence of limited transmission risk.[1912] Similarly, policies on hospital visitation ignored the critical role parents play in caring for their children.[1913] When children have been mentioned in policy discourse, it has been in terms of the impacts on adults, and particularly workforce participation.[1914]

> *The response needs to be more balanced between education, health and economy, which was not present. There was a panic approach to physical health – Parent/carer of a primary school aged child, Melbourne*[1915]

We heard that the failure to explicitly consider the impact of policies on children and young people stemmed in part from inadequate engagement with, and representation of, their interests in decision-making at all levels of government. There were also a lack of mechanisms that would allow children and young people to feed information into decision-making.[1916] This was exacerbated by limited coordination and ownership of policy for children and young people. The Australian Human Rights Commission has noted that 'policy affecting children is uncoordinated, widely spread across portfolios, and there is a lack of monitoring and accountability for reform'.[1917]

> *The needs of children and adolescents were largely neglected during the pandemic, and there was no mechanism for their needs to be heard. - Murdoch Children's Research Institute*[1918]

The Inquiry heard there was a lack of accessible communication about COVID-19 tailored to children and young people. In a 2020 survey of over 1,000 young people, UNICEF Australia found 51 per cent thought there had not been 'enough effort put into communicating effectively with children and young people in an inclusive manner' during the COVID-19 pandemic.[1919] The Australian Research Alliance for Children and Youth noted more work needs to be done to 'expand child-friendly methods of communication in media especially during future pandemics, and enhance this by doing so in partnership with children and young people'.[1920]

> *[Information is] very confusing because someone says something and someone says another thing and I have to put it all together. - Primary school student, Victorian Commission for Children and Young People COVID-19 snapshot*[1921]

> *I think it's extremely important that the government is relaying information regarding COVID-19 to children in child mind ways, where we are told info in ways that keep us safe, make us feel safe and in a way we can comprehend and not get us worried, information we can see and understand! – High school student, Victorian Commission for Children and Young People COVID-19 snapshot*[1922]

3. Experiences of the response

3.1. Response

3.1.1. Vaccine rollout

While young people aged 16 and over were included in phase 2b of the vaccination rollout along with the balance of the adult population, other children were approved for a primary

course of COVID-19 vaccination later than most other groups. Following Therapeutic Goods Administration approval, the Australian Technical Advisory Group on Immunisation recommended vaccination for children and young people as follows:

- 2 August 2021: Aboriginal and Torres Strait Islander children aged 12 to 15 years and all children aged 12 to 15 years with specific medical conditions or living in remote communities[1923]
- 27 August 2021: All children aged 12 years and older[1924]
- 10 January 2022: All children aged 5 to 11 years[1925]
- 3 August 2022: Children aged 6 months to 5 years at risk of severe illness from COVID-19.[1926]

There were no specific vaccination channels for children and young people - they used the same primary care and state and territory mass vaccination clinics as adults.[1927]

The Department of Health produced resources to support the vaccine rollout to children. For example, the Children's COVID-19 Vaccination Program Community Kit provided information about the vaccine and resources for organisations, schools and community groups. The kit provided social media post templates, fact-based information to address misinformation, advice on fear of needles in children, translated resources, and colouring-in activities.[1928] Specific fact sheets were also developed with guidance on how to speak to children about COVID-19 vaccination, and resources were tailored for Aboriginal and Torres Strait Islander children.[1929]

3.1.2. Broader response measures

The Australian Government developed several initiatives to support children and young people. Most of these were focused on mental health and wellbeing. For example:

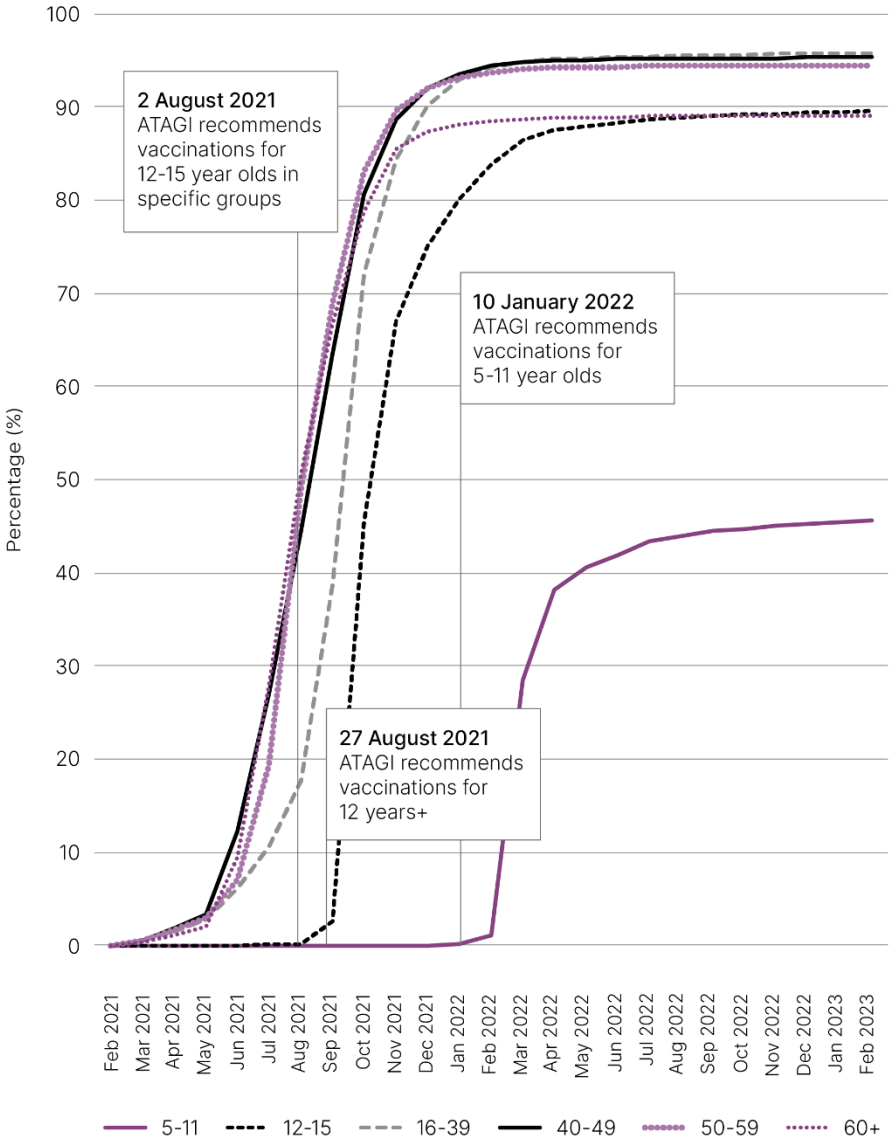
- in the 2021-22 Budget, initiatives aimed at children and young people were funded under the National Mental Health and Suicide Prevention Plan. This included $40.6 million to provide wellbeing training and resources in schools and ECEC under the Be You initiative; and $276 million for other school-based wellbeing programs, such as the Student Wellbeing Hub[1930]
- from July 2021, $3 million was allocated to support young people in Victoria and $3.5 million was allocated to support young people in New South Wales to access mental health support through headspace services, with a particular focus on students in years 11 and 12.[1931] This funding package included $300,000 to Kids Helpline to extend online sessions to secondary schools.[1932]

3.2.Impact

3.2.1. Vaccine rollout

Children had a much lower risk of severe disease than adults pre-vaccine. However, their risk of infection matched adult risk after the variants of concern appeared.[1933] When 12 to 15 year olds were approved for vaccination there was relatively fast initial uptake, similar to other age groups (see Figure 1).[1934] However, 5 to 11 year olds reached a much lower rate of vaccination coverage than older age groups, who were at greater risk from severe disease and may have been subject to vaccine mandates.[1935] There were also disparities in coverage across groups. For example, by February 2022 there was a 19 per cent gap in coverage between Aboriginal and Torres Strait Islander children and non-Aboriginal children aged 5 to 11 years, and a 28 per cent gap between the most and least socio-economically disadvantaged areas.[1936]

Figure 1: Cumulative percentage of people with two COVID-19 vaccination doses, by age group (2021–2023)[1937]



The Inquiry heard a range of concerns on vaccination from parents and carers which may have impacted uptake.

- Focus group participants raised concerns about what testing had been undertaken to ensure the safety of vaccines for children and noted it was difficult to find information about potential impacts of vaccination on children.[1938]
- Despite the Australian Government's targeted communications and rollout campaign, 28 per cent of respondents to the Inquiry's community input survey who had a dependent child during the pandemic rated the Australian Government's communication on the safety and efficacy of the vaccine as poor.[1939]
- Vaccinations were never mandated for those under 18 years of age. Despite this, we heard some parents were fearful that their child would be subject to mandatory vaccination and one stakeholder noted some parents did not send their children to school for fear of them being vaccinated without consent, despite this not occurring.[1940] The interaction of mandates with public health orders also impacted children and young people. For example, in Victoria, unvaccinated teenagers could not visit a café with their vaccinated parent, although vaccinations had never been mandated for them.[1941]

> *Don't force experimental vaccines on peoples especially children. - Survey respondent, male with dependent child, Queensland regional [1942]*

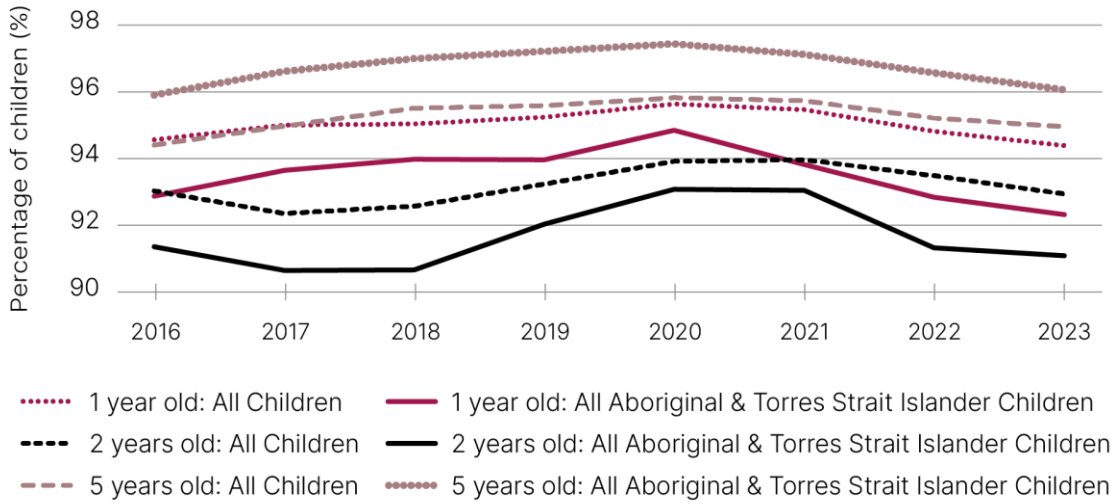
In contrast, we heard some parents of children under the age of 5 remain concerned about the risk of exposure to COVID-19 for children for whom vaccination is not approved.[1943] Fear and confusion worsened when parents compared vaccination approaches internationally with that in Australia – for example, booster shots were being made available to all children in the United States but not to those in Australia.[1944]

> *Presently our child cannot get vaccinated (he could if we lived in USA as he is 6-months old, why not here?) and he is also too young to wear a mask. The simple act of accessing healthcare at the moment risks exposing him to catching COVID-19, as no healthcare setting in Australia currently requires persons to wear a mask, and if they ask people to wear one not everyone wears one or does so properly. – Submission 1725[1945]*

Some stakeholders also said they were concerned about the impact that the COVID-19 vaccine rollout would have on the uptake of routine vaccinations for children.[1946] Since 2020 there has been a downward trend in the proportion of children fully immunised (see Figure 2). The decreases are largest among Aboriginal and Torres Strait Islander children.[1947] Research on the perceptions of routine childhood vaccination before and after the pandemic found 'concerning increases between 2017 and 2023 in the proportions of Australian parents expressing misperceptions about childhood vaccinations'.[1948]

Further, the Inquiry's community input survey found 28 per cent of respondents who had a dependent child during the pandemic said they would not get a vaccine offered by the government in a future pandemic.[1949] This rose to 51 per cent among some single-parent families - the highest of any group.[1950]

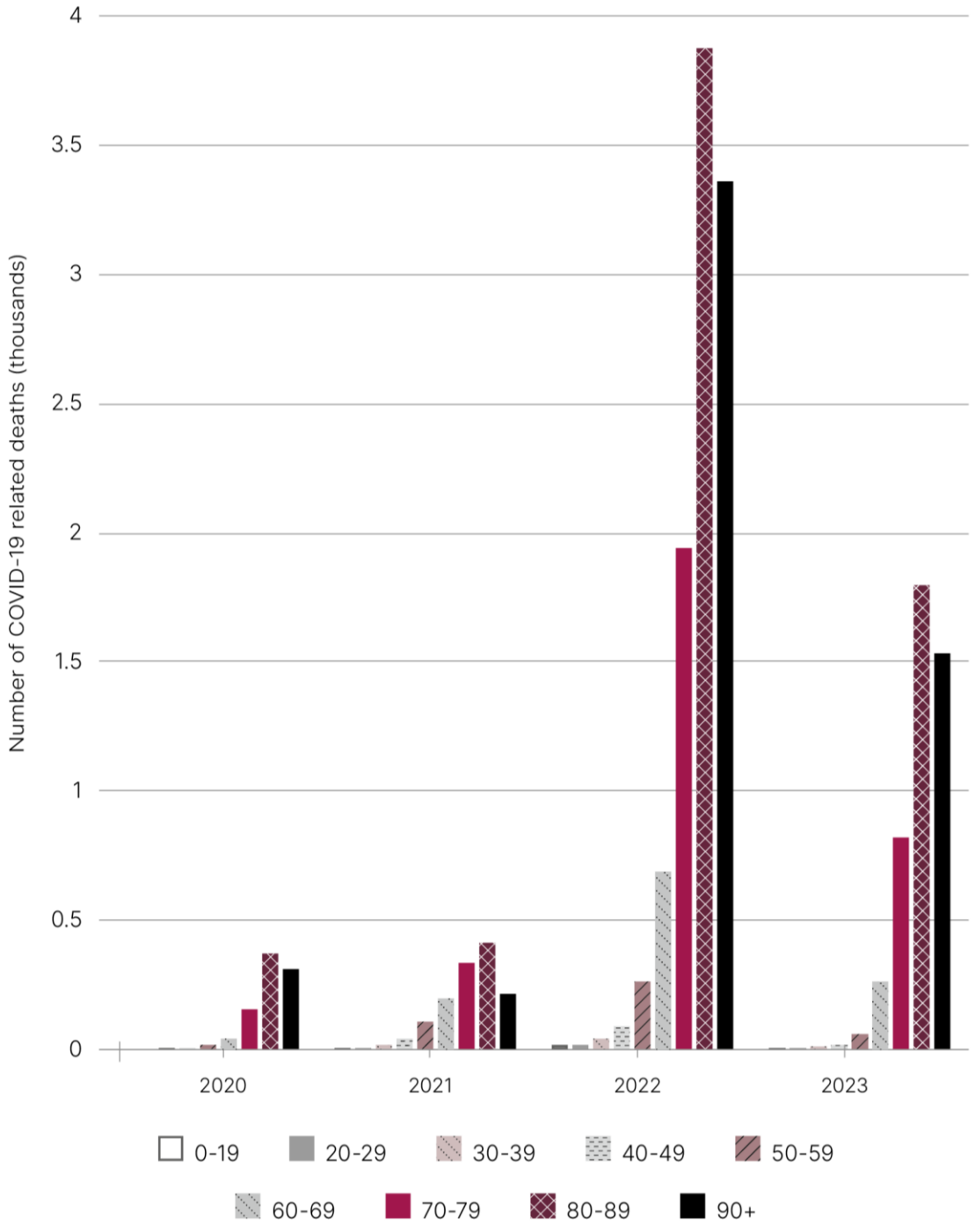
Figure 2: Routine vaccination – fully immunised Australian children at 1, 2 and 5 years of age[1951]



3.2.2. Broader response measures

Throughout the COVID-19 pandemic, the direct health impacts of the virus on children and young people were relatively mild and rarely caused severe illness.[1952] Between March 2020 and September 2023, the lowest number of total COVID-19 registered deaths occurred among those aged 0 to 19 (32), followed by those aged 20 to 29 (44).[1953] The highest number of COVID-19 deaths occurred among those aged 80 to 89 years (6,005) (refer to Figure 3).[1954]

Figure 3: COVID-19 deaths by age, 2020–2023[1955]



Instead, the effects of pandemic response measures on children and young people tended to be flow-on or indirect impacts. For example, public health orders that restricted movement and social interaction, limited access to ECEC, closure of schools and playgrounds in some jurisdictions and reduced access to key services.[1956]

Impacts of online schooling and isolation on students[1957]

Noor* is a teacher at an Islamic school and had been teaching for 12 years when the pandemic occurred. When teaching went online during the pandemic, she was teaching a Year 1 class and she noticed that her students struggled to pay attention and keep up with the content she was teaching. The students suffered from the isolation they experienced from their friends and teachers. Noor felt that she was unable to adequately help them to learn and develop at the critical juncture of their schooling experience. These students spent their first school year in online classes due to the extended lockdowns. Noor now finds that these students, who are currently in Year 4, are still struggling not just academically but also socially and psychologically.

Children and young people's mental health and wellbeing were significantly impacted by the pandemic. The pandemic occurred at a time when children's mental health was already seen to be in crisis in Australia and globally.[1958] Increased social isolation, stress, anxiety, uncertainty, loss of control, disruption to daily routines and concerns for the wellbeing of family and loved ones created the conditions for either the onset of mental ill health or deterioration of existing conditions.[1959] School closures and remote learning also led to increased engagement with social media, triggering weight and body-checking behaviours among some young people.[1960] Research also suggests that lifestyle disruptions during lockdowns caused changes in brain biology in children and young people, with a greater impact on the adolescent female brain than the adolescent male brain.[1961]

> *COVID has destroyed my routine and I was most of the time depressed … My mum got me some help but they were not that helpful … I hate COVID, I hate what it has taken from me. – Young person, Victorian Commission for Children and Young People COVID-19 snapshot*[1962]

> *[Online is not the same because] … when you go to school you see your friends and you talk about life and stuff like that … I feel like that's really impacted everyone's mental health … it's kind of really upsetting … I think it's that whole one-on-one human interaction that it really counts. – Young person, UNICEF Australia*[1963]

These impacts are well-established in both the Inquiry's independent research and a range of external studies. Children and young people's mental health and wellbeing were significantly affected by the pandemic. The pandemic occurred at a time when children's mental health was already seen to be in crisis in Australia and globally. The Inquiry's community input survey found 52 per cent of respondents who had a dependent child during the pandemic noted the pandemic had a negative impact on the wellbeing of their child.[1964]

- In a 2022 Australian Human Rights Commission national survey of 4,559 children, 41 per cent of respondents reported the pandemic had a negative impact on their wellbeing.[1965] Negative impacts reported by children increased by age, and were higher among children identifying as non-binary or other, and girls.[1966]
- A longitudinal study of 1,211 students in years 11 and 12 in 2020 and 2021 who had experienced extended lockdowns in Melbourne found over 50 per cent reported symptoms of depression and 25 per cent reported symptoms of anxiety.[1967] There were higher risks for students with pre-existing mental health conditions, but 20 per cent experienced mental ill health for the first time.[1968]
- At the Adolescent Medicine Eating Disorder Unit at Monash Children's Hospital there was an increase of 126 per cent in total eating disorder admissions in 2020 compared with the mean yearly admissions from 2016 to 2019.[1969]
- The Royal Children's Hospital Eating Disorder Service, Melbourne, found that COVID-19 restrictions were reported to be a trigger for eating disorder behaviours in 40.4 per cent of adolescents diagnosed with anorexia nervosa in 2020.[1970]
- The rate of intentional self-harm hospitalisations for females aged 15 to 19 years spiked in 2020 to 2021.[1971]

Submissions and focus group participants highlighted that it was difficult to access mental health treatment during the pandemic.[1972] We heard that this impacted demand on schools for support that they were not always well-placed to provide.[1973] These impacts are ongoing. The Lancet Psychiatry Commission on Youth Mental Health notes that young people have experienced disproportionately poorer mental health outcomes since the COVID-19 pandemic.[1974]

We also heard concerns about accessing health care. Focus group participants who were parents or carers during the pandemic noted that COVID-19 put further pressures on healthcare services that were already strained. When they tried to access health care for their children, there were long wait times and stringent protocols that prevented them from attending hospital with their child.[1975]

The COVID-19 pandemic had mixed impacts on child welfare, with some response measures reducing child poverty while others increased risk factors for abuse or neglect. Child poverty rose sharply in the alert phase of the pandemic, from 16.2 per cent in the September quarter of 2019 to 19 per cent in the March quarter of 2020.[1976] However, by June 2020 this fell to a 20-year low of 13.7 per cent.[1977] This decline can be attributed to the introduction of the Coronavirus Supplement in March 2020. However, once supports were withdrawn, poverty rates increased again. Studies also suggest limited access to food programs during school closures increased concerns for children and young people who were experiencing food insecurity.[1978]

Risk factors for child abuse and neglect increased during the COVID-19 pandemic. Risk factors include financial hardship, housing stress, mental ill health, a lack of oversight of children in

settings such as schools and child care and decreased access to in-person medical or maternal and child health services.[1979] Safer Care Victoria found that, between September 2020 and January 2022, five Victorian children aged 0 to 4 died from complications associated with malnutrition and neglect.[1980] This was a concerning increase from the two neglect-associated deaths recorded between 2000 and 2019.[1981]

Some indirect impacts of the pandemic response on children and young people are already apparent. However, the full extent may not be evident for some time. We heard data collection and sharing related to children and young people was inadequate during the COVID-19 pandemic and remains unavailable to provide a nuanced understanding of the impacts.[1982] A lack of uniformity on key metrics for children and young people across jurisdictions and insufficient collection of data related to mental health and wellbeing were raised as particular issues.[1983]

4. Access to education

4.1. Response

For many children and young people in Australia, education was significantly disrupted during the COVID-19 pandemic. The level of disruption varied between ECEC and schools, and between jurisdictions.

4.1.1. Early childhood education and care

The ECEC sector delivers education and care for children in a variety of settings including: in-home care, family day care, outside school hours care, centre-based day care, and dedicated preschool.[1984] In 2022, there were 14,187 Australian Government Child Care Subsidy approved childcare services, and 4,314 dedicated preschool services (of those services 12,999 delivered preschool programs). In the third quarter of 2022, more than 1.4 million children attended Australian Government Child Care Subsidy approved child care services and 550,000 children (aged 3 to 6 years) were enrolled in a preschool program.[1985]

All levels of government have different roles and responsibilities for the delivery of ECEC. The Australian Government subsidises the cost of ECEC through the Child Care Subsidy. Under the National Quality Framework (NQF) it sets standards to ensure a national approach to the regulation and quality assessment of ECEC services.[1986] State and territory governments are responsible for the health, safety, wellbeing and educational outcomes of children. They deliver preschools and regulate ECEC services in line with the NQF.[1987]

From the beginning of the COVID-19 pandemic, early childhood services were deemed essential to the economy. Centres were allowed to stay open to care for children and enable parents, particularly those in frontline services, to work. This approach was supported by advice from the Australian Health Protection Principal Committee, which consistently noted throughout the pandemic that ECEC was an essential service, the risks to children of COVID-19 were low, and closures were not necessary as a public health intervention.[1988]

> *Whilst the ECEC sector was no different to others in requiring additional funding to survive the impact of the lockdowns, it stood out as being unique in terms of providing an essential service and acting as a backbone to the Australian economy. – Australian Childcare Alliance*[1989]

However, some parents were concerned about the risks of COVID-19 on children, which had a negative effect on early childhood education attendance during the alert phase. Providers use an attendance-based funding model, so this lack of attendance threatened providers' economic viability.[1990] In response to these trends, the Australian Government provided a range of supports to keep ECEC services open, particularly during the suppression phase. These supports are explored in more detail in Chapter 24: Supporting industry.

The Australian Government published the National Framework for Managing COVID-19 in Schools and Early Childhood Education and Care in January 2022.[1991] The Framework set out principles for limiting the impact of COVID-19 on children during the transition/recovery phase, including that ECEC services are essential and should remain open wherever possible, particularly for vulnerable children or children of essential workers.[1992]

4.1.2. Schools

State and territory governments are responsible for the delivery and regulation of schools in Australia, supported by Australian Government funding.[1993] The Australian Government and state and territory governments collectively agree national policy settings for education, such as the Australian Curriculum and the National Assessment Program.[1994]

During the COVID-19 pandemic, states and territories made decisions about schools informed by a combination of expert, national and state-based health and education advice.[1995] Their decision-making was supported by national coordination mechanisms such as the Education Ministers Meeting, the Australian Education Senior Officials Committee, and an informal cross-jurisdictional COVID-19 education officials' network.[1996] However, we heard from experts that evidence used to inform decisions to close schools should have been broader.[1997]

Health advice provided by the Australian Health Protection Principal Committee throughout the pandemic did not recommend school closures.

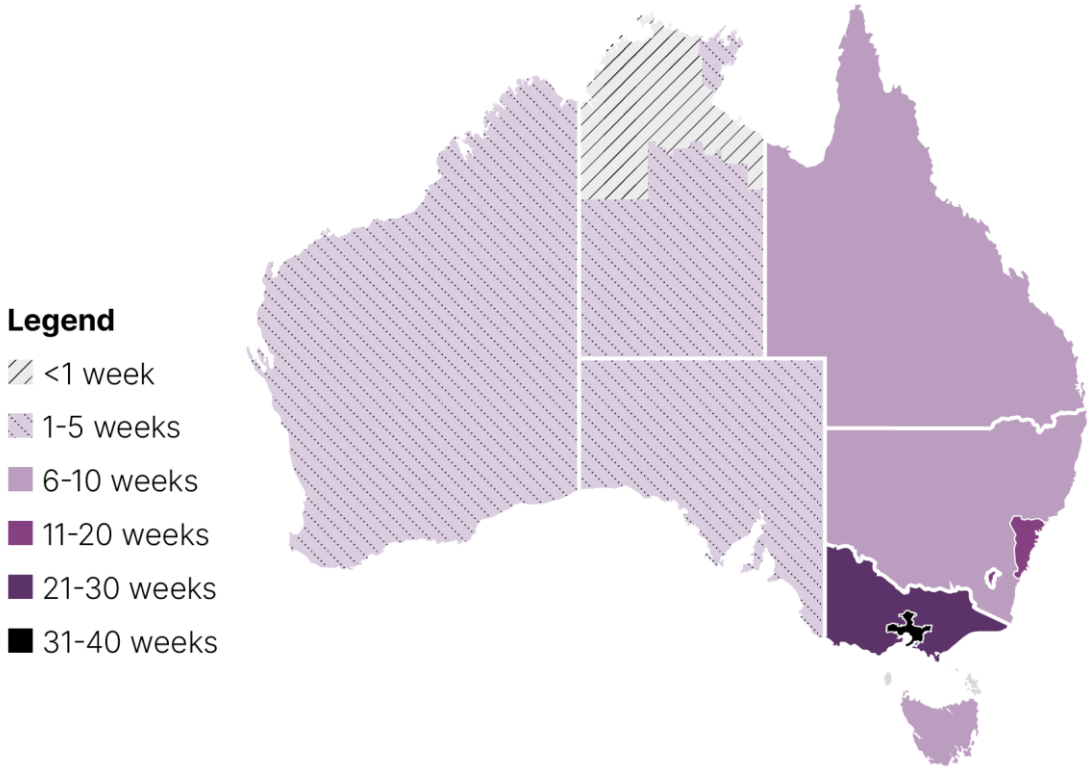
- Its advice on 17 March 2020 noted 'pre-emptive [school] closures are not proportionate or effective as a public health intervention to prevent community transmission of COVID-19 at this time'.[1998] The advice acknowledged the considerable costs associated with school closures and the low risk to young people internationally.[1999]
- Australian Health Protection Principal Committee advice for National Cabinet on 22 March 2020 noted school closures pose 'a major risk to children's education, mental health and wellbeing, particularly those from low socioeconomic regions'. The advice also noted the likely 'impact on the critical workforce and potential exposure of elderly relatives caring for children'.[2000]

- Advice published on 17 April 2020 noted the limited evidence of transmission in schools and provided guidance on physical distancing, hygiene and cleaning 'to reduce even further the relatively low risk' of COVID-19 transmission in schools.[2001] This advice was updated on 24 April 2020 to clarify that standard venue density rules were not appropriate or practical in classrooms.[2002]
- Advice throughout 2021 continued to refrain from recommending school closures.[2003] On 3 February 2021 the Australian Health Protection Principal Committee advised that 'schools remain safe places'.[2004] On 1 October 2021 it restated its position 'that schools are an essential service and should open and remain open whenever possible'.[2005]

Ultimately, states and territories made decisions about closing and reopening of schools. This resulted in significant variation in approaches and duration of remote learning across jurisdictions. Figure 4 shows the duration of remote learning across states and territories in 2020 and 2021. Metro Melbourne and Mitchell Shire experienced significantly more weeks of remote learning (36 weeks) than other areas of Australia:

- Most jurisdictions had their first periods of remote learning before the end of term 1, 2020, with further periods in 2021 and 2022.[2006]
- In general, schools located in metropolitan areas where the virus spread more rapidly delivered remote and online learning for longer periods compared to schools in regional and remote areas (see Figure 4).[2007]
- Some students were still able to access face-to-face learning or a blend of face-to-face and remote learning for some or all of the remote learning periods.[2008]

Figure 4: Total weeks of remote learning across states and territories 2020-2021[2009]



State/territory	T1 2020	T2 2020	T3 2020	T4 2020	T1 2021	T2 2021	T3 2021	T4 2021	Total
New South Wales (Greater Sydney, Central Coat and Illawarra)	3	4					10	3	20
New South Wales (Regional*)							3-7	1-3	4-10
Victoria (Metro Melbourne and Mitchell Shire)	1	8	9	3	2	2	11		36
Victoria (Regional)			9	1	1	1	11		23
Queensland (Brisbane and South East)	1	5			<1		1		7.5
Queensland (Cairns)	1	5					<1		6.5
Queensland (Remainder)	1	5							6
Western Australia		3							3
South Australia	1			<1				1	2.5
Tasmania		6							6
Australian Capital Territory	3	5					5	3	16
Northern Territory (Darwin)							<1		<1
Northern Territory (Katherine)							1	2	3

**Regional New South Wales lockdown periods varied across local government areas.*

As noted above, the Australian Government's National Framework for Managing COVID-19 in Schools and Early Childhood Education and Care (January 2022) set out principles for limiting the impact of COVID-19 on children during the transition/recovery phase.[2010] Similar to its position on ECEC, the Framework noted schools are essential and 'should be the first to open and last to close wherever possible in outbreak situations, with face-to-face learning prioritised'.[2011]

A number of 'catch-up' programs were implemented to address concerns about students falling behind as a result of pandemic disruptions. The Australian Government invested $3 million over 2021-22 and 2022–23 to support the expansion of the Smith Family's Catch-up Learning program, which strengthens the literacy and numeracy skills of more disadvantaged students, could be expanded.[2012] States and territories also introduced initiatives such as the Victorian Government's $1.2 billion Tutor Learning Initiative and the New South Wales Government's $279 million COVID Intensive Learning Support program.[2013]

The Australian Government launched a range of other school-related initiatives as part of the COVID-19 response. For example:

- The Schools Hygiene Assistant Fund enabled payments to 97 per cent of non-government schools to cover costs of hygiene items and cleaning products to prevent the spread of COVID-19 when students returned to classrooms by June 2020.[2014]

- The National Code for Boarding School Students, endorsed by National Cabinet on 17 September 2021, outlined a national approach to supporting boarding students during COVID-19 lockdowns.[2015]
- The Emerging Priorities Program funded emerging priority projects in schools, including recovery from COVID-19.[2016]
- In 2022 and 2023 the Schools Upgrade Fund provided grants for schools to improve equitable access to resources and facilities.[2017]
- In 2022 the Australian Government provided funding on a 50:50 cost-sharing basis with states and territories for the use of rapid antigen tests in schools.[2018]

4.2. Impact

Access to education is essential for the development of children and young people, and is a protective factor in mitigating negative impacts during a crisis. The impacts of disruptions to education on children and young people were consistently raised with the Inquiry.

4.2.1. Early childhood education and care

The impact of Australian Government financial support measures for the ECEC sector and broader impacts on the workforce are explored in Chapter 19: Women, Chapter 23: Workers and workplaces, and Chapter 24: Supporting industry.

ECEC supports the development of foundational social, emotional, language and communications skills in the initial years of children's lives.[2019] It promotes 'cognitive and social development benefits … intellectual development and improved independence, concentration and sociability'.[2020] ECEC is particularly important for more vulnerable children with less access to educational opportunities at home.[2021] In the context of a pandemic, we also heard ECEC is essential for maintaining stability for children at a critical period in their development.[2022]

> *Early child development and learning lays foundations for life and provides critical windows to ascertain developmental milestones. Through social relationships and play children learn how to think, understand, communicate, behave, express emotions and develop social skills. - Australian and New Zealand Paediatric Infectious Diseases Group*[2023]

The Inquiry heard that stakeholders broadly approved of the Australian Government's early recognition that ECEC was a critical service.[2024] Roundtable participants supported its fiscal interventions to ensure ECEC services remained open and remove financial barriers so that families could send children to ECEC during the COVID-19 pandemic.[2025] Evidence shows mixed results from these measures. For example, during the period of free child care from 6 April to 13 July 2020:

- a University of Melbourne study of over 382,000 children across over 4,000 ECEC services nationally found that attendance rates declined rapidly from 66 per cent in early March 2020 to 26 per cent a month later.[2026] The introduction of free ECEC did

have a positive effect on attendance, but it took 10 weeks to reach close to pre-pandemic levels nationally, and attendance disparities for the most vulnerable children persisted[2027]

- a study of 70,000 children attending Goodstart Early Learning services in 2020 found that, while there were no statistically significant changes in overall enrolment patterns, there were changes for some groups.[2028] For example, 18 per cent of all children and 47 per cent of Aboriginal and Torres Strait Islander children increased their average days of attendance. Many children who had not previously attended ECEC, as their family was not eligible for subsidies, attended for the first time. While 25 per cent of families said they would have withdrawn their children from ECEC without the intervention, low-income families were least likely to access free ECEC[2029]
- a survey of services conducted by the Department of Education indicated that by mid-May 2020 attendance levels across the sector had risen to 74 per cent of pre-COVID levels. The combination of the Relief Package and JobKeeper had helped services to stay open, keep children enrolled and provide care to children of essential workers and to vulnerable children.[2030]

Data suggest that key fiscal measures to ensure services remained open and reduce financial barriers for families helped to maintain attendance rates and opened new opportunities for access for some children.[2031] However, it is clear there were still gaps – many children reduced their ECEC attendance during the pandemic, and it was the most vulnerable children who were the most likely to miss out.[2032]

> *The unequal effect of school and preschool closures on children from disadvantaged backgrounds further exacerbates existing educational disparities. The pandemic has exposed and magnified pre-existing inequalities, with vulnerable children disproportionately affected by a lack of access to essential educational tools and support – Murdoch Children's Research Institute*[2033]

We heard that we should not underestimate the long-term developmental impacts for children who did not attend ECEC during the pandemic. ECEC providers noted that, anecdotally, educators are seeing the impacts on preschool aged children who missed out on ECEC earlier in their development.[2034] This aligns with research demonstrating the importance of ECEC attendance for minimising developmental problems upon school entry and ensuring children are happy at school.[2035]

Declining ECEC attendance levels despite fiscal interventions were in part due to the mixed messaging from governments about the risks to children in ECEC settings.[2036] While information was initially scarce, clear health advice for children was not provided fast enough when evidence of the lower risk of severe illness and lower transmission risk did emerge.[2037] This contributed to fear among parents. For example, an Australian Institute of Family Studies survey found 44 per cent of families who stopped using ECEC in 2020 did so due to because of concern about the health risks to their children.[2038] We heard this led to many parents and staff

accessing accessed information from overseas or through informal channels in the early stages of the pandemic because local information was not available.[2039]

The health risks that children in ECEC faced were different from those faced in many other settings, including schools. For example, measures to minimise the spread of COVID-19 are more difficult to implement in ECEC.[2040] Social distancing is challenging with young children, and the very nature of ECEC means staff and children interact closely.[2041] The Australian Health Protection Principal Committee did not recommend masks for children but did recommend reducing mixing of children by separating groups, including staggering meal and play times.[2042] However, the varied attendance patterns of children in ECEC makes this more challenging than in schools.[2043]

Despite the different risk profile for ECEC, we heard the sector had to advocate for sector-specific advice to address these challenges.[2044] When advice was published, stakeholders said it did not recognise the diversity of ECEC settings and was complex and difficult for providers to understand and apply in practice.[2045] Messaging from different levels of governments was often contradictory. This caused further confusion, particularly for providers that operate services across multiple states and territories.[2046] We heard peak bodies played a significant role in interpreting and disseminating government advice and public health orders to providers. Providers appreciated this, but it placed a significant burden on peak bodies, which did not receive government funding to perform this work.[2047]

Despite ECEC being designated an essential service, many stakeholders said the sector and its workers were not consistently treated as essential.[2048] The Inquiry heard from educators who said they felt they were not properly recognised or supported for their contribution to the pandemic response, even though they played a vital role in supporting children and enabling others to participate in the workforce. They faced an increased workload and health risks on a daily basis.[2049] We heard educators were not given adequate mental health support or training in how to manage pandemic risks.[2050] This was particularly highlighted through the vaccine rollout, when ECEC workers were not prioritised for vaccination.[2051]

> *The omission of vaccination of early childhood education and care workers as a priority group is considered a missed opportunity, given their position as frontline workers and significant flow-on effects of inadequate staffing in the event of local COVID-19 outbreaks. - Australian Research Alliance for Children and Youth*[2052]

4.2.2. Schools

The Inquiry heard there was a lack of national consistency and inadequate communication and transparency about the evidence on which decisions about schools were taken. This created confusion for students, parents, schools, and teachers. Inquiry focus group and roundtable participants emphasised the importance of governments providing clear and consistent advice to families and schools and providing reassurance, even as evidence is evolving.[2053]

In the early days of the COVID-19 pandemic, when evidence was rapidly evolving, it was difficult to provide clear communication on the health risks in schools. As a result, by the time the

Australian Health Protection Principal Committee provided official advice on 17 March 2020, the public debate around school closures was already well underway and some schools had already announced they would transition to remote learning given challenges in practising social distancing in classrooms.[2054] The Inquiry's community input survey found 21 per cent of respondents who had a dependent child during the pandemic rated Australian Government communications on educational arrangements for children poor or very poor.[2055]

> *There were mixed messages from a lot of different sources … it could change daily, and there was a lot of misinformation coming out at the time too … it was too much. – Parent/carer of a primary school aged child, very remote Queensland*[2056]

National Cabinet and the National Coordination Mechanism did discuss a nationally consistent and coordinated pandemic response for schools, but, as the Prime Minister stated on 13 March 2020, 'each and every state and territory that is represented here is completely sovereign and autonomous in the decisions that they make'.[2057] For example, on 22 March 2020 the New South Wales, Victorian and Australian Capital Territory governments announced that schools would transition to remote learning from 24 March 2020.[2058] However, later the same day following a meeting of National Cabinet, the Prime Minister announced that 'all leaders agreed that children should go to school tomorrow', directly contradicting the announcements made only hours earlier.[2059]

> *Better integration of decision-making between States and Territory governments and the Australian Government about schooling … would have significantly reduced the confusion experienced by not only Independent schools but also the students who attend them and the families of those students. – Independent Schools Australia*[2060]

We heard there was not enough transparency around the health advice that was informing decisions. For example, on 17 March 2020 National Cabinet endorsed Australian Health Protection Principal Committee advice to keep schools open.[2061] A day later, National Cabinet endorsed Australian Health Protection Principal Committee advice to prohibit non-essential indoor gatherings of greater than 100 people.[2062] The rationale, as agreed by National Cabinet, to keep schools open was provided to the public, 'pre-emptive closures are not proportionate or effective as a public health intervention to prevent community transmission of COVID-19 at this time'.[2063] However, the health advice was not provided to the public to explain why it was considered safe for schools to remain open when non-essential large gatherings were no longer permitted.

We heard concerns that decisions about school closures did not respond to evolving evidence over the course of the pandemic.[2064] A stakeholder suggested decision-making did not adequately consider international evidence that pointed to low rates of transmission in schools and reduced health risks to children and young people.[2065] Even though AHPC continued to advise that school closures were not recommended, policy settings were not adjusted and many schools remained closed through 2021.[2066]

Where schools were closed, the transition to remote learning had a significant impact on students, teachers and families. The Inquiry's community input survey found 61 per cent of respondents who had a dependent child during the pandemic said the pandemic had a negative impact on the education experience of their child.[2067] The Inquiry conducted focus groups in which many families said they found the transition difficult, including balancing the role of teaching their children while managing their own work; additional stress and pressure on those in cramped households; and there were extra financial costs in purchasing digital devices.[2068] Parents and carers with larger families, limited English proficiency and from remote communities who relied on boarding schools for their children found the school closures especially challenging.[2069] We also heard concerns about the 'digital divide' increasing inequities given some students 'lacked access to reliable internet and digital devices, hindering their ability to participate in online learning'.[2070] These experiences reflect findings by the Australian Human Rights Commission that many students reported 'struggling with remote learning due to boredom, lack of supports, lack of structure, poor focus and inaccessibility of digital technologies'.[2071]

> *It was weird, confusing and hard doing stuff online. - Primary school student, Victorian Commission for Children and Young People COVID-19 snapshot*[2072]

> *Look at what our children missed out on at school, we will never get any of that back. - Survey respondent, male with dependent child, Queensland metro*[2073]

Navigating remote learning

During the pandemic, Chris* was living in with his wife and two children, Mia (aged 7) and Nate (aged 10). His heart sunk when he heard that Victorian children would need to shift to home-schooling. His family was living in a small apartment at the time, and he was working full-time from home. His wife was a frontline worker, so it was up to Chris to manage home schooling. The only work and study space in their home was the master bedroom so each day Chris and his kids crammed into one room on their laptops – Chris at his desk, Nate next to him and Mia on the floor. Nate was able to keep up with his remote lessons independently, but Mia really struggled. Mia needed a lot of help from Chris to keep up with her mathematics learning, but Chris needed to also uphold his work responsibilities so was often only able to help her after work hours. There were many days when Mia ended up in tears because she was not able to keep up with her lessons and was anxious about getting behind. This left Chris guilty and distressed. While Chris' family is coping now, there was a large amount of strain and tension placed on him and his relationships with his wife, children and work colleagues.

School closures had a significant impact on student experiences and mental health (see Section 3.2.2). However, the evidence on the magnitude of effects on academic outcomes is mixed. NAPLAN data from 2021 show no statistically significant changes in student learning achievement in reading and numeracy for students who experienced longer periods of remote learning and no variation based on level of socio-economic disadvantage.[2074] Similarly, a study of years 3 and 4 students across 113 New South Wales government schools found no statistically significant differences in student achievement in mathematics and reading between

2019 and 2020.[2075] NAPLAN testing was not conducted in 2020 and its measurement scales were altered from 2023.[2076] These factors make it difficult to assess the impact of COVID-19 on outcomes since 2022, particularly for students who started school in 2020 but were not assessed until 2023.

However, other data sources suggested there was an impact. Check-in assessments conducted after school closures in New South Wales government schools in 2020 found that students fell behind in reading approximately 3 to 4 months in year 3 and 2 to 3 months in year 5.[2077] A 2022 survey of year 10 students nationally found most young people felt their education had been hindered by the pandemic, with 52 per cent reporting their year 9 studies had suffered and 59 per cent not feeling prepared for year 10.[2078] The reported impact increased in line with the length of time spent learning remotely.[2079] Mission Australia's 2021 Youth Survey found 62.3 per cent of respondents said COVID-19 had negatively impacted their education.[2080] This aligns with the anecdotal evidence presented to the Inquiry about the impact on student experiences and learning gaps.[2081]

Impacts on academic outcomes varied across groups. For example, some students with disability experienced increased isolation and educational disadvantage when adjustments were not made for remote learning. In one survey of year 10 students, 34 per cent of students with disability who experienced remote learning reported falling behind in their studies, compared with 16 per cent of students with no disability.[2082] The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability found many students were impacted by the transition to remote learning without adequate adjustments and shortages of teachers and support staff.[2083] However, we also heard some students with disability benefited from the transition to remote learning and felt more comfortable in their home setting.[2084] Boarding school students also had significantly different experiences - many students who attended schools in different jurisdictions were not able to return home or see their families for extended periods.[2085]

There were also substantial impacts on students from more disadvantaged backgrounds. School closures increased longstanding inequities.[2086] The previously mentioned study of years 3 and 4 students in New South Wales schools did not find a significant impact on education achievement overall, but there were differences for less advantaged students.[2087] Parents' ability to engage and support their child's education during periods of remote learning was a significant protective factor. For example, 27 per cent of year 10 students surveyed in 2022 who did not have a parent with a university education reported falling behind, compared with 15 per cent of students with at least one parent with a university education.[2088]

> *Everyone likes to say we're all in the same boat. But different schools are really giving out different levels of help to the students. – Female, regional New South Wales, UNICEF Australia*[2089]

Educational impacts also extended to post-pandemic attendance rates. Inconsistencies in data on school refusal nationally make it difficult to understand the prevalence of school refusal. However, evidence received during the National Trend of School Refusal and Related Matters

Inquiry suggests it is increasing. Inquiry participants stressed that while COVID-19 had intensified the issue, the rate of school refusal had been increasing well before the pandemic.[2090] National reporting on attendance shows attendance rates declined from 91.4 per cent in 2019 to 86.5 per cent in 2022 but rose to 88.6 per cent in 2023.[2091] However, a study of 14,135 secondary school students in Tasmanian government schools found attendance rates for higher socio-economic status students were similar before and after the pandemic, but there were significant declines in attendance among lower socio-economic status students after the pandemic.[2092] Attendance levels, the proportion of children attending school 90 per cent of the time, was also lower in 2023 (61.6 per cent) than in 2019 (73.1 per cent). [2093]

Various catch-up initiatives have had mixed results. For example, an evaluation of 400 students who participated in a 2022 trial of the Australian Government funded Smith Family Catch-Up Learning program found 44 per cent of participants 'made greater than expected progress in both literacy and numeracy', with '67 per cent making greater progress in numeracy than might typically be expected over a six month period'.[2094] However, evaluations of both the Victorian Tutor Learning Initiative and New South Wales COVID Intensive Learning Support program found the programs did not have a substantial impact on learning.[2095]

School closures also had a significant impact on teachers and schools. The Inquiry received submissions from unions representing school employees noting concerns including information on the safety of workplaces for employees and students. We would have welcomed discussions to better understand their concerns, and how the interests of children and teachers may be more effectively addressed in future health emergencies. However, we heard that teachers pivoted to remote teaching very quickly. There were many examples of teachers rapidly upskilling in technology, developing online content, adapting their teaching approach and collaborating more with colleagues.[2096] It is clear Australian teachers and families demonstrated significant dedication and agility throughout this challenging period.[2097]

However, not all Australian schools were prepared to transition to remote learning and teachers were not consistently trained in delivering content remotely. Many jurisdictions had to institute pupil-free days to allow time for the transition.[2098]

Analysis commissioned by Education Ministers in 2022 found 'schools and teachers had to prepare and deliver lessons under emergency conditions, without warning or time to plan'.[2099] This resulted in some inconsistencies. For example, in March 2020 Catholic Schools NSW noted 'the capacity of schools, families and communities to any such transition [to online learning] is not consistent across NSW', and it was reported at the time that teachers in the public school system were particularly concerned about resourcing and capacity to deliver remote learning.[2100] A review of Victoria's transition to remote learning in 2020 noted 'some schools were better positioned or prepared prior to the period of remote and flexible learning' to provide tailored supports to students.[2101] This was reflected in concerns that Inquiry focus group participants raised about the inconsistencies in the level and quality of support that schools offered students.[2102]

Teachers experienced a significant increase in workloads and work complexity, anxiety about their personal health risks and declining morale and mental health.[2103] Collectively, these challenges contributed to increasing numbers of teachers leaving the profession, with ongoing impacts for students.[2104]

5. Evaluation

Pandemic planning failed to acknowledge that children and young people may face unique risks, and maintaining access to education can help mitigate these

The direct health risks from COVID-19 to children and young people were low. However, the indirect impacts of response measures were of much greater concern. The panel considers that the focus on the direct health impacts for the general population came at the expense of children and young people.

Children and young people experienced significant and negative indirect harms at a critical point in their development. Governments did not focus enough on mitigating and minimising these harms during the COVID-19 pandemic and have not invested adequate resources to address the ongoing effects.

Future emergency planning and response frameworks must recognise and account for these risks to children and young people to ensure more equitable response measures. The panel notes that the 2023 National Disaster Mental Health and Wellbeing Framework emphasises the needs of children and young people in times of crisis.[2105] This is a positive development that should be built on, with youth impact assessments conducted for all emergency plans. In particular, assessments should ensure that existing inequities are not exacerbated.[2106]

Access to education – either ECEC or school – is an essential protective factor and helps mitigate these risks for children and young people during times of crisis. Children and young people need to have ongoing access to ECEC and schools during a public health emergency because it provides stability as well as ongoing education and development. This is particularly important for children and young people who are already facing educational disadvantage.

Emergency plans should recognise how critical it is that educational institutions remain open – in line with both the 2022 National Framework for Managing COVID-19 in Schools and Early Childhood Education and Care and the 2019 Australian Health Management Plan for Pandemic Influenza.[2107] The panel notes both the Plan and the Framework prioritise schools and ECEC remaining open, unless there is evidence of significant health risks or transmissibility in children. This should be coupled with fully recognising school and ECEC staff as essential and prioritising them for measures such as vaccination.

ECEC services and schools demonstrated great agility during the COVID-19 pandemic, but more work is needed to enhance preparedness for future emergencies

Both the ECEC sector and schools showed significant resilience, agility and innovation in managing pandemic risks and transitioning to remote learning where necessary. However, we heard neither sector was adequately prepared for the pandemic, including how to manage

health risks and deliver effective remote learning. This put significant pressure on the workforce and resulted in inequities in the level of support given to children and young people.

To improve preparedness for future pandemics, as well as disruptions from other emergencies, governments must work with both sectors to develop response plans and strategies for mitigating disruptions to children and young people's education.[2108] This would help ensure education settings can safely remain open wherever health advice allows. Plans should consider evidence-based options for minimising the transmission of communicable diseases, taking into account differences between schools and ECEC cohorts and settings.

A key challenge the panel heard about was the lack of clarity and consistency in criteria for closing schools. The Australian Government was able to coordinate an effective response for the ECEC sector during the COVID-19 pandemic because it has primary responsibility for the relevant policy levers. However, there was no consistency in the approach for closing schools across the nation. We heard this led to confusion, fear and distrust among many families. To better prepare for a future pandemic, governments should agree frameworks that guide decision-making across jurisdictions on issues such as school closures. This must be balanced with flexibility for jurisdictions to respond to local contexts.

We also heard school teachers should be better supported to deliver learning remotely when it is not advisable to keep schools open – for example, where a pandemic poses greater health risks to children and young people. Teachers should be given additional training on developing and delivering online content, and an accessible online learning resources that can be quickly adopted in a rapid transition to remote learning. This should draw on lessons learnt from international examples, such as the UK's Oak National Academy. Funded by the UK Department of Education, the Academy rapidly developed online learning resources, including pre-recorded lessons, in line with the National Curriculum at the outset of the COVID-19 pandemic.[2109]

Mechanisms for engaging with and including children, young people and advocates in decision-making processes would ensure responses address the needs of children and young people

Representation in decision-making processes is vital for ensuring the unique experiences and needs of priority populations are considered in planning for and responding to emergencies. The inquiry heard the lack of engagement with children and young people or advocates contributed to a failure to adequately consider and plan for indirect impacts.

Governments should use mechanisms such as youth councils to gather information direct from children and young people about the decisions that affect them. They should build on positive post-pandemic initiatives such as re-establishing the Australian Government Office for Youth, a Youth Engagement Strategy and Youth Advisory Groups.[2110] Young people from a range of backgrounds should be supported to actively contribute to and advise on the development and implementation of pandemic plans.

Paediatric health, education and human rights experts should also be included in relevant decision-making bodies and supporting advisory groups so they can contribute expertise and

represent the interests of children and young people. Stakeholders have advocated for a dedicated role such as a Chief Paediatrician to be included in key decision-making forums, including the future Australian Centre for Disease Control.[2111] A dedicated position would ensure the needs of children and young people are considered in all aspects of pandemic planning and response efforts. There should also be a role for the National Children's Commissioner or similar to advocate for the rights of children and young people.

The panel notes the Australian Human Rights Commission's recent recommendations to improve the representation of the interests of children at all levels of government to ensure 'the rights and wellbeing of children [are] at the centre of all decisions that affect them'.[2112] Initiatives such as the introduction of dedicated impact assessments will help ensure decision-makers take into account the impact of future pandemics and response measures on children and young people.[2113]

There needs to be a greater focus on building the evidence base early in a pandemic to inform decision-making

In the initial stages of the COVID-19 pandemic, evidence on the risks to children was unclear and it was uncertain how disease patterns emerging overseas might apply in the Australian population. We heard that a priority for the future Australian Centre for Disease Control at the outset of a pandemic should be to rapidly gather evidence on disease impacts on children, the role of children in transmission and the appropriateness and impacts of non-pharmaceutical interventions.[2114] Steps can also be taken ahead of a future pandemic to ensure evidence can be rapidly gathered and assessed as risks emerge, including undertaking trials and establishing protocols for future research.[2115]

The panel heard that Australia must be prepared to collaborate with international agencies to ensure children and young people are included in early high quality vaccine and therapeutic trials.[2116] This should build on the World Health Organization's work to develop pre-approved vaccine protocols in advance of a future pandemic.[2117]

The panel notes that a critical factor for pandemic planning is understanding the role of schools in transmission. While the impact of school closures on COVID-19 epidemiology remains unclear, evidence shows that 'reopening schools did not alter the existing trajectory of COVID-19 hospitalisations and deaths during the Delta and early Omicron period.[2118]

The Doherty Modelling Final Report to National Cabinet did report impacts on both downstream infection risk as well as face-to-face teaching days lost under various scenarios of infection control.[2119] When we have reliable data on transmission and the effectiveness of disease control strategies, this sort of modelling can be very valuable to policy makers. However, it is not clear whether data collected in the jurisdictions on effectiveness of routine testing in schools, mask wearing and other strategies were shared, or whether there was any attempt to invest in collecting these data to inform evidence-based policy.

Scenario-based planning for schools would help to improve preparedness for responding to future pandemics.

Throughout a pandemic, decisions on significant response measures that affect children and young people should be based on a range of evidence, including an understanding of transmission and disease risk, other data inputs on the impacts of the interventions, and international observations.[2120] It is essential that policy can be adjusted in response to evolving health advice on the risks to children, young people and educators.

Clear and early communication of risks and public health advice regarding children and young people helps address confusion and fear

A strong theme from the inquiry's consultations was that information given to families, schools and the ECEC sector lacked clarity, and messaging was contradictory. This extended to communications about risks and restrictions for attending education, as well as information about the vaccine rollout. Information was often not well coordinated, timely or sufficiently tailored. This contributed to significant confusion and fear for families and educators.

In the absence of information, we heard people turned to schools or international sources. This put significant pressure on teachers and increased the risk of the spread of misinformation. It also had very real impacts for children. For example, it is clear that fiscal responses alone were not enough to maintain ECEC attendance in the face of significant fear, and a lack of tailored communication about the risks and benefits of vaccination for children impacted uptake. Clear, consistent, tailored and timely messaging about the risks to children are essential to encourage parents, where appropriate, to continue sending their children to ECEC or school to support their development.[2121]

In line with the inquiry's recommendations for other priority groups, in any public health emergency communication on risks and restrictions, tailored to a range of specific needs and circumstances, is very important. Information needs to differentiate between risks for ECEC and school settings, and between students and educators. Given the diversity of the ECEC sector, peak bodies should be resourced and supported to interpret and disseminate health advice for providers.

Communications on pharmaceutical interventions such as vaccinations need to explicitly address the concerns of parents and carers. There should also be improved communication tailored to children and young people themselves. The more evidence on effectiveness and safety that can be collected and reported for all pandemic control measures, the greater the level of trust and reassurance and the more effective the communication will be.

The long-term impacts of COVID-19 must be monitored to inform support for children and young people now and inform responses to future pandemics

The full impacts of the COVID-19 pandemic on children and young people are not yet known, will continue to emerge over time, and will be interrelated.[2122] There is a need for ongoing comprehensive monitoring and evaluation of the impact of COVID-19 and the response on young people's wellbeing.[2123] This evidence should inform the response to future crises.

We heard that improved data collection, linkage, sharing and data access for researchers will support the monitoring and evaluation of these impacts. This could include a universal identifier

to support the collection and linkage of longitudinal data (see Chapter 12: Broader health impacts). But these systems cannot be set up during a crisis - investment is needed now to improve preparedness.[2124]

COVID-19 pandemic impacts on children and young people are likely to continue to emerge and will be further exacerbated by the cost of living crisis. It will be essential for governments to respond. This includes addressing increased demand for mental health and wellbeing supports post-pandemic. The panel welcomes recent initiatives and investment in mental health and wellbeing supports for children and young people, such as the National Children's Mental Health and Wellbeing Strategy, launched in 2021,[2125] and the $203.7 million Student Wellbeing Boost, announced in 2023, which provide additional funding to schools to support students' mental health and wellbeing.[2126] These should continue to be built on to mitigate the long-term impacts on children and young people.

The panel notes with concern evidence of a decline in early childhood vaccination rates since the beginning of the pandemic. This is particularly concerning given the importance of these vaccinations during the early years and increasing pressure on the health system as a result of preventable illness. Dedicated work is necessary to address this trend and minimise ongoing harms from the pandemic. This could build on initiatives such as the Vaccine Insights Project's efforts to understand the drivers of under-vaccination in children, or the Sharing Knowledge About Immunisation online platform.[2127]

6. Learnings

- Representation of the interests of children and young people in decision-making mechanisms is vital to ensure their interests and wellbeing are adequately considered and key decisions appropriately balance direct health risks and longer-term indirect impacts.
- Even if public health emergencies do not pose a significant direct health risk to children and young people, response measures that prioritise immediate health impacts for the broader population may have negative indirect impacts on children and young people. Public health emergencies and government responses may exacerbate existing inequalities for children and young people. Where such impacts are identified, programs and interventions should plan for and mitigate potential lasting negative impacts.
- Maintaining access to schools and ECEC in a public health emergency is essential for child development, social, emotional and mental wellbeing, educational outcomes, oversight of children and young people, and essential workforce capacity. Criteria for the closure of ECEC and schools in response to a pandemic would benefit from greater transparency and national consistency.
- Children should be a focus of data collection in a response so that direct and indirect impacts of a pandemic and the control measures are monitored and understood on a rolling basis.

- Health risks and the evidence and advice informing government decisions should be communicated transparently, clearly and early in any public health emergency. Advice should recognise the differences between ECEC and schools, and between children and young people and educators.
- Future pandemic response measures should be informed by ongoing assessment and evaluation of the long-term impacts of the COVID-19 pandemic on children and young people.
- Where trust is eroded during a pandemic it may compromise adherence to ongoing public health measures, such as vaccinations.
- Effective remote teaching requires specialist skills. Training and resourcing for teachers should enable them to rapidly pivot to remote learning in future emergencies.

7. Actions

7.1. Immediate actions – Do in the next 12–18 months

Action 1: Address critical gaps in health recovery from the COVID-19 pandemic, including prioritising greater investment in mental health support for children and young people and a COVID catch-up strategy in response to a decline in the delivery of key health prevention measures.

- This should include prioritising additional mental health funding and investment in services for children and young people, to help manage the ongoing mental health impacts of the pandemic on this cohort.

Action 4: Establish structures to ensure young people and their advocates are genuinely engaged, and impacts on children are considered in pandemic preparedness activities and responses to future emergencies.

This should include:

- Establishing the role of Chief Paediatrician.
- Including the Chief Paediatrician and National Children's Commissioner on the Australian Health Protection Committee.
- Ensuring consultation mechanisms facilitate genuine engagement with children and young people and advocates charged with representing their interests in pandemic preparedness activities and responses to future emergencies.

Action 5: Develop updated health emergency planning and response arrangements in conjunction with states and territories, and key partners, including consideration of escalation and de-escalation points, real-time review and a focus on post-emergency recovery.

As part of this, develop:

- Management plans under the National Communicable Disease Plan for priority populations
- Modular operational plans for specific sectors, including high-risk settings, which can be deployed in response to a variety of hazards.

The Management Plan for children and young people should consider the differential health and indirect impacts children and young people may face and specific interventions that may be required. The plan should be aligned with the operational plan for early childhood education and care and schools.

The Early Childhood Education and Care and Schools plan should:

- recognise access to education as an essential service for children and young people and consider strategies to maintain early childhood education and care (ECEC) attendance

and keep schools open during public health emergencies, where consistent with health advice

- document triggers and criteria for the closure of ECEC and schools where recommended by health advice, and criteria for reopening
- be developed in consultation with states and territories, education providers, peak bodies, education and public health experts, and children and young people
- commit governments to shared principles, triggers and criteria, while allowing flexibility to respond to local risks and circumstances
- recognise that ECEC and school educators are essential workers if health advice recommends children and young people continue attending ECEC or school, and should receive priority access to vaccination; PPE and infection, prevention and control training
- include development of a more responsive ECEC emergency funding model that can be deployed rapidly, respond to different needs, support consistency in children's access to services, be predictable for parents and sustainable for providers, and account for a transition out of emergency settings.

Action 8: Establish mechanisms for National Cabinet to receive additional integrated expert advice for a whole-of-society emergency, including advice on social, human rights, economic and broader health impacts (including mental health considerations), as well as specific impacts on priority populations.

- In parallel with making decisions based on key public health advice, National Cabinet should consider the differential impacts of a pandemic across the population and economy. This must include considering and mitigating unintended consequences, and seek to minimise negative impacts on broader health, mental health, educational, equity, economic and social outcomes.
- Human rights considerations should be embedded into National Cabinet's decision-making processes, particularly where measures are intended to significantly restrict rights and freedoms.
- This might include mechanisms for a national health emergency that allow expert advice to be sought from the Australian Human Rights Commissioner and other commissioners (e.g. National Children's Commissioner) to support better understanding of the broader impacts of their decisions on human rights and priority populations.

Action 11: Improve data collection, sharing, linkage, and analytic capability to enable an effective, targeted and proportionate response in a national health emergency.

This should include:

- improvements to data collection and pre-established data linkage platforms, including investment in improved longitudinal data to monitor educational outcomes and wellbeing of children and young people
- finalising work underway to establish clear guardrails for managing data security and privacy and enabling routine access to linked and granular health data, and establishing pre-agreements and processes for the sharing of health, economic, social and other critical data for a public health emergency. Key health and education data on children and young people should be prioritised

Action 16: Develop and agree principles for the transparent release of advice that informs decision-making in a public health emergency.

- National Cabinet (and other key decision-making bodies) should be more transparent in disclosing the expert advice that underpins their decisions, and the other multi-sectoral factors that must necessarily influence policy decisions.

Action 17: Develop a national strategy to rebuild community trust in vaccines and improve vaccination rates.

As part of this:

- Health Ministers should urgently agree a strategy for addressing the broad decline in COVID-19 vaccination, especially among priority cohorts, with a view to formalising policy responsibility to improve these vaccination rates by target dates.
- There should be an emphasis on lifting early childhood vaccination rates for other communicable diseases to pre-pandemic levels.

Action 18: Proactively address populations most at risk and consider existing inequities in access to services (health and non-health) and other social determinants of health in pandemic management plans and responses, identifying where additional support or alternative approaches are required to support an emergency response with consideration for health, social and economic factors.

- All plans and response measures should have an equity lens applied, including for health, social, human rights and economic factors (see Action 1).

Action 19: Develop a communication strategy for use in national health emergencies that ensures Australians, including those in priority populations, families and industries, have the information they need to manage their social, work and family lives.

The strategy should account for the distinct communications preferences and requirements of priority populations – including:

- reflecting the key role of community and representative organisations in communicating with priority populations, including peak bodies for children, young people and education providers
- funding community and representative organisations to tailor and disseminate communications through appropriate channels and trusted voices
- providing plain English messaging to community organisations for tailoring in a timely manner.

7.2.Medium-term actions – Do prior to the next national health emergency

Action 20: The Australian Government to work with the states and territories to improve capability to shift to remote learning if required in a national health emergency.

Led by the Department of Education, this should include:

- incorporating competency in developing and delivering remote learning into initial teacher training and the Australian Professional Standards for Teachers
- investing in the development of a suite of remote learning modules consistent with the Australian Curriculum, made available to all schools, teachers and students to improve preparedness for future emergencies that may require school closures.

Action 25: Continue to invest in monitoring and evaluating the long-term impacts of COVID-19, including long COVID and vaccination adverse events, mental health, particularly in children and young people, and educational outcomes.

- Where evidence from ongoing monitoring and evaluation shows long-term impacts of the COVID-19 pandemic continue to be seen, governments must ensure policies and programs in place are tailored to actively address the impacts.
- Evidence collected from ongoing monitoring and evaluation should inform plans and responses to future public health emergencies in order to mitigate similar long-term impacts.

Chapter 15 – Culturally and linguistically diverse communities

1. Context

Multicultural diversity is one of Australian society's great strengths, with 27.6 per cent of Australians born overseas and 48.2 per cent having a parent born overseas.[2128] However, in a public health emergency, culturally and linguistically diverse (CALD) communities' needs are different from those of broader society. Therefore an effective response to an emergency must incorporate an understanding of those diverse needs and the structural, socio-economic and cultural factors that can lead to disproportionate health, social, and economic impacts in public health emergencies.[2129]

Mortality statistics for CALD communities were significantly higher than for the broader population, with people born overseas having an age-standardised death rate 1.4 times higher than people born in Australia.[2130] Some people in those communities were also more likely to receive the COVID-19 vaccination later than those in the broader community. Many people in CALD communities found it difficult to find comprehensive and timely information in their language. They also experienced increased racism and discrimination, were less likely to be eligible for financial supports, faced challenges in accessing mental health support, and were more likely to live in areas with more restrictive government lockdowns.

The pandemic exposed pre-existing gaps in planning and engagement with CALD communities. It can be seen that, when the government collaborated with CALD representative organisations, community leaders and bicultural workers and when these organisations were funded and empowered to develop and deliver tailored solutions for their communities, CALD communities' experiences during the pandemic improved. Responses were also more effective when data collection and linkages were strengthened and informed by local knowledge.

A note on terminology

People in CALD communities are born overseas or have a parent born overseas, have migrated to Australia as a refugee or asylum seeker, may be in Australia temporarily for work, study or a long-term visit and/or speak languages other than English. The panel acknowledges there is diversity between and within CALD communities in Australia that the term 'CALD communities' cannot fully capture. It notes that some groups prefer alternative terms. The term 'CALD communities' is used respectfully in acknowledgment of the thousands of cultural, religious, language and ethnic identities that exist.[2131] The terms 'multicultural communities' and 'migrant communities' are also used in this chapter.

2. Planning, coordination and engagement

2.1. Response

All levels of government share responsibilities for emergency responses for CALD communities. At the national level, responsibilities are spread across departments. The Department of Home Affairs has responsibility for the Australian Multicultural Council and the Multicultural Access and Equity Policy.[2132] The policy acknowledges the 'obligation on Australian Government departments and agencies to ensure their programs and services are accessible by all eligible Australians, responsive to their needs, and deliver equitable outcomes for them, regardless of their cultural and linguistic backgrounds'.[2133]

CALD engagement and response strategies are embedded in national health and COVID-19 response plans, including:

- the Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)[2134] (18 February 2020)
- the COVID-19 Vaccination Program – Culturally and Linguistically Diverse Communities Implementation Plan[2135] (13 February 2021)
- the National COVID-19 Health Management Plan for 2023[2136] (13 December 2022).

To support engagement with CALD communities, in December 2020 the Department of Health established the National CALD COVID-19 Advisory Group (CALD Advisory Group), later renamed the Culturally and Linguistically Diverse Communities Health Advisory Group.[2137] The group's members are multicultural community leaders; public health and medical experts; and representatives of Australian, state and territory governments. During the pandemic the CALD Advisory Group provided advice on many topics – for example, it translated COVID-19 materials, developed communication and outreach strategies and made improvements to CALD data collection.[2138] The government engaged with CALD communities through existing structures including the Department of Home Affairs' Community Liaison Officer network and the Australian Multicultural Council,[2139] Services Australia's Multicultural Services Officers,[2140] and dedicated programs through some of the Department of Health's Primary Health Networks.[2141]

The Australian Government provided grant funding as part of the response for CALD communities for community organisations. The funding was used to design and lead short-term, one-off communication and outreach projects tailored to meet the needs of their communities.[2142]

During the COVID-19 pandemic, a number of Commonwealth agencies[2143] collaborated on the Understanding Socio-Demographic Cohorts in the COVID-19 Vaccines Strategy Project (linking the Australian Immunisation Register and the Person Level Integrated Data Asset).[2144] This data-linking initiative gave a more granular breakdown of CALD population data and informed outreach strategies to CALD communities, including during the vaccine rollout.[2145] Separately, in October 2020, two CALD fields (country of birth and language spoken at home) were added to the National Interoperable Notifiable Disease Surveillance System to improve data collection.[2146]

2.2.Impact

Before the COVID-19 pandemic, there were no specific public health emergency plans in place for CALD communities. That meant plans needed to be developed rapidly and reactively during the pandemic.

> *The pandemic exposed major gaps in government communication and engagement with multicultural communities … In contrast, communication with CALD communities in later stages of the pandemic was successful because it was supported by settlement providers and community leaders … The pandemic created a new level of community strength as CALD community leaders stepped up to keep communities informed and safe. – Settlement Services International*[2147]

We heard that there were not enough channels for coordination between government and CALD communities before the pandemic.[2148] As a result, there were inefficiencies and duplication of effort between governments, and they were often drawing upon the same small group of community leaders and competing to deliver the same message.

> *There was no consistency between states … it tells me the government is unorganised … they all lost a little bit of credibility – Participant from a CALD background, Brisbane*[2149]

Engagement with CALD communities was slow to begin and generally lacked the connections and processes required to support the intensive COVID-19 response. When consultation did begin, it was challenging to get the right mix of attendees to ensure information was heard and acted on.

The CALD Advisory Group was established more than nine months after the first COVID-19 case in Australia. Although it was established late, many stakeholders said that it was a positive and effective mechanism for providing advice to government on the nature of tailored responses. During the pandemic, it effectively embodied the improvement in consultation processes with CALD communities.

There was improved recognition of the importance of relationships with and use of multicultural and community organisations, intermediaries and community leaders during the COVID-19 pandemic. We heard that the funding that was provided to community organisations to leverage their networks and expertise was essential. In particular, the CALD COVID-19 Health Small Grants Fund was seen as a positive initiative. The fund was an important way for organisations to engage with and provide feedback to government, actively contribute to solutions, and help build trust in vaccination messaging.[2150] We heard that, for many organisations in receipt of funds, 'this was their first time engaging with Government agencies, offering a valuable platform to voice their concerns and actively contribute to solutions'.[2151]

> *Engagement of appropriate local leadership should have been a strategy from the beginning and has since proven effective in these communities. – The Royal Australian College of General Practitioners*[2152]

Accurate and accessible data were essential to the pandemic response. For example, analysis of COVID-19 vaccine and oral antiviral treatment uptake data from CALD populations showed that those populations had low rates of vaccination, so targeted campaigns and strategies were developed to boost uptake.[2153] A data-sharing agreement between the Department of Health and the Victorian Department of Health also allowed for analysis of patterns of COVID-19 antiviral treatment dispensation for Victorian residents from CALD backgrounds.[2154] Lessons learned are being applied to other immunisation programs – for example, for HPV, influenza, and measles-mumps-rubella (MMR).[2155]

However, we also heard that data collection about CALD communities is still a significant challenge. Key data – for example on language needs, preferences and requirements for translators – are not consistently collected in primary or acute healthcare settings.[2156] As a result there was not enough information to develop tailored response measures and communications; and there was not enough appropriate support for individuals.[2157]

> *Without accurate and adequate data, these [CALD] communities risk becoming invisible, making it increasingly challenging to address their unique needs. – Federation of Ethnic Communities' Councils of Australia*[2158]

3. Access to information

3.1. Response

During the COVID-19 pandemic, the Australian Government undertook many different types of communications activities to reach people from CALD communities. For example:

- Government departments published translated COVID-19 information in a range of languages (for example, see Figure 1).[2159] By November 2020 the Department of Health had made information available in 85 languages other than English,[2160] and all of the department's campaign phases included a targeted CALD stream.[2161] In total, the department developed almost 3,000 translated COVID-19 resources.[2162]
- COVID-19 information was provided across the Special Broadcasting Service (SBS) channels in 63 different languages.[2163]
- SBS created in-language videos for the Department of Health and developed the SBS COVID-19 portal, embedded in Australian Government websites.[2164]
- In early 2020 the Department of Foreign Affairs and Trade established a Communities Hub containing translated general travel advice.[2165]
- In 2020 and 2021 the Department of Home Affairs ran the 'Strengthening Social Cohesion' campaign, which aimed to reduce racism and encourage reporting.[2166]
- From July 2021, the Department of Health ran a campaign to increase awareness of the types of mental health services and support that were available for CALD communities in New South Wales.[2167]

- In February 2022 the National Coronavirus Helpline guaranteed free interpreter assistance for multilingual callers.[2168]
- The CALD Advisory Group undertook communication activities with key stakeholders.[2169]

Figure 1: Rapid antigen test instructions in Indonesian[2170]

Community organisations were also funded to undertake communications activities. For example:

- In June 2020, Dementia Australia was funded to translate COVID-19 Help Sheets into 38 languages.[2171]
- Throughout the vaccine rollout, peak multicultural organisations were funded to develop and deliver vaccination information campaigns.[2172]

- The CALD COVID-19 Health Small Grants Fund provided funding to community organisations for grassroots communication activities to support the vaccine rollout.[2173]

3.2.Impact

The government used a range of channels to provide COVID-19 information to CALD communities. Information materials were translated from English into community languages, which was widely appreciated, and the level of satisfaction with government communications improved throughout the COVID-19 pandemic. See also Chapter 5: Trust and human rights for more information on trust and confidence in government throughout the COVID-19 pandemic.

However, we heard there were concerns about the timeliness, frequency, accessibility and relevance of messaging:[2174]

- Most information was provided in written formats through government channels, including social media.[2175] However, this form of distribution did not take into account CALD communities' communications preferences and habits.[2176] For example, many people prefer to receive information in community languages, but younger people often prefer information in English.[2177] Some people prefer to seek information from within their own communities, face technical or digital literacy barriers navigating government websites, or prefer audio-visual resources.[2178]
- There was a lack of clarity and consistency in government communications, and this created some specific challenges.
- Communications lacked cultural sensitivity. For example, the Australian Government's 'Arm Yourself' campaign 'was an inappropriate message for young Muslim men after years of peace-related communication'.[2179] The cultural and historical context of particular languages was not well understood. For example, we heard from one stakeholder that information was provided in Arabic to the South Sudanese community. For many people in that community, Arabic is the language of the oppressor · information in Dinka would have been more appropriate.[2180]
- Translated materials often took too long to produce. By the time information reached communities, it was often out of date, no longer relevant, or incomprehensible.[2181] Many materials were directly translated and not nuanced for the audience, so some official translated materials contained errors.[2182] Material was not always translated into a sufficient number of languages.[2183] There was also a heavy reliance on translations, without considering broader engagement strategies.[2184]

Many CALD community members found it difficult to access or understand the information given to them, which had a range of impacts:

- There was a lack of clarity in and understanding of public health orders. Some CALD community members did not comply with public health advice simply because they did not properly understand it or misunderstood the health advice and policy decisions.[2185]

- Some CALD community members were not able to access or understand health information.[2186]
- Some people sought information from international news, family and friends overseas or social media. This information was not always relevant to the Australian situation and may have contributed to misinformation.[2187]
- Vaccine rollout communications to CALD communities were not as effective as communications to the general population. A lower proportion of the CALD population recalled seeing, hearing or reading vaccine campaign advertising materials.[2188]
- Some groups felt forgotten by government when their language was not one of those translated.[2189] This was particularly true for languages such as Telugu, Marathi, Somali, Hakha, Chin, Hazaragi, and Urdu.[2190]

  I had WeChat where Chinese people translated government information, but it's not official, so we were influenced by a lot of biased information. It would have been better to have government translated information. – Focus group CALD participant[2191]

Lack of access to information[2192]

Jane* is a South Sudanese refugee living in regional Victoria. She didn't speak English and couldn't read or write in her first language. She was not aware there was a pandemic until her children were sent home from school. During the pandemic, she relied solely on her children for updates on restrictions and services available. At one point, she became sick with COVID-19 and feared she might infect her family and community so didn't leave her bedroom for any reason. She spent two weeks confined to her room and relied on 'home remedies like ginger and lemon'. Some nights, Jane was terrified she wouldn't make it through until morning but didn't know how to get medical advice. Her children shared her fear and were worried she would die. Jane wishes there had been services and information to better support her during this time.

Trusted advocacy groups, community organisations, community leaders and connectors, local governments, and bicultural and bilingual health workers played a key role bridging gaps in official communications.[2193] CALD community organisations provided translations and undertook other communications and outreach activities.

Bilingual and bicultural intermediaries were essential. Where there were well-established community infrastructure and intermediaries, it was easier to reach communities. For example, the Settlement Council of Australia in Western Sydney mobilised 22 of its member organisations to make over 14,000 phone calls in language and ran a social media campaign that reached over half a million people.[2194] Community intermediaries have played a critical role in Australia for decades, but the panel heard that the Australian Government did not really recognise or support this, so during the COVID-19 pandemic, intermediaries did a lot of work without additional government support.[2195]

4. Experiences of the government response

4.1. Response

The government's response to the COVID-19 pandemic included a range of initiatives specific to CALD communities, in addition to responses for all Australians (see Chapter 9: Buying time, Chapter 10: The path to opening up, Chapter 12: Broader health impacts and Chapter 21: Supporting households and businesses).

4.1.1. Vaccine rollout

A key principle of the Australian COVID-19 Vaccination Policy, which National Cabinet endorsed on 13 November 2020, was that vaccination would be free for every person in Australia, regardless of their citizenship status or Medicare eligibility.[2196] Australia's COVID-19 Vaccine National Roll-out Strategy was released on 7 January 2021. Although CALD communities were not identified as a priority group for vaccination,[2197] it was recognised some people in those communities would need greater assistance and support to access the vaccine. Therefore, a dedicated COVID-19 Vaccination Program – Culturally and Linguistically Diverse Communities Implementation Plan (CALD Implementation Plan) was released on 13 February 2021.[2198]

There were a number of specific initiatives to support the vaccination rollout, including:

- the Vulnerable Vaccination Program, developed by the Department of Health to ensure access to COVID vaccinations for people who might otherwise miss out
- making vaccinations available through Commonwealth Vaccination Centres, community pharmacies and state and territory clinics regardless of Medicare eligibility
- extension of the Department of Home Affairs' Free Interpreting Service to cover non-Medicare patients receiving the vaccine from September 2021[2199]
- updates to the COVID-19 Vaccine Clinic Finder in October 2021 to assist multicultural users, including by adding details such as languages spoken at each vaccine clinic[2200]
- the Easy Vaccine Access project, launched in March 2022, through which people could text a number to request help booking a COVID-19 vaccine appointment in their preferred language[2201]
- funding provided by the Department of Health for the national vaccine bicultural health educator program Health in My Language, administered by the Multicultural Centre for Women's Health.[2202]

4.1.2. Broader health response

- From July 2021 the Department of Health funded Primary Health Networks to provide targeted mental health support and work with CALD communities and leaders in impacted areas.[2203]

- In 2020 and 2021 the Department of Health provided funding for the CALD Assertive COVID-19 Outreach Program for New and Emerging Communities. The program addressed the needs of older people in new and emerging CALD communities by supporting them to access services; giving them up-to-date, culturally appropriate and in-language information; and doing wellbeing checks. It was delivered by National Seniors Australia and Australian Unity.[2204]
- All Australian governments signed the National Mental Health and Suicide Prevention Agreement, which has a focus on improving outcomes for people from migrant and refugee backgrounds.[2205]

4.1.3. Financial supports

As discussed in Chapter 21: Supporting households and businesses, the Australian Government provided financial support to those who were unable to work or study at times during the COVID-19 pandemic:

- Some CALD community members (for example, temporary visa holders, international students and asylum seekers) were not eligible for some of those early financial supports (like the COVID-19 Disaster Payment, JobKeeper, and Coronavirus Supplement) because they could not meet the residency or employment status requirements.[2206]
- From 25 March 2020 to 31 March 2021, the newly arrived residents' waiting period for income support was waived. This meant some CALD community members became eligible for income support.[2207]
- Eligibility for some later iterations of financial supports, such as the Pandemic Leave Disaster Payment, was expanded to include temporary visa holders with the right to work.[2208]

4.2. Impact

4.2.1. Vaccine rollout

Vaccine rollout initiatives which helped facilitate access to vaccinations for CALD communities included:

- the dedicated CALD Implementation Plan, which recognised the need for tailored strategies for some CALD community members
- a new Medicare Benefits Schedule number which allowed GPs to provide vaccine advice as well as delivery[2209]
- facilitating access to local doctors who spoke languages other than English[2210]
- basing vaccination centres in suitable locations (such as places of worship)[2211]

- health literacy campaigns, such as the Health in My Language Program, which were tailored to the experiences of CALD communities.

Health in My Language Program[2212]

The Health in My Language Program is a National Bicultural Health Educator program that aims to improve health literacy and reduce barriers to health service navigation for people from migrant and refugee communities. It is funded by the Department of Health and led by the Multicultural Centre for Women's Health. The first stage of the program focused on people who experience higher levels of vaccine hesitancy and barriers to accessing COVID-19 vaccinations. Between March 2022 and June 2024, the program trained 44 Bilingual Health Educators to deliver information about COVID-19 and the vaccine rollout in language. The program reached over 10,400 people through community engagement activities and conducted 2,800 health education sessions in over 30 languages, reaching 42,900 people.

However, we also heard from some stakeholders about practical barriers to accessing vaccines:

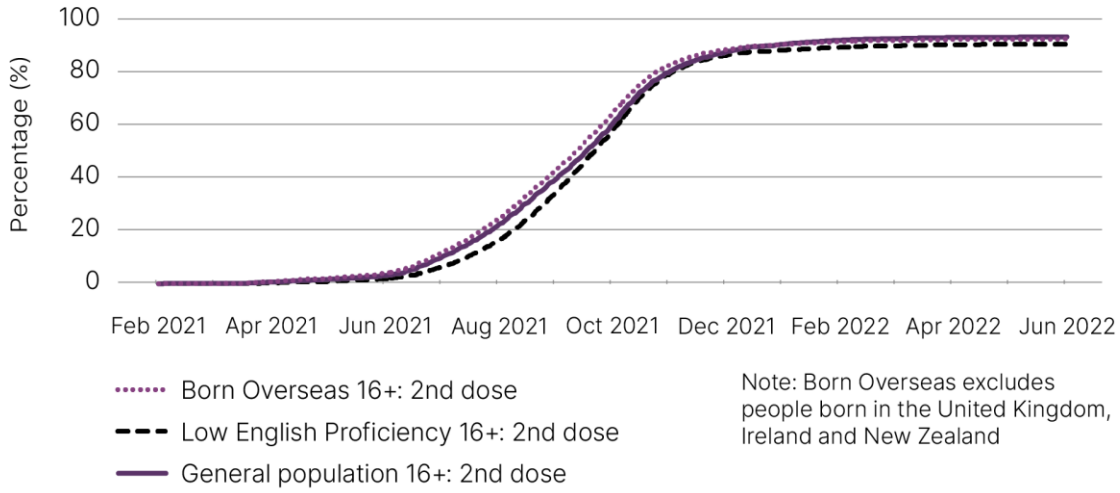
- Some vaccination centres only offered services to those with a Medicare card, which some CALD community members did not have.[2213]
- Important cultural sensitivities in the administration of vaccinations (such as women being vaccinated by women) were not always considered.[2214]
- A reliance on digital tools for the vaccination rollout, including for booking appointments or accessing vaccination records, impacted CALD community members who did not have access to suitable devices.[2215]
- Some CALD community members experienced vaccine hesitancy as a result of language barriers, lack of awareness about how to navigate Australia's healthcare system,[2216] location of vaccination clinics,[2217] lack of paid vaccination leave for casual workers, lower English and digital literacy, and negative perceptions of immunisation programs.[2218]

Some sectors of CALD communities lagged behind the general population in vaccination. For example, people aged 16 and over with low English proficiency had lower rates than the general population (see Figure 2). Socioeconomically disadvantaged metropolitan local government areas, which also tend to have the highest populations of CALD communities, were also more likely to have lower vaccination rates and took longer to reach vaccination targets.[2219] This resulted in earlier and greater numbers of infections.[2220] By 21 November 2021, 91 per cent of the total Australian population over 12 years had received at least one vaccination dose.[2221] The Australian National Audit Office found rates were comparatively lower at this stage for some groups – only 81 per cent of people over 12 years with low English proficiency and 84 per cent of people born overseas (excluding the United Kingdom, Ireland, or New Zealand) had received at least one dose.[2222]

Despite challenges with the rollout, as Figure 2 demonstrates, CALD cohorts ultimately reached similar levels of vaccination to the general population. This was achieved through 'a combination of robust, targeted community engagement, mass deployment of appropriate

workforce, vaccination services tailored to cultural needs and sensitivities and accessibility to mass vaccination sites on a backdrop of state-wide policies that incentivise vaccination'.[2223]

Figure 2: Cumulative two dose COVID-19 vaccination coverage for CALD cohorts aged 16+, February 2021 – June 2022[2224]

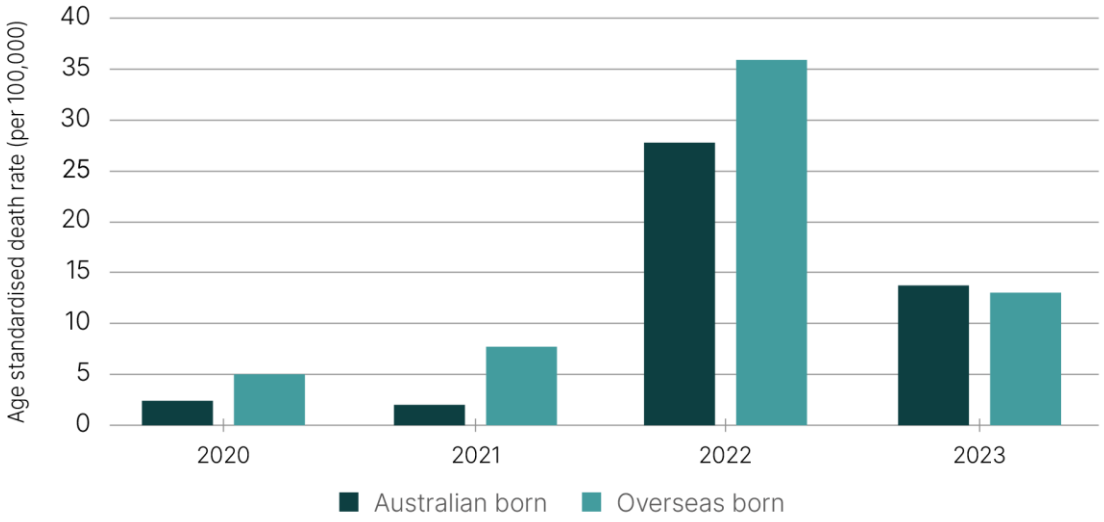


4.2.2. Broader health response

> *People from CALD backgrounds have been profoundly affected by the COVID-19 pandemic, with a majority of its members reporting worsened livelihoods and mental health during the pandemic. Worse mental wellbeing exacts a huge individual and family price and a significant economic toll. – Federation of Ethnic Communities' Councils of Australia*[2225]

Throughout much of the COVID-19 pandemic, CALD communities experienced higher mortality rates than the general population.[2226] This is particularly alarming given that in 2019, Australians born overseas had lower standardised mortality rates than people born in Australia.[2227] CALD communities represent around 30 per cent of Australia's total population.[2228] However, in 2022, 44.5 per cent of all COVID-19 deaths in Australia were of people born overseas (4,551 deaths among people born overseas, compared to 5,669 deaths among people born in Australia).[2229] Across the pandemic, people who were born overseas had a standardised death rate 1.4 times higher than people born in Australia.[2230] While this varied over time, people born overseas had a consistently higher death rate (Figure 3). There were also significant differences within CALD communities. For example, during the Delta wave in 2021, the mortality rate was 80 times higher for people born in Tonga and 47.7 times higher for people born in the Middle East.[2231]

Figure 3: COVID-19 age standardised death rates by country of birth[2232]



Conclusive data on the drivers for these higher mortality rates for CALD communities is not available. However, the Inquiry heard about a wide range of contributing factors. For example, CALD community members are:

- older on average than the general population[2233]
- more likely to work in frontline employment with greater exposure risks[2234]
- more likely to work in insecure employment and face barriers in complying with isolation requirements[2235]
- less likely to have access to reliable health information[2236]
- less likely to receive early vaccination[2237]
- less likely to attend hospital with severe illness, due to familial responsibilities or fear of family separation.[2238]

Some CALD communities felt the impacts of public health restrictions differently compared to the general population. We heard that collectivist CALD communities who regularly visit family each week were deeply affected by restrictions.[2239] CALD communities also experienced lockdowns and social distancing differently because members are more likely to live in intergenerational, shared, or overcrowded accommodation.[2240] For some, lockdowns resulted in increased family tensions, particularly in intergenerational houses with differences in cultural expectations of behaviour during a pandemic.[2241]

Mental health impacts were exacerbated in CALD communities. This stemmed from factors such as increased financial stress and limited access to financial supports, disruption of cultural norms, challenges supporting children academically, and international and domestic border closures.[2242] For some CALD communities, people who access mental health support can be stigmatised. During the pandemic, this meant some people did not utilise telehealth consultations because they were worried about doing so from home.[2243] Despite government initiatives to improve awareness of mental health supports, we heard that some found it

challenging to find a psychologist who understood their cultural backgrounds and experiences:[2244]

> *I'm Hindu, and once somebody passes away, we bring the body back home into the house, do rituals, say goodbye in the house and do cremation. When my uncle passed, his last wish was to come home and it wasn't fulfilled, so of course it impacts you. – Focus group participant from a CALD background, Sydney*[2245]

> *My mental health suffered but I did not know who to tell and what to do about it... I just suffered by myself without knowing about any mental health services. – Focus group participant from a CALD background, Sydney*[2246]

Many CALD community members also experienced increased racism and discrimination during the pandemic. Anti-Asian sentiment was common because of perceptions about the origin of the virus. Migrants were often depicted as a health threat and economic burden, despite often being essential workers in their communities.[2247] The Australian Human Rights Commission received a significant surge in complaints[2248] and in February 2020 alone, recorded more complaints than at any time over the previous year.[2249] The situation for CALD community members was exacerbated by reporting and public discourse that 'unjustly blamed CALD communities which perpetuated prejudice and threats towards CALD communities'.[2250]

Concerns were raised that state and territory enforcement of lockdown and other public health measures were over-policed or unfairly focused in areas with large CALD or refugee populations.[2251] For example, analysis of COVID-19 fines issued in Victoria in 2020 found African and Middle Eastern people were four times more likely to receive fines, and local government areas with higher proportions of non-English speaking backgrounds had higher levels of fines.[2252] The tightest pandemic restrictions also occurred in areas with a high proportion of CALD residents.[2253] In Sydney, local government areas with large CALD populations were more likely to experience more stringent lockdown restrictions. The lockdown of nine public housing complexes in inner-city Melbourne also drew public criticism for unfairly stigmatising ethnic minorities.[2254] These factors, combined with a lack of engagement with multicultural communities, eroded trust in government.

> *Increased policing in the 'areas of concern' including helicopter surveillance and increased police presence on the local streets heightened fear, particularly from refugee and migrant communities who had fled civil conflict and persecution in their homeland. – Australian Services Union*[2255]

The Inquiry heard that community organisations led positive initiatives to improve access to health care and support for CALD communities during periods of lockdowns. For example, in 2020 the Multicultural Centre for Women's Health provided support to public housing residents in Victoria. The project aimed to increase COVID-19 testing and provide information and health referrals to migrant women. There were 1,912 calls made in 21 languages, leading to 1,107 conversations about COVID-19, testing and women's health concerns. As a result, 664 people agreed to take a COVID-19 test.[2256] Similarly, Multicultural Aged Care South Australia undertook

a comprehensive program of activities to support older Australians from CALD communities. They conducted welfare check calls, distributed activity packs to maintain cognitive engagement, delivered culturally appropriate meals and food packs, made driveway visits and distributed bilingual resources.[2257]

4.2.3. Financial supports

Many members of CALD communities did not meet the eligibility criteria for major financial support programs such as JobKeeper and were therefore ineligible for government support. We heard this had negative consequences for many people– for example, international students and temporary migrants who were not able to return to their home country and lost casual employment as a result of the pandemic.[2258] Others faced difficulty in navigating the process of applying for support they were eligible for because of language barriers and administrative ability.[2259] Surveys of the experiences of international students found that 61 per cent of respondents lost their job, 54 per cent experienced financial difficulties, and only 13 per cent felt positive about support from the Australian Government.[2260] Further information on financial supports can be found in Chapter 21: Supporting households and businesses.

> *I lost my job as an international student. I wasted all my savings trying to survive … neither the Australian Government nor my home country supported me. – Focus group participant from a CALD background, Darwin*[2261]

Many people experienced increased financial stress. For example, many found it difficult to pay bills and expenses. This led to a rise in food insecurity and increased reliance on food bank services.[2262] Some CALD community members experienced worsening housing situations or increased risk of homelessness.[2263]

We also heard that a lack of access to financial supports undermined social cohesion and exacerbated a sense of exclusion for some CALD community members.[2264] Cumulatively, these impacts resulted in increased demand for community services and support from other organisations.[2265] Specifically, we heard from one stakeholder that the lack of support for international students placed responsibility on universities, which were not resourced to provide this support.[2266]

5. Evaluation

Public health emergencies are likely to exacerbate inequities for some CALD communities

The inquiry consistently heard about CALD communities' differentiated and often negative experiences of the COVID-19 pandemic. Many of those difficulties were exacerbated by longstanding inequities and structural and cultural barriers. CALD communities were often at greater risk of contracting the virus, experienced increased racism and discrimination, faced challenges accessing mental health support, and were more likely to live in areas with harsher government lockdowns and compliance requirements.

Eligibility criteria for financial support had a significant impact on some CALD communities. Many temporary migrants and international students who had no other means of assistance were excluded from financial supports (see Chapter 21: Supporting households and businesses). Similarly, public health orders often disproportionately affected areas with high CALD populations, where many people were employed in key service, health and social care roles, or failed to take into consideration how communities with different cultural norms might be affected.

The pandemic exposed pre-existing gaps at the national level in planning and engagement structures relating to CALD communities

These gaps meant there was limited preparedness for a tailored response, and delay in shaping some key initiatives in the early stages of the pandemic. There was no clear understanding of who was in the 'CALD cohort' and what their needs were. Relationships at the national level were less developed and there were no clear communication channels with CALD community leaders.

While CALD communities were referenced as a potentially vulnerable group in the 2020 Australian Health Sector Emergency Response Plan for Novel Coronavirus, there were significant delays in the development and rollout of CALD-specific plans. Although the need to prioritise CALD communities in the vaccine rollout was recognised and the CALD Implementation Plan was commendable and necessary, people in CALD communities were still less likely to receive the COVID-19 vaccine.

Given that the engagement and advisory structures that are needed to support a pandemic response were initially absent, early opportunities to minimise harms and mitigate public health and broader economic and social risks associated with the pandemic were missed. In the future, plans need to be in place before an emergency to ensure the needs of CALD communities are met.

Emergency responses are enhanced by genuine consultation, partnerships and co-design with CALD communities

It is critical that governments build and maintain genuine relationships with priority groups and the community organisations that represent them. These partnerships are essential for timely and effective development and delivery of tailored responses and communications in a health

emergency. Consultation and coordination with communities must be effective, genuine and in place before an emergency – once a crisis is underway, it is too late to establish these forums.

CALD communities uniformly agree that genuine engagement with them was slow to begin. The establishment of the CALD Advisory Committee, nine months after the first reported COVID-19 case, is acknowledged as a turning point in the pandemic response. By providing advice to the key health technical advisory committees, the CALD Advisory Group was able to assist in tailoring health responses and the framing of key messaging. The response was most effective where the government was able to harness the expertise and networks of community organisations – for example, by providing organisations with flexible funding to develop agile local responses, culturally appropriate and tailored communications and wraparound supports. Effective consultation mechanisms that elevate the voices, needs and preferences of CALD communities are demonstrably critical to shaping and modifying responses to rapidly changing conditions, minimising the risk of harm, maintaining dignity of CALD communities, and maximising health objectives.[2267]

The panel notes that since the pandemic, investments have been made to increase coordination and engagement with CALD communities – for example, the Department of Health's $2.5 million investment in the 2023–24 Budget to the Federation of Ethnic Communities' Councils of Australia to establish the Australian Multicultural Health Collaborative.[2268] To complement the July 2024 release of the independent Multicultural Framework Review final report and the government's response, the government has committed more than $100 million to support a stronger multicultural Australia.[2269] These are positive initiatives that should be built on to enhance pandemic preparedness.

The panel notes that the CALD Advisory Group is currently only in place until 31 December 2024. It supports the continuation of the CALD Advisory Group or a similar body to ensure effective consultation and coordination in preparing for and responding to a future pandemic. Any advisory body should have clear mechanisms for feeding into decision-making processes, commensurate with those for other potentially at-risk groups.

Tailored communications initiatives designed and delivered in partnership with trusted community voices are essential in an emergency

While communications for CALD communities improved over the course of the COVID-19 pandemic, many actions came long after they were first needed, amplifying underlying inequities.[2270]

Early on, challenges arose because of inadequate planning and preparedness for tailored communication requirements; poor data on language needs, preferences and requirements for translators; and the absence of existing relationships with communities. As a result, where information was provided, the varying needs of CALD communities were not adequately taken into account. This could be seen in inaccurate or poor translations, not enough or too much information, an over-reliance on community intermediaries, and a lack of nuanced understanding about the suitability of various communications channels. We heard this resulted in a decline in trust and potentially enhanced fear and confusion amongst members of CALD

communities. Communities were more likely to rely on the advice and experience of overseas relatives even though Australia faced very different circumstances from those other countries.

Stakeholders noted it can be difficult to translate materials into all languages in a public health emergency, particularly given the pace and frequency of public health information updates. We heard that the use of simple English messaging in public communications is one way to address some issues.[2271] Another important solution is to give trusted community voices the funding and support to tailor and disseminate messages to their communities using the most appropriate channels. This would enhance intersectional communications for other priority groups, including people with disability.

Communications improved significantly where trusted community members and organisations were engaged to develop tailored communications that reflected the diversity of CALD communities. For example, the National Bicultural Health Educator program provides a model for improving health literacy through a well-trained bilingual health education workforce and supporting resources.[2272]

Clear communication with CALD communities is a whole-of-government responsibility that should be embedded in government processes and a national public health emergency framework now before the next public health emergency. Coordination of communications between governments, including states and territories, would enhance consistency of messaging, avoid duplication of efforts and allow for better targeting of resources. The important role that local government can and needs to play in a future pandemic must be acknowledged, resourced and reflected in future pandemic plans.

CALD communities are not sufficiently visible in health data, and where data do exist it is inaccessible to those who need it to make informed decisions in a crisis

It is acknowledged that the CALD population faces unique risks in crises like the COVID-19 pandemic. Accurate evidence is essential to inform the pandemic response and assess the effectiveness and proportionality of the public health measures. However, the lack of comprehensive data and the inadequacy of linkages was, and remains, a key challenge in developing tailored pandemic responses for CALD communities. Current data collection practices in both acute and primary health settings meant doctors were not aware of language needs, preferences and requirements for translators for people in their community. Therefore, in many instances, they were unable to provide adequate assistance in a timely manner.

Because there was inadequate data collection early in the pandemic, it took time to identify, much less understand, issues for different populations and develop tailored responses for initiatives including the vaccine rollout.[2273] Also, there are structural gaps in information, so it is not possible to drill down and get accurate information into different population groups. Significant improvements were made in data linkages, but many persistent challenges remain. These issues must be addressed before we encounter another public health emergency in the future.

6. Learnings

- CALD communities should be recognised as an at-risk population in pandemic planning and related economic supports due to underlying health determinants and cultural factors which can lead to disproportionate health, social, and economic impacts in public health emergencies.
- Proactive and bespoke interventions based on an understanding of the different experiences of CALD communities are essential to meet public health objectives in a public health emergency.
- Embedding input from CALD communities within Australia's policy and operational frameworks, emergency planning and coordination across all levels of government are key to improving preparedness for future emergencies.
- Diversity between and within CALD communities influences information preferences. Co-designing communications with communities in response to this diversity is vital. Communicating tailored and accurate information in a timely way helps people comply with public health directions, improves trust, and reduces the likelihood of individuals relying on informal information sources.
- CALD representative organisations, community leaders and connectors, bilingual and bicultural workers, and intermediaries play a critical role during emergencies as trusted voices, in devising solutions, and in filling service gaps.
- Targeted and flexible grants to established community organisations with links to CALD communities are rapid and effective mechanisms for providing direct support and empowering communities to develop and deliver solutions which are tailored to their communities.
- CALD community members are over-represented in frontline and essential work. This must be considered in the design of future public health measures and economic and social supports.
- Public health orders and decisions about financial supports will have a different impact on some CALD communities, in particular temporary migrants, international students, and casual or frontline workers.
- CALD communities may be targets for increased racism and discrimination in public health emergencies. Specific measures are required to mitigate harm and impacts on social cohesion.
- Robust, accessible and linked demographic and health data on CALD communities is critical to an effective pandemic response and helps identify and understand service access and disparities in a crisis.

7. Actions

7.1. Immediate actions – Do in the next 12–18 months

Action 5: Develop updated health emergency planning and response arrangements in conjunction with states and territories, and key partners, including consideration of escalation and de-escalation points, real-time review and a focus on post-emergency recovery.

As part of this, develop management plans for priority populations under the National Communicable Disease Plan, including for culturally and linguistically diverse communities.

- The Management Plan for culturally and linguistically diverse communities should include co-designing strategies to ensure culturally appropriate delivery of vaccination and healthcare services that acknowledge the specific language and cultural barriers different communities may face. This plan should consider the role of community organisations, leaders and intermediaries.

Action 6: Develop legislative and policy frameworks to support responses in a public health emergency, including for quarantine.

- The National Quarantine Strategy should establish culturally appropriate options for culturally and linguistically diverse communities.
- The Economic Toolkit should draw on lessons from reviews of significant aspects of Australia's COVID-19 response, including ensuring all residents, regardless of visa status, are supported during the response.

Action 8: Establish mechanisms for National Cabinet to receive additional integrated expert advice for a whole-of-society emergency, including advice on social, human rights, economic and broader health impacts (including mental health considerations), as well as specific impacts on priority populations.

- In parallel with making decisions based on key public health advice, National Cabinet should consider the differential impacts of a pandemic across the population and economy. This must include considering and mitigating unintended consequences, and seek to minimise negative impacts on broader health, mental health, educational, equity, economic and social outcomes.
- Human rights considerations should be embedded into National Cabinet's decision-making processes, particularly where measures are intended to significantly restrict rights and freedoms.
- This might include mechanisms for a national health emergency that allow expert advice to be sought from the Australian Human Rights Commissioner and other commissioners (e.g. National Children's Commissioner) to support better understanding of the broader impacts of their decisions on human rights and priority populations.

Action 11: Improve data collection, sharing, linkage, and analytic capability to enable an effective, targeted and proportionate response in a national health emergency.

This should include:

- improvements to data collection and pre-established data linkage platforms, including prioritising collection of key metrics in primary and acute healthcare settings, including country of birth, language spoken, interpreter requirements, ethnic/cultural background and year of arrival
- finalising work underway to establish clear guardrails for managing data security and privacy and enabling routine access to linked and granular health data, and establishing pre-agreements and processes for the sharing of health, economic, social and other critical data for a public health emergency. Key health data on culturally and linguistically diverse communities should be prioritised.

Action 14: Embed flexibility in Australian Government grant and procurement arrangements to support the rapid delivery of funding and services in a national health emergency, for instance to meet urgent community needs and support populations most at risk.

This should include:

- funding mechanisms that allow organisations to rapidly develop and deliver solutions tailored to their communities
- funding to culturally and linguistically diverse community organisations during a national health emergency.

Action 15: Ensure there are appropriate coordination and communication pathways in place with industry, unions, primary care stakeholders, local government, the community sector, priority populations and community representatives on issues related to public health emergencies. Structures should be maintained outside of an emergency, and be used to provide effective feedback loops on the shaping and delivery of response measures in a national health emergency.

- Build and maintain engagement mechanisms outside of an emergency with the community sector.
- Maintain and build on effective structures that were established before or during the COVID-19 pandemic, including those with priority populations such as culturally and linguistically diverse communities.
- Consult these groups on the development and updating of pandemic plans, and ensure they participate in stress-testing exercises.
- Ensure there are clear mechanisms to feed into decision-making processes in an emergency, and genuinely engage relevant bodies in pandemic preparedness activities and responses to future emergencies.

- Utilise these structures in national health emergencies to provide effective feedback loops on the delivery of response measures.

As part of this:

- make the Culturally and Linguistically Diverse Communities Health Advisory Group, or similar advisory body, a permanent subcommittee of the Australian Health Protection Committee
- ensure the permanent advisory structure for culturally and linguistically diverse communities has a role consistent with the National Aboriginal and Torres Strait Islander Health Protection subcommittee and the Aged Care Advisory Group, including reporting to the Australian Health Protection Committee.

Action 18: Proactively address populations most at risk and consider existing inequities in access to services (health and non-health) and other social determinants of health in pandemic management plans and responses, identifying where additional support or alternative approaches are required to support an emergency response with consideration for health, social and economic factors.

- All plans and response measures should have an equity lens applied, including for health, social, human rights and economic factors (see Action 1).

Action 19: Develop a communication strategy for use in national health emergencies that ensures Australians, including those in priority populations, families and industries, have the information they need to manage their social, work and family lives.

The strategy should account for the distinct communications preferences and requirements of priority populations – including:

- reflecting the key role of community and representative organisations in communicating with priority populations, including culturally and linguistically diverse community organisations
- funding community and representative organisations to tailor and disseminate communications through appropriate channels and trusted voices
- providing plain English messaging to community organisations for tailoring in a timely manner.

Chapter 16 – People with disability

1. Context

In any public health emergency, some people with disability are likely to be at greater risk than the general population.[2274] This stems from clinical factors contributing to a greater risk of severe disease or death from communicable diseases, and barriers to accessing and using health services.[2275] The risks and barriers faced by people with disability vary according to factors such as age, gender identity, nature of disability, ethnicity, sexual orientation, accommodation type, support needs and migration status.[2276]

People with disability come from all demographic and socio-economic groups, have varying support needs, and live in a range of settings. In June 2020 there were 392,000 National Disability Insurance Scheme (NDIS) participants, and 754,180 Disability Support Pension recipients.[2277] This represents only a small fraction of people with disability. There are an estimated 5.5 million Australians with disability, or 21 per cent of the total population.[2278]

Some people with disability have a greater risk of acquiring COVID-19 and are more likely to have serious health consequences as a result.[2279] During the Delta wave between 16 June and 14 December 2021, people receiving the Disability Support Pension and NDIS participants were 3.1 and 2.8 times respectively more likely than the general population to be admitted to intensive care with COVID-19.[2280] These rates increased to 4.7 and 4.8 times respectively in the first Omicron wave from 15 December 2021 to 28 February 2022.[2281] For many people with disability, access to PPE and access to support workers or carers are essential requirements for daily living.

Responsibility for supporting people with disability is shared between levels of government and between government agencies. During the COVID-19 pandemic, governments took steps to deliver a tailored response for people with disability. However, we heard from a number of stakeholders that delays, inadequacies in targeted actions, and the de-prioritisation of vaccinations for people in disability residential settings had negative impacts for many people with disability.[2282]

The experiences of people with disability early in the pandemic and during the vaccine rollout were considered by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission).[2283] Many of the issues raised in the Disability Royal Commission were echoed in what this Inquiry heard. Implementing the Royal Commission's recommendations will improve preparedness for a future pandemic.

All Australian governments have a duty under the United Nations Convention on the Rights of Persons with Disabilities to ensure the protection and safety of people with disability.[2284] It is essential that governments learn from the experience of the COVID-19 pandemic to ensure people with disability have full and equal access to health care, information and essential services in future public health emergencies.

A note on terminology

In this report, we use the term 'disability' in the context of the internationally recognised social model of disability. This describes disability as a social construct. In this model, the obstacles to equal participation are intersecting societal barriers, not people's impairment.[2285] We recognise the diversity of people with disability and that language preferences vary between disability communities.

2. Planning, coordination and engagement

2.1. Response

Responsibility for the pandemic response for people with disability was shared across government and between governments. At the Australian Government level, agencies involved in the response included the Department of Social Services, the Department of Health and Aged Care, the National Disability Insurance Agency and the NDIS Quality and Safeguards Commission. From March 2020 a team in the Department of Social Services coordinated the social services response for people with disability.[2286]

In August 2021 the Department of Social Services established a COVID-19 Response Taskforce.[2287] The Department of Health led activity that enabled vaccination and other COVID-19 healthcare responses to COVID-19 for people with disability, supported by the Department of Social Services taskforce.[2288] Operation COVID Shield also had a team coordinating across these departments.[2289] There were also weekly meetings between the Health and Social Services portfolios at a ministerial and senior officials level.

The key plan guiding the response for people with disability was the Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19): Management and Operational Plan for People with Disability (Management and Operational Plan for People with Disability), released by the Department of Health on 17 April 2020.[2290] Under Operation COVID Shield a vaccine campaign plan was also published on 3 August 2021.[2291]

Governments formed various groups or used existing ones to improve coordination and engagement with people with disability and disability organisations.[2292] The primary mechanism for this was the Advisory Committee on the Health Emergency Response to COVID-19 for People with Disability (the Disability Advisory Committee), first convened by the Department of Health on 3 April 2020.[2293] Initially reporting to the Chief Medical Officer, it included representatives of people with lived experience of disability, disability organisations and government officials. [2294] The Disability Advisory Committee helped to develop and oversee the implementation of the Management and Operational Plan for People with Disability and advised the government on the needs and experiences of people with disability throughout the pandemic.[2295] The Department of Social Services' taskforce also held weekly meetings with states and territories and NDIS workforce peaks.

There is no complete dataset that identifies all people with disability in Australia, or even in the Australian health system.[2296] To fill the gap, government agencies initiated projects to improve

COVID-19 data on people with disability. The Department of Social Services worked with other agencies to use linked, de-identified vaccination data to identify cohorts and areas with low vaccination rates.[2297] The NDIS Quality and Safeguards Commission captured COVID-19 case and mortality data for people with disability reported by registered providers. From June 2023, this was replaced by data matched with the Multi-Agency Data Integration Project (now the Person Level Integrated Data Asset).[2298]

2.2.Impact

Emergency plans established before the COVID-19 pandemic did not include strategies to support people with disability.[2299] This flowed through to the COVID-19 response. We heard that people with disability were not recognised through specific planning as early in the response as some other priority populations, such as Aboriginal and Torres Strait Islander people. The Disability Advisory Committee first met on 3 April 2020 and released the Management and Operational Plan for People with Disability on 17 April 2020.[2300] We heard the creation of the Committee and development of the Plan took considerable advocacy by disability groups.[2301] A number of stakeholders noted that established relationships between key individuals were critical in breaking through in a system that was not set up for effective consultation.[2302]

The Disability Advisory Committee played a significant role in improving engagement with the disability sector and had a genuine and positive impact on policy development. For example, the Disability Advisory Committee provided valuable input on guidance for managing outbreaks in disability residential settings, helped secure a vaccine mandate for disability support workers and increased collaboration between government and the disability sector.[2303] The presence of people with lived experience and expertise on the Disability Advisory Committee was critical, given the lack of specialised knowledge and experience of disability in government.[2304]

> *[T]he pandemic starkly demonstrated how little governments – at every level – knew about the experiences, needs and rights of people with disability. – Inclusion Australia*[2305]

The pandemic revealed poor coordination of responses for people with disability across government.[2306] Notably the Department of Health did not have structures in place to prioritise planning for people with disability, which it saw as the responsibility of the Department of Social Services. We heard of the Department of Health referring health-related issues to the Department of Social Services, and the National Disability Insurance Agency referring pandemic-related issues to the Department of Health.[2307] No department took responsibility for the health of people with disability during the pandemic. Analysis by the Centre of Research Excellence in Disability and Health found that 'compartmentalisation between disability and health systems with a lack of connection and communication between the systems acted as a barrier to a cohesive COVID-19 disability response'.[2308]

Given this, the path for raising issues to government was unclear. Advocates found it difficult to determine which agencies to approach on health and economic support measures.[2309] This was especially challenging in states where there was no minister or agency with clear accountability for disability services.[2310]

We heard that these issues contributed to delays in developing policies for people with disability, and to a response that did not adequately consider the experiences and needs of people with disability. This resulted in many people with disability feeling forgotten. For example, we heard that when concerns about hospital capacity became public during the alert phase many people with disability held fears that healthcare rationing would be introduced and they would be de-prioritised.[2311]

We also heard that collaboration with the disability community improved during the pandemic. Stakeholders highlighted how Disability Representative Organisations and other community organisations stepped in to fill gaps left by government. For example, they provided support services, responding to a significant surge in demand for systemic and individual advocacy, provided information resources and translated information into accessible formats.[2312] The Disability Advocacy Network Australia received an ad hoc grant of $150,000 in May 2020 to coordinate individual advocacy.[2313] However, we heard that government support for other organisations did not account for their expanded role during the pandemic.

> *[A]dvocacy groups and other community-run organisations were effectively forced, in an ad-hoc capacity, into becoming 'accidental emergency workers' for the provision of food, medication, disability supports and other essentials. Whilst they did provide supplies, information and support at a rapid pace, this was without the support of governments. – First Peoples Disability Network*[2314]

We heard that the lack of disability data was a barrier to developing and evaluating policy responses that addressed the needs of people with disability, and that this contributed to lower relative priority, compared to older Australians, for example, for people with disability in accessing PPE and vaccines.[2315] For much of the pandemic, COVID-19 case and mortality data for people with disability were based solely on NDIS provider reporting. Once data linkages were improved, it became apparent this early data significantly under-represented the numbers of cases and deaths among people with disability.[2316] Similarly, at the start of the pandemic there was no vaccination data for people with disability.[2317] Advocates had to push for data linkages.[2318] Even where data did exist, lack of transparency limited the ability of academics and advocates to access it.[2319]

3. Access to information

3.1. Response

The Australian Government undertook a range of activities to develop and deliver tailored communications for people with disability. These efforts were guided by the Department of Health's Communications Strategy for People with Disability, released in May 2020.[2320] This

outlined the national approach and activities to inform people with disability, their families and carers about the latest health advice on COVID-19. The Disability Advisory Committee's communications working group helped to develop tailored messaging for all communications activities and to identify suitable distribution channels.[2321]

The government's communication efforts included the following key initiatives:

- The Department of Health developed accessible communications capability, including seconding specialist staff from the Department of Social Services to assist.[2322]
- The Department of Social Services created health communication products for people with disability for the Department of Health so communications were tailored for the end user.
- The Department of Social Services provided accessible COVID-19 information and support for vaccination appointments through the Disability and Carer Gateway.[2323] The Department of Social Services established the Disability Information Helpline to provide accessible information, including to people who are blind, deaf or have intellectual disability.[2324]
- In April 2020 the government reallocated funding intended for Disability Royal Commission support services to COVID-19 information, counselling and outreach services for people with disability.[2325]
- The Department of Social Services and Services Australia ran five text message campaigns in 2021 and 2022 to boost vaccination rates among Disability Support Pension and carer payment recipients.[2326]
- The Department of Health engaged the NSW Council for Intellectual Disability and Down Syndrome Australia in September 2021 to develop tailored resources.[2327]

3.2.Impact

There were some positive developments in communications for people with disability during the pandemic. One was the development of the Communications Strategy for People with Disability. Another was that Auslan interpreters became the norm at press conferences. However, many stakeholders raised concerns about the quality, accessibility and timeliness of government communications, particularly in the alert phase of the pandemic. Issues raised included:

- delays in information being tailored to people with disability[2328]
- inaccessible websites, such as the online vaccine eligibility checker, which significantly affected people who are blind or have low vision[2329]
- a lack of materials for people with intellectual disability, such as Easy Read publications[2330]

- materials for the residential aged care sector being rebadged for the disability sector, but otherwise unchanged.[2331]

People with disability had a real hard time getting information … it wasn't easy in the beginning – Focus group participant, person with disability, Geelong[2332]

The lack of accessible government information caused distress, uncertainty and distrust of government. We heard that this led to reliance on informal sources such as support workers, other residents in group homes, family and friends, and social media.[2333] This contributed to confusion and increased exposure to misinformation.

To fill the gap, the disability sector took on an active information-sharing role, demonstrating their efficacy in tailoring and distributing information. For example:

- Inclusion Australia hosted webinars for people with intellectual disability about the vaccine rollout[2334]
- Women with Disabilities Australia produced an Easy English 'What is Coronavirus?' resource in 11 languages[2335]
- the First Peoples Disability Network produced a 'COVID warrior resource' in partnership with the New South Wales Government.[2336]

4. Experiences of the response

4.1. Response

The COVID-19 pandemic response included a range of initiatives specific to people with disability in addition to responses for all Australians (see Chapter 9: Buying time, Chapter 10: The path to opening up, Chapter 12: Broader health impacts and Chapter 21: Supporting households and businesses).

4.1.1. Vaccine rollout

COVID-19 vaccination is particularly important for people whose disability increases their risk of transmission and serious adverse health outcomes, and for their families and support workers.[2337]

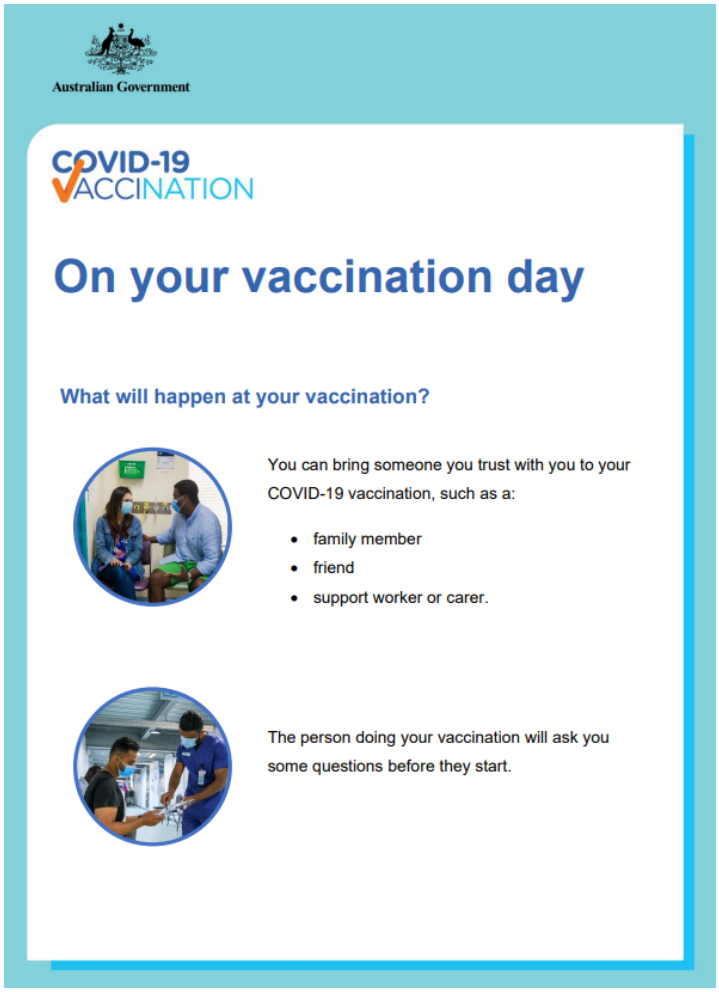
Disability care residents and workers were included in phase 1a of the vaccine rollout.[2338] From 22 February 2021, a trial rollout began to a small number of disability residential settings.[2339] On 20 April 2021 the Department of Health informed the Senate Select Committee on COVID-19 that it had pivoted to focus on aged-care residents in the vaccine rollout.[2340] From 8 June 2021 all NDIS participants aged 16 years and over and carers aged 16 years and over of NDIS participants of any age became eligible to receive the COVID-19 vaccine.[2341]

There were a number of specific initiatives to support the vaccination rollout. For example:

- Dedicated vaccination hubs provided safe and accessible locations for NDIS participants, support workers and primary carers to receive a vaccination.[2342]

- The COVID-19 In-reach Vaccination Incentive encouraged GPs to provide vaccinations to disability support workers in their workplace. This was extended to residents of disability residential facilities.[2343]
- In September 2021 NDIS vaccination facilitation through community pharmacies was launched to support NDIS participants.[2344]
- In December 2021 the NDIS Quality and Safeguards Commission undertook in-reach booster program contacts to eligible participants living in shared supported accommodation and their workers.[2345]
- In the first half of 2022 around 3.2 million rapid antigen tests were delivered to supported independent living facilities through the collaboration of the National Disability Insurance Agency, Department of Health and Department of Social Services. This measure included distribution through the significant weather events of March 2022.[2346]
- A range of communications initiatives were introduced (see Section 3.1 and Figure 1, for example).

Figure 1: COVID-19 vaccination Easy Read information[2347]



4.1.2. Broader response measures

- Some NDIS participants could use their plan for pandemic-related support, such as one-off deep cleans; meal preparation and delivery services; and buying PPE, tests and low-cost assistance technology, including ventilation.[2348]
- In early 2022 the Department of Social Services negotiated to address the gap in access to free rapid antigen tests for vulnerable cohorts, resulting in more than 800,000 tests being delivered to NDIS Supported Independent Living participants and workers, allocated at 14 tests per participant and worker to manage outbreaks.[2349]
- States and territories took measures to improve access to health care for people with disability. For example, the Victorian Government established a disability liaison officer program to support people with disability to access COVID-19 vaccination, testing and support.[2350]

4.2. Impact

4.2.1. Vaccine rollout

The Department of Health's public statement in April 2021 that it had pivoted to prioritise aged care residents for vaccination over people with disabilities in residential facilities was a surprise to people with disability.[2351]

Appearing before the Disability Royal Commission on 17 May, then Associate Secretary of the Department of Health, Caroline Edwards noted 'I did not make a decision to de-prioritise disability, I made a decision to save the people most at risk of disease and death'.[2352] The Disability Royal Commission found the Department of Health's 'lack of transparency in decision-making in effect denied people with disability the information they were entitled to receive … In the absence of this information, people with disability and their representative organisations lost the opportunity to challenge or protest against the decision to defer the vaccination of people with disability'.[2353] This caused significant distress and loss of trust in government.[2354]

The Disability Royal Commission described the vaccine rollout for people with disability as 'seriously deficient'.[2355] The Australian National Audit Office also noted the slow rollout, particularly for people in residential disability settings.[2356] The ANAO found the vaccination rate of NDIS residential disability residents did not reach 80 per cent double vaccinated until 9 November 2021. This was approximately the same time as the Australian population aged 16 years and over (2 November 2021), even though residential disability workers and residents were eligible to get vaccinated six months earlier than the majority of Australians aged 16 years and over.[2357]

Our Inquiry heard that inadequate planning, coordination and engagement contributed to the slow and poorly targeted rollout.[2358] Specifically:

- government underestimated the complexity of delivering vaccination services in disability group living settings, incorrectly assuming that they were similar to residential aged care[2359]
- people with disability, particularly those who were not able to travel independently, found it difficult to attend vaccination hubs[2360]
- communications strategies were not always fit for purpose (see Section 3.2).

We did hear of some positive examples of vaccination centres facilitating access for people with behaviour support needs.[2361]

4.2.2. Broader response measures

We heard that many people with disability had difficulty with the accessibility of health services. For example, people with disability were often not able to have support workers or carers accompany them to hospitals, and other health services.[2362] In some cases this compromised their safety and dignity and reduced their ability to get the best health outcomes.[2363] Policies on the presence of support people varied in strictness between jurisdictions, facilities and regions.[2364] Not being able to use the services of familiar support workers was a particular issue for people with intellectual disability.[2365] In contrast, we heard that Victoria's Disability Liaison disability liaison officer program was an effective and valued initiative that improved access to health care for people with a disability, including vaccination and testing.[2366]

The pandemic response saw a rapid increase in funding and demand for medical services by telehealth. Despite some challenges in the effective implementation for people with disability, we heard that telehealth was a highly positive development for people with disability. [2367] Stakeholders advocated for its continuation beyond the pandemic.[2368] A study of NDIS participants accessing allied health care during the pandemic found that 63 per cent transitioned to remote delivery.[2369] Of these, 59 per cent reported that the care was effective, and 32 per cent said they were likely to choose remote services post pandemic.[2370]

Availability of PPE during the alert phase was consistently raised as a key issue. PPE products are essential requirements for daily living for many people with disability and their support workers and carers. Increased demand from the general public made it more challenging for these people to get PPE. We heard that the approach to distributing PPE was impacted by availability, was 'highly medicalised' and did not consider settings such as supported accommodation, home-based care and disability support services.[2371]

People with disability also had difficulty accessing testing. Item limits on rapid antigen tests ignored the requirement for people with disability to test every time a new support worker came into their home.[2372] Many PCR testing sites were inaccessible for people who could not drive or were unable to queue for a long time.[2373]

Overlooking disability when accessing preventive health[2374]

Nirel* is a person with multiple disabilities, who faced substantial challenges accessing necessary health support during the pandemic. As she explained in the focus group, some people with disabilities 'need support on the ground that is brought to them'. However, Nirel felt that face-to-face support became severely compromised during the pandemic. Unable to drive and being severely immunocompromised, Nirel found herself in a difficult situation when she felt unwell and needed a COVID-19 test. She couldn't use a drive-through testing site because no one from her support network was available or allowed to drive her, due to restrictions on being in close contact with anyone outside her household bubble. In an urgent bid to get tested, Nirel contacted an old support worker who arranged for an official to come to her apartment and administer the test in the front car park of her building. Though the experience was 'embarrassing' and 'undignified' (with the official in full PPE and all her neighbours watching), it was her only option. Nirel believes the government overlooked people with disabilities during the pandemic, assuming everyone was able-bodied and fit. Without the advocacy of her former support worker, Nirel feared she would have been left without any means to get tested and properly protect her health and the health of others.

The National Disability Insurance Agency responded quickly in relation to temporary measures and active check-ins on participants.[2375] However, we heard conflicting perspectives on the National Disability Insurance Agency's adjustment rules for NDIS plans. Increased flexibility in use of funding was beneficial, as it allowed participants to purchase items such as PPE, rapid antigen tests, and iPads for remote delivery of therapies.[2376] Despite this, we heard that the National Disability Insurance Agency was not quick enough to adjust rules, and that some participants' NDIS funding was cut after COVID on the basis of that they had underspent during the pandemic when services could not be accessed.[2377]

Many people with disability experienced significant mental health challenges during the pandemic.[2378] The Australian Institute of Health and Welfare found that 29 per cent of adults with disability had high or very high levels of psychological distress in 2021, compared with 17 per cent of adults without disability.[2379] A study of the impact of COVID-19 on women with disability found that their mental health and wellbeing had suffered significantly.[2380] In a survey of children with disability and their family members conducted by Children and Young People with Disabilities Australia, 50 per cent of respondents reported a decline in their child's or their own mental health.[2381]

We heard the COVID-19 pandemic increased the risk of human rights breaches towards people with disability. The Australian Human Rights Commission reported that complaints data on disability discrimination almost doubled in 2021–22.[2382] Lockdowns and public health orders limited the operation of formal oversight mechanisms, such as Community Visitor Schemes, and curtailed informal oversight from family, friends, supporters and advocates.[2383] This increased the risk of violence, abuse, neglect and exploitation, particularly for people living in specialist disability accommodation.[2384] There is not a clear picture of the extent to which the use of restrictive practices – such as limiting visits and outings – in closed or group living settings increased during the pandemic. However, we heard reports of providers 'justifying

restrictive practices … under the guise of precautionary welfare measures'.[2385] People with disability, and women with disability in particular, faced increased risk of family and domestic violence as perpetrators were more easily able to restrict their access to services.[2386] Family and domestic violence is discussed further in Chapter 19: Women.

Access to genuine supported decision-making is central to protecting the human rights of people with disability, particularly those with intellectual disability.[2387] We heard that access to supported decision-making was reduced during the pandemic. For example, some disability service providers did not consistently ensure that people with intellectual disability had access to a GP to discuss vaccination, and made decisions on their behalf instead.[2388]

> *[S]upported decision-making for health choices and access to services as a result of COVID-19 arrangements has become non-existent for many people with intellectual disability. – Inclusion Australia*[2389]

Many people with disability experienced financial pressure during the pandemic. Even before the pandemic, 50 per cent of people with disability lived in financial stress.[2390] During the pandemic, many struggled with the increased cost of PPE, groceries, deliveries and medical equipment.[2391] Some people with disability also had less ability to undertake paid work, due to the risk of contracting COVID and the lack of safe transport.[2392] Despite these challenges, Disability Support Pension recipients were excluded from the Coronavirus Supplement, along with other pension recipients. This caused significant distress and anxiety, and drove some Disability Support Pension recipients further into poverty.[2393] In the Inquiry's community survey, 64 per cent of respondents with disability indicated that they needed financial support from the government during the pandemic (whether or not they actually received it), compared with 51 per cent of people without disability.[2394] People with disability were significantly less likely (36 per cent) to agree that the government provided appropriate support for those who faced financial difficulties than people without disability (50 per cent).[2395]

Public health measures disrupted access to essential supplies, including food, transport and medication. This had disproportionately negative impacts on the health and wellbeing of people with disability.[2396] For example, some were unable to secure grocery deliveries, as demand among the general public increased and some services stopped.[2397] Rules around support workers undertaking shopping for a person with disability meant that some people had to make difficult decisions between breaking the law or going without food.[2398] Similar trade-offs were necessary for people accessing medicine during shortages.[2399]

Stakeholders highlighted that governments failed to consult on the transition out of pandemic settings or consider the ongoing health risks for some people with disability. The emphasis on 'moving forward' left many feeling that their health was not valued.[2400] We consistently heard that 'the pandemic is not over' for people with disability. Some people said they felt safer during the height of the pandemic, when mask wearing and social distancing were common.[2401] In 2023 People with Disability Australia found that 39 per cent of people with disability did not feel safe leaving the house and 25 per cent avoided health services.[2402]

5. Disability support workforce and carers

5.1. Response

Australian Government measures during the COVID-19 pandemic to support carers, disability service providers and the disability support workforce included:

- an online COVID-19 infection prevention and control training program published in March 2020[2403]
- a panel of disability providers created by the National Disability Insurance Agency in August 2020 to offer additional workforce for residential support settings[2404]
- the Emergency and Disaster Management Practice Standard, launched in November 2021 by the NDIS Quality and Safeguards Commission, which outlined the provider requirements for preparing for, preventing, managing and responding to emergencies[2405]
- the NDIS Quality and Safeguards Commission requiring registered providers to report on workers' vaccination status, subject to state and territory public health orders, from November 2021[2406]
- the NDIS Commission requiring registered providers to notify it of outbreaks and infections from the start of the pandemic. These reports were triaged and information routinely shared with states and territories and the Department of Health to allow timely intervention where risks were identified
- the National Disability Insurance Agency allowing providers to claim payment for workers to receive COVID vaccines or boosters
- the Disability Worker COVID-19 Leave Grant for workers who were unable to attend work due to a COVID-19 infection between 1 April and 31 December 2023[2407]
- the National Disability Insurance Agency working with Aspen Medical to deliver PPE webinars in July 2022, and the Department of Social Services providing webinars in August 2022 on infection control and prevention.[2408]

The Department of Social Services introduced initiatives to support informal carers, including:

- requiring all existing Australian Government funded providers delivering carer support to conduct welfare checks from March to May 2020[2409]
- providing additional funding to Carer Gateway service providers in June 2020 to support carers impacted by COVID-19.[2410]

5.2.Impact

Early in the pandemic it was not clear whether disability support workers met the definition of essential worker. For example, the Prime Minister's announcement on 29 March 2020 that indoor and outdoor 'gatherings' were to be restricted to two people caused confusion for

people with disability and their support workers.[2411] This was particularly distressing for some people with disability, who may need two or more support workers at the same time to provide personal care and other basic activities of daily living. It took significant advocacy from the disability sector to clarify the guidelines.[2412] Categorisation of essential workers is discussed further in Chapter 23: Workers and workplaces.

A range of concerns about health and safety for both disability support workers and people with disability were raised with the Inquiry.

- Overlap between the disability and aged care workforces was 'a significant risk vector for COVID-19'.[2413] A June 2020 survey found that 14 per cent of disability support workers worked for multiple providers, and 6 per cent worked across aged care and the disability sector.[2414] While some providers implemented strategies to mitigate associated risks, a policy on managing these risks would be helpful.
- The disability support workforce has high levels of casualisation, and casual workers have more incentive to attend work when sick.[2415]
- The lack of priority access to PPE meant that disability workers and the people they supported were more exposed to the risk of infection (see Section 4.2.2).[2416]
- The absence of formal minimum education requirements meant many workers had limited knowledge on infection prevention and control.[2417] A June 2020 survey revealed 23 per cent of disability support workers had not received any COVID-19 infection control training.[2418]
- There was an overall lack of guidance for providers on managing COVID-19 risks. Stakeholders noted that the NDIS Quality and Safeguards Commission did not provide adequate guidance on how to apply COVID-19 restrictions and protections.[2419]

The disability support workforce experienced high levels of stress, mental pressure and anxiety during the pandemic. This led to shortages, burnout, and staff leaving the sector.[2420] The casual workforce pool was further impacted by border closures.[2421]

Pandemic-related workforce shortages had an impact on access to services for people with disability. Continuity of support was a key issue for many people, who reported that service providers were withdrawing essential supports, particularly during the alert phase.[2422] National Disability Insurance Agency research found that NDIS participants, family members and carers felt that overall it was harder to get services or supports during the COVID-19 pandemic.[2423] In an Every Australian Counts survey, one in five survey respondents said they could not find anyone to provide services in May to June 2020.[2424] In a survey by Children and Young People with Disability Australia, one in three respondents reported experiencing cancellation of support workers and NDIS services in March to April 2020.[2425] We also heard that the National Disability Insurance Agency's initiatives to support providers experiencing workforce disruptions failed to address all issues, as NDIS participants who self-manage were unable to access the National Disability Insurance Agency pool.[2426]

> *Many people with disability rely on supports to be able to function day to day. For these people, workforce shortages can mean things such as getting out of bed, showering, dressing and eating become unavailable to them. – National Disability Services*[2427]

Informal carers play a critical role in supporting people with disability. Around one in nine Australians provide unpaid care to an elderly person or a person with disability.[2428] We heard that during the pandemic some people with disability restricted the number of support workers they had contact with, to lower the risk of exposure to COVID-19. This often increased pressure on family and informal supporters, who were not compensated.[2429]

> *It was incredibly challenging for people with disabilities … and equally as hard for their informal supports that covered extreme amounts of cared time unpaid and unsupported. There was no refuge. – Community sentiment survey respondent, person with disability*[2430]

We also heard public health measures did not consider the vital role played by carers. This was particularly evident in the exclusion of carers from congregate care settings during lockdowns.[2431] This had flow-on impacts on the continuity of care for people with disability, their social connection and wellbeing, and oversight of risks

6. Evaluation

Engagement with people with disability should be embedded within Australia's policy and operational frameworks for emergency planning

The Department of Health worked well with existing structures and leaders in Aboriginal and Torres Strait Islander communities (see Chapter 13: Aboriginal and Torres Strait Islander people). This was not always the case in the disability community. While there were strong relationships between the community and key individuals in government, the government's broader failure to consult people with disability at the start of the pandemic and the delay in establishing the Disability Advisory Committee to inform the development of the response were significant and consequential oversights.

There was widespread consensus among stakeholders that the Disability Advisory Committee or a similar body should be maintained to ensure the voices of people with disability are heard in a future crisis. The Disability Royal Commission recommended the Disability Advisory Committee or a similar body be maintained after the pandemic has come to an end.[2432]

We note the Department of Health and Aged Care has transitioned the Disability Advisory Committee to an ongoing working group under the Disability and Health Sector Consultation Committee, with the remit including providing advice on emergency response preparedness beyond COVID 19. This body should have clear mechanisms for feeding into decision-making processes, including those of the Australian Health Protection Committee. Its position should be equal to that of consultative bodies for other priority populations.

We note the surge in demand for advocacy organisations during emergencies to make representations to government and provide accessible information. We support the Disability Royal Commission's recommendation that the Australian Government provide funding and support for disability representative organisations in any future pandemic.[2433] Flexible funding mechanisms to community service providers should be established to, among other things, allow them to develop and deliver agile solutions tailored to their communities.

Access to tailored and disability-specific health information is vital for people with disability to stay safe during a pandemic

We heard that communication gaps were often filled by disability representative organisations and community groups but that government did not use the expertise and networks of the disability sector as early or effectively as it could have. This applied to both the development and the distribution of information. These organisations and groups were also not resourced for the work they did in finding and communicating information relevant to the sector and the community. The delay in developing the Communications Strategy for People with Disability contributed to delays in the production of timely, tailored, disability-specific communications, particularly in the alert phase of the pandemic.

It is critical that governments leverage the trusted voices and expertise of disability representative organisations. It should acknowledge that channelling communications through the National Disability Insurance Agency and the Department of Social Services will only reach some people with disability, and will miss many people who do not access funding or supports through these agencies.[2434] Maintaining disability community networks will help the government produce and channel accessible information in a more timely and effective way.

We note that the Australian Government is leading the development of a plan connected with Australia's Disability Strategy 2021–2031 to promote accessible information and communications for people with disability, as recommended by the Disability Royal Commission. This plan should focus on information and communications about preparing for and responding to emergencies, natural disasters and public health crises.[2435] It should be coupled with investment in building capability across the Australian Public Service to deliver accessible information for people with disability.

Disability support workers and carers need assistance to continue providing essential services in a pandemic

Disability support workers provide a range of critical support services and should be identified as essential workers. They should be given equitable access to PPE and provided with appropriate training to manage health and safety risks and comply with public health orders. The NDIS Quality and Safeguards Commission can play a key role in developing guidance for both providers and workers in emergencies.

Public health orders should take into account the need for ongoing supports for people with disability and be clearly communicated to minimise confusion. Health system protocols should

provide for people with disability in hospitals to be accompanied by the support workers or carers they rely on to access and navigate health care.

The Australian Government provided financial assistance to NDIS providers and took steps to establish a mechanism to support providers experiencing workforce disruptions. In future emergencies, workforce supports must be extended to NDIS participants who self-manage their care arrangements.

Robust data on people with disability and sharing of evidence on best practice are critical elements of an effective pandemic response

The Australian Government's data systems, analytic capability, linkages and data transparency did not adequately support informed evidence-based decision-making, planning and communication during the crisis.

We are concerned about the lack of transparency around data related to people with disability during the pandemic, including mortality data. We heard that external researchers, who would be faster and more adept at data analysis, faced and continue to face barriers in accessing and using disability data.[2436] Governments should use external expertise, especially in a pandemic when time is of the essence.

We are encouraged by the potential of the National Disability Data Asset (NDDA) to improve responses in future emergencies. To fulfil its potential, it needs to draw on datasets that give a whole-of-population capture of key groups. Government agencies responsible for emergency planning, including the Australian Centre for Disease Control, should engage proactively with the NDDA to identify data linkages and metrics that would help governments to target responses. Investment in the NDDA needs to be supported by building and maintaining capability across the Australian Public Service in understanding and analysing data. Pandemic planning needs to include pre-agreements regarding access to data, to avoid delays caused by negotiating during a pandemic.

We support the Disability Royal Commission's recommendations regarding disability data. These include a nationally consistent approach to data collection, disability flags in data collection for mainstream services, improvements in disability data collection, and long-term support for the NDDA.[2437]

We heard that there is a need for more sharing of positive innovations and best practice within the disability sector and between jurisdictions. We learned about many positive initiatives that emerged during the pandemic to support people with disability, such as sharing best practice in infection prevention and control. However, often these initiatives were localised, such as within a local health district, in the absence of centralised ways to share innovation and emerging knowledge. When the evidence base is evolving, stakeholders need a mechanism to rapidly hear what other people have done and what is working. We consider that a centralised online platform for rapidly sharing information would be a valuable resource in a future emergency.[2438]

Action on key recommendations of the Disability Royal Commission is necessary to ensure the protection and safety of people with disability during a future pandemic

We note that the Australian Government has accepted, or accepted in principle, 130 of the 172 recommendations of the Disability Royal Commission's final report for which it has primary or shared responsibility.[2439] In addition to the recommendations already mentioned in this chapter, we consider the following to be essential to Australia's preparedness for a future pandemic:

- Review and reform laws to give effect to supported decision-making principles, including in disability services,[2440] and co-design practical guidance on supported decision-making for service providers.[2441]
- Introduce disability health navigators to support navigation of health care for people with disability.[2442]
- Engage with state and territory governments about funding and arrangements for a provider of last resort scheme.[2443]
- Integrate community visitor schemes with the NDIS.[2444]

7. Learnings

- Pandemic plans should take into account potential risks to people with disability due to the disproportionate health, social and economic impacts they are likely to face. Embedding provision for people with disability within Australia's policy and operational frameworks for emergency planning would improve preparedness for future emergencies.
- Clear roles and responsibilities across and between governments for the health and safety of people with disability are essential in a public health emergency. Clarity in responsibilities needs to be backed up by capability and knowledge about disability across all relevant departments and agencies.
- People with disability and the disability sector are best placed to advise governments and authorities on their circumstances and needs. In the spirit of 'nothing about us without us', people with disability and the disability sector should be included in established consultative and broader feedback mechanisms that influence decision-making during times of crisis.
- Disability Representative Organisations, researchers and advocacy groups play an important role during emergencies in devising solutions and filling gaps. Governments should leverage relationships and resource experts and trusted voices during emergencies.
- Communications for people with disability must be easily accessed, understood and tailored to the diverse experiences and needs of people with disability. Community and sector-led organisations should be engaged in the process of tailoring communications, or resourced to tailor communications to ensure they are relevant.

- Robust data on people with disability is critical to an effective pandemic response. Data systems that identify people with disability by nature of disability and by level of supports relied upon would enable public health responses to be tailored. Improved data in both primary care and acute care settings would allow public health responses to be much more proactive by reaching out to individuals and offering solutions and access to vaccines and treatments that are tailored to their needs.
- People with disability may be at higher risk of experiencing violence, abuse, neglect and exploitation during emergencies. Pandemic response measures and public health orders can increase those risks. Measures should be designed with these risks in mind and protections put in place to minimise them.
- Disability support workers and carers are essential workers and many people with disability rely on them to survive. Support workers and carers need to be recognised as essential, given tailored infection prevention and control training and provided with priority access to PPE and vaccination.

8. Actions

8.1. Immediate actions – Do in the next 12–18 months

Action 5: Develop updated health emergency planning and response arrangements in conjunction with states and territories, and key partners, including consideration of escalation and de-escalation points, real-time review and a focus on post-emergency recovery.

As part of this, develop management plans for priority populations under the National Communicable Disease Plan, including for people with disability.

- The Management Plan for people with disability should include co-designing strategies for in-reach vaccination services in residential settings, ensuring continued access to supported decision-making and oversight of closed settings, ensuring support workers and carers can access health settings, and expanding virtual and telehealth services. This plan should consider the interface between the disability and health systems and link to other related agreements and strategies, including the National Health Reform Agreement.

Action 6: Develop legislative and policy frameworks to support responses in a public health emergency, including for essential services and essential workers.

Essential services and essential workers frameworks should include:

- arrangements for priority access to vaccination, PPE, and infection, prevention and control training in a national health emergency for disability support workers.

Action 8: Establish mechanisms for National Cabinet to receive additional integrated expert advice for a whole-of-society emergency, including advice on social, human rights, economic and broader health impacts (including mental health considerations), as well as specific impacts on priority populations.

- In parallel with making decisions based on key public health advice, National Cabinet should consider the differential impacts of a pandemic across the population and economy. This must include considering and uences, and seek to minimise negative impacts on broader health, mental health, educational, equity, economic and social outcomes.
- Human rights considerations should be embedded into National Cabinet's decision-making processes, particularly where measures are intended to significantly restrict rights and freedoms.
- This might include mechanisms for a national health emergency that allow expert advice to be sought from the Australian Human Rights Commissioner and other commissioners (e.g. National Children's Commissioner) to support better understanding of the broader impacts of their decisions on human rights and priority populations.

Action 9: Agree and document the responsibilities of the Commonwealth Government, state and territory government and key partners in a national health emergency. This should include escalation (and de-escalation) triggers for National Cabinet's activation and operating principles to enhance national coordination and maintain public confidence and trust.

This should include:

- greater clarification of roles and responsibilities, including around key areas of shared or intersecting responsibility such as the health and social care of people with disability in a national health emergency.

Action 11: Improve data collection, sharing, linkage, and analytic capability to enable an effective, targeted and proportionate response in a national health emergency.

This should include:

- improvements to data collection and pre-established data linkage platforms, including ongoing investment in and stewardship of the National Disability Data Asset, including enhanced data transparency such as facilitating access and analysis by researchers and relevant non-government organisations
- finalising work underway to establish clear guardrails for managing data security and privacy and enabling routine access to linked and granular health data, and establishing pre-agreements and processes for the sharing of health, economic, social and other critical data for a public health emergency. Key health data on people with disability should be prioritised.

Action 14: Embed flexibility in Australian Government grant and procurement arrangements to support the rapid delivery of funding and services in a national health emergency, for instance to meet urgent community needs and support populations most at risk.

This should include:

- funding mechanisms that allow organisations to rapidly develop and deliver solutions tailored to their communities
- funding to Disability Representative Organisations during a national health emergency.

Action 15: Ensure there are appropriate coordination and communication pathways in place with industry, unions, primary care stakeholders, local government, the community sector, priority populations and community representatives on issues related to public health emergencies. Structures should be maintained outside of an emergency, and be used to provide effective feedback loops on the shaping and delivery of response measures in a national health emergency.

- Build and maintain engagement mechanisms outside of an emergency with the community sector and industry (including businesses and entities across the supply chain).
- Maintain and build on effective structures that were established before or during the COVID-19 pandemic, including those with priority populations such as people with disability.
- Consult these groups on the development and updating of pandemic plans, and ensure they participate in stress-testing exercises.
- Ensure there are clear mechanisms to feed into decision-making processes in an emergency, and genuinely engage relevant bodies in pandemic preparedness activities and responses to future emergencies.
- Utilise these structures in national health emergencies to provide effective feedback loops on the delivery of response measures.

As part of this:

- make the Advisory Committee for the COVID 19 Response for People with Disability, or a similar advisory body, a permanent subcommittee of the Australian Health Protection Committee. The advisory body should also have clear mechanisms to feed into the Disability and Health Sector Consultation Committee
- ensure the permanent advisory structure for people with disability has a role consistent with the National Aboriginal and Torres Strait Islander Health Protection subcommittee and the Aged Care Advisory Group, including reporting to the Australian Health Protection Committee.

Action 18: Proactively address populations most at risk and consider existing inequities in access to services (health and non-health) and other social determinants of health in pandemic management plans and responses, identifying where additional support or alternative approaches are required to support an emergency response with consideration for health, social and economic factors.

- All plans and response measures should have an equity lens applied, including for health, social, human rights and economic factors (see Action 1).

Action 19: Develop a communication strategy for use in national health emergencies that ensures Australians, including those in priority populations, families and industries, have the information they need to manage their social, work and family lives.

The strategy should account for the distinct communications preferences and requirements of priority populations – including:

- reflecting the key role of community and representative organisations in communicating with priority populations, including Disability Representative Organisations
- funding community and representative organisations to tailor and disseminate communications through appropriate channels and trusted voices
- providing plain English messaging to community organisations for tailoring in a timely manner.

8.2.Medium-term actions – Do prior to the next national health emergency

Action 23: Progress development of the Australian Centre for Disease Control in line with its initial progress review and to include additional functions to map and enhance national pandemic detection and response capability.

This should include establishing a library of living guidelines for high-risk clinical, residential and occupational settings and health professions that can be readily adapted for a new health emergency. This should include nationally agreed testing and tracing principles. These guidelines should be developed in partnership with:

- the Department of Health and Aged Care, states and territories and relevant professional bodies
- the NDIS Quality and Safeguards Commission in relation to disability settings.

Chapter 17 – Homelessness and housing insecurity

1. Context

Access to secure, safe and affordable housing is a significant determinant of the success of public health interventions. People experiencing homelessness or living in overcrowded housing were at higher risk of transmitting COVID-19.[2445]

The Inquiry heard that the housing and homelessness sector was quick to respond to COVID-19 and acted remarkably quickly to protect those experiencing housing insecurity and homelessness. However, once the worst of COVID-19 was over, supports were quickly withdrawn. In many instances this left people in the same position they were in before the pandemic, and in some cases worse off.

The pandemic had major implications for housing demand in Australia. The rental market shifted with temporary residents leaving Australia and internal migration out of capital cities.[2446] There was also a change in composition of demand, with more people working from home.[2447] All levels of government quickly enacted emergency measures to protect homeowners experiencing mortgage stress, renters, and people experiencing homelessness.[2448]

The pandemic had a substantial impact on housing policy and on the housing system, with implications still being felt today.

A note on terminology

Homelessness is an umbrella term used to describe four broad situations:

- rough sleeping
- supported accommodation (e.g. refuges or crisis accommodation)
- short-term accommodation without tenure (e.g. boarding houses or couch surfing)
- accommodation in institutional settings (e.g. hospitals, drug and alcohol rehabilitation centres, or jail).[2449]

Low-income renters and homeowners spending over 30 per cent of their income on housing costs are considered to be experiencing housing stress.[2450]

2. Response

Policy responsibilities for housing and homelessness are divided between levels of government. States and territories are primarily responsible for housing, tenancy and homelessness policies.[2451] The Australian Government makes payments to states and territories to support people experiencing homelessness, to increase housing supply and to provide supports for people to enter the housing market.[2452]

2.1. Initiatives to address homelessness and rough sleeping

The realisation that rough sleeping had the potential to lead to rapid transmission triggered significant state and territory investment in homelessness services early in the pandemic.

This mainly took the form of providing emergency accommodation, outreach activities and transition programs from emergency to more stable housing.[2453] For example, between April and September 2020, over 40,000 people were assisted into safe temporary accommodation in New South Wales, Victoria, Queensland, and South Australia.[2454]

The design and implementation of these initiatives often involved close partnerships between state and territory governments and homelessness service providers. Partnerships extended to the delivery of tailored health care and vaccine rollout programs for rough sleepers, people experiencing homelessness or those in insecure accommodation and social housing. In the City of Sydney alone there were five interventions:

- May 2020: Inner Sydney COVID-19 Rough Sleeper Taskforce
- April 2020 to March 2022: mobile primary care clinic pop-up testing
- April 2020 to 2021: boarding house outbreak management response
- May 2021 to September 2022: outreach vaccination clinic
- August to November 2021: PCR testing 'Swab Squad'.[2455]

2.2. Initiatives to ensure security of housing tenure

Governments also took steps to ensure people were able to maintain their housing tenure during the pandemic. The Australian Government played a leadership role, through National Cabinet, to ensure a consistent national response on housing issues. On 29 March 2020 National Cabinet agreed to national consistency on eviction moratoriums for a period of six months.[2456] This applied to commercial and residential tenants who were 'in financial distress [and] unable to meet their commitments due to the impact of coronavirus'.[2457] Most jurisdictions extended the moratoriums beyond the original six months, and most had some form of transitional provisions.[2458] They also implemented moratoriums on rent increases or provided some form of rent relief (see Figure 1).

Figure 1: First wave of measures[2459]

State	Eviction moratorium	Rent relief	Land tax relief
ACT	22/4/20–28/03/21[2460]		Up to $100 per week[2461]
SA	30/3/20–31/5/21[2462]	Up to $1,000[2463]	Up to 25% reduction
VIC	29/3/20–28/3/21[2464]	Up to $3,000[2465]	Up to 25% reduction
NSW	29/3/20–26/3/21[2466]		Up to 25% reduction[2467]
QLD	29/3/20–29/9/20[2468]	Up to $2,000[2469]	Up to 25% reduction[2470]
NT	N/A[2471]	Extended notice timeframe for tenancy agreement terminations.[2472]	
TAS	29/3/20–31/1/21[2473]	Up to $2,000[2474]	
WA	30/3/20–28/3/21[2475]	Up to $2,000[2476]	

On 30 March 2020 the Australian Competition and Consumer Commission (ACCC) authorised the Australian Banking Association to introduce mortgage deferral arrangements to support people in mortgage stress as a result of the pandemic.[2477] The ACCC reauthorised the arrangement on 8 October 2021 in response to later pandemic waves and lockdowns.[2478]

Initiatives put in place by the Australian Government for the broader economic response, such as income support measures, were also vital in helping people cover their housing costs during the pandemic (see Chapter 21: Supporting households and businesses). These measures operated alongside existing supports such as Commonwealth Rent Assistance.[2479]

States and territories implemented a range of supports for:

- social housing (e.g. funding to increase supply and refurbishment of existing social housing)
- private rental (e.g. implementation of eviction moratoriums and introduction of rent relief measures including prohibitions on rent increases, cash payments, and land tax rebates)
- homeowners (e.g. home building and home buying grants, stamp duty concessions, home maintenance programs, and reduced loan application times).[2480]

3. Impact

We heard that the initial rapid response was effective in providing temporary accommodation but depending on location other supports varied. A key criticism of the government response was that both income support and homelessness services were withdrawn too quickly and without proper consideration for the impact on people experiencing housing insecurity and homelessness.

Overall the COVID-19 pandemic exposed the range of underlying inequities in Australia's housing system. This was particularly evident for people with disability, Aboriginal and Torres Strait Islander people, some culturally and linguistically diverse communities, people fleeing domestic violence, and people who did not have access to income support. For example, Aboriginal and Torres Strait Islander people are over-represented in the number of people counted as homeless in Australia, making up 3 per cent of the total population but 20 per cent of all people who are experiencing homelessness (see Chapter 13: Aboriginal and Torres Strait Islander people).

3.1. Planning, consultation and coordination

The Inquiry heard that homelessness services had plans that existed before the pandemic but that these were focused on contingencies for short-term weather events, and not for health emergencies.[2481]

Collaboration and consultation between the housing and homelessness sectors and government was slow at the start of the pandemic, particularly in relation to policy.[2482] There was also limited understanding of the issues at the national level and in public health orders.

The lack of consultation impacted the effectiveness of policies and the allocation of resources. For example, we heard that the main responses from government were for people sleeping rough but the risks were more significant for people living in overcrowded settings.[2483] Had this been addressed early, the public health response to COVID-19 would have been more effective, and the quality of life of the people concerned would have improved.[2484]

We heard examples of the leadership role that the homelessness sector had in the pandemic response – from advocating to have the risks of people experiencing homelessness recognised, to securing access to personal protective equipment and rapid antigen tests, to developing guidelines for its workers' health and safety.[2485] The Inquiry's consultations reported that this led to critical delays in response and that many in the sector felt they were an afterthought.[2486]

Engagement improved significantly during the pandemic and resulted in innovative and successful initiatives. Stakeholders told the Inquiry that because no one had any answers there was a real sense that everyone needed to work together to solve issues no one had ever contemplated.[2487] However, we also heard that once the pandemic ended this collaborative approach reverted to business-as-usual engagement between the sector and government.[2488]

Despite housing and homelessness services being essential, the sector was under-resourced during the pandemic and had no surge workforce or workforce plan in place.[2489] We heard that many workers have since left the sector due to burnout and because they were disillusioned that the immense strides taken during the pandemic did not continue.[2490]

Availability and access to accurate data were essential to inform the pandemic response.[2491] However, there are not enough data or information concerning the housing status of people who have died or been hospitalised due to COVID-19. The Inquiry heard that there is a lack of data that actively tracks who is coming in and out of homelessness.[2492] For example, there are no data on the age of homelessness service users or on their first language, which means responses cannot be tailored as effectively as they could be. Even where data were available, such as from service providers, there was no means of bringing it together and using it effectively to develop and target responses during the pandemic.[2493]

> *The deaths of Australia's rough sleepers are largely invisible. We don't know how many are dying on a national scale, how they are dying or how many deaths can be attributed to systemic failings in housing, health and the justice sector. There is simply no national data or government reporting. – Knaus and Evershed*[2494]

3.2.Financial supports

As discussed in Chapter 21: Supporting households and businesses, the Australian Government provided financial support to those who were unable to work or study during periods of the COVID-19 pandemic. Many Australians who were experiencing chronic housing insecurity prior to the pandemic were eligible for these increased support payments.

> *Income support did more [than other measures in the housing sector] to absorb the income shock of the pandemic, to a significant extent letting housing policy and, especially, landlords, off the hook. – Australian Council of Social Service*[2495]

The doubling of income support payments improved rental affordability.[2496] Research shows that 'the number of households living in housing affordability stress would have increased by 74 per cent without the income support measures, and the number living with severe housing affordability stress would have increased by 167 per cent'.[2497] The increases in income support eased the bottleneck of clients in temporary accommodation and it was easier to place people in tenancies during the pandemic.[2498] However we also heard that this has reversed since income support measures ended and rents have increased post-pandemic.[2499]

3.3.Homelessness services

We heard the pandemic response largely prevented an outbreak of COVID-19 in the homeless community, which highlighted how government can move quickly in a crisis and come up with solutions.[2500]

> *Australia provided a world leading response to supporting people experiencing homelessness during the height of the COVID 19 pandemic, particularly in New South Wales and Victoria. This was developed in consultation with health and homelessness experts and adapted good practice identified in other countries … It was critical that steps were taken to support people experiencing homelessness to help keep them safe and well during this period … the impact of COVID for people experiencing homelessness was no greater than the general population and in some areas, such as vaccination, exceeded the general population targets. – Homelessness Australia*[2501]

There was an expectation among stakeholders that National Cabinet would ensure national consistency in the approach to homelessness. However, while the jurisdictions shared a common sense of direction – to protect people experiencing homelessness and minimise movement – in practice they introduced different measures.[2502]

We heard that accessibility of essential services and supplies was limited for people experiencing homelessness. People experiencing homelessness during the pandemic reported difficulties accessing preventive health supplies (e.g. masks), tailored information and resources, and mental and physical health care.[2503] Access to charities and food banks was strained due to social distancing requirements and a reduced volunteer workforce.[2504]

> *They should extend the mental health measures even after COVID because it's now that you're feeling the effects of COVID. – Focus group participant experiencing homelessness, Sydney*[2505]

Specialist homelessness services received government funding to help with adherence to social distancing requirements and to house rough sleepers in emergency hotel accommodation. From March 2020 to September 2020 over 40,000 people were assisted into safe temporary

accommodation in New South Wales, Victoria, Queensland and South Australia.[2506] As a result of government and community sector initiatives, rough sleeping was eliminated in some cases.[2507]

The Inquiry heard that emergency hotel accommodation was particularly beneficial when the hotel used was small (30 to 40 rooms maximum) and when there was consideration of the unique challenges faced by rough sleepers. For example, some may be experiencing mental health issues or detoxing from drug and alcohol abuse.[2508] These programs were also more successful when they provided complete wraparound supports and resulted in people connecting with health support services.

Primary healthcare model for people experiencing homelessness in Victoria

The Victorian Government and homelessness sector collaborated to develop intensive respite facilities to house people experiencing homelessness who tested positive to COVID-19 or to avoid infection. The accommodation was at four sites in inner Melbourne and was operated by Anglicare Victoria, Brotherhood of St Laurence, Launch Housing, Sacred Heart Mission and VincentCare Victoria. Homelessness services provided health care and supported accommodation for more than 200 rough sleepers over a six-month period through this initiative.[2509]

The hotel accommodation programs had some unintended consequences. For example, hotel providers had challenges with upkeep of hotel rooms.[2510] There were also concerns about those in the hotel program 'jumping the queue' of the social housing waitlist, which is needs based rather than first in, first served.[2511]

> *Whilst the focus on emergency housing through temporary accommodation was welcomed, this occurred with patchy support, potentially re-traumatising those accessing emergency temporary accommodation. People experiencing homelessness, including rough sleepers, were moved into hotels and some were initially only guaranteed 3–5 days accommodation during the COVID-19 pandemic. Some people were left in temporary accommodation for weeks with no food or contact. – Homelessness NSW*[2512]

There were reflections made to the Inquiry that providing emergency accommodation in larger hotels was not as successful. In some instances it led to complex health and safety issues around drug use, violence between residents, boredom, and interaction in the buildings. This made some of the hotels challenging environments.[2513] In some cases, governments responded by hiring security guards and on-site nursing staff, which residents sometimes resented.[2514]

> *We were treated like animals [in temporary housing]. Police would visit 3 times a day to check on us and lock us up if we weren't there. I got back into smoking after being clean for a year, mainly because I was staying with excons who weren't doing well and were violent. – Focus group participant experiencing homelessness, Sydney*[2515]

Communication of public health orders and guidance on how to comply did not take into consideration the unique factors of emergency accommodation. For example, there was no guidance on cleaning or staff interaction in group living environments such as boarding houses and hotels.[2516]

When the vaccine rollout began, people who were homeless or in social housing were considered priority populations.[2517] However, no specific plan was put in place for these groups.[2518] Because people experiencing or at risk of homelessness are less likely to access primary healthcare services, a tailored approach to the vaccine rollout was considered suitable.[2519] Community hubs such as mobile clinics for people experiencing homelessness were often joint responsibilities of the Australian and state and territory governments.[2520]

Vaccination rollout for people sleeping rough in the City of Sydney

The Inner City COVID-19 Vaccine Hub was established by St Vincent's Hospital Sydney, South Eastern Sydney Local Health District and the Kirketon Road Centre in May 2021. Health and non-health partners in inner-city Sydney were engaged to establish a collaborative approach. The goal was to improve access to vaccination for people sleeping rough, people in specialist homelessness services and people at risk of homelessness, such as those living in social housing or temporary accommodation.

This model involved going out to people on the streets with vaccinations and setting up a declinicalised vaccination centre with wraparound services. For instance, a barbeque was set up at the back of the clinic, and the service provided food, nurses, vaccine consent forms and information about consent.

It also established a process for sharing resources, such as accredited nurse immunisers, and a common approach to messaging. Having existing infrastructure in place, in the form of St Vincent's Hospital homeless health team, meant there was already great trust in the services being delivered.

Approaching the vaccine rollout as a community and recognising the unique needs of those experiencing homelessness in the City of Sydney resulted in higher vaccination rates than anticipated.[2521]

3.4. Housing security supports

The COVID-19 pandemic affected rental market demand and supply and disproportionately affected the 31 per cent of Australians who rented their home in 2019–20.[2522] Renters are more likely to be employed in the sectors which were most affected by the economic shutdowns and have lower average wealth.[2523]

> *Many people, especially those in already insecure and low-paying jobs, lost employment and were unable to pay rent or bills and therefore were unexpectedly made homeless. – Australian Nursing and Midwifery Federation (Federal Office)*[2524]

The pandemic had major implications for housing demand. Temporary residents leaving Australia reduced demand, particularly in capital city apartment markets, and this led to lower rents during the initial phases of the pandemic.[2525] Meanwhile there was internal migration out of capital cities into the regions due to the ability to work from home, the perception that transmission risk for COVID-19 was lower in less populated areas, and often less restrictive public health orders.[2526] This led to high rental price growth in regional areas across Australia.[2527] There was also a change in demand for particular types of housing. With more people working from home, the preference for additional bedrooms increased across the housing market and the number of people per dwelling reduced.[2528] This continues to contribute to housing shortages almost five years after the pandemic began, which are undermining housing security and affordability.

In cities, rental prices fell at first, particularly for apartments. But between mid–2020 and Q3 2021, city rents increased by over 8 per cent – far ahead of wage growth (at 1.7 per cent).[2529] In regional Australia, rental prices escalated to 12.4 per cent in same period.[2530] Regional rent inflation was driven partly by increased migration but mostly by lower turnover of existing rental stock and less responsive new housing stock.[2531]

The national approach to safeguards for renters was helpful in providing security but was complex in terms of delivery. This was due to differences between jurisdictions and homeowner expectations.

> *It is likely that many of the negative impacts of the pandemic on the rental market will persist for a considerable time, and may emerge to be near-permanent features of the tenure. – Australian Housing and Urban Research Institute*[2532]

State and territory measures to provide eviction moratoriums were broadly considered positive.[2533] Within a month of the March 2020 moratorium announcement by National Cabinet, all states and territories had enacted legislative frameworks for temporarily preventing evictions and regulating rents.[2534] Eviction moratoriums were different between jurisdictions in scope, length and detail. Research shows a spike in families seeking out cheaper housing in 2018 and a dip in 2021 reflecting eviction moratoriums.[2535] The trend to seeking cheaper housing has now returned to pre-pandemic rates.[2536]

> *During the pandemic various state and territory governments put in place moratoriums on evictions. However, the time taken to implement these policies, the duration for which they were in place and the provision of follow up support varied considerably across the country. – St Vincent de Paul Society*[2537]

The eviction moratoriums, rent variations and relief schemes implemented in 2021 were not as robust as those introduced in 2020. Only New South Wales and the Australian Capital Territory reintroduced restrictions on evictions. Rental relief schemes in 2021 were undersubscribed, perhaps due to the protective impact of the increases in federal income support, which reduced housing insecurity.[2538]

The measures had unintended consequences for state and territory tenancy tribunals. Renters and landlords struggled to get 'a tribunal hearing to sort out disputes, including over bonds, due to disruption from the COVID-19 pandemic'.[2539] Tribunals had insufficient additional resources to manage the increase in demand arising from eviction moratoriums. For example, the backlog in Victoria had 'blown out to more than 130 per cent compared to the number of pending cases pre-pandemic'.[2540]

More than 1.4 million Australian households were in mortgage stress (i.e. spending more than 30 per cent of pre-tax income on paying off a mortgage) in June 2020.[2541] Almost 100,000 were at risk of defaulting on their home loans as a result.[2542] The Inquiry heard from people who struggled to make mortgage payments during the pandemic.[2543] An ACCC decision on 30 May 2020 led to almost 500,000 home loans being deferred (approximately 7 per cent of all housing loans).[2544] By February 2021, 87 per cent of deferred housing loans had resumed repayments.[2545]

> *Mortgage payment deferrals … along with income support, eviction moratoriums and emergency accommodation for those experiencing homelessness contributed to avoiding a housing market collapse. – Australian Council of Social Service*[2546]

3.5.End of supports

There were successful measures introduced during the pandemic but we heard that many ended too abruptly. Some stakeholders called it a 'perfect storm', as the end of eviction moratoriums coincided with the end of social support payments. The economy had not yet recovered, rents rose, and many people did not have a job to go back to.[2547] The abrupt cessation of payments following the pandemic led to increased financial instability and difficulty readjusting to life on a lower income.[2548]

> *Everyone got JobSeeker payments … you were getting double the money you usually made and when it stopped … it stopped so suddenly … It caused a lot of mental health struggles. – Focus group participant experiencing homelessness, Sydney*[2549]

The transition out of emergency settings, including emergency hotel accommodation, happened very quickly as lockdowns ended, often with poor results for individuals.[2550] We heard there was a mixed level of planning for transitioning people into secure accommodation.[2551] In many cases people returned to homelessness. We heard that the homelessness workforce found the experience of having to rapidly end support for clients deeply distressing.[2552] In central Sydney, for example, rough sleeper numbers fell from 334 just ahead of the pandemic to an estimated 87 in May 2020, only to rise again to 270 in February 2021.[2553]

> *The number of people experiencing homelessness rose again after emergency accommodation ended, exposing the challenges in maintaining support for rehoused people previously experiencing homelessness when government-funded*

assistance expires … The early hopes for significant policy resets to address housing inequalities resulting from the pandemic have largely gone unfulfilled. Housing affordability pressures are now even more acute, indicating a need for sustained and comprehensive policy responses to address longstanding housing issues. – Australian Council of Social Service[2554]

4. Evaluation

Secure housing is a critical determinant of outcomes in a public health emergency

People experiencing homelessness or living in insecure housing are likely to be at greater risk in any public health emergency. Access to secure, safe and affordable housing is a significant determinant of the success of public health interventions. This was demonstrated during the COVID-19 pandemic. People experiencing homelessness, either rough sleeping or in temporary accommodation, had a higher risk of exposure. They also had a higher risk of poorer health outcomes from COVID-19, due to a high prevalence of comorbidities and inequities in access to preventive health care and treatment.[2555]

The pandemic also caused significant financial and mental health challenges for people experiencing housing insecurity. This included those who were already in mortgage stress and those who experienced it for the first time as a direct result of the pandemic. The pandemic illustrated the critical need for emergency interventions to address these challenges during a crisis.

However, it is always going to be difficult to provide emergency housing when there is a shortage of subsidised social and affordable housing. Housing rough sleepers in hotels was a highly successful initiative, made possible because the public health measures meant many hotels were underused. This would not necessarily be the case in a future health emergency. We note that improving housing security more broadly will be essential for improving Australia's preparedness for future crises.[2556]

Interventions during the COVID-19 pandemic were largely successful

The combination of social security payments and regulatory measures from both the Commonwealth (e.g. JobKeeper) and the states and territories (e.g. rent rise relief, eviction moratoriums and homelessness interventions) has been widely recognised for its success in minimising the impact of the pandemic on housing security. The number of households living in housing affordability stress would have increased by 74 per cent without income support measures.[2557]

Of particular note are the successful state, territory and local government interventions which filled gaps in the Australian Government response and were targeted to address local and regional factors. In a future pandemic, it will be essential to establish such emergency response measures early.[2558]

Where responses were tailored to communities they were more effective. The City of Sydney vaccination rollout case study demonstrates that tailored responses achieve better health

outcomes. Similarly, emergency hotel accommodation was most successful when delivered with wraparound support and connection to services. Understanding the unique needs of those experiencing homelessness and tailoring responses accordingly resulted in better outcomes and provides a model for future interventions.

The pandemic highlighted the importance of collaboration between the sector and all levels of government

States and territories worked with the sector to devise innovative and effective responses to homelessness and housing insecurity. Case studies show the importance of existing relationships with the community. The strength of these relationships is an essential resource for government when responding to housing insecurity and homelessness.

The COVID-19 pandemic demonstrated that in a public health emergency, the Australian Government can play a leadership role on housing and homelessness issues to provide a consistent national response. It can also lead conversations about regulatory changes and income support payments in an emergency. While states and territories ended up addressing the issues quite differently, the role of National Cabinet was important. It was a forum for all jurisdictions to meet and agree on the principles motivating policies addressing housing insecurity and homelessness.

Supports provided during a pandemic need to be phased out in a planned manner

While the pandemic response for people experiencing homelessness and housing insecurity was broadly successful, some financial supports were phased out before lockdowns ended and before vaccinations became widely available.

Similar concerns were raised regarding the cessation of other supports, including temporary accommodation. For example, we heard that the experience of having to tell clients that supports were ending had resulted in workers leaving the sector. Better planning and transitional support would prevent such consequences.

The lack of data on housing insecurity and homelessness makes it more difficult to provide services

The lack of data limits the overall picture of homelessness and the impact of COVID-19 on people experiencing homelessness. This makes it difficult to determine how services should be structured, including in any future health emergency. For example, poor evidence on the makeup of households experiencing overcrowding and the impact of overcrowding on the spread of disease contributed to governments focusing more on providing accommodation for people sleeping rough than on measures to address overcrowding.

We heard that individual service organisations hold data that are not necessarily available nationally or well linked with other services used by the same people, including medical services. We need a formal mechanism to bring all sources of data together to inform policy and emergency responses.

It is important to implement improved data collection processes, policies and methodologies in order to ensure that robust data are available to help inform targeted response measures in a future public health emergency.

As such, the panel supports Recommendation 8 from the House of Representatives Standing Committee on Social Policy and Legal Affairs 2021 Inquiry into Homelessness in Australia: 'the Australian Government and state and territory governments, in consultation with homelessness and community services, improve data collection and reporting on the COVID-19 vaccination of Australians experiencing homelessness, particularly rough sleepers'.[2559]

There have been changes post COVID in housing security and homelessness.

The housing and homelessness landscape has evolved significantly since the pandemic. The Australian Government has undertaken several new initiatives in this area. It has taken a national coordination role, including reinstating the Housing and Homelessness Ministerial Council, which is working on an outcomes-based funding agreement and an agreed definition of affordable housing and renters rights.[2560]

Another post-COVID initiative is the National Agreement on Social Housing and Homelessness, which has been in place since 1 July 2024. This is an agreement between the Australian and state and territory governments to work together to support the effective operation of Australia's social housing and homelessness services sectors.[2561] The Australian Government is developing a National Housing and Homelessness Plan, which will be a 10-year strategy to inform future housing and homelessness policy.[2562]

However, rates of housing insecurity and demand for homelessness services are increasing due to a critical shortage in affordable housing stock and the cost-of-living crisis. The more Australians living in overcrowded or insecure housing at the time of the next pandemic, the more difficult the public health response will be.

5. Learnings

- The most effective protection for people experiencing homelessness or insecure housing will be addressing the underlying issues which lead to housing precarity before a future emergency. This will ensure, as much as possible, that people can face such challenges from a more equal foundation. Security of housing is essential at all times, particularly in a public health emergency.
- People experiencing homelessness (including overcrowding) and those who are at risk of housing insecurity should be recognised as an at-risk population in pandemic planning and related economic supports due to underlying health determinants and cultural factors which can lead to disproportionate health, social, and economic impacts in public health emergencies. Proactive and bespoke interventions are required to meet key health objectives.
- Embedding input from, and collaborating with, housing and homelessness experts within Australia's policy and operational frameworks, emergency planning and

coordination across all levels of government is key to improving preparedness for future emergencies.

- Responses must be tailored to individual communities' circumstances and needs.
- Robust financial support is crucial in limiting the impact of health emergencies on people experiencing housing insecurity and homelessness. Moratoriums on evictions and provision of rental relief are also essential.
- Early local planning is key to the effectiveness of the on-the-ground response.
- At such time that emergency measures end, they should be carefully timed and phased out to minimise unintended consequences.
- Robust and accessible data on people experiencing homelessness and insecure housing is critical to an effective pandemic response.

6. Actions

6.1. Immediate actions – Do in the next 12–18 months

Action 5: Develop updated health emergency planning and response arrangements in conjunction with states and territories, and key partners, including consideration of escalation and de-escalation points, real-time review and a focus on post-emergency recovery.

As part of this, develop:

- Modular operational plans for specific sectors, including high-risk settings, which can be deployed in response to a variety of hazards.

The Housing plan should:

- be aligned with the National Agreement on Social Housing and Homelessness
- include development of potential emergency measures in advance of a future pandemic to ensure access to secure and affordable housing is maintained.

Action 11: Improve data collection, sharing, linkage, and analytic capability to enable an effective, targeted and proportionate response in a national health emergency, including:

This should include:

- improvements to data collection and pre-established data linkage platforms, including enhanced data collection on different types of homelessness and on ages, cultural backgrounds, hospitalisation and mortality rates of people experiencing homelessness.

Action 18: Proactively address populations most at risk and consider existing inequities in access to services (health and non-health) and other social determinants of health in pandemic management plans and responses, identifying where additional support or alternative approaches are required to support an emergency response with consideration for health, social and economic factors.

- All plans and response measures should have an equity lens applied, including for health, social, human rights and economic factors (see Action 1).

Action 19: Develop a communication strategy for use in national health emergencies that ensures Australians, including those in priority populations, families and industries, have the information they need to manage their social, work and family lives.

The strategy should account for the distinct communications preferences and requirements of priority populations – including:

- reflecting the key role of community and representative organisations in communicating with priority populations, including community service providers
- funding community and representative organisations to tailor and disseminate communications through appropriate channels and trusted voices
- providing plain English messaging to community organisations for tailoring in a timely manner.

Chapter 18 – Older Australians

1. Context

Older Australians are a diverse group of around 4.2 million people aged 65 and over (as at 30 June 2020).[2563] In any public health emergency, older Australians are more likely to be at risk because of weakened immune systems, higher likelihood of comorbidities, overall frailty and increased dependence on assistance in normal daily functions. Also, for a range of reasons, it can be difficult to prevent infection transmission for older Australians who are living in communal living arrangements, such as residential aged care facilities.[2564]

It was apparent from the outset of the COVID-19 pandemic that risk of severe disease and death from the virus increased with age and comorbidity. In 2020 the majority of the 900 or so people who died from COVID-19-associated illness in Australia were older people – 24 per cent of those who died were in the 85 to 89 year age group and 34 per cent were aged 90 and older.[2565] The pandemic had a disproportionate effect on residential aged care facilities – during 2020, 75 per cent of all reported COVID-19 deaths occurred in residential aged care.[2566] While these figures represented a tragic loss of life, older Australian aged care residents were protected by lower levels of community transmission and fared better than their overseas counterparts. Up to early 2022, 1 per cent of the total number of Australian aged care residents died of COVID-19 associated illness, compared to Sweden (8 per cent), Scotland (13 per cent), and the United States (13 per cent).[2567]

About one-third of older Australians receive Australian Government funded aged care, such as assistance with daily living supports through the Commonwealth Home Support Program (57 per cent of aged care service recipients) and home care (23 per cent) through to high care support in residential aged care facilities (20 per cent).[2568]

The majority of aged care services are funded and regulated by the Australian Government and delivered by not-for-profit, government, and for-profit organisations.[2569] The Department of Health and Aged Care manages policy and payment administration. Independent agencies are responsible for pricing, data, regulation and provider approvals. The Aged Care Quality and Safety Commission oversees conduct within the industry. State and territory governments regulate retirement villages and independent living units and run a small number of aged care homes (8.2 per cent of all residential aged care facilities in 2023) – most of these are in rural and regional Victoria.[2570]

Australia's aged care system was not prepared for the COVID-19 pandemic. In 2020 the aged care workforce was understaffed, and residential aged care facilities' preparedness plans and infection prevention and control resources were inadequate. At the time the pandemic began, the Royal Commission into Aged Care Quality and Safety (Aged Care Royal Commission) was already examining the aged care system.

2. Planning, coordination and engagement

2.1. Response

2.1.1. Planning and governance

No specific pandemic response plans were developed for older Australians who were outside of the aged care system. However, the Australian Government developed a number of aged care sector plans, including:

- the Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19) (18 February 2020), which set out responsibilities for the Australian Government in aged care. The plan was activated on 27 February 2020 and supported by a range of guidelines and material provided to aged care providers[2571]
- the National COVID-19 Aged Care Plan (August 2020) endorsed by National Cabinet.[2572] The sector-specific plan for aged care was publicly released on 30 November 2020[2573]
- the National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia (13 March 2020), released by the Communicable Diseases Network Australia.[2574] Residential aged care facilities developed their own outbreak management plans, mostly based on these guidelines
- *First 24 hours: managing COVID-19 in a residential aged care facility* (29 June 2020), released by the Department of Health. These guidelines were intended to assist in management of outbreaks at a facility level[2575]
- the National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (Including COVID-19 and Influenza) in Residential Care Facilities (30 September 2022). These guidelines replaced the Communicable Diseases Network Australia guidelines of 13 March 2020.[2576]

The Department of Health website presented a range of other guidance and planning materials for the COVID-19 pandemic – for example, Winter P*lan: A guide for residential aged care providers* (2022), which gave advice on managing COVID-19 and influenza outbreaks in residential aged care facilities;[2577] *Home Care Packages Program Operational Manual: A Guide for Home Care Providers* (2023);[2578] and an annotated summary of COVID-19 aged care resources.[2579]

2.1.2. Coordination and engagement

The Department of Health and Aged Care and the Aged Care Quality and Safety Commissioner were in regular contact with the aged care sector on the need to plan for COVID-19. On 26 February 2020 the Chief Medical Officer wrote to all aged care providers about preparedness for COVID-19.[2580] On 2 March 2020 the Aged Care Commissioner wrote to all aged care providers regarding planning for and preparing for COVID-19.[2581]

From 1 March 2020 the Australian Government commenced providing daily case management conferences for aged care homes experiencing a COVID-19 outbreak. These meetings brought together representatives from the Department of Health, the Aged Care Quality and Safety Commission, the state/territory government, the local public health unit and the aged care provider.

On 11 March 2020 the Australian Government announced a $2.4 billion package to protect Australians from COVID-19, which included $101.2 million in aged care workforce supports and training in infection prevention and control.[2582] On 13 March 2020 the government agreed the National Partnership on COVID-19 Response. Over the course of the pandemic, the agreement dealt with funding arrangements to respond to COVID-19, including temporary staffing surge and temporary isolation and quarantine for aged care residents.[2583] See Chapter 12: Broader health impacts for more information on the agreement.

The Australian Government established several formal bodies, largely focused on the aged care system, in response to the pandemic and Aged Care Royal Commission recommendations. This included establishing:

- the Aged Care Advisory Group (21 August 2020)[2584] · a subcommittee of the Australian Health Protection Principal Committee that was made permanent in late 2020[2585]
- the National Aged Care Advisory Council (24 November 2021)[2586]
- the Aged Care Council of Elders (24 December 2021)[2587]
- the Office of the Inspector-General of Aged Care (16 October 2023).[2588]

The Australian Government also engaged regularly with the aged care sector. For example, on 6 March 2020 the then Minister for Aged Care and Senior Australians held a forum with more than 70 representatives from the aged care sector, including providers, peak bodies, workforce, consumers, and state and territory governments.[2589] At the peak of the pandemic, the Department of Health held weekly webinars with providers[2590] and circulated a daily newsletter, 'Protecting Older Australians'.[2591]

2.1.3. Emergency response models

When systems became overwhelmed, the Australian Government adopted collaborative emergency response models with states and territories. The first of these, the Victorian Aged Care Response Centre was established with the Victorian Government on 25 July 2020 in response to sharp increases in cases and outbreaks in Victorian residential aged care facilities.[2592]

The Victorian Aged Care Response Centre provided important support – including assistance with the transfer of residents to hospital, provision of additional staffing to residential aged care facilities, senior leadership to support facility management and oversight, waste management, and family engagement and communication.[2593] The Victorian Aged Care Response Centre also visited non-outbreak facilities to observe their preparedness and provide infection prevention and control and personal protective equipment training.[2594]

On 21 August 2020 the Department of Health published the Guide to the Establishment of an Aged Care Health Emergency Response Operations Centre. The guide summarised lessons learned from the Victorian Aged Care Response Centre and COVID-19 outbreaks across the country.[2595]

2.1.4. Reporting and evaluation

Throughout the pandemic there were various reviews, inquiries and investigations of the response. The Aged Care Royal Commission had been established on 8 October 2018. It continued through the pandemic and did not table its final report until 1 March 2021.[2596] Between 10 and 13 August 2020 the Aged Care Royal Commission held special hearings on the impact of COVID-19 on aged care, making a number of interim findings to aid the response.[2597]

Also, early in the pandemic, the Australian Government commissioned reviews of major outbreaks in residential aged care facilities. These were published on the following dates:

- Newmarch House COVID-19 Outbreak Independent Review (24 August 2020)[2598]
- Review of Dorothy Henderson Lodge COVID-19 Outbreak (25 August 2020)[2599]
- Independent review of COVID-19 outbreaks at St Basil's and Epping Gardens aged care facilities (21 December 2020)[2600]
- Independent review of COVID-19 outbreaks in Australian Residential Aged Care Facilities (1 November 2021).[2601]

2.2.Impact

> *The Australian Government failed to develop a COVID-19 plan for the sector, which was unprepared and ill-equipped to protect the safety of residents when the pandemic hit. – First interim report of the Senate Select Committee on COVID-19*[2602]

Aged care providers deal regularly with disease outbreaks, including seasonal influenza. However, they were largely unprepared for a pandemic. The failures in the aged care response were due to a combination of factors, including pre-existing structural weakness across the sector, a lack of planning, and underdeveloped sector representation to government.[2603] The Inquiry heard that the emergency plans that were in place at the start of 2020 were often generic and designed to deal with single-facility outbreaks.[2604] COVID-19 quickly overwhelmed existing systems, regulations and policies.[2605] An Aged Care Quality and Safety Commission report on Victorian aged care providers that experienced outbreaks noted, 'while many providers undertook detailed outbreak management planning prior to any outbreak occurring, none felt they were fully prepared for the magnitude of what they encountered'.[2606]

> *Residential and home care providers didn't seem to have pandemic plans or disaster recovery plans in their risk management frameworks. – Older Persons Advocacy Network*[2607]

Providers' levels of readiness and capacity to deal with outbreaks varied significantly. The issues that already existed were exacerbated by a lack of systems, processes and oversight. The Inquiry has heard that the factors that determined how well aged care facilities managed an outbreak were the strength of their governance structures and their leadership. At times, there was inadequate or no leadership in managing outbreaks at facilities, and government intervention was required.[2608]

For emergency plans to be effective, they needed to be detailed and take into account the building design, individual residents and their case needs, impact of the layout on capacity to deliver services, and local service providers and contractors.[2609] In July 2024, the government published National Aged Care Design Principles and Guidelines promoting safe and comfortable environments for older people and staff.[2610]

In August 2024 the government published dedicated infection prevention and control guidelines for aged care settings to supplement the Australian Guidelines for Prevention and Control of Infection in Healthcare. The new guidelines used resources developed by the Australian Commission on Safety and Quality in Health Care, the Aged Care Quality and Safety Commission, the Department of Health and Aged Care and the World Health Organization.[2611]

The aged care sector response was guided by the overarching health sector COVID-19 plan and supporting aged care guidance materials, until a sector-specific aged care plan was publicly released in late 2020. While welcomed, we heard there needed to be better planning and specific strategies for the aged care sector in response to the pandemic.[2612] The National COVID-19 Aged Care Plan built on advice on the management of COVID-19 in residential aged care by the Australian Health Protection Principal Committee on 17 March 2020,[2613] as well as advice from its Infection Control Expert Group sub-committee provided on 2 April[2614] and 30 July 2020.[2615] The establishment of the Aged Care Advisory Group and other advisory committees with aged care experts was well received, but it highlighted the lack of formal engagement with the aged care sector up to that point.[2616]

The panel heard that, before the advisory structures were established, it was difficult to activate and engage the right experts quickly.[2617] Private providers with experiences of outbreaks overseas said it was impossible to provide advice to government.[2618] This lack of representation made older Australians feel that they had no voice, adding to their sense of being undervalued and vulnerable.

There was a lack of clarity on governments' roles and responsibilities for aged care. The Aged Care Royal Commission found that 'all too often, providers, care recipients and their families, and health workers did not have an answer to the critical question: who is in charge?'.[2619]

> *Governance arrangements also failed at times to be clear in relation to the roles and responsibilities of various stakeholders involved in the response delivery. This resulted in duplication of effort and some confusion. – PHN Cooperative*[2620]

Advocates noted that complications also arose from the fact that state and territory governments set different local health restrictions, and individual providers set their own rules and

restrictions.[2621] Providers found it difficult to comply with all of the different requirements across jurisdictions and had to duplicate reporting to various bodies, including the Australian Government Department of Health, Public Health Units, the Aged Care Quality and Safety Commission, and Local Hospital Networks.[2622]

Hospital transfers and 'Hospital in the Home'

At the onset of the COVID-19 pandemic, there were no agreed protocols or plans in place setting out how or when to transfer COVID-19 positive patients from residential aged care facilities to hospitals. In March 2020 the first Communicable Diseases Network Australia National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia said residents should be transferred 'only if their condition warrants', which left room for interpretation.[2623]

Experts and state health departments did not agree on the question of whether to hospitalise residents who tested positive.[2624] In some cases COVID-19 positive residents were admitted to hospitals, but in other cases infected residents were kept on site with 'Hospital in the Home' plans.[2625] Some hospitals did not want to take on the risk of accepting COVID-19 positive patients from residential aged care facilities.[2626] Some residential aged care facilities found it difficult to convince local GPs to sign off on the transfers.[2627] During the Dorothy Henderson Lodge outbreak, the NSW Health made transfer decisions on a case-by-case basis.[2628]

The main exception was South Australia. In that state there was an automatic transfer policy for residents of aged care facilities who tested positive to the virus and also a dedicated COVID-19 hospital.[2629]

When patients were transferred, it could be difficult for hospitals to provide the extra care needed for aged care residents, particularly those with dementia. Sometimes it was difficult to return residents to residential aged care after they were discharged from acute care. Older people's physical and mental health had often deteriorated by the time they returned from hospital.[2630]

Agreed principles and protocols needed to be in place ahead of the pandemic to reduce uncertainty about where and how aged care residents with COVID-19 would receive care, when aged care residents with COVID-19 would be transferred to hospital. – Aged and Community Care Providers Association[2631]

The Inquiry heard state and territory governments provided hands-on support – for example, workforce support, infection prevention and control expertise, resources such as PPE and rapid antigen tests, in-reach support services, and crisis management support – to facilities that had outbreaks.[2632] This put additional pressure on state and territory workforces, which were already under strain.[2633] The panel heard that states and territories did not consider they were adequately funded for this extra support.[2634]

The Victorian Aged Care Response Centre was established to coordinate Australian Government, state and local systems after the aged care outbreaks in Victoria in mid–2020. Through the centre, the Australian Government brought together stakeholders from across

agencies and the sector to identify issues and coordinate responses. Where aged care systems were overwhelmed, the government provided crisis management and other supports.[2635] Stakeholders said that the ability to be agile was important for the operation of the centre, as was incorporating local knowledge and understanding. Several stakeholders said the Victorian Aged Care Response Centre was effective and all state and territory pandemic plans should include similar arrangements when pandemics are declared.[2636] The Inquiry heard that the model was adapted in states and territories other than Victoria, and Australian Government officials were embedded in response teams, but the model was not always as effective in those other jurisdictions.[2637]

3. Experiences of older Australians and other supports

3.1. Response

3.1.1. Supports for older Australians

The Australian Government funded grief and trauma support services for older Australians to deal with impacts of COVID-19. For example, it provided funding for:

- the Australian Centre for Grief and Bereavement, which provides tailored support, advice and specialised counselling
- a resources library, developed by Dementia Support Australia, to help aged care providers ease the impacts of lockdown on residents living with dementia
- the National Aged Care Advocacy Program, which provides COVID-19 advice and advocacy through the Older Persons Advocacy Network[2638]
- the Older Persons COVID-19 Support Line ・a joint initiative of COTA Australia, Dementia Australia, National Seniors and the Older Persons Advocacy Network.[2639] The line provided information, advice and wellbeing checks for older Australians, especially those at risk of isolation, carer stress and elder abuse.

Other targeted initiatives were put in place for older Australians. For example:

- between March 2020 and 30 June 2022, the COVID-19 Home Medicines Service Program funded pharmacies for home delivery of Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme medications[2640]
- there was extra funding for Meals on Wheels and similar services to provide prepared meals, food staples and essential daily items to senior Australians[2641]
- some major supermarkets introduced dedicated early shopping hours from 7 am to 8 am for older people[2642]
- the Commonwealth Home Support Programme used flexible funding arrangements to provide different supports ・for example, individual social support to prevent social isolation and funds for purchasing PPE[2643]

- the Aged Care Volunteer Visitors Scheme, which began on 1 July 2023 (replacing the Community Visitors Scheme), provided phone and virtual friendships and connections[2644]
- funding for specialist elder abuse support services was increased to maximise protections for vulnerable senior Australians[2645]
- funding was increased to improve access to primary care for senior Australians, including the transition of older Australians between aged and healthcare settings.[2646]

3.1.2. Vaccine rollout and antivirals

Australia's vaccine rollout began on 22 February 2021, and vaccinations against COVID-19 were administered in line with group risk profile. Older Australians were prioritised. Aged care residents were highest priority, followed by people aged over 70 and then those aged 60 to 69.[2647]

Responsibility for vaccinating older Australians outside the aged care system was split between the Australian, state and territory governments (for further details see Chapter 10: The path to opening up). The Australian Government was responsible for the vaccination rollout in residential aged care facilities. Vaccine Administrative Service providers administered vaccines through in-reach clinics and vaccination hubs.[2648] In early 2021 the Department of Health began engaging the four private Vaccine Administrative Service providers that delivered most of the vaccine rollout in residential aged care facilities: Aspen Medical, Healthcare Australia, International SOS, and Sonic Clinical Services.[2649] The New South Wales, Victorian and South Australian governments were responsible for vaccinating residents and staff of state-run residential aged care facilities.[2650]

On 9 March 2021 the Department of Health published the COVID-19 Vaccination Aged Care Implementation Plan.[2651] The plan introduced the following measures to ensure access to antiviral medications:

- On 6 February 2022 the Department of Health began to distribute COVID-19 oral antiviral treatments from the National Medical Stockpile to residential aged care facilities.[2652]
- On 22 June 2022 antivirals were made available on the Pharmaceutical Benefits Scheme for any person aged 70 and above who was diagnosed with COVID-19 regardless of other risk factors or whether they had symptoms.[2653]

For further information on antivirals, see Chapter 10: The path to opening up.

3.1.3. Visitation and carers in residential aged care facilities

To protect older Australians in residential aged care from infection, urgent restrictions were placed on visits to those facilities. For example:

- on 18 March 2020 National Cabinet agreed to restrictions on visitor entry into residential aged care facilities.[2654] Visitor numbers were capped, visit times were limited and there were restrictions on visitor age. Some residential aged care facilities went beyond this guidance and banned visitors altogether.[2655]
- On 1 May 2020 National Cabinet endorsed the sector-led Industry Code for Visiting Residential Care Homes During COVID-19 (Visitation Code).[2656] The Visitation Code was developed as a result of sector advocacy for easing visitation restrictions and created a nationally consistent approach that safeguards residents' rights to receive visitors while minimising the risk of spreading COVID-19. The Visitation Code has been regularly revised since its inception.[2657]
- On 1 October 2020 the Aged Care Royal Commission's *Aged care and COVID-19: a special report* underlined the important role that family and friends have as informal carers and the importance of visitation to the health, enablement and happiness of residents. The special report recommended the Australian Government immediately support and secure visitation in residential aged care facilities during the COVID-19 pandemic.[2658]

The Australian Government accepted the Royal Commission's recommendation on visitation and provided $450 million to residential aged care providers to support preparedness and response to COVID-19, including visitation to facilities by families and friends.[2659] It also released guidance to support visitation. For example:

- on 1 October 2020 the Australian Health Protection Principal Committee updated guidance to support greater visitation access in residential aged care facilities[2660]
- on 12 November 2020 the Visitation Guidelines for Residential Aged Care Facilities, including escalation tiers and aged care provider responses, were released[2661]
- on 7 December 2020 a letter from the Aged Care Quality and Safety Commission on visitor access to residential aged care facilities was released[2662]
- on 11 February 2022 interim guidance on managing public health restrictions on residential aged care facilities was published and endorsed by National Cabinet[2663]
- on August 2023 the Aged Care Quality and Safety Commission published a fact sheet on ensuring safe visitor access to residential aged care facilities.[2664]

After lockdown periods in 2020 and 2021, the Australian Government implemented programs to support the return of visitors and volunteers to residential aged care facilities, including:

- the Re-engaging Volunteers into Residential Aged Care Facilities Program, which ran from 7 March to 30 September 2022 across 224 participating residential aged care facilities[2665]

- the Partnerships in Care program, where a resident can choose a close family member or friend as a 'partner in care' who can continue to visit even during infectious outbreaks.[2666]

In some areas there was strong engagement between Local Health Districts and aged care facilities.[2667] Local Health Districts held regular forums with community partners and drew on Primary Health Networks and local primary care providers to improve support for local aged care outbreaks.[2668]

3.2.Impact

Older Australians are a diverse group, with different levels of independence, socio-economic backgrounds, life experiences and lifestyles. Their experiences of the pandemic also differed.[2669]

In 2020 workers aged over 60 years faced the greatest job losses and wage reductions of any age group.[2670] However, retired health workers were both encouraged and motivated to return to work to support the COVID-19 health response.[2671] In April 2020 the Australian Health Practitioner Regulation Agency and the National Boards established the pandemic response sub-register for a surge health workforce – 40,000 retired doctors, nurses, midwives and pharmacists registered to rejoin the medical workforce.[2672]

Older Australians who were not frontline workers often experienced isolation and loneliness. The 2011 Census found that just over half of older Australians live with a partner, while 25 per cent live alone in a private dwelling, with that proportion increasing with age.[2673] Older Australians with a disability or chronic illness, or who were carers, were more likely to suffer decreased social interactions with service providers, social groups and community organisations.[2674]

An Australian Institute of Family Studies survey published in July 2020 showed that older Australians were among the most isolated from family and friends.[2675] Only 23 per cent of those aged 70 and over had daily contact with family, compared with 40 per cent of those aged under 40.[2676] For some, the sense of loneliness was exacerbated by poor digital literacy and lack of access to technology[2677] – 30 per cent of those aged over 70 relied on handwritten letters to stay in contact with their family.[2678] However, we also heard that those in the 50 to 60 year age group significantly increased their use of video calls and social media during the pandemic.[2679]

> *The masks took our smiles. Part of the enjoyment for walking for me is saying hello to people passing the time of day very briefly as you walk by, and so many people use the mask as an excuse not to look at you. – Female, 67, Victoria*[2680]

Peak bodies for older Australians report that the pandemic had profound effects on the mental health and wellbeing of those aged 75 and over.[2681] Independent research from the Council of the Ageing found that 14 per cent of older Australians said their mental health worsened during the pandemic. This decline was largely driven by feelings of separation and isolation from family.[2682] One in five of those who struggled with their mental health had no one to talk to and 8 per cent who reported their mental health suffered said they could not get the help they

needed.[2683] Instead, they relied on their family, GPs and community-based organisations.[2684] This was especially the case in regional areas, for those living in residential aged care, and for people from culturally and linguistically diverse backgrounds.[2685]

Submissions to the Inquiry point out that older Australians, wherever they resided, found it difficult to access information during the pandemic, including about infection prevention measures, isolation requirements and vaccine and antiviral availability.[2686] One study of older women from culturally and linguistically diverse backgrounds reported that some thought information about COVID-19 was inadequate, while others found it excessive and at times contradictory.[2687] In both cases, this led to confusion.[2688]

> *Older and vulnerable Australians do not all live in residential aged care facilities or receive aged care services. These older Australians, including those living in retirement villages, also needed timely and relevant advice about COVID-19 – including infection prevention measures, isolation requirements and vaccine availability. – Aged and Community Care Providers Association*[2689]

During the pandemic there was some public discussion about whether community-wide stringent measures to protect the vulnerable, mainly the elderly, were justified.[2690] Some elderly people felt discriminated against or threatened by those opinions. Others were relieved that government policy aimed to protect everyone, but ageism remained a factor. The effects of the pandemic on aged care facilities were seen as a reflection of this.[2691]

Wraparound services are essential in supporting older Australians in the community. We heard that older Australians who relied on these supports were adversely affected when they were disrupted or stopped because of the COVID-19 pandemic and public health measures.[2692] Disruptions to meal services and transportation were particularly challenging for some older Australians.[2693]

> *For older people living in the community and receiving home care services, there was no-one with ultimate responsibility for ensuring continuity of care. It was difficult for providers to continue support/ramp up support when staff became unwell themselves. – Older Persons Advocacy Network*[2694]

Older Australians were at higher risk of elder abuse when they lost services and support networks,[2695] and there was an increase in the number of calls to elder abuse helplines in various states and territories.[2696] The National Elder Abuse Prevalence Survey estimated that one in six older Australians living in the community experienced some form of elder abuse in 2020. More women were reporting any form of abuse compared with men (15.9 per cent compared with 13.6 per cent) and women were more likely to experience psychological abuse and neglect.[2697] We heard that various factors contributed to the rise in elder abuse, including social isolation, troubled family relations, pressure on older people to assist their adult children financially, and a lack of regular wraparound service touchpoints.[2698]

Role of community organisations – COTA SA COVID-19 Social Outreach Project

Community organisations that stepped up and filled gaps in services for older Australians were a key factor in reducing isolation during the COVID-19 pandemic.[2699]

Between March and November 2020 the South Australian branch of Council of the Ageing (COTA) ran a COVID-19 Social Outreach Project to support older Australians in the community. Throughout the project, 32 COTA volunteers called members to ask them about their wellbeing, listen and empathise, provide information and support, and offer them regular social calls. The project was focused on reducing social isolation, and single members living alone were prioritised.

The COTA program was positive for both volunteers and members receiving calls. One volunteer said, 'I will call this lady weekly. She was really excited about this. Said I had made her smile. We connected really well. Says this is a fantastic initiative.'

In total, 1,948 calls were made and 1,036 conversations were held.

3.2.1. Vaccine rollout for older Australians

> *The implementation of the vaccination roll-out to vulnerable Australians living in residential aged care was initially complicated by a lack of coordination between the delivery of the vaccine (with strict handling requirements) and the vaccination teams on the ground. This resulted in confusion, delays and increased administrative burden. – Aged and Community Care Providers Association*[2700]

From the start of the pandemic the government was aware that older Australians needed to be vaccinated as quickly as possible. However, the rollout did not meet a single key target for vaccinating older Australians, either in or out of residential aged care facilities.[2701] The rollout to residential aged care facilities was slower than planned.

Many of the factors that impacted the broader vaccine rollout (see Chapter 10: The path to opening up) also affected the rollout to older Australians. We heard about many complicating factors:

- There was poor planning and an under-appreciation of the logistical and operational requirements - for example, the implementation plan was released after the rollout began;[2702] and, due to a lack of sector engagement, the government did not initially understand the complexity of administering in-reach services.[2703]
- Lockdown restrictions and fear of contracting COVID-19 on public transport meant that older Australians had difficulty getting to testing and vaccination centres if they did not have their own transport.[2704]
- There was poor communication between Vaccine Administrative Service providers and residential aged care facilities – for example, in-reach teams turned up to nursing homes only to find no vaccines and vice versa.[2705]

- There was insufficient vaccine supply.[2706]
- There were issues in obtaining informed consent from older Australians (particularly where a relative was responsible for providing this consent).[2707]
- Vaccine providers found it challenging to stay up to date with vaccine information and recommendations.[2708]
- There was poor data on vaccination status. Australian Government mandates for the reporting of vaccination status of residents and staff only began from June 2021.[2709]

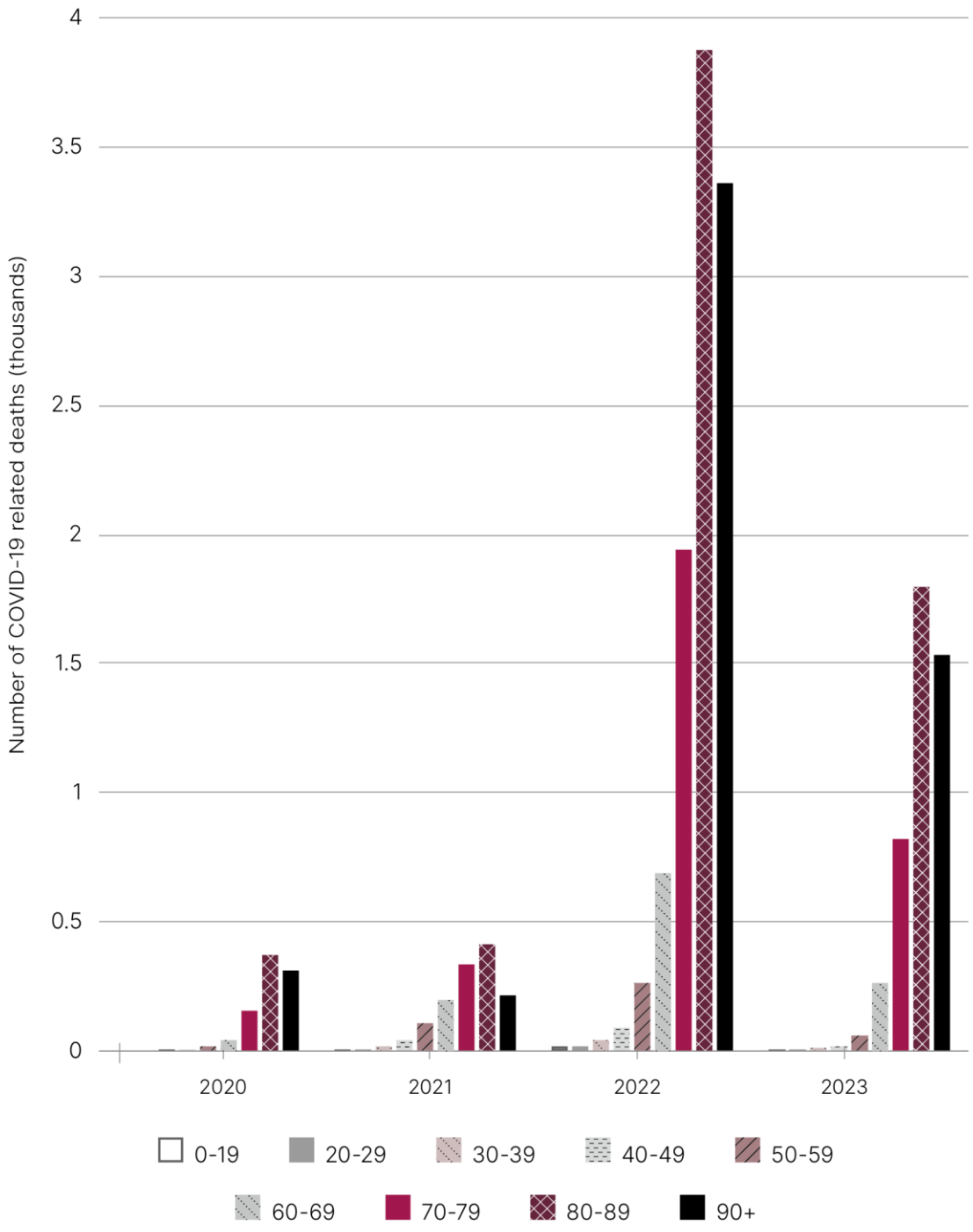
> *Our stakeholders reported difficulties accessing Covid vaccination for people living with dementia in the community and residential aged care for a variety of reasons including poor communication, erroneous assumptions about decision-making for people living with dementia by those planning and providing vaccinations, failure to consult a support person if vaccination was declined, and inadequate record keeping and follow up when vaccination opportunities were missed. – Dementia Australia*[2710]

3.2.2. Outbreaks, infections and mortality

The target for two-dose vaccination of residents was reached in late June 2021, two months later than the initial target of 30 March 2021.

The consequences of a stalled vaccine rollout for older Australians generally and for those in the aged care system were profound. Research has shown that older Australians are the group most at risk of infections and death from COVID-19. Figure 1 shows that for each year of the pandemic, the highest number of COVID-19 deaths occurred among those aged 80 to 89 years.[2711]

Figure 1: COVID-19 related deaths by age, 2020–2023[2712]



Older Australians in residential aged care facilities were, and continue to be, at a high risk of exposure to infection given living and care arrangements, and mortality associated with COVID-19 due to underlying, age-related vulnerabilities.[2713] Up to 12 March 2021 residents in residential aged care facilities accounted for only 7 per cent of cases but 75 per cent of deaths in Australia.[2714] Between the start of the pandemic to 15 June 2021 residents in residential aged care facilities were 14.7 times more likely to die from COVID-19 than older Australians not in aged care.[2715] However, improvements in management, the availability of vaccines and the reduction in severity of the virus have contributed to reduced case mortality rates over time.[2716]

Most residential aged care facilities across Australia experienced at least one outbreak of COVID-19.[2717] Many factors influenced the severity of outbreaks – for example, the number of shared rooms, demographic mix of residents, removal of daily visitor caps, mandatory staff vaccinations, access to antivirals, proportion of vaccinated residents and staff-to-resident ratio.[2718]

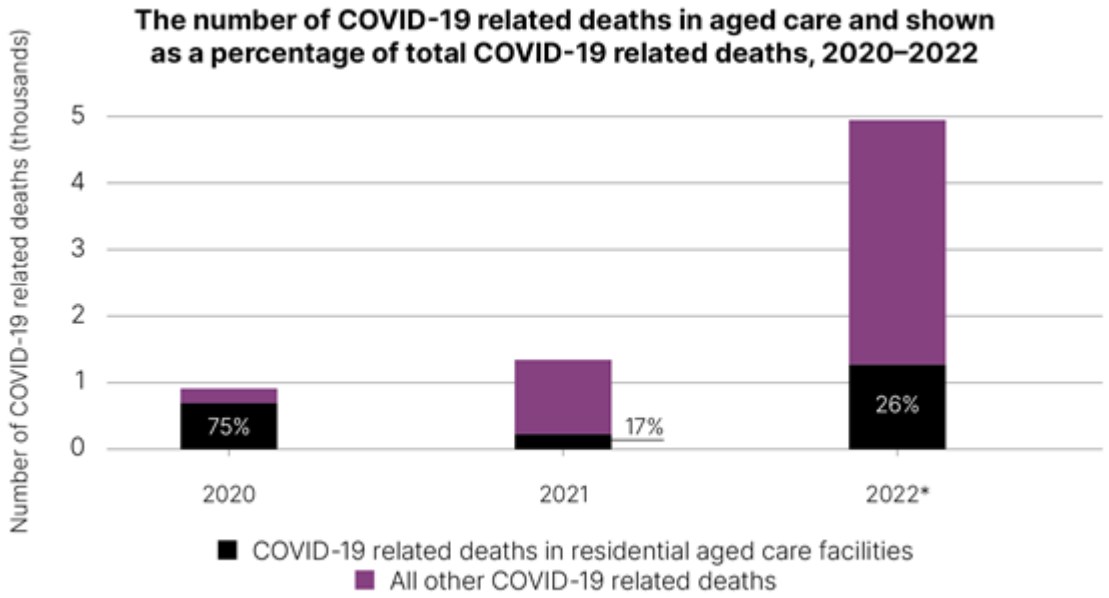
There were several highly publicised aged care outbreaks in 2020, including:

- Dorothy Henderson Lodge, New South Wales (3 March – 7 May): 17 residents and 5 staff were infected and six residents died[2719]
- Newmarch House, New South Wales (11 April – 15 June): 37 residents and 34 staff were infected and 19 residents died[2720]
- St Basil's Home for the Aged, Victoria (8 July – 31 July): 94 residents and 94 staff were infected and 45 residents died[2721]
- Epping Gardens, Victoria (20 July – 3 Sept): 103 residents and 86 staff were infected and 38 residents died.[2722]

The St Basil's and Epping Gardens outbreaks were part of the 2020 Victorian outbreaks in which thousands of staff and residents were infected across more than 200 outbreaks, mostly between July and September 2020.

By 2022, the number of COVID-19 deaths in residential aged care had risen, although the proportion of all COVID-19 deaths in residential aged care facilities compared to the broader community had dropped to 26 per cent as community-wide exposure increased (Figure 2).[2723]

Figure 2: The number of COVID-19 related deaths in aged care and shown as a percentage of total COVID-19 related deaths, 2020-2022[2724]



Note: Data for 2022 include deaths that had occurred by 28 April 2022, and include deaths both with and from COVID-19 where COVID-19 may not be a cause of death.

3.2.3. Impact of restrictions on visitation

The Inquiry consistently heard that it is essential for residential aged care facility residents to have visitors for social contact and their mental health and emotional wellbeing. Visitors often assist with essential daily tasks, such as meals and personal care[2725] and they also play an informal oversight role, ensuring any issues with the care of residents are identified and addressed early.[2726]

> *Often, when a person enters residential aged care, either permanently or for respite, carers still find themselves assisting with meals, washing, appointments, personal care, and both social and emotional support. The restrictions on these activities caused great distress and confusion. – Carers Tasmania*[2727]

Restrictions may have prevented transmission of the virus, but they came at the cost of quality of life, dignity and choice for older Australians.[2728] We heard about immediate and long-term impacts from the lack of visitors, including confusion, frustration, distress, loneliness, poor mental health, cognitive decline, malnutrition and loss of weight and declining physical function.[2729] Visitor restrictions were also challenging for carers of residents. Even when restrictions eased, families were not able to take residents out for appointments, meals or shopping or to their own homes.[2730]

> *My mum experienced dementia deterioration, hygiene issues escalating due to room isolation, increased depression and anxiety due to 'neglect' and staff shortages. – 2022 National Carer Survey respondent*[2731]

Restrictions were particularly distressing for residents receiving palliative or end-of-life care.[2732] We heard that the Grief and Bereavement Service was important for older people who were socially isolated and also very important for those whose family members had died in residential aged care facilities. However, it took too long to set the service up.[2733]

> *So many older people died alone and afraid [and] passed away well before their time due to the fear, stress and heavy-handed restraints used. It was the most shameful and demoralising time in Australia's history of treatment of older persons. – Older Persons Advocacy Network*[2734]

We heard that the Visitation Code improved the situation for those in residential aged care. It also showed the importance of evidence-based and experience-based policy development.[2735]

> *The evolution of a visitor code is an example of the sector coming together to find a way forward to enable providers to ensure safe and quality care, while also supporting social needs during a stressful period for older people, their families and carers. – Aged and Community Care Providers Association*[2736]

Despite the additional workload, aged care workers assisted residents to maintain contact with loved ones.[2737] Independent research found aged care workers assisted residents to use online video platforms and photo-sharing apps and facilitated window or veranda visits.[2738] The effectiveness and extent of these initiatives varied, but we heard many residents and families appreciated these efforts.[2739]

4. Aged care workforce and providers

Australia's 370,000 aged care workers provide care and support to older Australians by assisting with the maintenance of personal care, domestic duties and management of illness. Aged care workers can work from their clients' homes or residential aged care facilities as well as hospitals and clinics. They provide companionship and emotional support and promote independence and community participation.[2740]

> *Aged care workers worldwide are a relatively disadvantaged group. They are mostly women, in low paid insecure jobs, who often belong to ethnic minorities and are poorly trained for the physically and emotionally demanding work they do. – Independent Review of COVID-19 Outbreaks in Australian Residential Aged Care Facilities*[2741]

During the COVID-19 pandemic, most aged care workers earned as little as $2 above the minimum wage, 93 per cent of direct care workers were employed part-time,[2742] and many worked across multiple sites, providers and sectors.[2743] Some became unwitting transmitters of COVID-19[2744] – a UK study of workers in London care homes found those who worked in more

than one site were three times more likely to contract COVID-19 (52 per cent) than those who worked at a single site (17 per cent).[2745]

4.1. Response

4.1.1. Workforce furloughing, mobility and retention

Aged care workers who were unable to work due to COVID-19 illness or isolation requirements were eligible for the Pandemic Leave Disaster Payment (3 August 2020 to 14 October 2022) and the High-Risk Settings Pandemic Payment (15 October 2022 to 31 March 2023). See Chapter 21: Supporting households and businesses for more information on financial support.

The Australian Government also provided supports specifically for aged care workers, such as:

- paid pandemic leave for residential aged care workers[2746] from 29 July 2020 to 29 March 2021, which gave protection from dismissal for taking up to two weeks of paid pandemic leave following temporary changes (Schedule Y) to industry awards[2747]
- Aged Care Worker COVID-19 Leave Payment, which replaced the High-Risk Settings Pandemic Payment and was active from 1 April 2023 to 16 February 2024
- Aged Care Workforce Retention Bonus payments, which provided up to $800 for the first three payments and up to $400 for the last two payments across five payments in March 2020, August 2020 and February 2022[2748]
- Aged Care Registered Nurses' Payment, which provided core payments of up to $6,000 across two rounds in late 2022 and late 2023.[2749,2750]

To help providers minimise the risk of outbreaks, in August 2020 the Australian Government introduced the Support for Aged Care Workers in COVID-19[2751] grants.[2752] The grants were to assist with the additional costs of managing workforce impacts (including working at a single site, leave and training). They were initially limited to the COVID-19 hotspots of Greater Melbourne and Mitchell Shire (15 July 2020 to 28 September 2020) but were extended multiple times as other local government areas were declared hotspots.[2753]

To prevent COVID-19 spreading through residential aged care facilities, staff were 'furloughed' (temporarily stood down) if they were a close contact of a confirmed COVID-19 case. The stand-down was for 14 days regardless of test results or symptoms. Furloughing was first recommended by the Australian Health Protection Principal Committee on 12 March 2020. The committee stated that workers in health and aged care sectors should 'self-quarantine at home AND must not work for 14 days after the last possible contact with the confirmed case'.[2754] The Australian Health Protection Principal Committee restated this instruction on 17 March,[2755] 22 April[2756] and 19 June 2020.[2757] On 20 March 2020 the Australian Government announced additional funding for aged care in recognition of the challenges that furloughing was having on the sector – for example, $78.3 million for 'residential care to support continuity of workforce supply'.[2758]

Sometimes the entire workforce of a residential aged care facility was furloughed under state and territory public health orders. For example, all St Basil's Home for the Aged staff were furloughed on 22 July 2020. All clinical and support staff for Epping Gardens were furloughed on 29 July 2020.[2759] The Guide to the Establishment of an Aged Care Health Emergency Response Operations Centre, published in August 2020, gave guidelines on managing furloughed staff and returning them to work (see Section 2).[2760]

4.1.2. Surge workforce programs and initiatives

Australian Government surge workforce initiatives began when Healthcare Australia agency nurses were deployed to assist with Australia's first major COVID-19 outbreak at the Dorothy Henderson Lodge in New South Wales in early March 2020.[2761]

There were other Australian Government initiatives to support temporary surge workforces:

- the COVID-19 Aged Care Support Program Extension grant (4 June 2021 – 31 March 2023) , which received 11,418 applications for reimbursement of costs of managing direct impacts of COVID-19[2762]
- the Surge Workforce Support Program (22 January 2022 – 30 September 2022), which placed nurses from the Australian Health Practitioners Regulation Agency's pandemic sub-register and general register into residential aged care facilities in collaboration with the Recruitment, Consulting and Staff Association[2763]
- the 2023 COVID-19 Aged Care Support Program Grant (26 April – 3 April 2024), which received 4,475 applications for reimbursement of costs of managing outbreaks, including for contracts with labour agencies.[2764]

The Australian Government contracted a number of agencies to supply staff to aged care facilities.[2765] These agencies also subcontracted out to other agencies. For example, when all staff of St Basil's Home for the Aged were furloughed on 22 July 2020, the Australian Government deployed staff from Aspen Medical, along with staff from 22 other agencies subcontracted by Aspen Medical.[2766]

Other staffing support initiatives included:

- The Australian Medical Assistance Team completed 174 visits to 80 aged care facilities between 30 July 2020 and 18 September 2020.[2767]
- The National Aged Care Emergency Response deployed 70 interstate staff in 12 teams.[2768]
- The Australian Defence Force deployed an average of 30 personnel each week to 542 residential aged care facilities between February and September 2022.[2769]

On 6 January 2022 the government released interim guidance that recommended aged care facilities return workers to work with no isolation period where they had been close contacts of a COVID-19 case.[2770]

Some private hospitals also supported the aged care sector by sending their healthcare staff into facilities where outbreaks were occurring.[2771] In some instances, residents were transferred to public and private hospitals as part of outbreak management response. The outbreaks at St Basil's[2772] and Menarock[2773] in 2020 were managed in this way. Some private hospitals also rapidly upskilled their staff to assist the surge workforce effort in aged care.[2774]

4.1.3. Supports for aged care providers

Almost 3,200 aged care providers in Australia deliver care through 9,300 services.[2775] The Australian Government provided grant funding to aged care providers to help manage the impacts of the pandemic and to respond to unforeseen and exceptional circumstances. Other support included:

- increased waste collection services and the coordination of waste management in response to the increase in COVID-19 related clinical waste[2776]
- access for residential aged care facilities to on-site polymerase chain reaction (PCR) testing during outbreaks[2777]
- assistance for residential aged care facilities that were facing additional costs in preparing for and responding to COVID-19 (providers received around $900 per resident in major metropolitan areas and around $1,350 per resident in all other areas)[2778]
- pre-deployment of rapid antigen test kits from the National Medical Stockpile to residential aged care facilities for surveillance screening of residents, staff and visitors.[2779]

During the COVID-19 pandemic the National Medical stockpile deployed over 417.1 million units of Personal Protective Equipment, 187.6 million rapid antigen tests and 49,038 units of Molnupiravir (COVID-19 antiviral treatments) to residential aged care homes.[2780]

4.1.4. Vaccine rollout for the aged care workforce and mandates

On 15 June 2021 the Australian Government introduced mandatory vaccination reporting requirements. That meant all residential aged care facilities had to report to the Australian Government on staff vaccination rates. However, individual staff could not be forced to disclose their vaccination status.[2781]

Before the vaccine rollout began, the Australian Health Protection Principal Committee advised against mandating vaccination for the aged care workforce.[2782] However, the vaccination rate for residential aged care facility staff was lower than anticipated. So, on 28 June 2021, National Cabinet announced that mandatory vaccinations would apply for all workers in residential aged care facilities. All staff were required to receive a first dose by 17 September 2021.[2783] The Australian Nursing and Midwifery Federation released a position statement supporting vaccination of all health care workers.[2784] On 10 November 2021, after further consideration of

the evidence, the Australian Health Protection Principal Committee recommended mandatory vaccination of in-home and community aged care workers.[2785]

While it did not enact or enforce mandates the Australian Government provided a series of supports, alongside state and territory government initiatives, to assist with the mandates, including:

- the $11 million Residential Aged Care COVID-19 Employee Vaccination Support Grant program to support residential aged care facility staff to be vaccinated, launched on 28 June 2021[2786]
- a dedicated support hotline from 18 July 2021[2787]
- regular meetings between government and union and peak body representatives from 19 July 2021[2788]
- government webinars for workers in New South Wales, the Australian Capital Territory, the Northern Territory and Victoria between 1 and 10 September 2021.[2789]

More information on the vaccine rollout is in Chapter 10: The path to opening up.

4.1.5. Infection prevention and control and use of personal protective equipment

On 13 July 2020 the Australian Government mandated the use of surgical masks by aged care workers in residential aged care facilities and who provide home care support in Victoria's lockdown zones.[2790] The Department of Health published fact sheets, posters, checklists, a flowchart and a video on when and how to wear PPE and produced an online training resource on preventing infection spread.[2791] Providers could also access PPE from the National Medical Stockpile when commercial suppliers were unavailable or insufficient.[2792]

Between 1 March 2020 and 25 February 2021 the Aged Care Quality and Safety Commission undertook 3,238 unannounced visits and announced short notice visits to residential aged care facilities nationally.[2793] The purpose of the visits was to observe infection control practices and ensure that staff, management and visitors were adhering to safe PPE protocols and safe infection control arrangements.[2794]

Following the Aged Care Royal Commission's special report, from 1 December 2020 the Australian Government required all residential aged care facilities to have a dedicated on-site clinical infection prevention and control lead with specialist training.[2795] The government provided $217.6 million in additional funding for aged care providers, some of which helped support the additional costs of engaging infection prevention and control leads.[2796] More information on infection prevention and control can be found in Chapter 9: Buying time.

States and territories also provided on-site infection prevention and control expertise, additional resources like PPE and rapid antigen tests when National Medical Stockpile supplies were delayed, and crisis management support to providers.[2797] The government reimbursed states and territories for supplies they purchased in lieu of timely National Medical Stockpile supplies.[2798]

4.2. Impact

4.2.1. Experiences of aged care workers during the COVID-19 pandemic

During the pandemic, aged care workers faced many of the challenges explored in Chapter 23: Workers and workplaces, including heightened risks of exposure to COVID-19, increased workload, inadequate access to or training in use of PPE, and mental fatigue and stress.

> *A lack of staff and agency and surge workforce was repeatedly mentioned as the most significant challenge faced by aged care workers when dealing with COVID-19 and was a fundamental contributor to the degree of crisis faced by the sector. – 2022 National Aged Care COVID-19 Survey*[2799]

The pandemic exacerbated existing staffing issues (for example, undertraining, understaffing, overwork, insufficient resources and under compensation) and created new issues (for example, increased workloads, high infection rates, unsuitable PPE, inadequately trained surge workforce staff, and stigma following negative media reporting). We heard that aged care workers afraid of unknowingly bringing the virus into their family home or the residential aged care facility where they worked. This fear was intensified by their knowledge that older Australians were highly susceptible to severe COVID-19.[2800]

> *We're exhausted, we're getting injured, but the hardest thing is when you look at a resident and they're just so sad, and you can't spend five minutes just to sit down and talk to them. It's distressing. – Personal care worker, Victoria*[2801]

Many submissions to the Inquiry described the profound mental health impact and moral distress that aged care workers faced during the pandemic. Providers reported they are now providing counselling services and debriefing sessions because of the trauma and stress workers experienced:[2802]

- Aged care workers witnessed firsthand the effects of COVID-19 on those they cared for, but they were often so overworked that they could do no more than the bare minimum for aged care residents.[2803]
- Many found it difficult to see residents inactive, under-stimulated and isolated from their families and friends and to witness the confusion and distress of people with dementia who did not understand the changes.[2804]
- Those who had worked with residents for long periods did not have time to mourn their deaths and had to face distress and anger from resident's relatives.[2805]
- There was a perception they were not well compensated or recognised for the additional burdens brought by the pandemic and felt stigmatised by the media for perceived lack of effort to adequately protect older Australians.[2806]

Because of public health restrictions, aged care workers received less support from informal carers and volunteers than they normally would.[2807]

> *The other problem that emerged was that all volunteers were stopped which meant that countless programs had to be ceased. Unfortunately the elderly volunteers resigned out of fear thinking that they themselves would put frailer people at risk. – Submission 530*[2808]

The Department of Health and Aged Care's submission to the Inquiry acknowledged challenges with their volunteer programs. For example, many volunteers had trouble contacting residents in care by telephone or through the internet.[2809] Sector representatives criticised other Australian Government programs for being used as a way to fill staff shortages without paying workers.[2810]

We heard some volunteers said government communications were not clear about their role and the rules that applied for them. For example, it was not clear whether volunteers were included in National Cabinet's decision to make vaccinations mandatory for aged care workers until two months later.[2811] Some submissions suggest that vaccine mandates for volunteers impacted the return of some volunteers to residential aged care facilities (more information on vaccine mandates is in Chapter 10: The path to opening up).[2812]

4.2.2. Casual and mobile workforce

Research shows that, before the pandemic, 57.6 per cent of residential aged care facility residents lived in understaffed facilities.[2813]

> *Working conditions for aged care staff working in residential facilities deteriorated at the onset of the global COVID-19 pandemic. New occupational stresses were added to existing ones with staff, including facility managers, required to work longer hours to cover for staff shortages due to illness or self-isolation. – Aged Care Research and Industry Innovation Australia*[2814]

Providers criticised Australian Government measures to encourage retention of aged care workers because grants were made before tax, not after tax as originally promised.[2815] Worker representatives said that retention bonus payments were slow – more than 70 per cent of workers said they received the first payment four months after they were due to be paid.[2816]

Attendees at an Inquiry roundtable spoke about the high numbers of staff who quit their jobs when residential aged care facility outbreaks were declared – up to 80 per cent of the total facility workforce in some cases.[2817] Other staff left their roles during the pandemic because they were burnt out and exhausted[2818] or frustrated by the longstanding neglect of the system.[2819]

> *The casual nature of the workforce in aged care settings has been acknowledged as a significant risk vector for COVID-19 as it has meant that workers often need to work across multiple facilities to earn a living wage. – Inclusion Australia*[2820]

Many of the jobs in the aged care sector are low paid and insecure and often performed by casuals.[2821] One submission to the Inquiry noted that workers had to choose between paying their bills and risking exposing themselves and others to infection.[2822] UK-based research found

casual aged care workers were less likely to test and isolate if they were sick or had been in contact with an infected individual.[2823]

Some aged care workers generate a full-time income by working multiple jobs,[2824] and it is common for aged care workers to work across multiple sites for the same employer.[2825] However, government policies and programs to address multiple-worksite issues had a mixed impact. For example:

- despite assurances to the contrary, some workers had employment contracts terminated when they admitted they were working for multiple employers[2826]
- some staff were found to be in breach of the policy, perhaps to sustain a living wage where they were ineligible (or perceived they were ineligible) for support payments, or due to misunderstanding the guidelines (guidelines were not translated into languages other than English until late in 2020)[2827]
- the policies and programs put extra pressure on rostering and scheduling[2828]
- some staff were furloughed from one facility but still working in another.[2829]

4.2.3. Impact of the surge workforce response

Furloughing helped control the spread of COVID-19 but significantly impacted the delivery of aged care services.[2830] It exacerbated strains on an already stretched workforce and meant facilities had to use surge workers to fill the gap. We heard that furloughing left large gaps in workforce capabilities and resulted in residents not receiving minimum levels of care.[2831] The 7 April 2022 report of the Senate Select Committee on COVID-19 concluded that the Australian Government failed 'to learn crucial lessons from the earlier outbreaks in relation to impacts on staff, particularly where almost an entire workforce had to be removed and isolated'.[2832]

Independent reviews of residential aged care facility outbreaks found that management of residential aged care facility outbreaks was significantly affected by furloughing of all staff, a lack of business continuity plans and inadequate documentation.[2833] The Inquiry heard decisions that led to the furloughing of all exposed workers had implications for the usual care of residents and impacted the security of both residents and staff.[2834]

When workforce retention was inadequate or staff were furloughed, resulting in workforce shortages, providers were encouraged, in the first instance, to deploy staff differently[2835] – for example, by moving to 12-hour shifts instead of 8-hour shifts; recalling staff from leave; or re-tasking non-care staff.[2836]

Governments and providers also developed strategies to provide backup staff, primarily through surge workforce grants and programs, as discussed in Section 4.1.1.[2837]

> *Many of the surge workforce had never worked in aged care, were unsure what to do and had limited understanding of previous training in infection prevention and control [and] residents were distressed and endangered by their inability to*

communicate their needs to staff. – December 2020 Independent Review of the St Basil's Outbreak[2838]

We heard workforce planning and ability to source surge staff were particular challenges for providers.[2839] The panel heard criticism about surge workforce (agency) staff, including about the quality of care and service they provided and the levels of training and experience they had. Many felt these issues compromised the welfare of existing staff and residents.[2840] Reports cited instances of residents not being fed or given medication for days. Others were going completely unattended for up to a week at a time.[2841]

The reliance on insecurely employed and unregulated surge workforces … put workers and residents/clients at higher risk of harm due to these staff being unfamiliar with aged care environments and infection prevention and control procedures. – Australian Nursing and Midwifery Federation[2842]

There were insufficient staff available for surge workforces. In the first week of February 2022, there were 1,176 residential aged care homes with outbreaks. Surge workers completed 1,565 shifts in these homes.[2843] In the same month, providers reported that on average 25 per cent (or 140,000 shifts) were going unfilled per week.[2844] Government surge workforce shifts accounted for 0.4 per cent to 1.6 per cent of total unfilled shifts in the weeks from February to May 2022.[2845] We heard that government surge programs were not used by Victorian providers, as they were not convinced that staff would be available when required.[2846]

We ask for agency staff on a daily basis, but there are very, very few available. We are doing everything possible to make sure we have enough appropriately trained staff. There simply aren't any more out there. – Aged care manager, Victoria[2847]

As at 28 March 2024, 190,178 surge workforce shifts had been filled by agency staff, with surge support still being required for the aged care response to COVID-19 in August 2024.[2848]

We heard that public and private hospitals stepped up to support the aged care sector – particularly those facilities that had staff shortages as a result of an outbreak.[2849] Private hospitals with extra beds and healthcare workforce were able to provide a temporary safe haven for uninfected residents, although there were complications when residents were forced to transfer from their aged care homes to private hospitals.[2850] Rapid training of private hospital staff to support the aged care system was similarly commended.[2851]

4.2.4. Vaccine rollout and mandates

Even though aged care workers were a priority in the vaccine rollout, only a third of them had received their first immunisation by 26 June 2021.[2852]

A range of issues were likely to have contributed to this low rate, such as:

- a lack of data before mandated reporting in June 2021, which made it difficult to identify and address the pockets of low rates of vaccination among the aged care workforce[2853]

- confusion about responsibilities – two of the private surge vaccination workforce providers did not believe they were contracted to immunise aged care workers,[2854] while another stated it had been instructed to prioritise residents[2855]
- lack of funding to take time off to have the vaccine (the Residential Aged Care COVID-19 Employee Vaccination Support Grant only equated to about $30 a dose per unvaccinated worker)[2856]
- vaccine supply shortages.[2857]

> *The Commonwealth rollout of the vaccine was a total failure, particularly in both Aged Care and Disability Services. Poor coordination between the states and territories, combined with a deficient vaccine stockpile and the outsourcing of vaccine distribution to individual employers, left many workers unvaccinated because they worked for the wrong provider or lived in the wrong state. – Health Services Union*[2858]

Of those who left the sector in September 2021, around 42 per cent left between 16 and 30 September 2021, just before or after the deadline for mandatory vaccination.[2859] Total staff numbers stabilised from October 2021 onwards. As the mandate came into effect, 97.8 per cent of 261,732 reported residential aged care facility workers had received at least a first dose of the COVID-19 vaccine. By 14 October 2021 that had risen to 99.8 per cent. A year later, in October 2022, over 99 per cent of aged care workers were vaccinated with at least two doses.[2860]

However, we heard that aged care workers in home care support and informal carers were not sufficiently prioritised in the vaccine rollout – residential aged care facility staff were the main focus of the vaccination workforce rollout.[2861]

4.2.5. Infection prevention and control and personal protective equipment

> *There is nothing more important to help providers prepare for and respond to COVID-19 outbreaks than access to high level infection prevention and control expertise. Providers of aged care are required under existing Standards to minimise infection-related risks by implementing standard and transmission-based precautions to prevent and control infection. – Aged Care Royal Commission special report*[2862]

We heard that residential aged care facilities were unprepared to introduce comprehensive infection prevention and control measures at the start of the pandemic, including use of personal protective equipment.[2863] However, we have heard of major improvements to infection prevention and control measures in residential aged care facilities since the Australian Government's introduction of infection prevention and control leads.[2864]

> *There is considerable variability within the design, structure and resources allocated to the implementation and management of infection prevention and control programs around the country. – Australasian College for Infection Prevention and Control*[2865]

In August 2020 there were only 66 credentialed infection prevention and control specialists across Australia, mainly in major hospitals.[2866] At this point in time, formal infection prevention and control training was not included as a core requirement of the Certificate III, which is the qualification held by two in three personal care workers.[2867] Worker representatives reported that staff were not required to do training in PPE use, even during COVID-19 outbreaks.[2868] As of 9 September 2020, infection prevention and control became a core subject, requiring all newly enrolled students in Certificate III Individual Support (Aged Care) to complete modules on infection prevention and control as a mandatory part of their training.[2869]

Despite calls for better guidelines from the beginning of the pandemic, guidelines on PPE for health workers were only revised in June 2021.[2870] Masks were not mandated in residential aged care facilities until 4 months after the first deadly outbreaks in Australia.[2871] A report by Safer Care Victoria found that staff in public and private hospitals experienced similar challenges with infection prevention and control as their counterparts in Victorian aged care homes, which contributed to healthcare worker acquired infections in the workplace. [2872] Common factors contributing to infections in private residential aged care facilities included fatigue, increased clinical workload, and PPE donning and doffing task design.

We heard that it was difficult to access PPE during the pandemic. Between March and mid-August 2020 less than half of the 2,865 requests for PPE made by aged care providers were approved by the Department of Health.[2873] There was a lack of clarity about PPE access pathways, no centralised contact point and challenges in timely delivery of orders.[2874] Residential aged care providers told us they had PPE delivered from the National Medical Stockpile only after outbreaks had been resolved or that they had received inadequate or expired PPE.[2875] Difficulties in acquiring PPE led to rationing in some aged care facilities, with significant impacts on staff and residents.[2876]

5. Evaluation

During the COVID-19 pandemic, the Australian Government's focus was on protecting the lives of those most susceptible to the virus. This included older Australians, particularly those in the aged care system. However, restrictive non-pharmaceutical measures significantly impacted the health and wellbeing of older Australians. Outbreaks in residential aged care facilities have resulted in thousands of infections and deaths. There is a large reform agenda underway, part of which will involve implementing recommendations from the Royal Commission. But more needs to be done.

> *The COVID-19 pandemic has been the greatest challenge Australia's aged care sector has faced. Those who have suffered the most have been the residents, their families and aged care staff. – Royal Commission into Aged Care Quality and Safety*[2877]

> *The Commonwealth Government's handling of COVID-19 in the aged care sector was a failure. The COVID-19 crisis resulted in hundreds of preventable deaths as the Commonwealth Government failed to develop a COVID-19 plan for aged care*

and responded too slowly to the crisis. – Queensland Nurses and Midwives Union[2878]

Public health measures had a significant impact on older Australians

The impacts of social isolation – including from the restriction of visitation in residential aged care facilities and the cessation of social contact and wraparound supports in the community – was particularly harmful for older Australians. Visits from family and friends are incredibly important to aged care residents. The role these informal carers play was undervalued, particularly at the beginning of the pandemic. Health outcomes are negatively affected by the disruption of family and carer-supported models of care. Policymakers need to acknowledge and value the workforce and their contribution. At the response's worst, older Australians died alone, without family or loved ones present. The rollout of programs like Partnerships in Care were important in reconnecting family members and volunteers with residents, helping ensure continuity of care and social connection.

For those in residential aged care facilities, physical and mental health declined rapidly during the pandemic, in some cases leading to early deaths. Older Australians living in the community were deprived of support networks, which increased their risk of elder abuse. Many older Australians faced financial, isolation and extra health concerns during the pandemic. Technological innovations and online communications made a huge difference to the quality of life for many Australians but access to and capacity to use such tools for older Australians must be considered.

The duration of outbreaks and staff turnover increased the risk to the health and survival of aged care facility residents, including through neglect. The extended period and extent of reduced social mobility in some jurisdictions' response exacerbated the impacts of isolation on the health and wellbeing of older Australians, whether in residential aged care facilities or not. The Australian Centre for Disease Control should take a leadership role in advising on health and aged care furloughing and other measures. This will ensure that a balanced approach is taken so that older Australians have access to familiar and specialised geriatric care even in time of crisis.

Strong leadership and sector representation are needed to protect the lives of older Australians

The lack of clarity on roles and responsibilities and the absence of a sector plan caused confusion for providers. These fault lines in leadership and planning cut across governments, healthcare systems and providers and led to the inadequate, uncoordinated response and management of outbreaks, ad hoc care arrangements for residential aged care facility residents, and an overall sense of a lack of control and accountability. The Australian Government's establishment of a crisis response centre in Victoria was effective in bringing together people from across systems to provide outbreak coordination and support to providers and agencies. It should form the basis of future responses.

During outbreaks in aged care facilities, the Australian Government relied on the expertise and capability of states and territories in providing in-reach support services such as workforce

support, infection prevention control expertise, resources and crisis management support. However, states have indicated this additional support was not adequately recognised with funding.

Early in the pandemic there was a lack of aged care sector representation in decision-making. Bodies such as the Aged Care Advisory Group and the Aged Care Council of Elders were valuable once they were up and running, but the Australian Government entered the pandemic without representation from an aged care specialist in its key health advisory and decision-making committees. Consultation mechanisms with aged care specialists, providers and community members are key to designing and implementing measures in any public health emergency that considers the health, wellbeing and dignity of older Australians.

Even though the Australian Government used multiple avenues to communicate with residential aged care facility providers, staff, residents and families, there was still confusion and conflicting information. This was compounded by intersectional issues, such as for older Australians from culturally and linguistically diverse communities, as well as a heavy reliance on digital communications during the pandemic. In future crises the Australian Centre for Disease Control should play a central role in ensuring that the living guidance that now exists is maintained and quickly adapted to pandemic-specific requirements given the nature of transmission risks and the at-risk populations. It should also be involved in communicating this information to older Australians.

Planning and preparedness are the cornerstone to effective outbreak management

The Australian Government released an aged care specific COVID-19 plan in November 2020, months after the pandemic started. The aged care plan was intended to be 'periodically reviewed (at least every quarter)' with stakeholder feedback from across the sector. However, to date, no public review or amendment has been published, despite the changes in operating environments.[2879]

Facility-level outbreak management plans were developed in accordance with national guidelines, but these plans were sometimes rudimentary and inadequately assessed by the regulator. When they were tested by a COVID-19 outbreak, they were not effective. Insufficient guidelines, experts, training, experience and PPE, and poorly built environments, all led to, exacerbated or prolonged outbreaks.

Government should undertake emergency planning and preparedness in consultation with the aged care sector to ensure there is clarity around roles and requirements for government, providers and the broader health system. The panel believes that pre-arranged agreements as part of preparedness plans will help clarify roles and responsibilities on the critical elements of a pandemic response. Agreements should cover data collection and sharing, resourcing and logistics of critical medical equipment and consumables, workforce arrangements, integration with the health system and care of residents.

New residential aged care facility specific infection prevention and control guidelines are very welcome and a critical resource in preparing for and responding to future pandemics.

A well-trained, well-remunerated and appreciated workforce is critical

An adequately resourced and well-trained workforce is vital to ensuring that the aged care sector can respond to challenges and ensure continuity of quality care for older Australians, both within and outside residential aged care facilities. The emergency measures put in place in response to the pandemic, such as staff furloughing, did not always consider unintended consequences or compounding impacts of the pandemic. The furloughing of entire workforces at the same time is particularly unhelpful and carries great risk for the ongoing care and wellbeing of residents.

There was a trade-off between the risk involved in furloughing the workforce and that of not closing down outbreaks in a vulnerable community. This was particularly an issue with COVID-19 cases that were infectious before signs of symptoms. These cases could potentially unknowingly start an outbreak. This may not be the case in future pandemics, and there may be better workaround options that take less of a toll on the workforce and residents.

The surge workforce was broadly welcomed, but widespread workforce shortages made it difficult to recruit surge workers and meant that the workforce capacity was often insufficient, difficult to access and not adequately trained or experienced. This in turn created more issues. Government funding provided to aged care during the pandemic was welcome, but there were challenges with how it worked – grants for the workforce were too restrictive and divisive, and grants for providers were often too hard to access. Extra grant money was slow to be rolled out.

Aged care workers were burnt out by the pandemic. This was exacerbated by the emotional trauma and health risks. A professionalised, appropriately remunerated workforce will help but will not fully mitigate the issues that resulted from residential aged care facility workers working across multiple work sites in COVID-19. An individual facility may not be able to structure its complete workforce as full time-workers. Other medical and allied health workers will also continue to provide services across residential aged care facilities. However, infection prevention and control and workforce planning needs to recognise the significance in cross-facility infectious disease exposure risk.

It is vital to improve the interface between the health and aged care systems

Throughout the pandemic it was evident that the health and aged care systems are inadequately integrated. Some hospitals responded rapidly to support the aged care sector, and this was critical. However, the ad hoc decisions and different arrangements between regions to transfer unwell residential aged care facility residents to hospitals put lives at risk. There was a lack of appreciation of the differences between health and aged care settings and the different considerations for patient care, especially when there are complexities and comorbidities, including dementia. The Aged Care Royal Commission's 2024 progress report noted access to GPs and other clinical services for residential aged care facility residents is still inadequate, and current funding arrangements do not sufficiently recognise the important role of allied health services.[2880] There is a need for better integration across primary health, hospital

and aged care systems to ensure the healthcare needs of older Australians in residential aged care facilities are met, especially during a public health emergency.

A reform agenda is underway, but the effects of the pandemic continue

There has been a significant amount of reform in aged care since the pandemic, some of which has a direct bearing on preparedness. We heard that preparedness in residential aged care facilities has improved. Investment in infection prevention and control training has been noted as a particularly important feature of improvement.[2881] Stakeholders told us there needs to be vigilant maintenance of the dedicated infection prevention and control lead position to ensure the structures that are now in place remain. Also, the person nominated as infection prevention and control lead in a facility must be relieved of other duties or the role must otherwise be sufficiently recognised as an important one.

The Aged Care Royal Commission's final report in 2021 included 148 recommendations to reform the aged care sector, including recommendations on pandemic preparedness. Some recommendations have been fully implemented, but others have not. Recommendations still to be implemented, as outlined in the 2024 progress report from the Office of the Inspector General of Aged Care, include the development of a new Aged Care Act, review of the Aged Care Quality Standards, improvements to the design of aged care accommodation, an increase in award wages, and improvements to the transition between residential aged care facilities and hospital care.

The 2024 progress report also noted that the Australian Government has not adequately addressed fundamental issues that pre-date the pandemic and that have been exacerbated as a result of the pandemic. This includes workforce challenges, with a critical shortage of nurses, high reliance on agency staff and wage disparities between clinical and non-clinical roles.

Surges of COVID-19 cases in residential aged care have continued in 2023 and 2024, coinciding with a decline in vaccination coverage. Between 5 and 12 September 2024, there were 55 new outbreaks in residential aged care facilities, 106 active outbreaks, 638 combined new resident and staff cases, and 12 new resident deaths, bringing the total number of COVID-19-associated deaths in residential aged care facilities to 7,003.[2882] As at 12 June 2024, 170 residential aged care facilities (6.5 per cent of all facilities) have 20 per cent or less residents vaccinated against COVID-19 over the past 12 months.[2883] Australia is lagging behind in aged care vaccination rates for COVID-19 compared to other countries. At the end of the 2023 winter season, 54 per cent of Australian aged care residents were up to date with their COVID vaccination, compared to 90 per cent of their counterparts in England.[2884] This highlights the need for ongoing focus and concerted effort to address the preparedness and capacity of the sector to plan for and respond to health emergencies.

6. Learnings

- Older Australians are likely to be a priority population in future pandemics, especially those in communal living arrangements in residential aged care facilities.
- Existing issues in the aged care system are likely to be exacerbated in a pandemic. Appropriate planning and preparedness arrangements, the capacity to adapt business operations, and mechanisms in place for sharing learnings and experiences between stakeholders can help minimise risks.
- Strong leadership from the Australian Government and genuine engagement with aged care sector stakeholders from the start are needed to clarify roles and responsibilities, clearly communicate advice, and ensure older Australians are adequately considered in the decision-making process.
- The Australian Government needs to adequately scope the complexity and scale of the rollout of any vaccine or treatments in a future public health emergency, and mitigate the risks of a process with multiple failure points by learning from past experience, and leaning on existing systems and expertise.
- Older Australians are highly dependent on a broad support network, including carers, family and friends, that bring many benefits to their physical and mental health and wellbeing. Restricting visitation access may work as a temporary or short-term protection measure but can be traumatising for older Australians and their loved ones. Any restrictions on visitation should consider risks, benefits and compassionate exemptions.
- The risk of elder abuse increases during a public health emergency, when older Australians living in the community, either independently or with home care support, can experience increased social isolation and stress or declining levels of health.
- The aged care workforce is critical in maintaining continuity of care while responding to outbreaks. This needs to be recognised and considered in business-as-usual periods to encourage workforce structuring to reduce the need for workers to be employed across multiple facilities, and during a public health emergency to minimise disruptions to the workforce. Consideration also needs to be given to balancing the risks between conservative staff furloughing rules and the impact this has on the general health and wellbeing of residents of aged care facilities.
- Workforce shortages go beyond aged care, and a surge workforce cannot be solely relied on in a public health emergency. When a surge workforce is deployed, they should be adequately trained and experienced to fill the necessary gaps.
- Infection prevention and control in aged care is critical to responding to and preventing any infectious disease outbreak. The new dedicated infection prevention and control guidelines for residential aged care facilities need to be rapidly tailored according to the

specific nature of future pandemics; and training, experience and resourcing should undergo continuous improvement to maintain its effectiveness.

- A public health emergency can have long-term impacts on the aged care sector, long after the emergency phase is over, and there should be consideration of how to support older Australians, the aged care workforce and the sector more broadly to respond to these challenges.
- In the long term, changes to the physical design of residential aged care facilities, recognising the need to reduce intra-facility transmission risk in respiratory outbreaks, will also build greater flexibility into pandemic responses.

7. Actions

7.1. Immediate actions – Do in the next 12–18 months

Action 3: Conduct post-action reviews of outstanding key COVID-19 response measures to ensure lessons are captured

- This should include reviewing the aged care retention payment program.

Action 5: Develop updated health emergency planning and response arrangements in conjunction with states and territories, and key partners, including consideration of escalation and de-escalation points, real-time review and a focus on post-emergency recovery.

As part of this, develop:

- Management plans under the National Communicable Disease Plan for priority populations
- Modular operational plans for specific sectors, including high-risk settings, which can be deployed in response to a variety of hazards.

The Management Plan for older Australians should account for older Australians both in residential aged care facilities and their own homes. This should include co-designed strategies which embed a human rights approach to mitigate isolation and loneliness, prioritisation for vaccination and other treatments, and surge workforce requirements. Compassionate exemptions should be made to ensure people at the end of their lives are not denied visitation by family and friends.

The Aged Care plan should:

- document an agreed escalation response model for a sector-wide crisis
- include clearly defined triggers and criteria for escalation and de-escalation

- cover the clinical response, surge workforce capacity, infection prevention and control strategies, personal protective equipment, outbreak management strategies (such as compassionate quarantine, self-isolation and cohorting)
- identify data required to inform the response
- consider the interface between aged care and health services.

Action 6: Develop legislative and policy frameworks to support responses in a public health emergency, including for essential services and essential workers.

Essential services and essential workers frameworks should include:

- arrangements for priority access to vaccination, PPE, and infection, prevention and control training in a national health emergency for aged care workers.

Action 8: Establish mechanisms for National Cabinet to receive additional integrated expert advice for a whole-of-society emergency, including advice on social, human rights, economic and broader health impacts (including mental health considerations), as well as specific impacts on priority populations.

- In parallel with making decisions based on key public health advice, National Cabinet should consider the differential impacts of a pandemic across the population and economy. This must include considering and mitigating unintended consequences, and seek to minimise negative impacts on broader health, mental health, educational, equity, economic and social outcomes.
- Human rights considerations should be embedded into National Cabinet's decision-making processes, particularly where measures are intended to significantly restrict rights and freedoms.
- This might include mechanisms for a national health emergency that allow expert advice to be sought from the Australian Human Rights Commissioner and other commissioners (e.g. National Children's Commissioner) to support better understanding of the broader impacts of their decisions on human rights and priority populations.

Action 9: Agree and document the responsibilities of the Commonwealth Government, state and territory government and key partners in a national health emergency. This should include escalation (and de-escalation) triggers for National Cabinet's activation and operating principles to enhance national coordination and maintain public confidence and trust.

This should include:

- greater clarification of roles and responsibilities, including around key areas of shared or intersecting responsibility such as health and social care of older Australians in a national health emergency.

Action 18: Proactively address populations most at risk and consider existing inequities in access to services (health and non-health) and other social determinants of health in pandemic

management plans and responses, identifying where additional support or alternative approaches are required to support an emergency response with consideration for health, social and economic factors.

- All plans and response measures should have an equity lens applied, including for health, social, human rights and economic factors (see Action 1).

Action 19: Develop a communication strategy for use in national health emergencies that ensures Australians, including those in priority populations, families and industries, have the information they need to manage their social, work and family lives.

The strategy should account for the distinct communications preferences and requirements of priority populations – including:

- reflecting the key role of community and representative organisations in communicating with priority populations, including peak bodies for older Australians
- funding community and representative organisations to tailor and disseminate communications through appropriate channels and trusted voices
- providing plain English messaging to community organisations for tailoring in a timely manner.

7.2.Medium-term actions – Do prior to the next national health emergency

Action 23: Progress development of the Australian Centre for Disease Control in line with its initial progress review and to include additional functions to map and enhance national pandemic detection and response capability.

This should include establishing a library of living guidelines for high-risk clinical, residential and occupational settings and health professions that can be readily adapted for a new health emergency. This should include nationally agreed testing and tracing principles. These guidelines should be developed in partnership with:

- the Department of Health and Aged Care, states and territories and relevant professional bodies
- the NDIS Quality and Safeguards Commission in relation to disability settings.

Chapter 19 – Women

1. Context

Before the COVID-19 pandemic there was real, although slow, progress toward gender equality across the globe, but the pandemic put these advances at risk. In Australia, the government's response had a disproportionate impact on women and girls in many areas of life.

The response to the pandemic increased risk factors for family, domestic and sexual violence (FDSV). Many individuals, households, couples and families had to deal with extra financial stress because of job losses and reduced incomes. Financial stress was coupled with stress from isolation, restrictions on activity and movement, reported increases in alcohol consumption, and home learning and caring responsibilities. Many women were forced into lockdowns with their abusers and were unable to leave or access domestic violence support services.

The pandemic and social distancing measures mostly affected female-dominated sectors, so women faced greater economic risks. Living conditions and work–life balance were seriously diminished for women because they took on a disproportionate amount of housework and childcare duties. Women were also more likely to suffer from stress and anxiety, and their physical, emotional and mental health was adversely affected by the reduction in health services. Workload pressures in female-dominated jobs such as aged care, nursing and teaching were also increased during the pandemic. Women also generally earn less, save less, hold insecure employment and live closer to the poverty line than men, and these issues intensified as a result of the pandemic.[2885]

This chapter explores the impact of the pandemic on three key areas:

- women's experience of family, domestic and sexual violence
- women's health and access to health care
- women's workforce participation and economic security.

A note on terminology

There is no single definition of family, domestic and sexual violence (FDSV) in Australia, with the term encompassing a wide range of behaviours and harms that can occur in both family and non-family settings. For the purposes of this report, FDSV is used as an umbrella term to encompass family and domestic violence, sexual violence and partner violence.[2886]

Unless otherwise specified, gender is defined according to the binary classification, owing to the way data is often collected. This Inquiry acknowledges the individuals who identify with genders beyond this binary definition and highlight this as an area for future data improvements.

2. Women's experience of family, domestic and sexual violence

2.1. Response

The Australian Government and state and territory governments have a joint responsibility for ensuring the safety of women and their children who are experiencing, or at risk of experiencing, FDSV. State and territory governments are generally responsible for delivering frontline and preventive FDSV services and programs. The Australian Government's role is largely limited to national programs and research.

The Australian Government recognised that there was an increased risk of FDSV as a result of the pandemic response. To guard against this, on 29 March 2020 the government announced the Coronavirus Domestic Violence Support Package of $150 million in funding, with $130 million to be provided to state and territory governments to increase frontline family and domestic violence services.[2887] Service delivery was to be through a new National Partnership Agreement on COVID-19 Domestic and Family Violence Responses.[2888] The remaining $20 million was to increase the capacity of nationwide family violence services, including 1800RESPECT, MensLine Australia counselling services and other programs. In October 2021 the government announced a trial of the Escaping Violence Payment, with the aim of reducing financial barriers associated with leaving violent intimate partner relationships.[2889]

The Australian Government also provided:

- more than $64 million to extend grant agreements administered by the Department of Social Services for essential services such as family and relationship services and counselling, which had been due to cease on 31 March 2021[2890]
- $63.3 million to help the legal assistance sector to respond to COVID-19 · for example, through funding for frontline legal services and to assist legal services in transitioning to online service delivery[2891]
- $10 million to assist the eSafety Commissioner to respond to an increase in image-based abuse[2892]
- changes to Services Australia's payment and support systems, including the development of online Crisis Payment claims[2893]
- $10 million in 2020–21 for the Temporary Visa Holders Experiencing Violence Pilot, to support women on temporary visas affected by domestic and family violence to access social services, legal assistance and migration support.[2894]

2.2.Impact

2.2.1. The 'shadow pandemic' – increase in the incidence of FDSV

The United Nations uses the term 'shadow pandemic' to describe the rise in family and domestic violence during COVID-19.[2895] The combined impact of public health measures, financial stress and social pressures increased the risk factors for FDSV in Australia.[2896] However, some believe the increase in income supports (see Chapter 21: Supporting households and businesses) was a positive that increased protective factors through the pandemic.

In March 2020 containment measures were increased, with wide-ranging implications for people's mobility and social interaction. People spent much more time at home, often with additional caring and schooling responsibilities.[2897] This increased the risk of FDSV instances. The Inquiry heard from focus group participants that FDSV increased because of more pressure in the home environment or because there was no option but to live with a violent or volatile partner or ex-partner.[2898]

There are inherent difficulties in gauging the extent of FDSV in Australia (including a lack of an agreed definition and likely under-reporting).[2899] At times this can create a seemingly contradictory picture. There is also evidence that the COVID-19 restrictions made it more difficult for victims and survivors to seek assistance or leave abusive relationships, and this may not be reflected in the data.

One study found the pandemic coincided with experiences of first-time and escalating violence for a significant proportion of women.[2900] The authors noted that 'many women who wanted to seek help were unable to due to safety concerns, and this has left a significant proportion without access to formal support services'.[2901] It found that, for all forms of FDSV, rates are higher for women in a cohabitating relationship. This is a significant finding given the use of lockdowns during the pandemic.[2902]

> *I had my entire family move back in with me … including my ex-partner who was abusive and the whole situation was just so traumatising. – Focus group participant*[2903]

Focus group participants identified 'breakdown of relationships' as one of the main negative experiences of the pandemic at the family/community level.[2904] Research suggests that exposure to natural disasters or other extreme events is linked to an increase in the rates of FDSV.[2905] Submissions to the Inquiry noted there was an increase in rates of, or risk of, FDSV during the pandemic and a corresponding increase in demand for support services.[2906] The Australian Research Alliance for Children and Youth submission noted that:

> *Many parents report an increase in stress trying to manage work, home-educating their children, and financial strain throughout the pandemic. Some parents have felt isolated and unsupported throughout the pandemic. Unsurprisingly, these stressors likely contributed to a marked increase in family*

violence throughout the pandemic. – Australian Research Alliance for Children and Youth[2907]

Results from an online survey of adult women in Australia who had been in a relationship in the 12 months following the start of the pandemic found that:

- 1 in 3 (31.6 per cent) respondents reported experiencing emotionally abusive, harassing and controlling behaviours
- 1 in 10 (9.6 per cent) respondents reported experiencing physical violence
- 42 per cent of respondents said physical violence had increased in frequency or severity, and 43 per cent said sexual violence had increased in frequency or severity
- 1 in 4 (26 per cent) respondents who had experienced physical or sexual violence also said they had been unable to seek assistance on at least one occasion due to safety concerns.[2908]

Data from the NSW Bureau of Crime Statistics and Research show that there was a small increase in the number of police-reported domestic assaults from the start of the pandemic to 2022, but there was a significant (16.9 per cent) increase in breaches of apprehended violence orders over the same period.[2909] Also, in the four years to September 2022, reports of sexual assault increased 25.9 per cent.[2910] Of all family and domestic assault hospitalisations in 2022–23, 74 per cent were for females.[2911] Between March and May 2020, Australia's eSafety Commissioner recorded more than 1,000 reports of image-based sexual abuse, which is a 210 per cent increase on the average weekly number of reports they received in 2019.[2912]

As Dr Naomi Pfitzner of the Monash Gender and Family Violence Prevention Centre told the House of Representatives Standing Committee on Social Policy and Legal Affairs inquiry into family, domestic and sexual violence, 'pandemic control measures were providing new opportunities for perpetrators to exert power and control over women and their children'.[2913] For example, children were used to force women to move back into a shared residence; necessary items such as food, medicine, masks or hand sanitiser were withheld; and the threat of COVID-19 infection was used to restrict the movement of women and children.[2914]

However, the Australian Bureau of Statistics (ABS) Personal Safety Survey shows a statistically significant decline in cohabitating partner violence and emotional abuse.[2915] Data suggest that between 2016 and 2021–22 there was:

- a decrease in the proportion of women who experienced physical and/or sexual violence by a cohabiting partner
- a decrease in the proportion of women and men who experienced emotional abuse by a cohabiting partner
- no change in the proportion of women who experienced sexual violence
- a decrease in the proportion of men and women who experienced sexual harassment.[2916]

The lengthy timeframe between 2016 and 2021–22 highlights the need for more frequent data collection.

2.2.2. Demand and access for FDSV support services

The Inquiry heard that there was an increase in demand for FDSV services and also in the complexity of the services sought given social distancing and lockdown rules. The National Mental Health Commission submission noted:

> *Over the pandemic, the number of victim-survivors of sexual, domestic and family violence (SDFV) seeking support increased, with more complex client presentations including severe anxiety and distress. Exacerbated trauma impacts, caring duties, and increased life stressors contributed to increased suicide attempts, suicide ideation, depression and other mental health illnesses. – National Mental Health Commission*[2917]

The Salvation Army noted that 'between March and April 2020, demand for supports offered by us through family and domestic violence flexible support packages grew by almost 60 per cent'.[2918] The number of contacts to Kids Helpline counselling increased at the start of the pandemic. At that time there was also an increase in the number of family relationship concerns being discussed (44 per cent increase from Q2 2019 to Q2 2020), and another peak around June 2021.[2919]

Some organisations told the Inquiry in submissions that they struggled to meet the surging demands, particularly as lockdowns eased. Full Stop Australia told the Inquiry that, in the second year of the pandemic, it had a '26 per cent increase in calls received and a 27 per cent increase in average call duration, compared to the first year'.[2920]

Community services providers said that lockdowns limited people's access to family and other support and led to an increase in the complexity of services sought, requiring organisations to think carefully about how to provide services in a newly restricted and isolated environment.[2921]

2.2.3. FDSV disproportionately affected some groups during the pandemic

Australian and international research consistently demonstrates that FDSV disproportionately affects particular communities, due to factors such as systemic and structural forms of social injustice, discrimination and oppression.[2922]

Groups who were disproportionately impacted by instances of FDSV prior to the pandemic were also more likely to experience FDSV during the pandemic. Aboriginal and Torres Strait Islander women are particularly at risk, have much higher rates of hospitalisation because of family violence and were four times more likely to report experiencing physical or sexual violence.[2923] Further, the need to isolate caused hardship for many Aboriginal and Torres Strait Islander women as social distancing goes against cultural protocols.[2924] A report for Women's Safety NSW found that frontline domestic violence workers were seeing an increase in Aboriginal women seeking their services since the COVID-19 pandemic began.[2925] In this report, half of the survey respondents reported an increase in the complexity of their Aboriginal and

Torres Strait Islander clients' needs since the outbreak of COVID-19.[2926] In the Northern Territory, there were fears that isolation in remote communities would leave women experiencing family violence cut off from their support networks and unable to access emergency services due to poor phone coverage and distance from service centres.[2927]

Other at-risk groups include culturally and racially marginalised women and children, women living with a disability, women with long-term health conditions, pregnant women and younger women.[2928]

2.2.4. Economic insecurity increased likelihood of FDSV incidence

Financial insecurity is a known risk factor for FDSV, with research indicating that the provision of economic support may have contributed to reducing the incidence of FDSV.[2929]

A research report by Australia's National Research Organisation for Women's Safety found that women experienced economic insecurity during the first 12 months of the COVID-19 pandemic and, for women, economic insecurity was linked with an increased likelihood of intimate partner violence.[2930] The study showed that women who reported high levels of financial stress were three times more likely to experience physical and sexual violence and 2.6 times more likely to experience emotional abuse as those with low levels of financial stress.[2931]

During the pandemic, income support measures (as detailed below) increased the incomes of the bottom 40 per cent of households (some by over 20 per cent) and led to a reduction in rates of poverty and financial stress.[2932] Some submissions praised this additional financial support and indicated it allowed some women to flee violence and improve their personal situation. While the pandemic response likely increased FDSV risk factors overall, the additional financial support provided to low-income individuals and households likely acted as a protective factor.

Australia's National Research Organisation for Women's Safety notes that 'the finding that financial stress was associated with first-time physical and sexual violence in previously non-abusive relationships and not repeat violence, while job loss or lost work was associated with first-time and escalating violence, highlights the importance of measures that can alleviate financial stress or, when it occurs, reduce the likelihood it will lead to violence'.[2933] Women told the Australian Council of Social Service that the Coronavirus Supplement 'enabled them to escape domestic violence'.[2934]

> *I had a friend escaping DV [domestic violence] during the pandemic, and the Super access was a godsend. She was early 40s, really bad break up, and that saved her, she was able to leave and be free. – Focus group participant*[2935]

However, women on temporary visas were unable to access many government support payments during the pandemic (see Chapter 21: Supporting households and businesses), exacerbating their financial insecurity and increasing the risk of experiencing family and domestic violence. A 2020 report by Monash University, drawing on the analysis of 100 case files of women who held temporary visas and had experienced domestic and family violence during the first lockdown phase in Victoria, found that 92 per cent of perpetrators had recently

threatened to harm victim-survivors and/or their children, 87 per cent had emotionally abused women and more than half had threatened to have women deported or withdraw sponsorship.[2936]

2.2.5. Excessive alcohol consumption during the pandemic likely increased incidence of FDSV

Alcohol use is a risk factor for increased frequency and severity of family violence.[2937] A Foundation for Alcohol Research and Education (FARE) report in 2020 found that the fear, uncertainty and stress of the COVID-19 pandemic led to an increase in alcohol consumption as a coping mechanism.[2938] There was also an expansion in alcohol home delivery services, and marketing that targeted individuals that were in isolation.[2939] A FARE-commissioned YouGov survey in early April 2020 found that Australians reported they were:

- increasingly drinking on a daily basis in April–May 2020 (14 per cent), compared with January 2020 (5 per cent)
- concerned about their or someone in their household's drinking (13 per cent)
- drinking on their own more often (12 per cent)
- drinking to cope with anxiety and stress (11 per cent).[2940]

In May 2020 a Women's Safety NSW and FARE survey found that 51 per cent of domestic and family violence specialist service workers believed alcohol was more often involved in family violence situations since COVID-19 restrictions, and 40 per cent believed it had the same level of involvement as before the restrictions.[2941] 47 per cent reported an increase in their caseload since COVID-19 restrictions began.[2942]

3. Women's health and access to health care

3.1. Response

The public health measures put in place during the pandemic slowed the spread of the virus, but they made it difficult to access in-person health services. The Australian Government introduced a number of initiatives to improve this situation, including some that impacted women and women's health:

- In March 2020 the Australian Government expanded telehealth services to create new Medicare Benefits Schedule items during the pandemic, including blood-borne virus and sexual and reproductive health issues.[2943] Telehealth services were also used for maternity care. See Chapter 12: Broader health impacts for further details on telehealth.
- Some cancer-screening services were put on hold during the pandemic. BreastScreen Australia paused their services at different times between late March and early April 2020, based on separate jurisdictional decisions.[2944] There were disruptions to the National Cervical Screening Program services, with fewer screening tests in April 2020 and May 2020.[2945] See Chapter 12: Broader health impacts for further details on screening pauses.

- The government provided $74 million in funding for mental health services delivered through telehealth, a dedicated crisis line and other location-specific supports such as Head to Health Hubs.[2946] There was also additional support announced for Medicare Benefits Schedule billed sessions of psychological therapy, where individuals may claim up to 10 sessions from August 2020, which was extended to 20 sessions from October 2020 to December 2022.[2947] See Chapter 12: Broader health impacts for further details.

3.2.Impact

3.2.1. Effects of the pandemic on pregnant women and antenatal care

Pregnant women and mothers were especially affected by the changing health environment. For women who needed maternity services during the pandemic, there was uncertainty and disruption throughout their pregnancy, birth and postnatal experiences.[2948] The Centre for Women's Health said that many pregnant women and new mothers felt unprepared for pregnancy and motherhood because of appointment cancellations, a lack of support from health professionals and being prevented from receiving support of loved ones during maternal health appointments and birth.[2949]

Telehealth services offered some benefits for women receiving maternity care, but studies found women preferred a combination of telehealth and in-person services.[2950] Where telehealth services were the main form of contact between pregnant women and health professionals, the quality of care was much lower and a small number of women reported 'feeling isolated and forgotten'.[2951]

During the pandemic, reduced antenatal care for women led to higher levels of distress and isolation.[2952] Pregnant women felt that they were left to navigate a rapidly changing system with minimal guidance, as there was an increased expectation that they would manage and coordinate their own care.[2953] Respondents in a study on experiences of the maternity care system during the pandemic reported anxiety related to having to perform physical assessments, such as checking blood pressure and weighing their baby, at home before telehealth appointments.[2954]

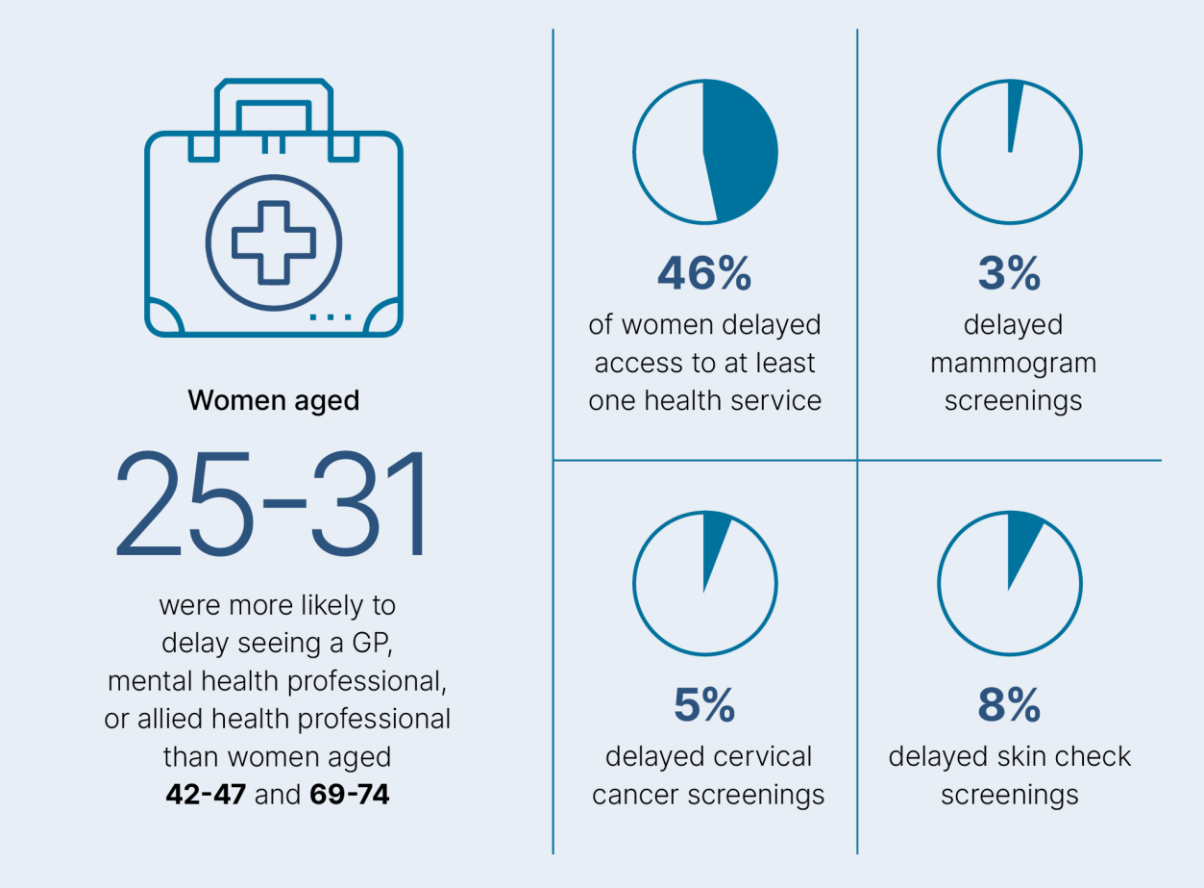
There were also delays and lapses in care for some pregnant women and mothers because appointments were reserved for later stages of pregnancy. Antenatal education was significantly reduced, and mothers and infants were separated unnecessarily after birth.[2955] However, pregnant women also identified some benefits. For example, they found they had a greater level of control over postnatal visitors and more time to recover and bond with their baby.[2956]

The Australian Institute of Health and Welfare has reported on the maternal and perinatal outcomes during 2020 and 2021.[2957] During this time, pregnancy care services were used less often by first-time mothers, and fewer first-time mothers made the recommended 10 or more antenatal visits. Importantly, there was no clear change in the stillbirth rate.[2958]

3.2.2. Delayed and forgone health care

A 2021 ABS survey found that, during COVID-19, females aged 15 and over were more likely than males to delay their use of health services, including GPs, dental services and medical specialists.[2959]

Figure 1: Women's health during COVID-19 restrictions (2020)[2960]



Public health measures also had an impact on access to, and uptake of, cancer-screening programs. Breast-screening services were suspended, so there was a significant decline in the number of mammograms – from more than 70,000 in March 2020 to just over 1,100 in April 2020.[2961] Women under the age of 60 were slower to return to screening mammograms once restrictions eased than women aged 60 and over.[2962]

There are limited data on the impact of suspension of mammogram services on rates of breast cancer and survival since the pandemic. However, one study found 'no evidence of a substantial change in the size of tumours diagnosed by BreastScreen NSW in clients whose breast cancer screening was delayed by the suspension of service due to the COVID-19 pandemic, relative to clients who screened on-time'.[2963] The study said long-term monitoring and evaluation of the impact on breast-screening services is needed so that more robust conclusions can inform similar decisions in future.[2964]

3.2.3. Effects of the pandemic on women's mental health

Women suffered from higher incidence of psychological distress and poorer mental health during the pandemic compared to men. The impact of the pandemic and the government's response on the broader mental health of Australians is explored in Chapter 12: Broader health impacts.

The pandemic's impact on women's mental health was compounded by existing mental health inequalities between genders and by intersectional experiences in people's everyday lives. Women took on a greater share of additional care responsibilities during the pandemic, including for children, other family members and at-risk community members who were self-isolating. Women were faced with 'triple loading' – carrying out paid work, unpaid care responsibilities and the mental labour of worrying for others.[2965] Other forms of inequality and discrimination – in particular, racism, ageism and economic inequality – compounded these mental health impacts for women.[2966]

The Australian Longitudinal Study on Women's Health noted that 'high levels of psychological distress were reported by women during the COVID-19 pandemic in 2020. Younger women were more likely to report high levels of psychological distress during the pandemic than older women'.[2967] Gender Equity Victoria research found that during the pandemic:

- 35 per cent of female respondents said they had moderate to severe levels of depression, compared with 19 per cent of males
- 27 per cent of female respondents said they had moderate to severe levels of stress, compared with 10 per cent of males
- 37 per cent of female respondents aged 18 ·24 said they had suicidal thoughts, compared with 17 per cent of males.[2968]

4. Women's workforce participation and economic security

4.1. Response

The Australian Government's economic response during the pandemic is discussed in detail in Chapter 21: Supporting households and businesses. The pandemic response including public health orders, economic supports and other measures had differential impacts on women. Economic supports included the JobKeeper Payment, the Coronavirus Supplement (and JobSeeker and other income support payments), the Early Release of Superannuation Scheme, JobMaker, HomeBuilder, and temporary free child care.

Specific measures to target women's economic experience over the COVID-19 pandemic included the second Women's Economic Security Statement (released in 2020) and measures included in the 2020–21 and 2021–22 Budget, such as:

- $240.4 million to deliver employment opportunities and support for women and parents in the workplace[2969]

- the $1.8 billion Women's Economic Security Package, including $1.7 billion for new Child Care Subsidy arrangements, and $100 million for other measures including boosting women's workforce participation.[2970]

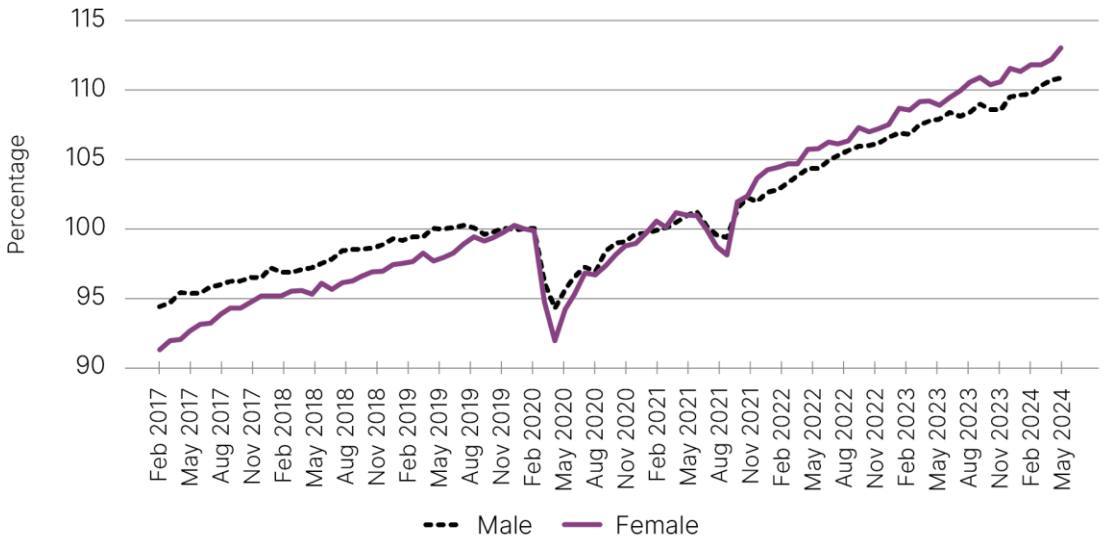
The government also provided funding for schooling and remote learning infrastructure and resources to help manage the transition to home-based learning and reduce the pressure on caregivers. However, there was limited guidance on home-schooling for parents,[2971] and most support was provided by state and territory governments.

4.2. Impact

4.2.1. Women faced different labour market outcomes

The COVID-19 pandemic had a major effect on Australia's labour markets. Employment was significantly reduced because of precautionary behaviour and social distancing requirements. However, women's labour force participation was disproportionately negatively affected, as shown in Figure 2.

Figure 2: Employment by gender (%)[2972]



Women were over-represented in the cumulative rise in unemployment and reduction in labour force participation. Between March and May of 2020, female employment fell by 7.9 per cent compared with 5.7 per cent for males.[2973] Women also faced higher rates of retrenchment. Labour force participation declined by 6.1 per cent for women but only 3.9 per cent for men.[2974] Conversely, employment figures for women recovered at a faster rate, increasing by 9 per cent between July 2020 and March 2022 compared with 5.8 per cent for men.[2975]

Australia has a high level of gendered job segregation. This partly explains why women's employment was affected more than men's – there were often higher employment losses in female-dominated industries.[2976] Also, insecure and short-term casual work is often found in a lot of female-dominated industries.[2977] Short-term casuals were not eligible for JobKeeper, so this disproportionately affected women. On average, 55 per cent of JobKeeper recipients were

male and 45 per cent were female, compared with male and female pre-pandemic shares of employment of 52.9 per cent and 47.1 per cent.[2978]

Frontline workers faced the highest risk of contracting COVID-19. They were also disproportionately women. The health care and social assistance industry is the largest industry by employment in Australia, taking in sectors such as hospitals, GPs, aged care and child care. In 2020 it accounted for 12.6 per cent of Australia's working population and was 77.9 per cent female.[2979]

Female health workers reported significantly increased levels of stress, anxiety, fatigue and occupational burnout during the pandemic.[2980] The mental health burden on health workers was exacerbated by high workloads, the need to severely limit social activity, including with close family at times, uncertainty about personal protective equipment access and correct usage, the impacts of temporary suspension from the workplace because of being a close contact or contracting COVID-19, and lack of communication about rapidly changing health advice.[2981]

Women also experienced larger increases in unpaid domestic work over the pandemic. Caring responsibilities increased for both women and men during the pandemic, but women spent more hours providing care for children or other family members, even in dual-income households.[2982] One study found that in 2020, women spent approximately five hours more per week on unpaid care work compared to men.[2983] This gap grew to nine hours per week when observing couples with dependent children. The same study found the gender gap in unpaid care work widened as a result of the Melbourne lockdown, especially for men and women living in a couple with children and especially in relation to unpaid care.[2984] Most families (64 per cent) used parent-only care during the initial lockdown, and the primary carer both before and during the crisis was predominantly the mother.[2985]

Single mothers were particularly impacted. The Grattan Institute found that single parents, 80 per cent of whom are women, faced a slower recovery from the labour effects of the pandemic.[2986] Many single parents held casual positions in retail and hospitality before the crisis, so were among the first to lose their jobs. It noted that single parents were more likely than parents in couples to drop out of the workforce during the crisis, probably due to caring responsibilities.[2987] Workforce participation rates for single mothers were 10 per cent lower at the peak of the 2020 lockdown – a more significant drop than for other parents – and have taken longer to recover.[2988] A Melbourne Institute report estimated only 13.3 per cent of single mothers received JobKeeper, compared to 17.8 per cent of single fathers and 18.1 per cent of partnered mothers.[2989]

Women's participation in education also declined during the pandemic, with implications for lifetime earnings. Net female enrolments in post-school education fell by around 85,600 in May 2020, relative to May 2019, while male enrolments fell by around 24,400.[2990] Enrolments in vocational training by young women aged 15 to 24 fell by 34,300 while women's enrolment at the graduate and postgraduate levels by women aged 20 to 29 fell by 27,800.[2991] Other studies showed changes in education participation rates relative to pre-pandemic trends varied by age

group, with the greatest disparity observed in the 25 to 29 years age cohort, where women's participation dropped 4.9 per cent below trend compared to 1.6 per cent for men.[2992]

The Inquiry heard the introduction of temporary free child care from April to June 2020[2993] was a positive measure for women. Single parents were the most likely to drop out of the labour force because of unpaid responsibilities.[2994] Additional caring responsibilities tended to fall on women, so the introduction of temporary free child care meant many women could keep working through the initial lockdowns. Early childhood education and care (ECEC) is also a female-dominated industry (97.6 per cent of ECEC teachers are female),[2995] so this measure both directly and indirectly boosted women's labour force participation. ECEC is explored further in Chapter 14: Children and young people and Chapter 24: Supporting industry.

Working from home had a mixed effect on women. Some have noted the option to work from home has boosted female labour force participation.[2996] The 2020 Household, Income and Labour Dynamics in Australia (HILDA) Survey found significant positive association between the increase in working-from-home arrangements and job satisfaction among women who were employed in both 2019 and 2021.[2997] However, some have also noted potential negative impacts from this increase, which were exacerbated in cases where working from home formed part of mandated lockdowns.[2998] These include a greater expectation to respond to more family and household demands during work hours, and loss of advancement opportunities due to reduced visibility and in-person interaction.[2999]

4.2.2. Economic supports disproportionately supported male-dominated industries

The panel heard many of the economic supports were targeted at male-dominated industries, while female-dominated industries were often excluded from support. In addition to the exclusion of short-term casuals, industries excluded (either explicitly or implicitly) from JobKeeper tended to be female-dominated, such as childcare and universities.

> *[D]espite women and female-dominated industry sectors bearing the brunt of the pandemic – men and male-dominated sectors were progressively targeted for industry and individual government support. – National Foundation for Australian Women*[3000]

There was, however, a separate measure targeted to the ECEC sector, with the Child Care Subsidy supporting families to access affordable child care and the government paying child care services an additional Transition Payment of $708 million to replace the JobKeeper Payment.[3001]

Some have criticised the JobMaker Plan[3002] for its gender imbalance. This scheme targeted male-dominated industries such as construction (87.9 per cent male) and manufacturing (72.9 per cent male).[3003] Other industry supports also tended to be for male-dominated sectors, such as construction through HomeBuilder.

Monash University estimated that although the 2020–21 Budget included new spending of $240 million over five years to enhance women's financial security, this would represent 'only

0.04 per cent of the Budget', even though the pandemic had a significant impact on women's employment.[3004] In the 2021–22 Budget; however, the Women's Budget Statement was reintroduced – the first since 2013. It boosted support for women, with $1.8 billion over five years to improve women's workforce participation and economic security.[3005] The overwhelming majority of this ($1.7 billion) was for childcare affordability.[3006]

4.2.3. The gender superannuation gap widened

The panel heard the Early Release of Superannuation Scheme disadvantaged women, further widening the gender superannuation gap.

> *Allowing Australians to plunder their super for purposes other than retirement has disproportionately impacted women and low-income earners, and for some, their balances will never recover. – Women in Super*[3007]

The gender gap in super balances has been narrowing over the last decade, but women in Australia still retire with about 20 per cent less superannuation than men on average.[3008] This is mostly because they have lower lifetime incomes or are less likely to have a super account to draw upon (especially older women). Data from the Australian Prudential Regulation Authority shows that the gender gap in super balances widened between June 2019 and June 2021.[3009] Stakeholders were concerned that women and single parents (mostly women) were the ones who accessed the most super under the scheme. Men had a higher take-up of the scheme than women, in all age brackets, but women withdrew a greater proportion of their account balance compared with men.[3010]

In 2020 Women in Super and the Australian Institute of Superannuation Trustees found that the gender gap in superannuation doubled for women under 34 if they used the Early Release of Superannuation scheme. Women aged 25 to 34 withdrew on average 35 per cent of their balance, compared with 29 per cent for men in the same age bracket.[3011]

5. Evaluation

The Sex Discrimination Commissioner, Kate Jenkins, noted that most governments failed to apply a gender lens to their pandemic responses, exacerbating existing inequalities and leaving more women further behind.[3012] Mechanisms that better target gender inequities for future pandemics must be underpinned by ongoing advances in gender equity.

The shadow pandemic

The COVID-19 pandemic exacerbated pre-existing challenges around gender inequality and violence against women. Social distancing and isolation measures used during the pandemic increased the risk of FDSV. A combination of economic insecurity, overcrowded housing, substance abuse, limited access to services and reduced peer support exacerbated these risks.

The public health orders that were put in place during COVID-19 were crucial to stemming the rate of transmission of the virus and minimising harm across all levels of households and society. However, it is likely they also increased fear, uncertainty and financial stress in many

households, creating a greater risk of FDSV. Governments and the community services sector showed leadership and agility in recognising quickly that public health orders would have an impact on women at risk of experiencing FDSV. The National Partnership Agreement on COVID-19 Domestic and Family Violence Responses and supporting key FDSV support services at the beginning of the pandemic were important in minimising the harm of public health orders.

The strength of community-led responses

Throughout the pandemic, the community services sector showed exceptional leadership, agility and innovation in their provision of critical services and support, particularly for those who experienced FDSV.

Many providers noticed a change in the types of individuals seeking their services, a change in the type of service they needed and an increase in the complexity of services they sought. These changes were happening at a time when organisations were losing their volunteer workforce and needing to upskill staff on new ways of delivering services. Without the agility these organisations showed in providing support services to some of the most disadvantaged in our communities, Australia's experience of the COVID-19 pandemic would have been vastly different. We owe much to the response by community services providers.

Economic support as a protective factor

During the pandemic, the increases in income support were important protective measures against FDSV. The main purpose of these measures was to protect individuals from income losses during the pandemic (see Chapter 21: Supporting households and businesses); however, they had the additional benefit of reducing financial stress and helping households, especially women, to escape financial stress and leave difficult situations. Even though it was established late in the pandemic, the Escaping Violence Payment also played a role in assisting women to escape FDSV. We note the Leaving Violence Program has been extended after its trial period, with the government noting the 'insidious links between financial insecurity and stress and vulnerability to family and domestic violence'.[3013]

The challenge of data

It is challenging to evaluate the effect of the pandemic on rate of FDSV, due to data discrepancies inherent in the nature of data collection for FDSV. These discrepancies, arising from the lack of a nationally consistent definition for family and domestic violence, result in seemingly contradictory evidence on FDSV incidence. This in turn creates challenges for effective evaluation and policymaking. This is an issue not only in context of the COVID-19 pandemic. Nationally coherent datasets on the instance and impact of FDSV would give policymakers crucial evidence that would allow them to apply a gendered lens and evaluate the impact of policies on specific cohorts and communities.

The differential impact on women's health and access to health care should have been considered more carefully

The government's response to the pandemic had various direct and indirect effects on women's health and access to health services. These challenges underscored the need for greater consideration of the implications of public health orders on women's mental health and continuity of health care, particularly antenatal and postnatal care.

During the pandemic, women delayed or did not access health care they should have had. This shows there is a need for a more coordinated government response, with public health messaging that focuses on maintaining access to health care and supporting mental health.

It is clear that women faced greater mental health challenges because they took on additional care, work and household responsibilities. To minimise harm, the panel considers that greater consideration and support needs to be given to overall health and mental health wellbeing for the community – in particular, women – in future crises. The panel also considers that there is a need for broad-based support for community groups and organisations that focus on women's health, including mental health. Organisations that handle referrals and follow-up services should also be supported.

Although data on the impacts of suspended medical screening services for women, such as breast cancer screening, have not shown there has been an increase in post-pandemic illness or severity of illness, it is essential that strategic management of risks posed by missed or cancelled appointments is considered during a prolonged crisis.

Telehealth had limitations for maternity care

Many women used telehealth services for maternity care during the pandemic. While it was necessary during the pandemic and may serve as a supplementary service in the post-pandemic context, telehealth should not replace face-to-face maternity services.[3014] Post-pandemic research indicated that 'quality of care was compromised when it came to properly assessing women, establishing rapport and effectively communicating'.[3015] The Queensland Nurses and Midwives' Union noted in its submission that:

> *In preparing for future pandemics there must be a balance between responding to a pandemic and the needs of the community. This is especially important in supporting normal, healthy life events such as childbirth. – Queensland Nurses and Midwives' Union*[3016]

Telehealth services need to be better structured to provide the continuity of care that women need from maternity services. Telehealth provided a sense of safety, as women could get health advice without risking infection, but it is clear that in a public health emergency the government needs to provide better communication and leadership around the implementation of telehealth services where continuity of care is required.

Reduced face-to-face interactions with healthcare providers also had a direct impact on women's wellbeing throughout their antenatal care. An over-reliance on telehealth services that

are not suitably equipped to provide adequate maternal care, coupled with inadequate access to psychological treatment, resulted in poor mental health outcomes for mothers.

The panel notes the MBS Review Advisory Committee's *Telehealth post-implementation review final report* was published in March 2024. However, it does not include recommendations on the use of telehealth during a crisis situation, including for maternity care. The use of telehealth services in the maternity care context should be carefully considered to inform future crisis responses.

Government economic supports would have benefited from a gender lens

As outlined in Chapter 20: Managing the economy and Chapter 21: Supporting households and businesses, Australia's economic response to the pandemic was effective and acted to minimise the economic and social harms that resulted from the pandemic. Women benefited from the unprecedented level of economic support that was available, especially JobKeeper and the Coronavirus Supplement. Overall, these supports helped to reduce unemployment and mitigate extreme financial stress.

However, the lack of a gender lens resulted in the design of government pandemic policies exacerbated gender imbalances. In particular, short-term casuals, ECEC workers and public universities were not eligible for JobKeeper, and this disproportionately affected women. Industry supports also tended to favour male-dominated industries.

The Early Access to Superannuation scheme resulted in women of all ages withdrawing a greater share of their superannuation balance than men. As outlined in Chapter 21: Supporting households and businesses, blanket early access to superannuation was not an appropriate policy response, and in future existing financial hardship processes should be relied upon instead.

While female labour force participation has recovered, and indeed surpassed pre-pandemic levels, this was not due to government policy intent and does not negate the disproportionately negative impact of the pandemic on women's economic security. Governments should consider how to support women during the pandemic, particularly given existing gender imbalances, the likely significant impact on female-dominated industries and the additional burden of caring responsibilities. In a future pandemic, applying a gender lens to the design of policies would help to better target supports and improve equity. A future government response should seek to remove existing gender imbalances and not exacerbate them to the detriment of women.

6. Learnings

- Policy measures should be analysed and developed through a gender lens to avoid adverse or disproportionate impacts on women. Policies should align with efforts to enhance gender equality more broadly.
- FDSV increases during and after crises, and the pandemic was no exception. During a crisis, the Australian Government must prioritise funding and measures to prevent and respond to FDSV.
- Greater economic security is a protective factor for women during crises. Financial support is important during times of crisis, when risk factors for FDSV increase.
- Women's mental health was disproportionately impacted during the pandemic. In a future crisis, governments should better target mental health support where the need is greatest.
- Community services providers play an important role in responding to a crisis. Governments should provide increased support to these providers to improve access to services during and following a crisis.
- The government's response to a pandemic can significantly affect women's ability to participate in the workforce. In future crises, the economic response should align with promoting gender equality, rather than exacerbating current imbalances.

7. Actions

7.1. Immediate actions – Do in the next 12–18 months

Action 6: Develop legislative and policy frameworks to support responses in a public health emergency, including for an Economic Toolkit.

The Economic Toolkit should:

- include measures that can be tailored to respond to different forms of economic crisis, including a public health emergency, with an appropriate gender lens applied.

Action 18: Proactively address populations most at risk and consider existing inequities in access to services (health and non-health) and other social determinants of health in pandemic management plans and responses, identifying where additional support or alternative approaches are required to support an emergency response with consideration for health, social and economic factors.

- All plans and response measures should have an equity lens applied, including for health, social, human rights and economic factors (see Action 1).

Action 19: Develop a communication strategy for use in national health emergencies that ensures Australians, including those in priority populations, families and industries, have the information they need to manage their social, work and family lives.

The strategy should account for the distinct communications preferences and requirements of priority populations – including:

- reflecting the key role of community and representative organisations in communicating with priority populations, including community service providers
- funding community and representative organisations to tailor and disseminate communications through appropriate channels and trusted voices
- providing plain English messaging to community organisations for tailoring in a timely manner.

7.2.Medium-term actions – Do prior to the next national health emergency

Action 25: Continue to invest in monitoring and evaluating the long-term impacts of COVID-19, including long COVID and vaccination adverse events, mental health, particularly in children and young people, and educational outcomes.

- Where evidence from ongoing monitoring and evaluation shows long-term impacts of the COVID-19 pandemic continue to be seen, governments must ensure policies and programs in place are tailored to actively address the impacts.
- Evidence collected from ongoing monitoring and evaluation should inform plans and responses to future public health emergencies in order to mitigate similar long-term impacts.

Economic and Industry Response

Overview

At the end of February, 2020, when Finance Ministers and Central Bank Governors from G20 countries met in Riyadh, Saudi Arabia, the full scale of the COVID-19 health crisis was only starting to emerge. It was clear that the pandemic would be unprecedented in the modern era. However, in the weeks following, it quickly became clear that the COVID-19 virus would lead to an economic crisis as well. Within five weeks, the Australian Government had announced over $213 billion in three separate economic support packages:

> *The pandemic was unlike any other downturn in recent history and precipitated the most severe economic downturn since the Great Depression. It was a health crisis before it became an economic crisis. Public health restrictions and cautious behaviour by people who didn't want to catch the virus severely disrupted daily life and led to a sharp decline in output. – Dr Stephen Kennedy PSM, Secretary to the Treasury*[3017]

In the 100 years since the last global pandemic, the world's economic and financial systems had changed almost beyond recognition. There was no precedent for how households or businesses, and therefore the economy, would respond or recover from such an event. Pre-existing pandemic plans did not deal with the economic impacts or involve any planning for potential economic supports. This meant that decision-makers needed to respond to the biggest economic shock in living memory without the benefit of a pre-developed playbook.

There was initially extreme uncertainty about the economic impacts of the COVID-19 pandemic. It was not known how the virus would change and spread over time; whether and when a vaccine would become available; and what a return to normal would look like.

In response to the pandemic, many businesses quickly started reducing their workforces to limit costs and control cash flows. Policymakers were faced with rapidly rising unemployment rates, business failures and a sudden increase in the number of people seeking social security payments (many for the first time in their lives) as the true impact of pandemic began to become clearer. The long lines of Australians outside Services Australia centres seeking financial assistance are some of the enduring images of the COVID-19 pandemic.

Many industries were also disproportionately impacted. Some were too critical to fail, and others were unable to continue operating. Supply chains faced massive disruptions as pandemic responses to control the transmission of the COVID-19 virus hampered the free flow of goods over domestic and international borders. The pandemic also posed significant challenges to Australia's workplaces, with workers facing heightened risk of infection. Essential workers bore the brunt of the pandemic, increasing their risk of exposure to the virus while still working to keep Australians safe.

The subsequent economic response was critical in achieving the desired public health outcomes. It helped people to adhere to restrictions while ensuring they kept their jobs and had the support they needed to weather the effects of the pandemic. Governments were driven

to provide unprecedented levels of support because of concerns of prolonged unemployment for households, as well as the impact of sustained loss of demand and restrictions on businesses and industries.

Overall, Australia's initial success at managing the health and economic crisis during 2020 meant that our economy performed well relative to comparator countries, and households and businesses were protected from the worst of the potential pandemic economic impacts. To achieve this success in a period of high uncertainty, Australia needed strong economic leadership that prioritised harm minimisation above all other considerations.

The economic response strengthened the health response, by supporting adherence to the public health measures. In turn, in 2020 the success of the public health response minimised the economic impact and positioned the economy well for recovery.

However, delays in the vaccine rollout through 2021, inadequate support for some industries and individuals, the long tail and unintended consequences of some of the supports, the failure to anticipate supply-side constraints and the surge in global demand when economies reopened all had negative economic consequences. These included widespread labour and housing shortages and persistently high inflation, which almost five years after the pandemic continues to have repercussions for the Australian economy.

Through examining the economic management of the COVID-19 pandemic in Australia, the Inquiry has documented the lessons for a future pandemic. This required evaluation, with the benefit of hindsight, of what worked and what did not. Such a process in no way diminishes the contribution that many made to protecting the livelihoods of Australians during the pandemic, but is done to ensure that we are better able to respond in the future.

This section will examine the Australian Government's economic management during the pandemic and the economic crisis in Australia that resulted from both the pandemic itself and the restrictions governments imposed to contain the spread of the virus. Chapter 20: Managing the economy covers the aggregate economic impacts, drawing the high-level lessons for future economic management during a pandemic. Chapter 21: Supporting households and businesses explores the design of economic policies and their distributional effects.

In Chapter 22: Supply chains, the impacts of the pandemic and associated public health restrictions on domestic and international supply chains will be outlined, along with the government's response. Chapter 23: Workers and workplaces will explore the impact of the pandemic on workplaces and the broader workforce, including essential workers. Industry-specific issues are considered in Chapter 24: Supporting industry.

Timeline

- 12 March 2020: First economic support package of $17.6 billion for households and businesses.
- 16 March 2020: Reserve Bank of Australia announces expansion of Australian Government bonds purchasing in the secondary market.
- 19 March 2020: Reserve Bank of Australia announces the yield target and the Term Funding Facility to lower costs for the banking system.
- 20 March 2020: Reserve Bank of Australia cuts the cash rate from 0.5 per cent to 0.25 per cent
- 22 March 2020: Second economic package providing an additional $66.1 billion.
- 30 March 2020: Third economic package announced, including the JobKeeper payment.
- 24 April 2020: Australian Government announces the $1 billion COVID-19 Relief and Recovery Fund.
- 3 June 2020: March quarter National Accounts show the economy contracted by 7 per cent, the largest fall on record.
- 4 June 2020: The HomeBuilder program announced.
- 21 July 2020: JobKeeper Payment and Coronavirus Supplement extended.
- 3 August 2020: Pandemic Leave Disaster Payment announced.
- 7 August 2020: Freight Movement Code for the Domestic Border Controls – Freight Movement Protocol released.
- 1 September 2020: Reserve Bank of Australia announces the extension and expansion of the Term Funding Facility.
- 6 October 2020: 2020–21 Budget announced, after being deferred from May.
- 3 November 2020: Reserve Bank of Australia announces a $100 billion bond purchasing program.
- 4 November 2020: Cash rate is cut from 0.25 per cent to 0.10 per cent.
- 2 February 2021: Reserve Bank of Australia announces the bond purchasing program will be expanded by a further $100 billion when the initial program is completed.
- 28 March 2021: End of the JobKeeper Payment.
- 31 March 2021: End of the Coronavirus Supplement.
- 11 May 2021: Release of the 2021–22 Budget.

- 3 June 2021: Temporary COVID-19 Disaster Payment announced.
- 6 July 2021: Reserve Bank of Australia announces that the bond purchasing program will be continued from September to at least mid-November 2021.
- 29 September 2021: Government announces winding-down of COVID-19 Disaster Payment.
- 2 November 2021: Reserve Bank of Australia announces that the yield target is discontinued.
- 20 December 2021: COVID-19 Disaster Payment closes.
- 1 February 2022: Reserve Bank of Australia announces its decision to cease further purchase under the bond purchasing program.
- 29 March 2022: Release of the 2022–23 Budget.
- 30 September 2022: End of the Pandemic Leave Disaster Payment.

Chapter 20 – Managing the economy

1. Context

Leading up to the COVID-19 pandemic, Australia's economy had not experienced an official recession in almost 30 years but had been in an extended period of moderate economic growth. Unemployment stood at 5.2 per cent – higher than most estimates of 'full employment'.[3018] In the five years before the pandemic, wages growth had been low by historical standards, averaging 2.1 per cent in the five years before the pandemic, and inflation was largely below the Reserve Bank of Australia's target of 2 to 3 per cent.[3019]

After a period of low wages growth and an undershooting of the inflation target, household consumption growth was at its lowest levels in six years.[3020] Going into the pandemic, fiscal policy was focused on returning the budget to surplus. Meanwhile, monetary policy had become increasingly expansionary in the face of slow economic growth. After three rate cuts in 2019, the cash rate stood at 0.75 per cent, leaving little room for conventional monetary policy in the event of an economic shock.[3021]

Reflecting the changing economic challenges during each phase of the pandemic, this chapter is divided into three sections. The first section focuses on the initial response to the pandemic during the alert phase, which spans from the emergence of COVID-19 to the end of the initial nationwide lockdowns in May 2020. The second section covers the next two phases of the pandemic, which includes the ongoing management of the economy following the initial lockdowns, through to the late stages of the vaccine rollout at the end of 2021. The third section considers the reopening of the economy and macroeconomic trends coming out of the pandemic.

The chapter ends with key lessons for a future pandemic, before identifying actions for government to put Australia in a better position for a future public health crisis.

2. The alert phase of the pandemic

In the very early stages of the alert phase of the pandemic it was anticipated to have only a limited impact on Australia's economy. The main economic effects were expected to be from the impact on global supply chains and from reduced travel from our largest trading partner, China, including tourists and international students. However, once the virus reached Australia and a global pandemic was declared, it became clear that the virus would have direct and profound economic impacts.[3022]

Health restrictions and economic supports were progressively rolled out in March and April 2020. The alert phase was marked by the highest levels of uncertainty about the virus, including its health and economic effects. The potential course of the pandemic, including the characteristics of the virus, prospects of a vaccine and the length of health restrictions were all unknowable. This made forecasting the economic outcomes with any certainty impossible. In February and March 2020 attempts were made to model different scenarios. These models

placed the economic impacts of COVID-19 between 0.3 per cent and 7.9 per cent of gross domestic product (GDP), reflecting the level of uncertainty.[3023]

The pandemic involved both a demand and a supply shock to Australia's economy. People engaged in precautionary behaviour because of community transmission of the virus, and uncertainty about its risks and long-term effects. In seeking to lower their risk of contracting the virus, people reduced their spending on activities that would increase their risk of exposure to the virus, such as eating out or attending live entertainment. Others tried to limit their risk of exposure in their workplace by reducing the hours they worked. To add to this, public health orders effectively closed parts of the economy.

As a result of the demand and supply shocks on the Australian economy, household services consumption significantly reduced, while goods consumption remained robust. There was a record fall in employment. Between March and May 2020 around 880,000 fewer people (6.9 per cent of pre-pandemic employment) were employed.[3024] The largest falls in employment were seen in industries like arts and recreation services (35 per cent) and accommodation and food services (30 per cent).

During the alert phase of the pandemic, economists almost unanimously supported the public health measures on the basis that the best health policy was also the best economic policy.[3025] Economic modelling from McKibbon and Fernando highlighted the benefits of controlling the virus spread.[3026] However, the panel heard there were concerns that the welfare losses from the pandemic control measures did not outweigh the benefits.[3027] More broadly, it was consistently stated that the emphasis on measures to control the virus often failed to account for broader economic impacts.[3028]

2.1. Response

The economic response to the initial shock of the COVID-19 pandemic was characterised by the evolving nature of the crisis. Early responses were typical of those used in a standard economic downturn. There was an easing in monetary policy through a 25 percentage point reduction in the cash rate and fiscal measures to support aggregate demand (such as stimulus payments to social security recipients and increasing the instant asset write-off provisions for small businesses). These measures were shaped by the early understanding that the pandemic's main effects would result from an economic downturn in China, and from the reduction in international students and tourists coming to Australia.

On 5 March 2020 the Secretary to the Treasury stated that Treasury's preliminary assessment was that COVID-19 would detract 'at least half a percentage point from growth in the March quarter 2020'.[3029] Once it was clear that the virus was present and spreading in Australia, governments put in place restrictions to limit its spread. By the end of March, the Treasury considered a fall of GDP of around 20 per cent to be possible.[3030]

With this higher estimate of the economic impact of COVID-19, the government's understanding of the amount of economic support that would be required also rapidly evolved. Over three weeks in March 2020, the government announced three economic stimulus

packages totalling an estimated $213.7 billion.[3031] Each package built on the last in terms of the volume and value of measures. The Reserve Bank of Australia also acted to support the economic response, including through the use of both conventional and unconventional monetary policy. A full account of these measures is in Chapter 21: Supporting households and business.

The government's response was designed to be timely, temporary, targeted and tailored to the shock.[3032] The Prime Minister outlined a further set of principles on 10 March 2020. He stated that policies must be proportionate to the degree of the shock; timely and scalable; targeted; aligned with other arms of policy (in particular, monetary policy and state and territory governments); use existing delivery mechanisms where possible; be temporary and include an exit strategy; and favour measures that would lift productivity.[3033]

As occurred during the Global Financial Crisis, there was an initial focus on maintaining confidence through the direct economic supports to households. However, once the nature of health restrictions became clear there was a pivot to supporting businesses to maintain employment. The government wanted to prevent otherwise productive businesses from closing and maintain employment connections to reduce labour force 'scarring'.[3034] This occurs when an adverse experience for a worker as a result of macroeconomic conditions, such as an economic downturn, has negative long-term impacts on their labour market outcomes.[3035]

With the rapid escalation of the pandemic in Australia, and with its marked difference from previous economic downturns, the Treasury made a number of significant changes internally. It adapted its macroeconomic analysis framework, which typically focused largely on the demand side of the economy, and instead used new frameworks that looked through an industry and labour market lens.[3036] To support timely and granular analysis of rapidly changing conditions during the pandemic, the Treasury and the Australian Bureau of Statistics expanded their use of 'real-time' data. The Treasury also established the Coronavirus Business Liaison Unit to engage directly with peak business groups on systemic issues relating to COVID-19.[3037] The Prime Minister established the National COVID-19 Coordination Commission to address similar issues. See Chapter 4: Leading the response for further discussion of the Coronavirus Business Liaison Unit and the National COVID-19 Coordination Commission.

Use of data during the COVID-19 pandemic

The COVID-19 pandemic highlighted the need for timely and granular data to inform rapid policy decision-making. The scale and agility of data sharing that was possible during COVID-19, and the number of new high-frequency and granular datasets that are now available, represents a step change in Australia's data landscape.

To support the economic response, the Australian Bureau of Statistics secured and utilised new sources of real-time data, such as integrating administrative data from the Australian Taxation Office's Single Touch Payroll and income support payments administered by the Department of Social Services into the Person Level Integrated Data Asset, credit card spending data from the major banks and more. Single Touch Payroll is an administrative dataset of payroll information, covering most businesses and employees in Australia.[3038] Payroll information reported includes

employee salaries, wages, Pay As You Go withholdings and superannuation.[3039] Single Touch Payroll was originally designed to reduce administrative payroll burden by standardising messaging and reporting for small-and-medium businesses.[3040]

As the Treasury's report *Looking under the lamppost or shining a new light: New data for unseen challenges* notes, 'the timeliness and broad coverage of Single Touch Payroll made it valuable in assessing the health of the labour market in close to real time'.[3041] The integration of Single Touch Payroll with JobKeeper data also enabled policymakers to model fiscal policy response options. Similarly, the credit card spending data from banks was used to monitor changes in consumer spending and behaviour in response to lockdowns.

However, as noted by the Treasury, making use of large and novel datasets requires investment in specialist data analytics skills and computer systems ahead of time.[3042] The success of JobKeeper may not have been possible without the Treasury's and Australian Taxation Office's investment in such capabilities. Further, there were some legal barriers to the use of some datasets, particularly data held by the Australian Taxation Office. The *Coronavirus Economic Response Package Omnibus (Measures No. 2) Act 2020* allowed the Treasury to use de-identified tax data for policy development and analysis in relation to COVID-19. Investment in data capability and removing barriers to data agility are key to the success of any future public health emergency response.

Beyond direct fiscal and monetary support, regulators gave businesses relief from usual regulatory requirements, in line with the model of regulatory stewardship.

Economic and financial regulation changes in response to the COVID-19 pandemic

Australia's economic and financial regulators took various actions to reduce business reporting requirements, minimise uncertainty and enable coordinated actions for businesses that are usually competitors.[3043]

Australian Securities and Investments Commission
1. Temporary relief to enable certain 'low doc' (requiring less documentation) offers to be made to investors, assisting Australia's capital markets to remain strong and efficient
2. Extended periods for lodging financial reports
3. New measures to manage record trading volumes and ensure the equity market remained effective and resilient – for example, requiring market participants to limit transaction volumes at the peak of trading in 2020; and continuing to monitor the performance of markets and financial market infrastructures

Australian Prudential Regulatory Authority
1. Adjustment to bank capital expectations
2. Delay of the authority's 2020 supervision and policy priorities
3. Change to reporting obligations for some of its regulated entities

Australian Competition and Consumer Commission
1. Adjustment to processes and analysis to more quickly grant urgent interim authorisations for cooperation amongst competitors, where this was in the public interest

2.2.Impact

The government's initial response to the COVID-19 pandemic came at a significant fiscal cost. However, stakeholders largely viewed it as highly successful. In particular, the economic response supported the health outcomes the government was aiming to achieve and provided protection against serious negative effects of the pandemic.

2.2.1. Health measures imposed a significant economic cost

In early 2020 voluntary social distancing and the closure of international borders had already started to reduce economic activity. However, in March 2020 mandatory 'stay at home' measures were introduced. These effectively closed parts of the economy.

The pandemic's effects were asymmetrical, with some industries almost completely closed for the sake of public health while others were able to continue to operate. This caused a significant disruption to the 'circular flow' of money between sectors of the economy. Early estimates of this potential 'second round' effect were as much as twice that of the direct initial effect.[3044]

> *Treasury developed forecasts based on which sectors were being shut down and used our macroeconometric model to assess the spill over effects. We expected there to be large forecasting errors, but falls in GDP of around 20 per cent were being seriously contemplated. – Dr Stephen Kennedy PSM, Secretary to the Treasury 3045*

Australia recorded the biggest drop in employment on record, but it was below early estimates of the potential impacts of social distancing requirements of between 1.9 and 3.4 million jobs.[3046] The asymmetric effects of the pandemic meant that younger people and women were more likely to have their employment impacted.[3047]

The Inquiry heard that the size of the shock and the relatively low replacement rate of the JobSeeker Payment (at 37.5 per cent of the minimum wage or 24.4 per cent of the median wage)[3048] meant that traditional automatic stabilisers were insufficient to counteract the costs of these lockdowns.[3049]

Australian Government pandemic supports were key in protecting employment relationships and protecting Australian workers who lost their jobs. The near-universal economic supports provided high (but uneven) levels of compensation to those who lost income. These supports flowed through to industries not affected by social distancing requirements, helping limit any further loss of economic activity.

2.2.2. The economic response supported health outcomes, which in turn supported economic outcomes

The public health measures announced in March 2020 effectively closed 'riskier' and 'non-essential' parts of the economy, reducing social contact to suppress the spread of the virus.

Without economic supports, the entire cost of suppression would have been borne by those employed in or owning businesses in these industries.

The panel heard that financial strain and uncertainty can place a heavy burden on people.[3050] Many stakeholders suggested that the measures introduced to ease this financial strain significantly increased compliance with health restrictions but also made a positive difference for other health and social outcomes – for example, improved mental health and wellbeing and reduced incidences of poverty.[3051]

> *Economically vulnerable individuals face the most challenging difficulties in coping with lockdown rules and have more substantial incentives to break social distancing norms. – Deiana, Geraci, Mazzarella and Sabatini*[3052]

However, the exclusion of certain groups of workers from these supports left some in extreme financial distress, including temporary residents.

Overall, Australia was able to achieve high levels of compliance with health measures in the early phase of the pandemic.[3053] This compliance and the early closure of Australia's international border resulted in low rates of hospitalisation and deaths from COVID-19 compared with other comparable countries. International evidence from the COVID-19 pandemic suggests that compliance with emergency health measures increased with economic supports and perceptions of fairness of the policy response.[3054]

The success of early health restrictions also contributed to stronger economic outcomes. Economic modelling of the COVID-19 pandemic finds that a successfully implemented public health policy supports stronger economic outcomes.[3055] But because there remains a trade-off between the severity of an economic downturn and the level of health restrictions,[3056] the optimal public health settings are those needed to support the successful health response.

2.2.3. Australia largely protected itself against significant negative effects

Between the December quarter of 2019 and the June quarter of 2020, Australia recorded its first recession in almost 30 years, with GDP falling by 6.9 per cent.[3057] However, Australia was mostly able to mitigate severe economic impacts. The pandemic recession differed from past recessions in that, to a large extent, it was deliberately engineered and there were higher levels of social support in place.

> *Although economic activity contracted and the effects of the pandemic on the economy were large, Australia outperformed all major advanced economies in 2020. – The Treasury*[3058]

Most organisations and individuals the panel spoke to saw Australia's aggregate economic response to the pandemic as successful during the alert phase. Most strongly agree that, despite the uncertainty, the size of the initial fiscal response was proportionate to the size of the economic downturn.[3059] In support of this, economic modelling by Chris Murphy found that an 'optimal' fiscal policy (with the benefit of hindsight) would include a similar sized initial response.[3060]

The design of some of the larger policies contributed to this proportionality. Major policies such as JobKeeper and the increase to JobSeeker through the Coronavirus Supplement aimed to compensate those who lost income due to the pandemic, were demand driven and therefore linked to the size of the economic downturn.[3061]

Australia's decline in employment was much smaller than in many other advanced economies. Japan and Korea had a smaller decline in the number of persons employed, but Australia had a much smaller decrease in total hours worked.[3062]

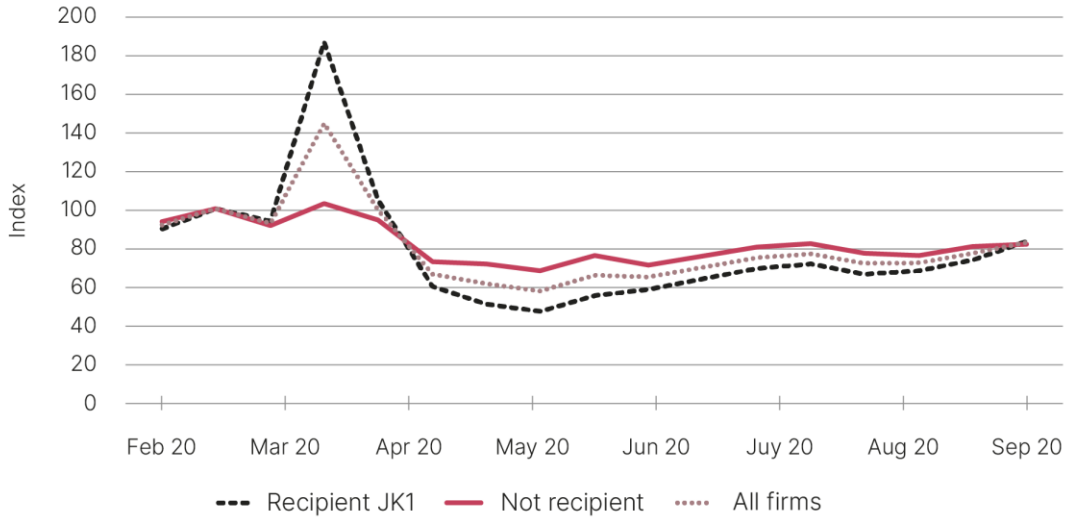
Watson and Buckingham (2023) estimated that, combined, Boosting Cash Flow for Employers and JobKeeper saved around 1.1 million to 1.3 million job-years.[3063] Staff at the Reserve Bank of Australia estimate that JobKeeper alone reduced total employment losses by at least 700,000.[3064] However, some have suggested that these studies overestimate the number of jobs saved – for example, by counting stand-downs as saved jobs.[3065] The Independent Evaluation of the JobKeeper Payment estimated that between 300,000 and 800,000 jobs were saved (or 2½ per cent to 6 per cent of pre-pandemic employment).[3066] Chris Murphy (2024) found that, excluding stood-down workers, the macro policy response reduced the peak unemployment by 2.0 per cent.[3067]

However, the design of supports in this initial period could have been improved in ways that would have increased value for money for taxpayers and supported the subsequent economic recovery (see Chapter 21: Supporting households and businesses).

In particular, JobKeeper, which aimed to maintain existing employment relationships, could have been implemented earlier. This may have reduced job losses. Between the announcement of the restrictions and the announcement of JobKeeper, 160,000 persons applied for JobSeeker.[3068] Foreign companies were not eligible for JobKeeper, so there were greater job losses in those companies.

> *Large queues of people displaced from work sought income support from Centrelink in the week commencing 22 March. – The Treasury*[3069]

Figure 1: Job separations by JobKeeper status (index)[3070]



While the closure of international borders halted new arrivals, many temporary migrants chose to leave Australia because they were not initially eligible for economic supports. Government messaging encouraged many of these temporary migrants to return to their home countries.[3071] Many stakeholders indicated that this contributed to the skills shortages experienced after the pandemic.[3072]

The Inquiry also heard that, if the government were designing economic supports with the full benefit of hindsight, it may not have used some of the earlier supports.[3073] In particular, many noted that some of the early measures were more typical of a standard economic downturn and designed to support demand.[3074] Such policies are less appropriate during a period of heavy supply disruptions. However, the first instalment of these more traditional stimulus payments, made in March 2020, may well have been appropriate if the economic impacts had remained more indirect, and this was not necessarily foreseeable at the time.

2.2.4. Economic supports did not just replace lost income; they gave extra

As the pandemic reduced economic activity, both household incomes and business revenues were expected to decline. The initial economic supports aimed to compensate households for lost incomes and provide cash flow support to businesses. The early health advice was that restrictions would need to be in place for around six months, and this was factored into the design of JobKeeper and the Coronavirus Supplement. However, Australia was able to begin relaxing health restrictions much earlier, and we heard this contributed to households and businesses being overcompensated.[3075]

Unusually for a recession, household disposable income and profits increased during 2020.[3076] The Inquiry heard that this increase in disposable incomes and in profits is strong evidence that Australia's economic supports overcompensated recipients for lost profits during the pandemic.[3077] Murphy (2023) estimates that, for the average small business operating at the eligibility ceiling for JobKeeper, it alone provided on average $2 compensation for each $1 of lost profits.[3078] If supports had been designed to turn on and off with the health restrictions, as occurred later in the pandemic, this overcompensation would have been reduced. The panel heard that in future we should aim to make no-one worse off, but also no-one better off as a result of pandemic supports.

The panel also heard divergent views as to whether modelling different scenarios including more targeted and time-dependent supports during the alert phase was possible. There was a view that it was not possible because take-up of JobKeeper may have been lower and household and business behaviour different.[3079] There was a broad view among economists and stakeholders that it was better to err on the side of providing too much support than too little.[3080] The then Treasurer, the Hon Josh Frydenberg, has confirmed that this was the advice at the time:

> *In the early months of the pandemic, Treasury's explicit advice was that it would be worse to underspend or withdraw support too quickly than to put extra dollars*

into the economy. It was advice we accepted and I am glad we did. – The Hon Josh Frydenberg[3081]

2.2.5. Financial markets were resilient

The onset of the COVID-19 pandemic had a marked effect on financial markets. After a period of stable (but moderate) growth, low inflation, low interest rates and low financial market volatility, the prices of a range of risky assets had been at high levels. Concerns about the economic effects of the virus and associated health restrictions led to steep declines in equity prices and an increase in bank and corporate bond spreads.[3082] This carried a risk of a contraction of credit as lenders sought to restore their capital holdings by reducing lending or by increasing interest rates on loans.[3083] If this were to eventuate, there was a risk the health crisis would create a financial crisis.

Australia's banks entered the pandemic in a strong position. Reforms implemented after the Global Financial Crisis increased the resilience of the global financial system, with banks having more capital and liquidity than previously.[3084] Australia's banks were among the world's most capitalised banks, and Australian businesses generally had low levels of debt.[3085] Household debt was high by international standards, but strong prudential policies in previous years (and strong asset positions for households) meant that borrowers typically had buffers to draw on, and mortgage arrears were low before and during the pandemic.[3086] That said, there were times during the pandemic when the Australian Government debt market was severely dislocated, reflecting similar forces affecting United States Treasuries. Equity prices also fell sharply and corporate term debt and asset-backed securities markets were significantly impaired.

During March 2020 the AOFM [Australian Office of Financial Management] had limited ability to raise funding due to dislocations in markets, while government funding requirements were materially increasing. The RBA [Reserve Bank of Australia] intervention into the Treasury Bond market announced in late March was successful in clearing the congestion and allowed the AOFM to substantially increase issuance. – The Treasury[3087]

Australia's banks and regulators helped to reduce some of the financial strain on individuals and businesses over this period by offering deferrals on loans.[3088] By agreeing to a uniform approach, the banks avoided adding further confusion to the already large number of new economic supports available. The Australian Competition and Consumer Commission facilitated the provision of standardised processes and conditions, and financial regulators ensured that customers' credit ratings would not be adversely affected by accepting a loan deferral. Almost one million customers took up a loan deferral over the pandemic, although not all stopped their repayments.[3089] The loan deferrals became available a full two and a half weeks before JobKeeper was announced, providing a form of insurance to mortgagees and businesses facing significant uncertainty over this period.[3090]

Interventions by the Reserve Bank of Australia, including government bond purchases in secondary markets and the provision of liquidity to the banking system through open market operations, helped to clear the dislocations in the Australian Government debt market. Other financial regulators also took actions that helped to maintain market functioning, such as limiting the number of daily trades when trading volumes were putting undue strain on market infrastructure.[3091]

3. The suppression and vaccine rollout phases of the pandemic

The next two phases of the pandemic were the suppression phase that followed the initial lockdowns in March 2020, and the vaccine rollout phase, which commenced in February 2021 and ended in late 2021 when Australia reached its target of 80 per cent vaccination.

After the rapid economic policy response to the initial pandemic shock, attention shifted to how to manage the economy during a pandemic and when a vaccine would become available. By early May 2020 national COVID-19 cases were down to fewer than 20 new cases a day.[3092] On 8 May 2020 National Cabinet announced a three-step recovery plan to ease restrictions. However, states eased restrictions at differing rates.[3093]

In late June 2020, just as states were easing restrictions, case numbers in Victoria started to rise again following a breach in its hotel quarantine program.[3094] Between 30 June and 9 July 2020 numerous Melbourne postcodes were put into lockdown. On 9 July a six-week lockdown was announced for metropolitan Melbourne and the Mitchell Shire. Restrictions continued to escalate, and on 2 August 2020 a state of disaster was declared in Victoria. This coincided with the closure of state borders. For example, on 8 July 2020 New South Wales closed the border to Victoria for the first time in over a century.[3095]

By the end of 2020, with the virus contained in Victoria, restrictions on activity were reduced and most state borders, apart from Western Australia's, were opened. Large parts of the economy continued to operate as normal. By the March quarter of 2021 the level of economic activity exceeded pre-pandemic levels.[3096] International border restrictions remained. Those restrictions affected the supply of labour and certain industries, including the education and tourism sectors.

The United States Food and Drug Administration gave the first COVID-19 vaccine emergency approval at the end of August 2020. The vaccine rollout commenced in the United States in December 2020. Australia's approach to vaccine procurement and approvals lagged behind other countries.[3097] This, as well as issues with vaccine rollout, contributed to Australia reaching vaccine targets later than other advanced nations. This is discussed further in Chapter 10: The path to opening up. By the time Australia started its rollout at the end of February 2021, the United States had administered 73 million doses.[3098] From March to late July 2021 Australia had the lowest vaccination rate in the Organisation for Economic Co-operation and Development (OECD). It only exceeded the OECD average from 27 October 2021.[3099]

Throughout 2021 state governments imposed local and state-based lockdowns in response to virus outbreaks. The longest lockdowns occurred in New South Wales and Victoria when the

Delta variant emerged in mid-2021. A number of state borders were also closed, limiting domestic travel and tourism and creating significant uncertainty. The economy contracted again in the September quarter of 2021 and unemployment, which had fallen to 4.6 per cent in August 2021, increased to 5.3 per cent in October 2021.[3100] Once vaccine targets were met and restrictions were eased, the economy quickly recovered. Economic growth of 3.7 per cent was recorded in the December quarter alone, and unemployment had dropped to 4.2 per cent by the end of 2021.[3101] However, there was still uncertainty about whether there would be more lockdowns into 2022 and when the international and state borders would be fully reopened.

3.1. Response

After the period of rapid policy development during the alert phases, there was an opportunity to review and refine economic supports, and the policy focus turned to economic recovery.

When the JobKeeper Payment was first announced, it was designed to be in place for six months and end on 27 September 2020. However, on 21 July 2020, following a three-month review, the JobKeeper Payment was extended for a further six months until 28 March 2021. At that point a number of design changes were made to improve targeting.[3102] The panel heard these refinements would not have been possible at the outset without delaying JobKeeper's introduction.[3103]

The Reserve Bank of Australia also extended its monetary policy supports. In September 2020 it announced the extension and expansion of the Term Funding Facility and updated its yield target.[3104] The yield target and messaging from the Reserve Bank Governor created a strong public perception that interest rates would not increase until 2024.[3105] On 4 November 2020 a final 15 basis point cash rate cut was announced, bringing the cash rate to 0.10 per cent. Inflation was –0.3 per cent through the year in June 2020. In its November 2020 Statement of Monetary Policy the Reserve Bank of Australia was forecasting inflation to be 1.5 per cent through the year at the end of 2022.[3106]

At its November 2020 meeting, the Reserve Bank of Australia also announced a reduction in the target for the yield on the three-year Australian Government bond to around 0.1 per cent, a reduction in the interest rate on new drawings under the Term Funding Facility to 0.1 per cent, and the establishment of a Bond Purchasing Program for the purchase of $100 billion of government bonds of maturities of around five to 10 years over the following six months.[3107]

The October 2020–21 Budget (which was deferred from May because of the impact of the COVID-19 pandemic) set out the government's Economic Recovery Plan for Australia.[3108] Its revised fiscal strategy sought first to facilitate economic recovery by promoting employment, growth and business and consumer confidence. Policies tended to support industries that are traditionally impacted during a recession, not those that had been heavily impacted due to the pandemic. Once unemployment returned 'comfortably below' 6 per cent, the strategy was to return to the medium-term fiscal objectives of stabilising and then reducing gross and net debt as a share of GDP.[3109]

The 2020–21 Budget included $74 billion in measures under the JobMaker Plan to lower the unemployment rate, which was not forecast to reach pre-pandemic levels until 2023–24.[3110] Also, there was a further $25 billion in the COVID-19 response package for the ongoing management of the pandemic, including the extension of JobKeeper and the vaccine rollout.

The JobKeeper Payment and the Coronavirus Supplement ended at the end of March 2021 (28 March and 31 March respectively) after being in place for one year.[3111] In June 2021, with lockdowns occurring in New South Wales and Victoria, the Australian Government once again provided support for individuals who were not able to work because of COVID-19 outbreaks. Due to data limitations with the Single Touch Payroll system used to deliver JobKeeper payments, it was not possible to localise the payment to areas that were having outbreaks and lockdowns. The panel also heard that there was concern that the Australian Government would create moral hazard by providing financial support for state-based lockdowns.[3112]

The COVID-19 Disaster Payment and the COVID-19 Disaster Leave Payment supported people in areas with outbreaks. Ultimately, $12.9 billion in COVID-19 disaster payments was provided to over 2.3 million Australians during the pandemic.[3113]

Without JobKeeper, which had also provided support to businesses affected by lockdowns, state and territory governments introduced a range of business support measures. Initially the states and territories unilaterally funded these, but subsequently the Australian Government co-funded them through bilateral agreements.[3114] Reporting and data-sharing requirements were built into these agreements so that the Australian Government could monitor how and where program money was being used.

The May 2021–22 Budget continued the focus on supporting the health response and the economic recovery. It included $1.9 billion for the COVID-19 vaccination strategy and $1.5 billion in other health measures, and a further $28.5 billion in tax and $15.2 billion in infrastructure measures to support economic recovery that was underway.[3115] By May 2021 unemployment had dropped to below pre-COVID levels and GDP was above pre-pandemic levels.

With the vaccine rollout underway, the Treasury engaged in an innovative partnership with the Doherty Institute to provide integrated health and economic advice to government on the relaxation of restrictions.[3116] This capability had not been available during the alert phase of the pandemic.

In July 2021 the Doherty Institute modelled a range of scenarios that considered the likely transmission of the Delta variant at different national vaccination rates under varying levels of restrictions. The Treasury then estimated the direct economic costs of these restrictions. The results were used to inform the National Plan to Transition Australia's National COVID-19 Response, which was agreed by National Cabinet on 6 August 2021.[3117] The plan set targets of 70 per cent and 80 per cent of the adult population to be vaccinated so that various restrictions could be lifted.[3118]

3.2.Impact

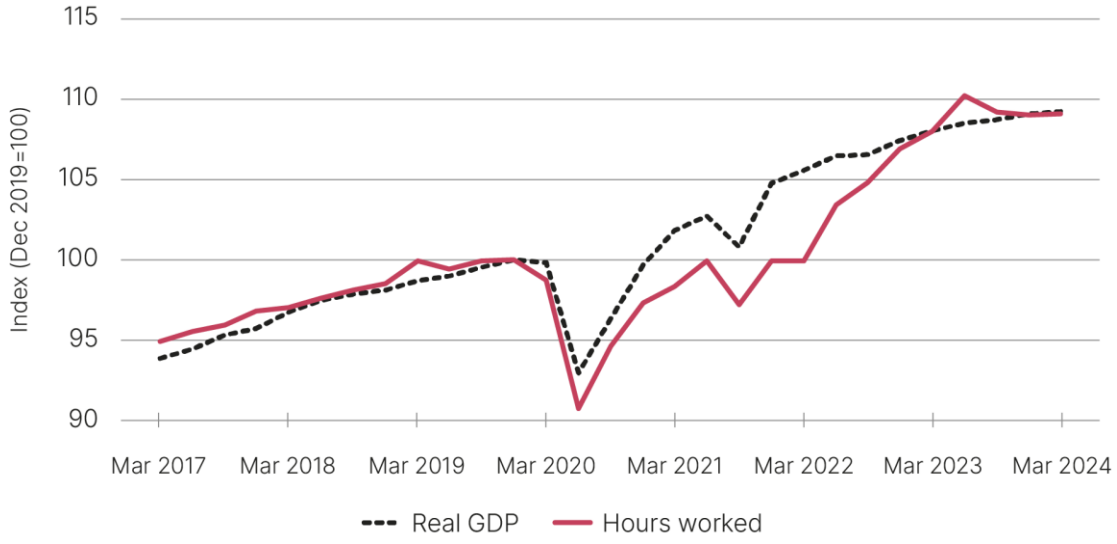
3.2.1. Economic activity recovered quickly following the initial lockdowns

Whether the economy would be able to bounce back was a matter of some debate early in the pandemic. While the Prime Minister expressed a strong belief that it would 'snap back',[3119] evidence on the 'shape' of a pandemic recession was unclear. As the Grattan Institute noted in April 2020:

> *History tells us that recovery from periods of high unemployment is rarely fast. This time may be different: the recession has been deliberately engineered as a matter of public health, and substantial economic support is in place. But the longer and more severe the downturn, the less likely the labour market can spring back afterwards. – Coates, Cowgill, Chen and Mackey*[3120]

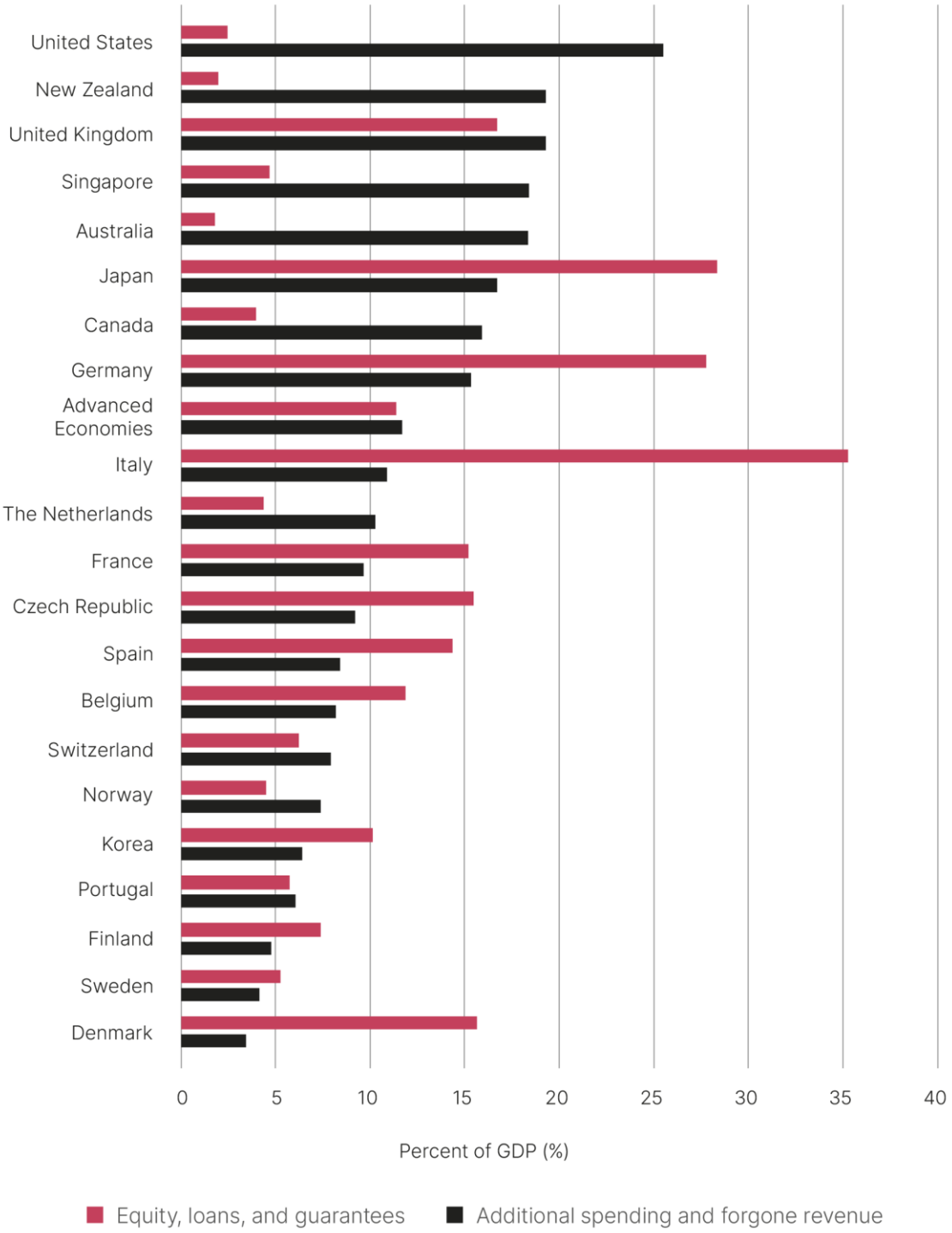
The successful suppression of the virus during 2020 enabled the economic recovery, which was stronger than most economists had forecast and well ahead of official forecasts from either the Reserve Bank of Australia or the Treasury. After the large falls in the June quarter of 2020, both total hours worked and GDP had recovered to pre-pandemic levels by the March quarter of 2021.[3121]

Figure 2: Real GDP and hours worked[3122]



The overall size of Australia's fiscal response to the pandemic was similar to those of other advanced economies (see Figure 3), but Australia was one of few countries to record an increase in household disposable income.[3123] We heard that the relative success of the health response was a significant driver of this increase. It meant Australia experienced a less severe economic downturn than many other countries and a faster economic recovery after the initial nationwide lockdowns.

Figure 3: Discretionary fiscal responses (per cent of GDP)[3124]

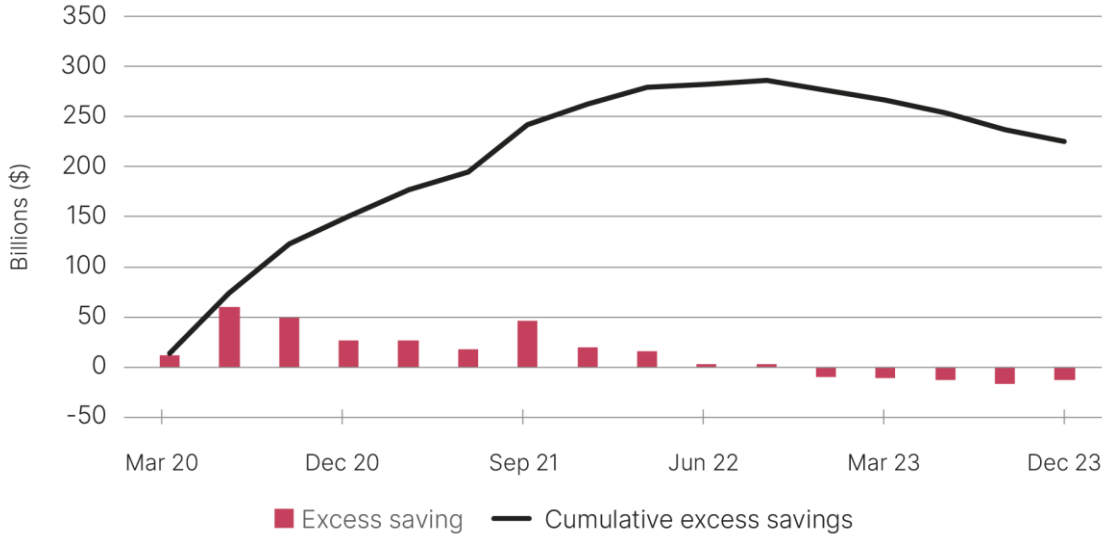


3.2.2. Savings increased across the economy

A record decline in household consumption, combined with increases in household disposable income, resulted in the household saving ratio surging to a peak of 24 per cent in the June quarter of 2020. The Reserve Bank of Australia estimates that, over the pandemic, Australian households saved almost $300 billion above pre-pandemic trend levels – representing around 20 per cent of annual disposable income.[3125] These savings started to be drawn down from late 2022 as interest rates became elevated; however, as of March quarter 2024 they remain high in

aggregate, with almost two-thirds of these savings yet to be drawn down (as shown in Figure 4) – although remaining savings are unevenly held across households.

Figure 4: Pandemic-related excess savings ($ billions)[3126]



These elevated savings, combined with historically low interest rates, contributed to a sharp increase in asset prices, particularly for housing. Dwelling prices initially fell by 2.1 per cent between April and September 2020, but subsequently surged.[3127] By February 2022 national dwelling prices were 24.6 per cent above their pre-pandemic level.[3128]

3.2.3. Despite fiscal consolidation, the macroeconomic environment remained stimulatory

There was steep fiscal consolidation in the 2021–22 financial year.[3129] However, ongoing fiscal support measures contributed to the Commonwealth Budget remaining in deficit, with government expenditure above pre-pandemic levels. Although many fiscal supports were phased out as intended, such as JobKeeper and the Coronavirus Supplement, others were extended, such as the low and middle income earner tax offsets.[3130]

Fiscal and monetary policy settings, along with the surge in demand when health restrictions were lifted, contributed to the strong household consumption seen throughout 2021 and 2022. Inflation had started increasing in other advanced countries through 2021. In Australia the annual inflation rate recorded went above the Reserve Bank of Australia's target range in the June quarter 2021, reaching 3.8 per cent, on its way to a peak of 7.8 per cent at the end of 2022.[3131]

Modelling by Chris Murphy (2024) finds that peak inflation could have been reduced by 2.1 per cent if macroeconomic policy settings had better matched the health restrictions, and the Reserve Bank of Australia had started lifting interest rates in May 2021 instead of May 2022 (Figures 5 and 6).[3132] The modelling demonstrates that on aggregate the fiscal settings in the alert phase were broadly appropriate, but that in subsequent phases households and businesses were overcompensated.[3133] He also finds that, under the optimal macroeconomic settings, monetary policy would have begun tightening in May 2021, at which point

unemployment had returned to around pre-pandemic levels and the Reserve Bank of Australia was forecasting trimmed mean inflation to remain below 2 per cent until June 2023.[3134]

Figure 5: Public net borrowing[3135]

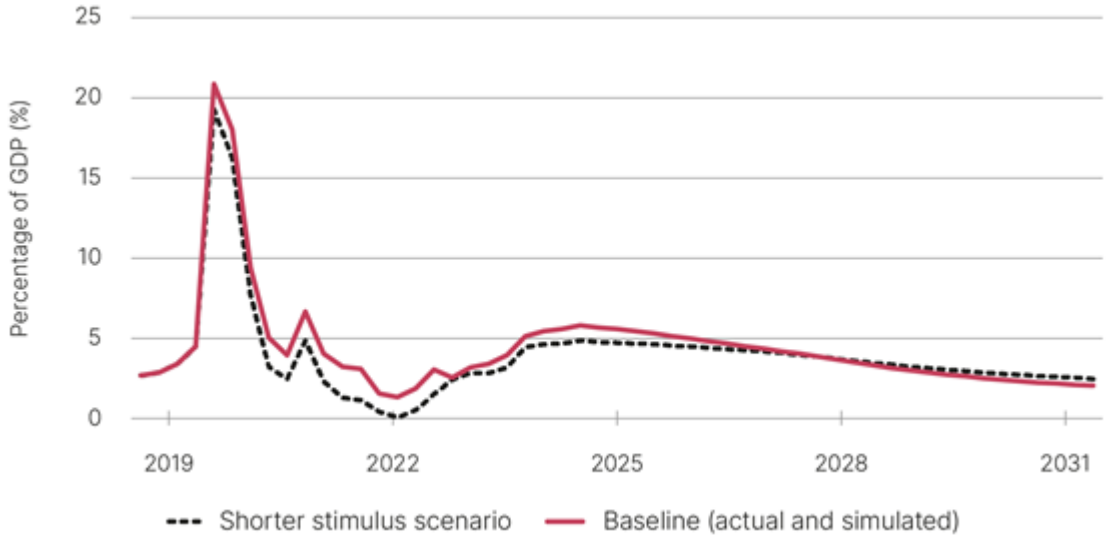
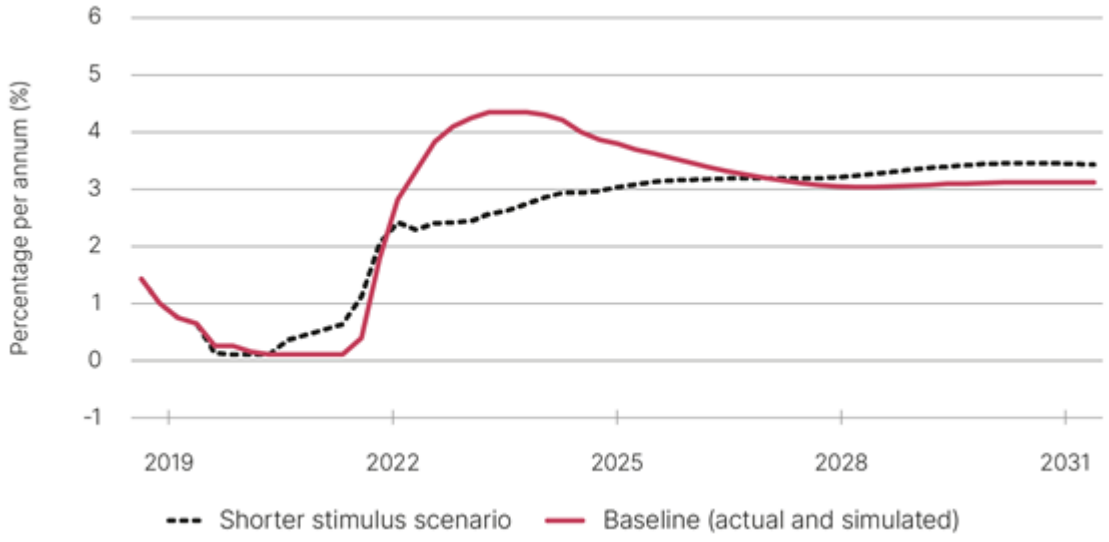


Figure 6: Interest rates[3136]



This post-pandemic analysis shows that optimal economic pandemic responses are likely to require levels of fiscal support well outside a normal recession; however, targeting of economic supports and matching them to health restrictions is important to reduce inflationary pressures during the recovery.

3.2.4. The pandemic supports also included some distortionary effects

Labour mobility declined at the onset of the pandemic. This is typical for an economic downturn as workers are less confident about switching jobs and there are fewer employment opportunities.[3137] However, there was evidence that JobKeeper increased this tendency because there was uncertainty about future health restrictions and the JobSeeker Payment was lower.[3138]

The Inquiry also heard concerns that, in the later stages of JobKeeper, the payment was largely supporting unproductive businesses as the economy recovered.[3139] Evidence indicates that to some extent it inhibited productivity-enhancing reallocation of workers[3140] – the tendency for more productive firms to expand (and less productive firms to contract) – which boosts long-term growth in an economy.

The Independent Evaluation of the JobKeeper Payment supported these findings, noting that there was a cost to productivity-enhancing labour mobility but that it was relatively small and temporary, and larger in the extension phase.[3141]

> *In the first six months of the program, JobKeeper went disproportionately to more productive businesses, particularly ones that were financially fragile and which may have had difficulty surviving a period of reduced revenue during restrictions. This helped prevent longer-term scarring by preserving important business-specific capital, knowledge and relationships. – The Treasury*[3142]

While many stakeholders noted these effects, most agreed that the benefits of JobKeeper far outweighed any negatives from this distortion.[3143] There were also significant long-term productivity benefits from 'hibernating' otherwise productive businesses through the pandemic.[3144]

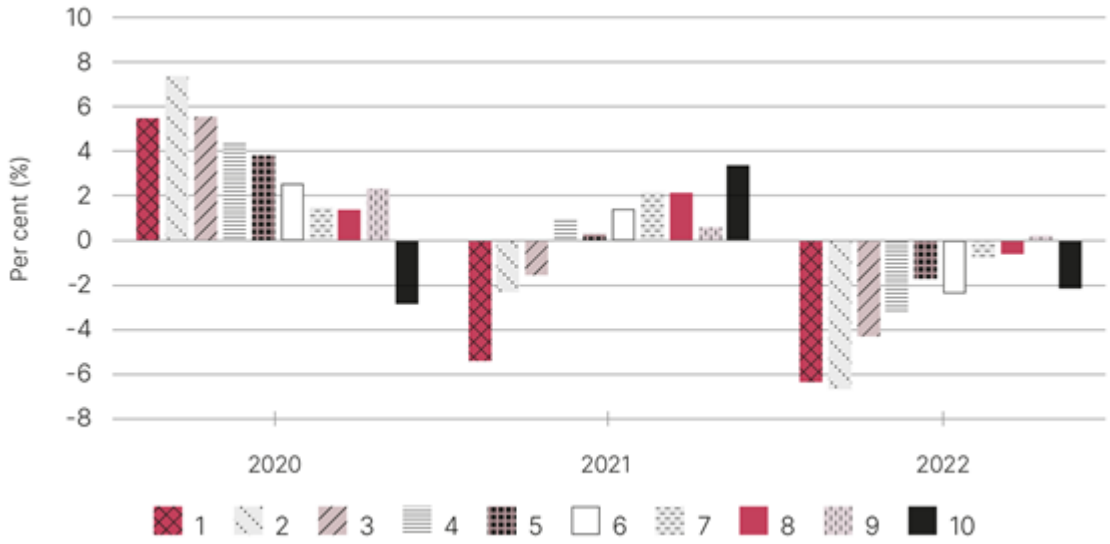
3.2.5. Many of the social gains over the pandemic were quickly reversed

The level of income inequality and poverty in Australia decreased early in the pandemic because of the introduction of JobKeeper and the Coronavirus Supplement.[3145] This was despite the rise in unemployment.[3146]

Although employment and earnings recovered in the first half of 2021, income inequality and rates of poverty increased when income supports were withdrawn.[3147] When the Coronavirus Supplement was cut to $75 per week in 2020 it led to rates of poverty increasing, exceeding pre-pandemic levels.[3148] Poverty rates rose again with the supplement's withdrawal in March 2021.[3149] This demonstrates how important the supplement was in protecting households at the height of the pandemic restrictions.

Productivity Commission analysis confirms that the lowest income deciles experienced the highest rates of growth in household disposable income between 2018–19 and 2019–20, but they experienced the sharpest contraction in disposable income in later years.[3150]

Figure 7: Annual change in median equivalised household disposable income by decile[3151]



Note: Income fixed to June 2023 dollars.

3.2.6. Delay in vaccine rollout had large economic costs

Many stakeholders said that Australia's relatively slow vaccine rollout had a significant economic cost.[3152] Australia ultimately achieved a high rate of vaccination, but through much of 2021 Australia had one of the lowest vaccination rates in the OECD.[3153] If Australia had achieved a high rate of vaccination earlier, it could have avoided much of the strict Delta lockdowns in the second half of 2021. One study estimates that, compared with international best practice, Australia's delayed vaccine rollout had a direct economic cost of $31 billion through additional lockdowns.[3154] The vaccine rollout is discussed in greater detail in Chapter 10: The path to opening up.

The Inquiry heard that the extent to which procuring a full supply of all leading vaccines allowed for an earlier reopening would have had a positive cost–benefit ratio compared with Australia's actual vaccine procurement strategy.[3155] That said, the portfolio approach (of buying different types of vaccines rather than all of them) was supported by health experts and by reviews of vaccine procurement.[3156] These reviews also note that it is unlikely that the Therapeutic Goods Administration would have had capacity to assess all leading vaccines.

The Treasury analysis of the scenarios modelled by the Doherty Institute for the spread of the Delta variant at different levels of vaccination placed the direct economic costs of nationwide strict lockdowns at $3.2 billion per week, while low-level restrictions had a direct cost of $0.65 billion. However, it was found that, without high levels of vaccination, a strategy of minimising cases would have a lower cost than a strategy of allowing higher levels of community transmission.[3157]

Some stakeholders told the panel that, even though states had agreed the National Plan to Transition Australia's National COVID-19 Response, they continued to take different approaches, reducing confidence that the plan would be followed.[3158] We heard that this

uncertainty made it difficult to forecast outcomes in the later stage of the pandemic, so it was harder to assess the level of stimulus required.[3159]

4. The transition/recovery phase

The transition/recovery phase of the pandemic marked Australia's transition out of pandemic restrictions and the reopening of the economy. Australia reached 80 per cent vaccination in late 2021. Public health restrictions began to be removed and economic supports phased out.

The reopening also coincided with the emergence of the Omicron variant. Omicron was milder than previous strains, but it was highly transmissible, and vaccines were less effective in protecting against the new variants. Omicron claimed the highest number of lives of any of the COVID-19 waves to hit Australia.

As infection rates increased so did demand for testing, and a shortage of rapid antigen tests (RATs) emerged. The inability to acquire a RAT and their cost impacted people's willingness to travel, work and engage in activities. With isolation requirements for positive cases still in force, there was a high level of absenteeism from work, which impacted output across the economy.

While the economy was still impacted by the pandemic throughout 2022, there were no further lockdowns. Restrictions were progressively relaxed, although mandatory isolation requirements continued until 20 September 2022. However, other shocks emerged – for example, the invasion of Ukraine by Russia in March 2022, which added to global inflationary pressures. China continued to enforce lockdowns throughout 2022, and restricted travel into and out of the country impacted the bounce-back in international tourist and student numbers in Australia.

The international border was reopened in a staged manner from 1 November 2021. All restrictions on vaccinated arrivals were lifted from 22 February 2022. Net overseas migration reached almost 400,000 during 2022[3160] and over 500,000 in 2022–23 – the highest financial year net overseas migration on record.[3161]

In July 2022 unemployment fell to the lowest rate since the 1970s. Inflation continued to increase, reaching a peak of 7.8 per cent in the December quarter of 2022.[3162] Job vacancies across the economy surged to a peak of more than double the pre-pandemic levels, and there were widespread labour shortages in sectors that had been most affected by restrictions – for example, hospitality and tourism.[3163]

4.1. Response

As Australia neared the established target of 80 per cent of the population fully vaccinated, restrictions started to be removed and the remaining economic supports for households began to be phased out.

On 29 September 2021 the government announced that, once a state achieved the threshold of 70 per cent of the population aged 16 years or older fully vaccinated (two doses of a COVID-19 vaccine), the COVID-19 Disaster Payment would cease to be automatically renewed. From that

time recipients would need to reapply each week for the payment to confirm that they remained eligible.[3164]

As states reached 80 per cent of the population aged 16 years or older vaccinated, the payment was stepped down over a two-week period and then abolished. The payment fully ceased when Western Australia became the final state to become fully vaccinated on 13 December 2021.[3165]

On 1 November 2021 the international 'Do Not Travel' restriction was removed, corresponding with 80 per cent of the population over 12 years of age being fully vaccinated.[3166] At this point there was a staged reopening of inward international travel for fully vaccinated visa holders.[3167] Australia's borders were fully reopened to all fully vaccinated visa holders in February 2022 and to all visa holders regardless of vaccination status from 6 July 2022.[3168]

Extraordinary monetary policy measures also began to be phased out.[3169] On 2 November 2021 the Reserve Bank of Australia announced that the yield target would be discontinued following stronger than expected inflation and a rise in bond yields.[3170] The Reserve Bank of Australia also announced it would cease further purchases under the Bond Purchase Program on 1 February 2022, with final purchases on 10 February 2022.[3171]

The government provided free rapid antigen tests for eligible concession card holders under the COVID-19 Rapid Test Concessional Access Program. The program was announced on 5 January 2022, and continued until 31 July 2022.[3172]

Western Australia's border, the final state border to remain closed, was reopened on 3 March 2022 and all emergency measures declared under the *Biosecurity Act 2015* (Cth) ended on 17 April 2022.[3173]

With headline inflation reaching 5.1 per cent, and trimmed-mean inflation at 3.7 per cent, the Reserve Bank of Australia commenced monetary tightening on 4 May 2022, increasing the cash rate to 0.35 per cent (from 0.10 per cent).[3174] Subsequent increases resulted in a 425 basis point increase in 18 months, and headline inflation peaked at 7.8 per cent in December 2022.[3175]

4.2. Impact

4.2.1. The economy performed strongly coming out of the pandemic, with the labour market continuing to tighten

After the strong rebound growth of 3.7 per cent in the December quarter of 2021, the economy continued to grow through 2022 and recorded 3.9 per cent annual growth in the year ending December 2022.[3176] This was broadly consistent with Reserve Bank of Australia forecasts from the beginning of 2021.[3177]

Even though economic supports had been withdrawn, the labour market performed strongly. In December 2021 the unemployment rate was at 4.2 per cent, well below its pre-pandemic level and almost 2 per cent below Reserve Bank of Australia forecasts at the beginning of 2021.[3178] It continued to decrease, and by July 2022 it had reached a low of 3.5 per cent, the lowest level since the 1970s and below previous estimates of full employment (or the non-accelerating

inflation rate of unemployment). There was also a large decrease in long-term unemployment. The number of persons unemployed for over a year increased during 2020 and 2021 but fell below its pre-pandemic level in early 2022. In July 2023 it recorded its lowest level since 2009.[3179]

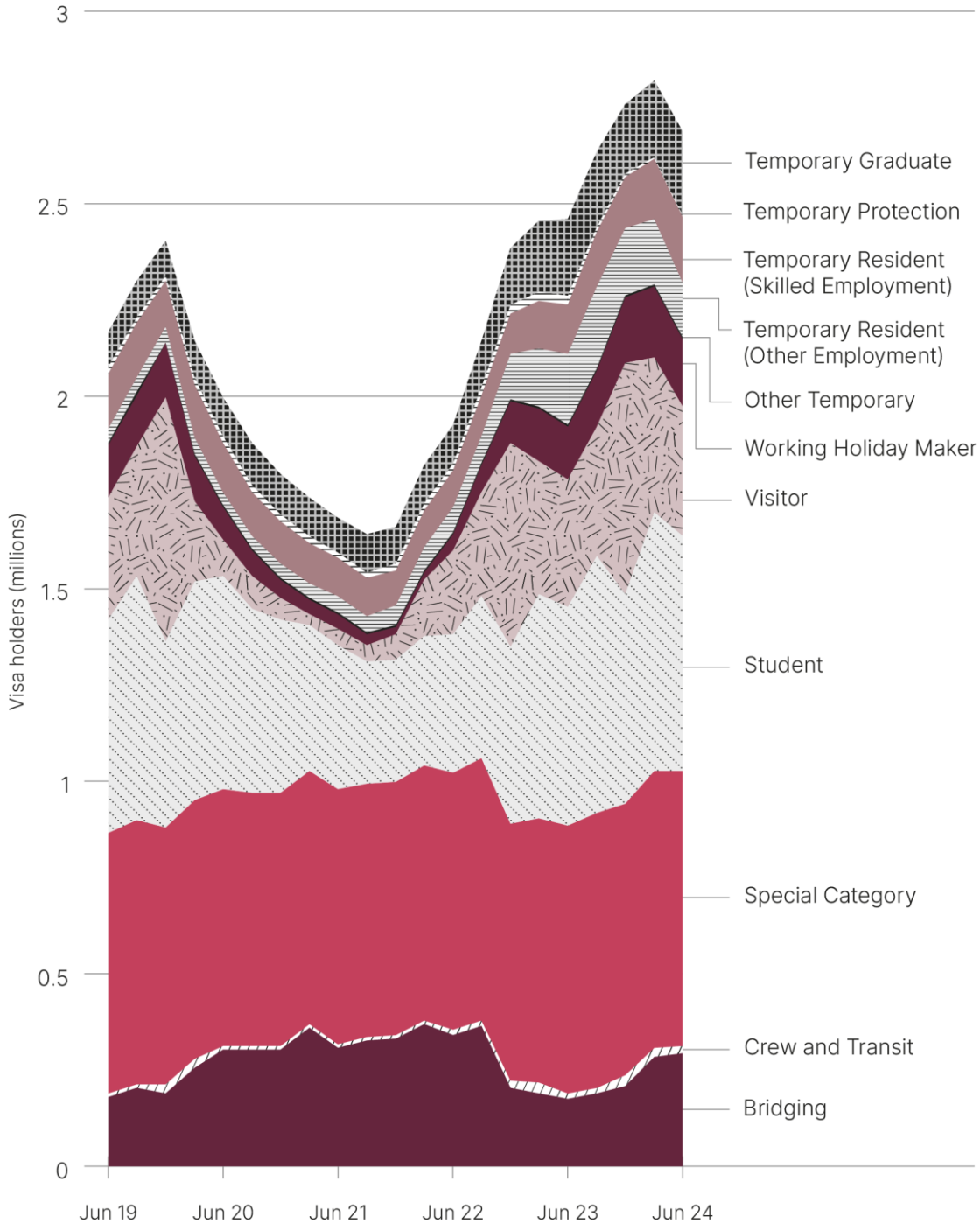
While many returned to the workplace, there was a high level of absences due to ill health. The Australian Bureau of Statistics Business Conditions and Sentiments survey reported in January that 22 per cent of businesses had employees unavailable due to COVID-19.[3180] This corresponded with a 7.2 per cent seasonally adjusted fall in hours worked between December 2021 and January 2022, as worker absenteeism due to ill health increased.[3181]

Over time, Australia's participation rate and employment to population ratio both increased above pre-pandemic levels and to historical highs. Having fallen during the pandemic, the female participation rate increased to record highs. The Inquiry heard that the strength in the labour market was at least in part due to the success in maintaining employment connections throughout the pandemic.[3182]

While most advanced economies experienced low unemployment rates after the pandemic, many, including the United States and the United Kingdom, did so with much lower participation rates. There appears to be some relationship between countries that protected employment connections and higher participation, which warrants further study.[3183]

Despite the strength in participation, there were widespread skill shortages. Job vacancies hit just under 400,000 at the end of 2021, on the way to a peak of 476,000 in May 2022 – over double the pre-pandemic levels.[3184] Many of the industries with the greatest need for labour were those heavily reliant on temporary migrants for labour. The closure of international borders had stopped the inflow of temporary workers during the pandemic. As temporary migrants were not initially eligible for support payments, many had left the country during the pandemic. There were more than half a million fewer temporary visa holders in Australia in September 2021 than June 2019.[3185] The number of temporary visa holders in Australia only returned to pre-pandemic levels in the March quarter of 2023.[3186] Migration is examined in more detail in Chapter 7: Managing the international border.

Figure 8: Temporary visa holders by type (millions)[3187]



4.2.2. Inflation continued to rise following reopening

As Australia transitioned out of health restrictions, inflation was at the top of the Reserve Bank of Australia's target band of 2 to 3 per cent, at 3.0 per cent.[3188] It then increased for four consecutive quarters to reach a peak at 7.8 per cent in December 2022, which was over 6 per cent higher than forecast by the Reserve Bank of Australia at the start of 2021.[3189]

Supply chain disruptions were widespread, with the Australian Bureau of Statistics reporting that 47 per cent of all businesses had supply chain issues in January 2022. Some sectors such as

wholesale trade (75 per cent), retail trade (71 per cent) and manufacturing (65 per cent) had higher prevalence of disruptions.[3190]

Early in the pandemic it was not predicted that there would be inflation coming out of the pandemic. Studies of past pandemics showed that they usually result in a period of lower inflation (or deflation), due to a long-term reduction in demand because of mortality, mass layoffs and bankruptcies.[3191] Indeed, the Reserve Bank of Australia and the Treasury estimated inflation to remain low 'for at least three years', which was incorporated into the Reserve Bank of Australia's forward guidance.[3192] However, the health, fiscal and monetary policy responses to COVID-19 resulted in demand remaining strong coming out of the pandemic.

While inflation was unforeseen early in the pandemic, it had emerged in several advanced economies before it emerged in Australia. Many at the time had suggested that this inflation was 'transitory', as supply constraints unwound.[3193]

The Inquiry heard from many that, with the benefit of hindsight, the Reserve Bank of Australia was late to respond to this inflation.[3194] This was true of many other central banks around the world. However, many noted that the pre-pandemic context, where inflation was largely under target and wage growth remained low, was important in the Reserve Bank of Australia's considerations.[3195] This was also reflected in the Reserve Bank of Australia Board's decisions during the pandemic to provide insurance against downside risks to inflation and employment, and a preference to err on the side of providing too much support rather than too little. That said, the Reserve Bank of Australia's forecasts, while broadly in line with those of the International Monetary Fund, the OECD and many market economists, consistently underestimated inflation.[3196] The Independent Review of the Reserve Bank of Australia found that the Reserve Bank's forecast models fell short in an environment of large and persistent supply disruptions and when monetary and fiscal policy interactions were important.[3197]

The Inquiry heard that the global fiscal and monetary policy response over the pandemic contributed to the rise in inflation coming out of the pandemic. Researchers from the Federal Reserve of San Francisco examined fiscal responses across countries and estimate that an increase of 5 percentage points in direct transfers (relative to trend) translates into a peak 3 percentage points boost to inflation and wage growth. This increase in inflation is not immediate but is lagged by a few quarters.[3198]

Macroeconomic modelling by Chris Murphy estimates that total increases in fiscal expenditure from the start of the pandemic added 2.4 percentage points to annual inflation in the December quarter of 2022 (when inflation peaked at 7.8 per cent), with monetary policy over 2021–22 adding a further 0.6 percentage points.[3199] He estimates this inflation effect to dissipate by mid-2025.[3200]

There is also evidence that the effectiveness of fiscal policy is delayed during a pandemic compared to a standard economic shock.[3201] Heightened uncertainty and activity restrictions decrease the immediate impact of fiscal stimulus measures. However, they have a larger effect as economies reopen, adding to pent-up demand. International Monetary Fund researchers

estimate that cumulative fiscal multipliers one year after a health crisis are about twice as large as during normal times, particularly in advanced economies.[3202]

However, stimulus and deferred savings were not the only contributor to inflation after the pandemic. The use of large-scale social distancing measures across the world and the temporary shutdown of large sections of economies created shocks to the global demand and supply of goods, which contributed to higher inflation coming out the pandemic. It is difficult to separate the effects of the pandemic from other supply shocks, such as the Russian invasion of Ukraine in February 2022, which was also an important driver of inflation.[3203]

The Reserve Bank of Australia estimates that the supply shocks coming out of the pandemic contributed between 3.1 and 3.5 percentage points to inflation in Australia through the year to March 2023.[3204] Other stakeholders noted non-pandemic-specific demand-side factors as adding to inflation. In particular, the 2022–23 Budget (March) was noted as more stimulatory than necessary.[3205] While the Commonwealth Budget returned to surplus in 2022–23, fiscal policy has been criticised as not being sufficiently disinflationary, although the Reserve Bank of Australia Governor classified fiscal policy as 'broadly neutral' at this time.[3206]

The return of migration after a two-year pause resulted in an historical financial year record of 518,000 people arriving through net overseas migration over 2022–23.[3207] This helped alleviate labour shortages, putting downward pressure on inflation, but also added demand in already constrained markets. This placed further pressure on inflation, including through rent prices.

Rents grew 6.7 per cent in 2022–23 and were one of the largest contributors to high inflation.[3208] Changing housing preferences as more people started working from home, insufficient supply due to construction industry pressures and the return of migration all added pressure to rental prices as vacancy rates hit historical lows across Australia.

Strong demand and supply chain disruptions combined to drive construction costs higher. Construction prices increased almost 30 per cent from the start of the pandemic to March 2024.[3209] Demand was fuelled by government infrastructure spending, which we heard was encouraged at National Cabinet and by the Australian Government's HomeBuilder program.[3210]

The rise in inflation has not been matched by a commensurate increase in wage growth, leading to a decline in real wages. Australia experienced one of the largest falls in real wages in the OECD during the post-pandemic inflationary episode.[3211] Real wages grew again in 2024, but they remained 4.8 per cent lower than before the pandemic at the March quarter in 2024.

4.2.3. The overall pandemic response had a significant fiscal cost

The Treasury estimates the total cost of the Australian Government's direct economic and health response to the pandemic was ultimately $343 billion, or 16.6 per cent of GDP.[3212] In assessing the overall macroeconomic impact of government policy over this time, some suggested that broader fiscal policy should also be considered beyond the direct COVID-19 response. All additional government spending over this period had a macroeconomic impact, so increases in non-COVID-19 related expenditure form part of economic management over

the pandemic. When these costs are included, a further $91 billion is added to the total fiscal impact of policies.[3213]

On top of this, some noted the costs of the Reserve Bank of Australia's Bond Purchasing Program, which purchased $281 billion in Australian Government (and semi-government) bonds.[3214] Having made these purchases at yields around 0.25 per cent and expecting interest rates to remain low, the sharp rise in interest rates earlier than forecast meant that the value of these bonds decreased significantly. Likewise, the yield earned from holding these bonds is now much lower than the interest the Reserve Bank of Australia paid on banks' exchange settlement balances, which were used to purchase the bonds.[3215] This is resulting in lower government revenues and should be considered as part of the cost of the response.[3216]

Many stakeholders suggested that, with the benefit of hindsight, the fiscal cost of the response was higher than necessary.[3217] There were views that the response overcompensated businesses and individuals, that some supports were provided for too long, and that some supports were not needed at all.[3218] However, one major objection to the fiscal cost of the pandemic came from some stakeholders, who questioned the appropriateness of the public health restrictions that made the economic supports necessary.[3219]

> *Having made the disastrous decision to impose broad lockdowns (rather than allowing individuals and businesses to make their own choices about how to manage the risks) governments then felt obligated to partially compensate those made worse off by their actions. – Narrow Road Capital*[3220]

Despite recording significant fiscal deficits over the pandemic, the Australian Government has benefited from a significant 'inflation surprise', which increased nominal GDP and revenues and eroded the value of government debt to bondholders. This, combined with elevated commodity prices, means that the Australian Government debt to GDP ratio has fallen below its 2020–21 peak.[3221] Net interest payments as a share of GDP remain below their pre-pandemic level.[3222] The International Monetary Fund has shown that Australia has saved a greater share of its 'revenue surprise' than most advanced economies.[3223]

The Australian Government's fiscal position has largely recovered from the pandemic, but the same cannot be said for all state governments. States that were less affected by the pandemic experienced a deterioration in their operating balance but have recorded strong net operating balances coming out of the pandemic. However, those that were most severely affected by the pandemic, notably Victoria and New South Wales, are yet to fully recover (Figure 10).[3224]

Figure 9: Commonwealth Government net operating balance ($ billions)[3225]

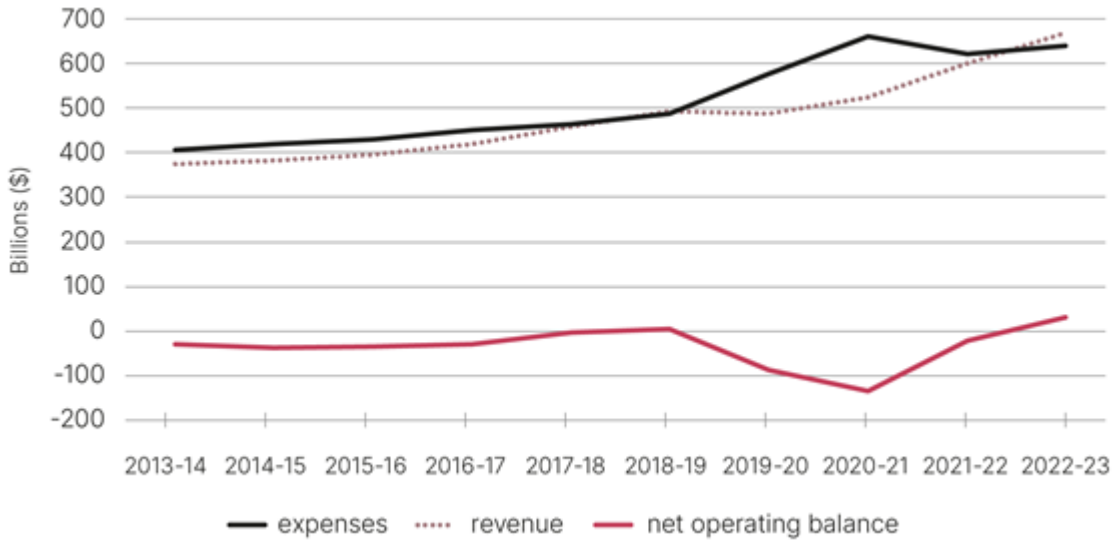
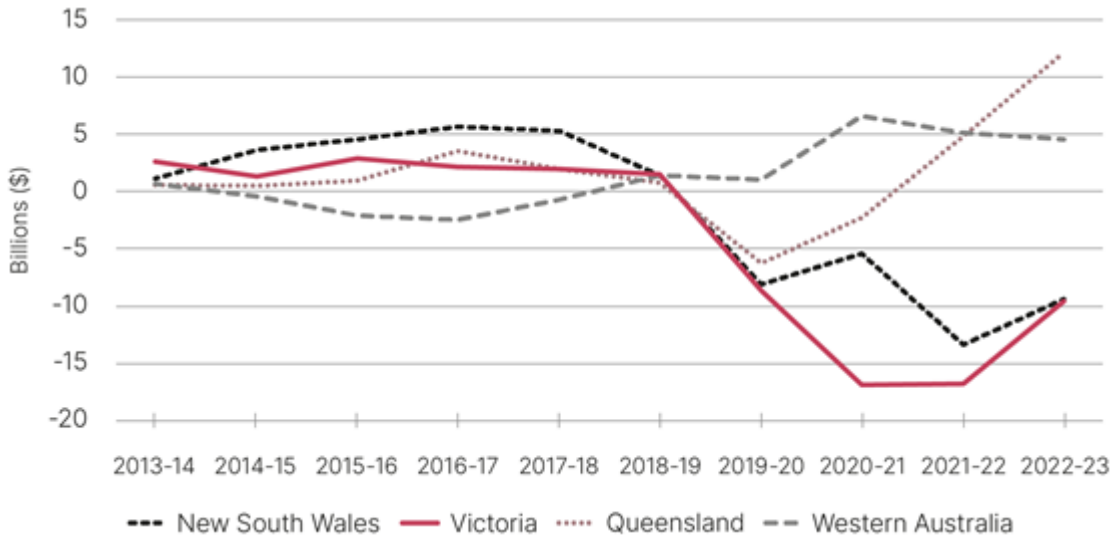


Figure 10: State government net operating balance ($ billions)[3226]



4.2.4. Few aspects of the pandemic response were evaluated

The pandemic response used a large number of fiscal and monetary policies that were innovative or had not previously been used in Australia. The most notable was the first use of a wage subsidy in the JobKeeper Payment. It was also the first time the Reserve Bank of Australia had conducted large-scale public sector asset purchases and established a Term Funding Facility. Also, the marked difference between the pandemic recession and other recent recessions provided an opportunity for further learnings on the appropriateness of traditional counter-cyclical policies in a pandemic.

Despite this, to date there has been limited evaluation of the effectiveness and appropriateness of most of the fiscal policy tools used in response to the pandemic. The Treasury commissioned the Independent Evaluation of the JobKeeper Payment and conducted earlier reviews of JobKeeper internally during the pandemic.[3227] However, other reviews, such as the Review of

the National Partnership Agreement on HomeBuilder, have focused largely on the administration of schemes rather than their effectiveness.[3228]

Other fiscal programs have received little public commentary. For example, Boosting Cash Flow for Employers, which at $31.9 billion was, when announced, Australia's largest single stimulus measure (until the JobKeeper Payment was announced the following week). There has been no formal review of Boosting Cash Flow for Employers. Similarly, there has been no review of the Coronavirus Supplement, despite the significant role that it played in the pandemic.

The Reserve Bank of Australia has comprehensively reviewed its response to the pandemic. It has published reviews of all of its extraordinary monetary policies over the pandemic – other than the Term Funding Facility, a review of which the panel heard is forthcoming.[3229] The 2023 Independent Review of the Reserve Bank of Australia noted that, while these reviews are helpful and a good practice, external perspectives are important in ensuring the conclusions drawn from the reviews are seen as credible and robust to different methodologies.[3230]

5. Evaluation

The alert phase

The Australian Government's economic agencies were largely unprepared for the type of economic response required for a global pandemic. Economic impacts were not featured in national pandemic plans. More broadly, economic scenario analysis exercises, or 'war gaming', of serious adverse economic conditions had not been conducted across government since the Global Financial Crisis.[3231]

Notwithstanding that Australia was largely unprepared for a pandemic-induced economic crisis, the response during the alert phase of the pandemic was excellent. The executive and bureaucracy showed strong economic leadership through the period to quickly respond to the challenges being faced. Fortunately, many of the senior leaders of economic agencies held senior roles during the Global Financial Crisis, so they were very aware of, and focused on, the potential economic effects of a prolonged downturn and the importance of moving early in a crisis.

Even though there was great uncertainty, the government delivered an unprecedented amount of economic support very rapidly and in proportion to the size of the downturn. The economic support underpinned Australia's strong health response in the alert phase and resulted in Australia's economy being one of the world's strongest through 2020.

The response had a strong focus on minimising harm by minimising financial stress, poverty and labour force 'scarring'. The economic supports that were put in place lessened the impact on unemployment. In fact, the increase in the social safety net through the Coronavirus Supplement actually reduced some pre-existing harms – unusually, the pandemic recession coincided with a decrease in income inequality and rates of poverty.

The government's responses demonstrated extraordinary agility – economic supports were set up very quickly in response to a rapidly evolving pandemic. In some cases, novel programs

were designed over a weekend and were largely successful. Australia's economic and financial regulators were able to quickly adapt their practices to support businesses and the economy. As we heard at the Inquiry's Economic Response Roundtable, the speed and overall size of the government's initial fiscal response was important in supporting households and businesses, but necessitated compromises in policy design which in future could be avoided through developing a toolkit of policy measures for use during a pandemic.[3232]

Relationships across government were key to the success of the economic response. The relationship between the Treasury and the Australian Taxation Office was an exemplar of the pandemic response. The development of JobKeeper in such a short period of time represented an extraordinary effort by officials to work together and support decision-makers to implement Australia's largest ever fiscal program. In the absence of planning, the success of JobKeeper was only possible because of the strength of relationships. Traditional barriers between policy development and regulatory functions were broken down so that officials could function effectively as a single team.

The Treasury and the Reserve Bank of Australia also worked well together during this period. The panel heard that National Cabinet highly valued the advice from the Secretary of the Treasury and the Reserve Bank Governor. Fiscal and monetary policy were closely aligned during this period, and economic messaging was consistent. This was also a theme coming out of the Inquiry's Economic Response Roundtable – the coordination of monetary policy and fiscal policy is important in a crisis, and measures should be balanced and complementary.[3233]

While these relationships were highly effective during the pandemic, they depended heavily on individual senior leaders.

The Council of Financial Regulators, consisting of the Treasury, the Reserve Bank of Australia, the Australian Prudential Regulatory Authority and the Australian Securities and Investments Commission, met throughout the pandemic to discuss regulatory issues. There was no similar structure for fiscal policy, and while National Cabinet's regular discussions of economic policy were well supported by the Reserve Bank of Australia Governor and Secretary to the Treasury, this was often without input from state Treasuries. In some cases, the Commonwealth and state governments announced similar policies on the same day, showing a lack of coordination.

Consistent with the Independent Evaluation of the JobKeeper Payment,[3234] there would be value in establishing structures for economic coordination in a crisis to support National Cabinet in its deliberations. The panel considers that in a future pandemic an emergency committee to coordinate economic policy and provide advice to National Cabinet could sensibly include Heads of Treasury, the Reserve Bank of Australia Governor and other economic regulators as required. This is explored further in Chapter 4: Leading the response.

Notwithstanding the extraordinary success of the economic response during the alert phase, the lack of planning meant the Australian Government was developing its economic policy response at the same time as dealing with a major health crisis. This led to compromises in policy design, which increased the fiscal costs of supports, led to unintended economic impacts and diminished the effectiveness of the government's response. Better planning and

preparedness that fully leverages the lessons from the COVID-19 pandemic could improve outcomes in a future pandemic. The panel supports Independent Review of the Reserve Bank of Australia recommendation 3 – that the Reserve Bank of Australia and the Treasury should undertake joint scenario analysis exercises to prepare for challenging circumstances.

The panel also largely supports the findings of the Reserve Bank of Australia's own reviews of their use of extraordinary monetary policy. In particular, the panel agrees that extraordinary monetary policy can be appropriate in times of crisis, where conventional monetary policy is limited.

The suppression and vaccine rollout phase

Following the highly effective economic response during the alert phase, with the benefit of hindsight, the levels of support remained too high during the suppression and vaccine rollout phases. This resulted in overcompensation of both businesses and individuals for losses. The panel agrees with most stakeholders that the greater error would have been to provide too little economic support. However, this does not diminish the need to carefully formulate and deploy appropriate economic response measures. Advance planning, in the form of an economic toolkit, would help ensure better targeted and tailored response measures can be deployed rapidly in future emergencies.

An economic tool kit may also help with the communication around the exit from temporary supports. The removal of supports was a significant challenge – there was strong pressure for the Australian Government to extend economic support measures throughout the pandemic. However, doing so would have made the fiscal policy setting more expansionary and added further to inflationary pressures. The challenge was highlighted by the response to the decision not to further extend the low and middle income earners tax offset – even though it had only been a temporary measure, its removal was widely seen as a tax increase.[3235]

There was also significant pressure to extend JobKeeper, despite the lifting of restrictions across much of the country. The panel notes that the modification of the JobKeeper Payment was an exemplar of the use of evidence and evaluation. The initial three-month review was informed by engagement with business, academic experts, the general public, government agencies and other national ministries, but it also relied on a large amount of administrative data. However, while the pre-commitment of JobKeeper gave a sense of certainty and boosted confidence at a critical time, in a future pandemic this could be achieved by guarantees to match supports to health restrictions and economic conditions.

The removal of the Coronavirus Supplement did place greater financial strain on those not in employment and reduced equity. While an ongoing increase was provided, it still left the unemployment payment below a level considered adequate to support a basic standard of living.

Even after JobKeeper and the Coronavirus Supplement had ended, the economic response continued to minimise the harmful effects of the pandemic and associated health restrictions. The introduction of the COVID-19 disaster payments meant that workers affected by localised

outbreaks were still able to receive economic supports. The support allowed people to stay home from work when sick or isolating, so it was also important for the health response. However, this payment was only put in place after strong calls for the return of JobKeeper during lockdowns in Victoria. There could have been more anticipation of and preparation for location-specific outbreaks that required lockdowns and supports for those affected. We heard at the Inquiry's Australian Council of Trade Unions Roundtable that insecure work was a vector for transmission, but paid pandemic leave helped to normalise individuals staying at home when they were sick to prevent the spread of infection to other workers.[3236]

There was insufficient consideration of the economic impacts of either the vaccine procurement or rollout in decision-making (see Chapter 10: The path to opening up). An earlier completion of the vaccine program would have significantly reduced the economic harms incurred from lockdowns in the second half of 2021, and should be factored into future decisions around vaccine procurement strategies.

Post vaccine

Despite delays in achieving target vaccination rates, issues with supply of and access to RATs, and differing state responses, Australia largely followed the national plan for reopening. As a result, economic and employment growth was strong, even with the withdrawal of economic supports.

However, supply chain disruptions coming out of the pandemic were widely unanticipated by government, which lacked well-developed sector plans (see Chapter 24: Supporting industry). These disruptions when combined with the stronger than anticipated demand contributed to inflationary pressures across the economy that were not anticipated at the time.

With the benefit of hindsight, the combined effects of fiscal and monetary policy on aggregate demand were larger than necessary to secure the economic recovery. This increased the fiscal cost and contributed to high inflation coming out of the pandemic. However, this was a period of rapid change and ongoing uncertainty around health outcomes, and there remained concerns that undershooting the economic response would have negative consequences for Australia's economic recovery.

The Australian Government's fiscal strategy to prioritise support for the economy first, and then reduce the debt through higher economic growth rather than austerity, has been largely successful. That said, a significant part of that success is due to post-pandemic inflation. Higher commodity prices also assisted the reduction in debt, which was fortuitous and cannot be relied upon in a future pandemic.

While inflation has helped to erode the value of government debt, it has also imposed large costs on everyday Australians. In particular, real wages remain lower than before the pandemic, and many Australians are continuing to experience cost-of-living pressures including from higher rents and mortgage interest rates.

The strong economic outcomes and the emergence of inflation coming out of the pandemic was particularly problematic for some of the extraordinary monetary policy supports, such as

the Bond Purchasing Program, the yield target and the Reserve Bank of Australia's forward guidance. This significantly increased the fiscal cost of these measures (e.g. the Bond Purchasing Program) and also undermined public confidence in the Reserve Bank of Australia. The panel supports the conclusions of the Independent Review of the Reserve Bank of Australia and the Reserve Bank of Australia's internal review that the bank's approach to forward guidance should be different in a future crisis.

Other supports did not adequately consider the capacity of industry to absorb them. In particular, the HomeBuilder program created excess demand in an industry facing supply constraints. This has been a significant contributor to inflation coming out of the pandemic, and the program's focus on renovations rather than new builds added to the general housing shortages. These types of demand-side stimulus measures are largely not appropriate in pandemics where industries are facing supply constraints.

When COVID-19 emerged, it had been over 100 years since the last major global pandemic, and there was little understanding or planning to address how such an event would impact a modern economy. We must draw the lessons, further outlined in the remaining chapters of this section, to improve preparedness for a future public health emergency.

6. Learnings

- A successful health response protects economic activity during a pandemic and promotes a strong recovery. A successful economic response is also critical for supporting health outcomes.
- A successful economic response includes measures to protect against pandemic losses. Well-designed policies providing targeted compensation are likely to deliver better economic outcomes, but will come at a high fiscal cost.
- Pandemics move quickly and being prepared with an economic toolkit to roll out during a crisis can limit compromises in policy design that can undermine the economic response and lead to unnecessary costs.
- Significant uncertainty is a key characteristic of pandemics. The sequencing of fiscal measures and their alignment to health restrictions is an important consideration in ensuring maximum effectiveness of the response.
- A successful health and economic intervention will likely result in a rapid, or v-shaped, recovery in aggregate demand. Given this, economic supports should be temporary and tied to the public health restrictions, with plans for their withdrawal clearly communicated in advance.
- Economic supports will have less immediate impact in a crisis where industry faces supply constraints, but a larger effect once economies reopen.

- Policies designed to support an economic recovery or maintain confidence need to be carefully deployed, as they risk overcompensation. Combined with supply-side disruptions, these can add to inflationary pressures.
- Key decision-makers benefit from coordinated economic advice during a pandemic. While this can be achieved through strong pre-existing relationships between senior leaders, there is value in a more structured approach.
- While every crisis differs, it is important to capture and learn the lessons from each through independent review of all major measures.

7. Actions

7.1. Immediate actions – Do in the next 12–18 months

Action 6: Develop legislative and policy frameworks to support responses in a public health emergency, including for an Economic Toolkit.

The Economic Toolkit should:

- be developed by Treasury and the Reserve Bank of Australia, in consultation with relevant departments and the states and territories
- include measures that can be tailored to respond to different forms of economic crisis, including a public health emergency, with an appropriate gender lens applied.
- cover the division of responsibilities of the Australian Government and state and territory governments for the development and implementation of economic response measures
- draw on lessons from reviews of significant aspects of Australia's COVID-19 response, including ensuring all residents, regardless of visa status, are supported during the response
- be updated over time to reflect research and reviews of economic settings (see Actions 8 and 22)
- consider the mechanisms for the implementation of measures, and whether these could be enhanced to better support delivery – such as upgrades to existing systems or data-sharing arrangements
- consider the role of transparency mechanisms in promoting public trust.

Action 8: Establish mechanisms for National Cabinet to receive additional integrated expert advice for a whole-of-society emergency, including advice on social, human rights, economic and broader health impacts (including mental health considerations), as well as specific impacts on priority populations.

- In parallel with making decisions based on key public health advice, National Cabinet should consider the differential impacts of a pandemic across the population and economy. This must include considering and mitigating unintended consequences, and seek to minimise negative impacts on broader health, mental health, educational, equity, economic and social outcomes.
- This might include mechanisms for a national health emergency that allow Heads of Treasuries to be expanded in a crisis to include the Reserve Bank of Australia Governor (and other key economic regulators as required) to bring together national economic expertise to support National Cabinet.

Action 11: Improve data collection, sharing, linkage, and analytic capability to enable an effective, targeted and proportionate response in a national health emergency.

This should include:

- Improvements to data collection and pre-established data linkage platforms, including:
    - Delivering actionable insights regarding optimal emergency response design to ensure emergency responses can be appropriately designed, tailored and adjusted through real-time evaluation of both intended outcomes and broader impacts.
- Expanded capability in Australian Government departments to collate and synthesise economic and health data to inform decision-making, including:
    - planning for how Treasury and the CDC will work together to integrate health and economic data and analysis.
- Finalising work underway to establish clear guardrails for managing data security and privacy and enabling routine access to linked and granular health data, and establishing pre-agreements and processes for the sharing of health, economic, social and other critical data for a public health emergency, including:
    - ensuring rapid mobilisation of real-time evidence gathering and evaluation
    - sharing within the Australian Government, between the Commonwealth and states and territories and with relevant sectors
    - establishing appropriate arrangements for the sharing of data related to the delivery of economic support measures, as described in the Economic Toolkit. This could encompass data sharing within the Australian Government, and with the state and territories.

7.2.Medium term actions – Do prior to the next national health emergency

Action 21: Build emergency management and response capability including through regular economic scenario testing to determine what measures would be best suited in different forms of economic shocks and keep an economic toolkit up to date.

Led by Treasury, this should include:

- a primary coordination role for Treasury and inclusion of state and territory treasuries
- testing a system-wide response, including Treasury, the Reserve Bank of Australia and key economic and financial regulators at the Australian Government level
- drawing on the Economic Toolkit to test the suitability of those measures to respond to different types of economic shocks
- reflecting any learnings from scenario testing exercises in updates to the Economic Toolkit.

Action 26: Include a focus as part of ongoing systems upgrades on modernising and improving data, systems and process capabilities to enable more tailored and effective program delivery in a crisis.

Consider preparedness for future crisis as part of ongoing investment in key data, system and process capabilities, including:

- building on the successful use of the Australian Taxation Office's Single Touch Payroll to deliver the JobKeeper payment, future IT system upgrades should consider potential 'emergency capability' that could support greater flexibility in program delivery in a crisis
- working to address known data gaps, which could enhance the effectiveness of policy measures, while being cognisant of the burden on the business and community sector.

Chapter 21 – Supporting households and businesses

1. Context

As outlined in Chapter 20: Managing the economy, the Australian Government provided unprecedented levels of support to households and businesses during the different phases of the pandemic. Supports included government payments, taxation concessions, the deployment of unconventional monetary policy, and the use of regulatory relief.

This chapter will explore the major measures implemented by the Australian Government in response to the economic challenges faced during the pandemic. It is organised into three sections reflecting the primary function of different measures: protecting against pandemic losses; maintaining consumer and business confidence; and securing the economic recovery. Measures that protected against pandemic losses had some element of targeting towards those who had suffered a fall in income due to the pandemic. Measures that maintained consumer and business confidence were more universal in their application, and provided broader support for aggregate demand across the economy. Measures that secured the economic recovery were focused on jobs recovery, stimulating activity and lifting economic growth.

The lack of pre-pandemic planning meant that most measures to support households and businesses through the pandemic were designed and implemented while Australia was responding to the pandemic. The panel heard that there would have been real and ongoing costs of letting perfection get in the way of providing support in a timely way. That said, this increases the value in reviewing individual measures and design features to learn what worked well and what could be improved. In particular, some decisions had unintended consequences. Leveraging the benefit of hindsight, these should be avoided in any future pandemic response.

This chapter will conclude with some key lessons to ensure preparedness for a future public health emergency. While measures have been grouped by the challenge they aimed to address, they will also be considered in terms of their impact on other challenges and outcomes.

2. Protecting against pandemic losses

The pandemic represented an economy-wide shock. However, some households and businesses faced more direct impacts from the pandemic, including job losses and reduced hours of work, restrictions on the ability to trade and reduced turnover for businesses.

Households and businesses that were directly affected by the pandemic needed support to manage economic uncertainty and preserve social cohesion. This in turn supported adherence to public health measures and the management of the pandemic. Policies that the Australian Government used to protect against pandemic losses included wage subsidies, increases in

income support, grants to impacted businesses and industry-wide support packages. Chapter 24: Supporting industry details the approach taken to industry-specific support packages.

2.1. Response

2.1.1. Wage subsidies

Pandemics impact both the demand for labour and the supply of labour, due to the impact of the illness and public health restrictions on the ability of workers to work. When workers are unable to work for extended periods, it can create risks of short-term economic harm from the fall in income, and long-term economic harm from labour market 'scarring'.[3237] These risks were quickly understood by governments around the world at the start of the pandemic.

While internationally the size and nature of fiscal supports provided by governments differed, job retention schemes were a common feature of the economic response to the pandemic across many advanced economies.[3238] Wage subsidies, which are a type of job retention scheme, involve paying businesses to either pay existing staff or employ new staff. They can also act as a support to businesses.

The Organisation for Economic Co-operation and Development (OECD) found that, on average, the use of job retention schemes peaked in April 2020.[3239] At that time, they supported around 20 per cent of employment and approximately 60 million jobs worldwide.

The JobKeeper Payment

The Australian Government announced the JobKeeper Payment (JobKeeper) on 30 March 2020.[3240] JobKeeper was a national wage subsidy and income support program provided to businesses that were significantly affected by the pandemic to help them retain and continue to pay their staff.[3241] It was the largest of the Australian Government's measures to support households and businesses and the largest labour market intervention in Australia's history.[3242] Its three main objectives were to:

- support business and job survival
- preserve the employment relationship
- provide needed income support.[3243]

The program was initially estimated to cost $130 billion, but concluded with a cost of $88.8 billion.[3244] It was originally designed to end six months after its announcement or on 27 September 2020 – referred to as phase 1 of the payment.[3245] From 28 September 2020 onwards, it was amended and extended for a further six months, until 28 March 2021.[3246] This was referred to as phase 2 of the payment.[3247] Employers, including self-employed individuals, were eligible for JobKeeper if they demonstrated that their turnover was likely to fall (for phase 1) or had actually fallen (for phase 2) by:

- at least 50 per cent, for businesses with an aggregated annual turnover of more than $1 billion)

- at least 30 per cent, for businesses with an aggregated annual turnover of $1 billion or less)
- at least 15 per cent, for organisations that were a registered charity with the Australian Charities and Not-for-profits Commission, excluding schools and public universities.[3248]

An employer was not entitled to JobKeeper if the entity was:

- an Australian Government agency or local governing body
- a sovereign entity
- a company in liquidation (or provisional liquidation)
- a company imposed with the Major Bank Levy.

Public universities were effectively excluded from JobKeeper from early May 2020. Approved early childhood education and care providers were explicitly excluded from early July 2020 onwards.[3249] Early childhood education and care providers were eligible for other payments. See Chapter 24: Supporting industry for further information.

An employee was eligible if they were:

- a permanent full-time, part-time, or long-term casual (a casual employed on a regular and systematic basis for longer than 12 months)
- employed by the eligible employer on 1 March 2020 (including those stood down or rehired)
- an Australian resident or a New Zealander on a Special Category 444 visa
- aged at least 18 years (or 16 or 17 years if they were independent and not undertaking full-time study).[3250]

Phase 1 of JobKeeper provided businesses with $1,500 per fortnight per employee. This is broadly equivalent to the national minimum wage for a full-time adult employee. Phase 2 of JobKeeper introduced a two-tiered payment structure as the economy progressed into its recovery phase. During both phases, employers were required to pass the full amount of JobKeeper to their employees. If an employee's total remuneration was less than that payment rate per fortnight, or they had been stood down, the employer needed to provide the employee at least the full payment rate per fortnight.[3251] If an employee earned more than the payment rate per fortnight, employers could use the payment to subsidise the employee's wages.[3252] Payment rates for both the first and second phases of JobKeeper are shown in Figure 1 below.

Figure 1: JobKeeper payment rates[3253]

JobKeeper phase 1	Flat payment
28 March to 27 September 2020	The payment was a flat rate of $1,500 per fortnight for all eligible employees, regardless of hours usually worked.

JobKeeper phase 2	Tier 1	Tier 2
28 September 2020 to 3 January 2021	The payment rate was $1,200 per fortnight for all eligible employees who were working in the business or not-for-profit for 20 hours or more a week on average.	The payment rate was $750 per fortnight for employees who were working in the business or not-for-profit for less than 20 hours a week on average.
4 January 2021 to 28 March 2021	The payment rate was $1,000 per fortnight for all eligible employees who were working in the business or not-for-profit for 20 hours or more a week on average.	The payment rate was $650 per fortnight for employees who were working in the business or not-for-profit for less than 20 hours a week on average.

JobKeeper was administered by the Australian Taxation Office and was integrated with its Single Touch Payroll functionality.[3254] This allowed for near real-time monitoring of the scheme. For further details regarding the use of Single Touch Payroll (as well as other data sources) during the pandemic, refer to Chapter 20: Managing the economy.

Supporting Apprentices and Trainees, Boosting Apprenticeships Commencements and Completing Apprenticeship Commencements

Another wage subsidy program introduced in the first Australian Government stimulus package on 12 March 2020 was Supporting Apprentices and Trainees.[3255] It was expected to cost $1.2 billion and benefit around 120,000 workers.[3256] Under the subsidy, employers were entitled to claim 50 per cent of an apprentice's wage for up to nine months between 1 January 2020 and 30 September 2020.[3257] The employee's payment was transferable to a new employer if the apprentice's employer was unable to keep employing them.

There were three extensions to the subsidy over the time it operated:[3258]

- 6 October 2020: The program was extended and rebadged as Boosting Apprenticeships Commencements (BAC). BAC payments could be made to existing workers, as long as the worker moved from non-apprenticeship employment to an apprenticeship contract with the employer during the relevant period.
- 28 September 2021: The government announced that the BAC wage subsidy would transition to the Completing Apprenticeship Commencements (CAC) program for the second and third years of an apprenticeship.
- 27 March 2022: The government announced that the programs were to be extended again as part of Budget 2022–23.

The BAC and CAC programs provided any employer who took on an apprentice or trainee until 30 June 2022 with access to:

- 50 per cent of the eligible Australian Apprentice's wages in the first year, capped at a maximum payment value of $7,000 per quarter per Australian Apprentice
- 10 per cent of the eligible Australian Apprentice's wages in the second year, capped at a maximum payment value of $1,500 per quarter per Australian Apprentice
- 5 per cent of the eligible Australian Apprentice's wages in the third year, capped at a maximum payment value of $750 per quarter per Australian Apprentice.[3259]

2.1.2. Additional support programs

There were a number of additional support programs that were either introduced or increased during the pandemic to help compensate for personal and business income losses. At the start of the pandemic, there were concerns that large job losses could lead to a prolonged decrease in individual and household welfare.[3260]

Unlike those of many advanced countries, Australia's social security system is non-contributory and does not provide recipients with payments linked to prior wages.[3261] The effective replacement value of unemployment payments is amongst the lowest in the OECD.[3262] This reflects that Australia's social security system provides a general safety net, is funded from consolidated revenue, is not time-limited (as it is in many other OECD countries) and provides targeted assistance based on private means.[3263]

When the pandemic hit, a large number of Australians faced a new reliance on an unemployment benefit that was 37.5 per cent of the minimum wage rate.[3264] This is well below the Henderson poverty line and not sufficient to maintain a basic standard of living.[3265] Without a substantial increase in income, many Australians would have faced additional risks of housing insecurity and financial stress. This would have undermined the broader public health objectives and added to the negative impacts of public health restrictions. There were also potential benefits for those already relying on the payment, with reductions in financial stress potentially offsetting the impacts of additional pressures resulting from the pandemic.

Alongside the new payments outlined below, changes were also made to a number of income support payment requirements that allowed people to claim and start receiving payments sooner, such as a suspension of the assets test, suspending waiting periods, extension of eligibility and more.[3266]

Income support payments are administered by Services Australia.[3267] Given the impact of the 2019–2020 bushfires, the uncertainty of the pandemic and the resulting increase in unemployment, there was an unprecedented surge in demand for government services.[3268] Services Australia's submission highlights that:

> *In 55 days Services Australia processed 1.3 million JobSeeker claims, a claim volume normally processed in two-and-a-half years. At the peak, more than 53,000 claims were completed in a single day. – Services Australia*[3269]

Coronavirus Supplement

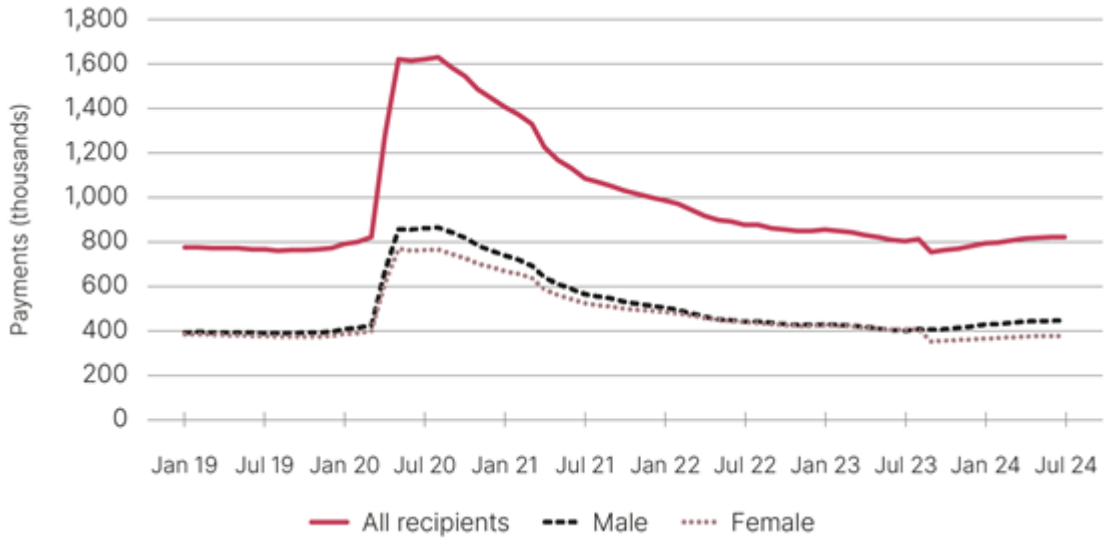
The Coronavirus Supplement provided a temporary increase in payment to those receiving working age social security payments during the pandemic and also temporarily expanded eligibility, on the basis that those of working age were most likely to have experienced income shocks or changes to their employment prospects.[3270] The supplement was announced on 22 March 2020 as part of the government's $66 billion second stimulus package.[3271] People would receive the Supplement if they were on:

- JobSeeker Payment
- Youth Allowance
- Parenting Payment (Partnered or Single)
- Austudy
- ABSTUDY Living Allowance
- Farm Household Allowance
- Special Benefit
- Eligible New Enterprise Incentive Scheme
- Department of Veterans' Affairs Education Schemes.[3272]

With the Coronavirus Supplement, the maximum amount a person could receive under JobSeeker was $1,124.50 per fortnight, which brought the amount much closer to the $1,500 payment provided under JobKeeper.[3273]

From 27 April to 24 September 2020 the Coronavirus Supplement was paid at a rate of $550 per fortnight. From 25 September to 31 December 2020 the rate was $250 per fortnight. From 1 February to 31 March 2021 the rate was $150 per fortnight. The supplement ceased to be payable from 1 April 2021. It was provided to approximately 2.25 million people.[3274]

Figure 2: JobSeeker payments by volume ($'000s)[3275]



Disaster and crisis payments

The Australian Government introduced a range of crisis and disaster payments to assist people who were required to quarantine and self-isolate and were unable to work due to the virus. The Crisis Payment is a non-taxable one-off payment available to income support recipients who are in severe financial hardship and have experienced a specific event.[3276] The rate of payment is half of the fortnightly maximum basic rate of the income support payment that the person receives.[3277] On 25 March 2020, the government introduced a new category of Crisis Payment for a National Health Emergency. This payment was provided to income support recipients who were required to be in quarantine or self-isolate, or who were required to care for an immediate family member or member of the person's household who was required to be in quarantine or self-isolation. The National Health Emergency crisis payment ceased on 1 October 2022, in line with the easing of COVID-19 restrictions across states and territories.[3278] Around 1.7 million payments were made of over $580 million from 2020 to 2022.[3279]

As the pandemic progressed beyond the initial alert phase, the government needed to ensure that people who continued to be affected by the virus would be able to remain in isolation. In both June 2020 and May 2021, a major driver of community transmission and outbreaks in Victoria was that individuals who did not have adequate leave entitlements were going to work while they had COVID-19 symptoms.[3280] State and territory governments introduced payments for those without access to paid leave entitlements, and the Australian Government announced two disaster payments that served as income support measures:

- the Pandemic Leave Disaster Payment, announced on 3 August 2020
- the COVID-19 Disaster Payment, announced 3 June 2021.[3281]

During the pandemic, other forms of assistance were implemented through legislation or as extensions of existing programs. However, both of the disaster payments were National Recovery and Resilience Agency grant payments and administered by Services Australia. Both payments were authorised under regulations issued by the Governor-General. The authority to make these payments was provided through the Financial Framework (Supplementary Powers) Regulations 1997.[3282]

The Pandemic Leave Disaster Payment was modelled on the Victorian Government's Coronavirus (COVID-19) Worker Support Payment. Initially, it provided $1,500 for each 14-day period in which an individual needed to self-isolate, quarantine or care for a person with COVID-19. This later changed to $750 for each seven-day isolation, quarantine or care period. On 18 January 2022, two different payment rates of $750 or $450 were introduced depending on hours of work lost.[3283] Unlike the JobKeeper Payment, eligible temporary visa holders could access the Pandemic Leave Disaster Payment. When it was first introduced, the Australian Government funded the entire payment. However, from 16 July 2022 onwards, the payment was co-funded by the states and territories until it ended on 30 September 2022.[3284]

The COVID-19 Disaster Payment was introduced in response to Victoria's state-wide lockdown, which was announced on 26 May 2021 – two months after JobKeeper ended. The COVID-19

Disaster Payment was provided to those whose income was affected by state and territory government lockdowns following COVID-19 outbreaks. A lockdown was defined in the regulations establishing the payment as a state or territory government public health order restricting the movement of persons.[3285] It had different rates based on number of hours of work lost and whether the person was eligible for income support payment. As with the Pandemic Leave Disaster Payment, eligible temporary visa holders could access this payment. On 29 September 2021 the government announced that the payment would begin to be phased out once states and territories reached 70 per cent and 80 per cent of the population aged over 16 years fully vaccinated against COVID-19.[3286] As at 13 December 2021 all states had reached the 80 per cent fully vaccinated threshold.[3287]

The Australian Government fully funded the payment for about one month after its introduction.[3288] After that, a shared funding model with the states and territories was introduced, whereby the Australian Government made the payment to people who were isolating in Commonwealth Chief Medical Officer declared hotspots; and the states and territories funded payments to people who were outside these hotspots.[3289]

The government implemented the High-Risk Settings Pandemic Payment in October 2022 after the end of the Pandemic Leave Disaster Payment.[3290] This was a taxable lump sum payment to help high-risk workers during the time they could not work and earn an income because they had tested positive for COVID-19. The payment ended on 31 March 2023.[3291] As with the Pandemic Leave Disaster Payment, the cost of the payment was shared equally between the Australian Government and the states and territories.[3292]

Early release of superannuation

As part of its COVID-19 economic response, the government allowed people who were significantly financially affected by the pandemic to access their superannuation savings early as another form of cash flow relief for households.[3293] Between 20 April 2020 and 30 June 2020 eligible individuals were able to access up to $10,000 of their super.[3294] Between 1 July and 31 December 2020 they could access a further $10,000. Eligible temporary visa holders were also able to apply for a single release of $10,000 before 1 July 2020.

To apply for the early release of superannuation, a person had to:

- be unemployed, or
- be eligible to receive a JobSeeker Payment, Youth Allowance, Parenting Payment (which includes the single and partnered payments), special benefit or Farm Household Allowance, or
- on or after 1 January 2020:
    - be made redundant, or
    - have their working hours reduced by 20 per cent or more, or

- be a sole trader whose business was suspended or whose turnover was reduced by 20 per cent or more.[3295]

The early release of superannuation scheme provided a total of $37.8 billion to 3.1 million individuals.[3296] The total estimated fiscal cost to the Budget (as a result of lower super tax collected) was $2.22 billion.[3297]

Business Support Payments

Businesses that were either directly or indirectly affected by the public health orders often required additional support to maintain operations and be in a position to resume trade once public health orders were lifted.

Early in the pandemic the JobKeeper Payment compensated businesses that suffered a fall in revenue due to the pandemic. However, when it ended in early 2021, there were no other supports in place. This posed a risk to businesses that faced restrictions or secondary impacts during the changing public health restrictions throughout 2021.

The Business Support Payments provided financial support to businesses adversely affected by lockdowns and border restrictions. These payments were introduced after JobKeeper had ended to support businesses and particular sectors and were funded jointly (50 per cent each) between the Australian Government and the states and territories.[3298] Figure 3 shows the different support schemes and programs for businesses that were generally split between the Australian Government and state and territory funding. The cost reflects the total estimated cost accumulated over the duration of the program (initial cost and subsequent top-ups).

Figure 3: Schemes and grants for businesses that were jointly funded by the Australian Government and the states and territories[3299]

State/territory	Cost over duration of support	Schemes/grants
New South Wales	$6,793.69 million	• JobSaver
Victoria	$6,201.52 million	• Business Continuity Fund • Licensed Hospitality Venue Fund 2021 • Alpine Business Support Program • Small Business COVID Hardship Fund • Business Costs Assistance Program
Queensland	$453.85 million	• COVID-19 Business Support Grants Program • COVID-19 Border Business Zone Hardship Grants • Tourism and Hospitality Sector Hardship Grant • Major Tourism Experiences Hardship Grant
South Australia	$28.10 million	• South Australia COVID-19 Additional Business Support Grant • COVID-19 Tourism and Hospitality Grant • COVID-19 Business Hardship Grant
Western Australia	$69.37 million*	• Western Australia Business Support Package

Tasmania	$72.91 million	• Business Hardship – Border Closure Critical Support Grant program • COVID-19 Micro and Small Business – Border Closure Critical Support Grant
Northern Territory	$4.05 million	• Business Support Grant – Business Support Supplement for Visitation Reliant Business • Tourism Support Scheme – Hardship Support for Touring
Australian Capital Territory	$326.45 million	• ACT COVID-19 Business Support Grant • COVID-19 Tourism, Accommodation Provider, Arts and Events and Hospitality and Fitness Grant

**Note that this amount is the total Commonwealth support provided, not the total cost of the program.*

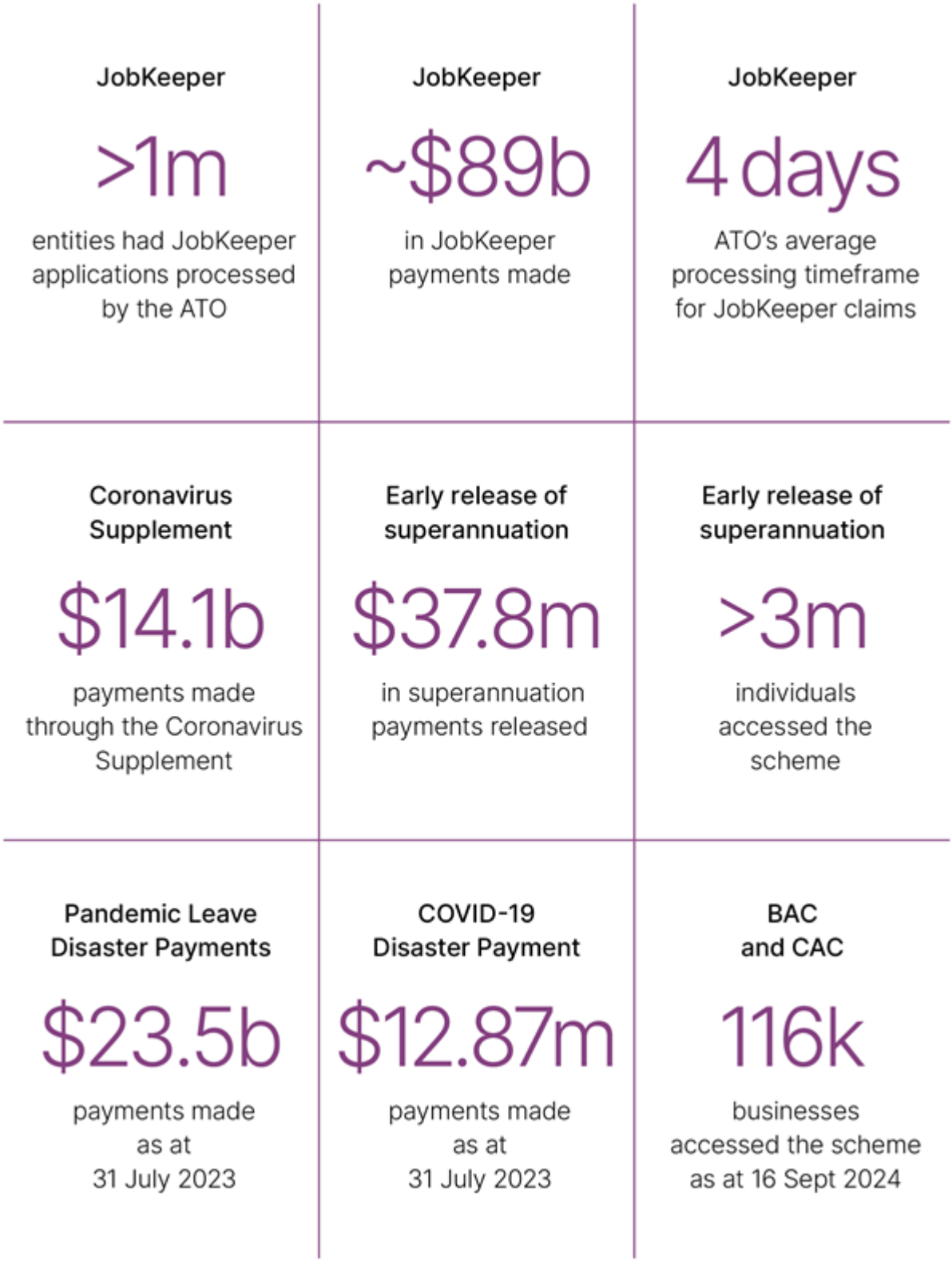
Temporary relief for financially distressed businesses

The Australian Government implemented a range of measures to support financially distressed businesses. For example, it:

- increased the threshold at which creditors could issue a statutory demand on a company (from $2,000 to $20,000)
- temporarily extended the time companies had to respond to statutory demands from 21 days to six months
- temporarily relieved directors of personal liability for insolvent trading with respect to debt incurred in the ordinary course of a company's business.[3300]

2.2.Impact

Figure 4: Statistics on program update[3301]



2.2.1. JobKeeper was important in preserving jobs in the economy

The scale of the labour market impact of the pandemic was unprecedented in the post-war era. Total hours worked declined by 10.1 per cent in April 2020 and almost 700,000 people left the labour force completely between March and May 2020.[3302] Images of newly unemployed Australians lining up outside Centrelink offices had created a sense of despair across the community.

It is difficult to assess the effect of JobKeeper on employment because there is no reliable counterfactual. There is some academic consensus that JobKeeper saved around 700,000 jobs.[3303] However, this estimate does include JobKeeper recipients working zero hours as employed, consistent with Australian Bureau of Statistics definitions.[3304]

In the absence of a social insurance system in Australia, the government responded to the pandemic by developing a bespoke wage subsidy scheme. Senior government officials, business leaders, economic experts and members of the public all told the Inquiry that JobKeeper was crucial in maintaining the employer and employee connection and supporting businesses and job survival.[3305] The panel heard that JobKeeper was important in providing employers and employees with certainty that they would be supported by the government through the pandemic.[3306]

The Independent Evaluation of the JobKeeper Payment (JobKeeper Evaluation), commissioned by the Treasury and conducted by Nigel Ray PSM, noted that JobKeeper supported around 4 million employees (almost one-third of pre-pandemic employment).[3307] This compares favourably to wage subsidies implemented internationally.[3308]

The Business Council of Australia noted that JobKeeper not only saved jobs but also helped to preserve employer–employee relationships.[3309] This in turn preserved 'matching capital' in the labour market. Australian Industry Group's submission to the Inquiry stated that JobKeeper 'correlated with positive improvements in business resilience', with the number of businesses surveyed that reported reducing employment decreasing from 48 per cent in April 2020 to 5 per cent in October 2020.[3310]

2.2.2. The use of existing systems allowed measures to be implemented quickly

We heard from many stakeholders that the use of existing channels for payment was a key factor in the success of the measures, particularly JobKeeper.[3311] Recent improvements in government systems, including the Reserve Bank of Australia payment system and the Australian Taxation Office's Single Touch Payroll system, allowed for the quick rollout of economic supports.[3312]

> *One element of the timely response in the pandemic was the important role played by the Australian Taxation Office and Services Australia in rolling out fiscal support. From the announcements of the Coronavirus Supplement and JobKeeper program to the receipt of the first payments was 3 weeks for households receiving the supplement and just over 5 weeks for businesses receiving JobKeeper. We owe*

that to the ability of these organisations to react quickly, leveraging off the investment they had made in their capability. – Dr Stephen Kennedy PSM, Secretary of the Treasury[3313]

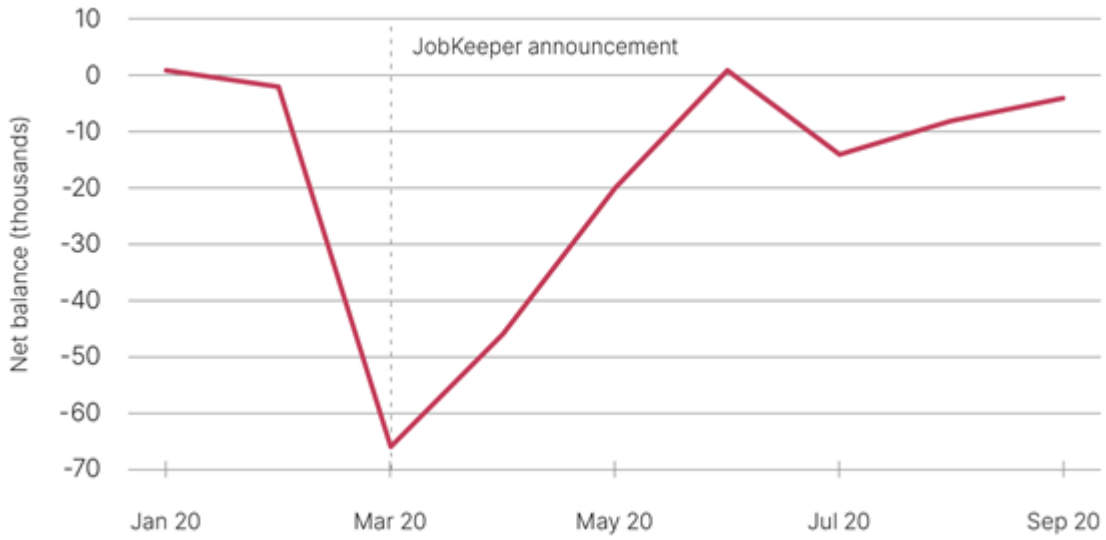
Stakeholders said JobKeeper could be implemented quickly because of the relationships between agencies, regulators and administrators.[3314] They also noted that it was important to combine the expertise of central policy design with the capabilities of service delivery so that fast, timely and efficient outcomes could be delivered.[3315] The effectiveness of policy was described as being dependent on all agency stakeholders 'being in the room' and contributing to both design and implementation of policy.[3316] Simplicity in policy design, and the use of the Australian Taxation Office's existing channels and Single Touch Payroll functionality have been credited with enabling speed while still managing risks.

2.2.3. There is a correlation between timing and effectiveness of wage subsidies

JobKeeper was designed and implemented exceptionally quickly, but there was a delay between the imposition of public health orders and it taking effect. The JobKeeper Evaluation noted that this delay resulted in job losses that could have been avoided.[3317] There was an immediate effect on consumer and business confidence at the announcement of JobKeeper (see Figure 5 and Figure 6).

Figure 5: ANZ consumer confidence[3318]

Figure 6: NAB business confidence[3319]



Note: Figure 5 presents weekly time series of consumer confidence, indexed to equal 100 in the week ending 15 March 2020. The announcement of JobKeeper was captured in the last week of March 2020. Figure 6 presents monthly time series of business confidence, so the impact of the announcement was captured in observations following March.

Some stakeholders and reports noted that Australia's delayed announcement of JobKeeper impacted those who lost their jobs in the weeks prior.[3320] Similar wage subsidy schemes had been announced earlier in other advanced economies – for example, the United Kingdom announced the Coronavirus Job Retention Scheme on 20 March 2020, and New Zealand introduced their temporary Wage Subsidy Scheme on 17 March 2020, just 17 days after the report of the first case of COVID-19 in New Zealand.[3321]

A comparative study of the fiscal response between Australia and New Zealand found that by introducing a wage subsidy earlier in a pandemic, the labour market could adjust to the crisis by simply reducing the number of hours worked, rather than laying people off.[3322] The delayed introduction may have allowed Australia to learn from the temporary wage subsidies deployed internationally.[3323] However, planning ahead of a future pandemic could avoid unnecessary job losses.

2.2.4. Eligibility requirements and exclusions reduced the effectiveness of wage subsidies and income support

The JobKeeper Evaluation discusses the negative economic consequences of the narrow eligibility criteria and how they reduced the effectiveness of the payment.[3324] The panel heard that some cohorts were deliberately excluded to maintain a level of labour mobility in the economy.[3325] However, as the Australian Council of Trade Unions submission to the JobKeeper Evaluation noted, those groups who were not eligible for the payment were in more disadvantaged communities in Australia, including those who were likely already 'experiencing job and financial insecurity long before the COVID-19 crisis began'.[3326]

In addition to being excluded from JobKeeper, temporary residents also did not initially qualify for income supports. Residency status is a core feature of Australia's social security system – international students and temporary migrant workers are generally not eligible for income support payments.[3327] The Australian Council of Social Service submission noted that 28 per cent of those who had lost their jobs, including asylum seekers and international students, were not eligible to receive income support payments.[3328] This undermined the effectiveness of the supports, which were partly intended to stop transmission by allowing people to isolate. It also caused significant hardship, which drove up demand for support services in the community sector.[3329]

Exclusion of short-term casuals and effect on young workers

The exclusion of short-term casuals from JobKeeper had long-term impacts on young workers. In early 2020, young people were over-represented in the short-term casual workforce, accounting for 46 per cent of short-term casual employees in August 2019.[3330] The OECD and International Labour Organization noted a key concern during the pandemic was labour scarring for young people, particularly following the experiences of the Global Financial Crisis.[3331] Many reports have noted that young people are likely to have borne the brunt of job losses during the pandemic.[3332] Evidence shows that 26.4 per cent of employees aged 15 to 24 were casual workers who had been with their current employer for less than 12 months, compared with 6.5 per cent of employees aged 25 and over.[3333]

The boost to the JobSeeker Payment ensured they received some lost income compensation, but it was less than what longer-term casuals received.[3334] The JobKeeper Evaluation found that the short-term casuals' employee–employer relationships were relatively weak, but others have said there is a risk that severing the employment relationship for this group can have longer-term generational impacts, despite a strong labour market recovery.[3335] For further details on the impact of JobKeeper on young job seekers, see Chapter 14: Children and young people.

Exclusion of temporary visa holders

At the start of the pandemic there were over 2 million temporary visa holders in Australia.[3336] The widespread job losses had a significant impact on them. Many temporary visa holders lost their jobs in highly casualised industries, such as retail and hospitality.[3337] Initially excluded from JobKeeper and income support measures, large numbers of temporary visa holders, including international students and refugees, could no longer afford basic needs.[3338]

A survey conducted in September 2020 by the Migrant Justice Initiative in association with the University of Sydney and University of Technology Sydney captured the experiences of temporary migrants in Australia during the pandemic. It found that one in seven international students (14 per cent) had been homeless for a period since 1 March 2020 (sleeping on campus, on a friend's couch, in a car or on the streets). As a survey respondent noted:

> *They didn't consider us as human. We're just some aliens who don't belong here. No rent help, no food help, not even a single penny. I have been surviving with my superannuation money till now. Thank god they at least decided to give it.*[3339]

There were also broader consequences, with many temporary visa holders leaving Australia and adding to labour shortages during the economic recovery, adding to inflationary pressures.[3340] There were more than half a million fewer temporary visa holders in Australia in September 2021 than June 2019.[3341] This affected industries that are heavily reliant on workers with temporary visas – for example, health, hospitality, agriculture and administrative services (see Chapter 24: Supporting industry for further details on the impact of labour shortages).[3342]

Other temporary visa holders could not leave Australia because their countries of origin had closed international borders; they could not afford airline fares to travel; or they had made significant investments in their education, work or future in Australia.[3343]

The impact of these exclusions was to create demand for emergency relief.[3344] The Australian Government provided $97 million as part of its broader Community Support Package to assist providers delivering services like emergency relief, food relief and financial counselling to assist people experiencing financial crisis, and to respond to increased demand.[3345] This support was broad but could be used to assist temporary residents excluded from income support measures during the pandemic.

State and territory governments – including Tasmania, South Australia, the Australian Capital Territory, New South Wales, Victoria and Queensland – also stepped in to provide emergency financial support. For example, in April 2020 the Victorian Government announced a relief payment of up to $1,100, as part of a broader emergency support package, for tens of thousands of international students living in the state.[3346] New South Wales provided a $6 million emergency support package for asylum seekers in its state.[3347] We also heard that many universities and community services organisations stepped in and supported temporary visa holders.[3348] We heard from the Higher Education and VET Roundtable that international students who were not eligible for other government supports were significantly affected. Many lost jobs following business closures and required assistance from institutions. A more comprehensive approach to support is needed to recognise the role and value of international students in Australia.[3349]

The JobKeeper Evaluation noted that the treatment of temporary visa holders under the JobKeeper scheme was not consistent with other short-term job retention schemes employed during the pandemic in other countries.[3350] One person interviewed during the Inquiry told the panel that the reason for this exclusion was that the government wished to draw a line in the support package and could not support everyone.[3351]

2.2.5. JobKeeper's narrow eligibility meant that businesses could change their employee profile to remain eligible for the payment, further entrenching the disadvantage of those who were ineligible

The design of JobKeeper and its overcompensation also gave businesses an incentive to structure their business so they could receive the payment.

> *If business owners respond to the profit incentive from over-compensation by reducing production to become eligible for JobKeeper, it has two harmful*

> *economic effects. First, it reduces national income. Second, it is inequitable, because most full-time workers who become inactive were only partially compensated by JobKeeper for their lost wages. – Chris Murphy*[3352]

The panel heard of a number of instances where firms were alleged to have done so, including standing down workers when otherwise not economically justified.[3353] During phase 2 of JobKeeper, the share of businesses with turnover that declined slightly more than 30 per cent (the eligibility threshold) was much larger than the share with declines slightly less than 30 per cent, suggesting that a significant number of firms did indeed adjust their business practices to qualify for phase 2 of JobKeeper.[3354]

2.2.6. JobKeeper overcompensated some businesses

The Parliament Budgetary Office estimated that, between April and September 2020, $38 billion of the total of $89 billion in JobKeeper payments was provided to employers who did not experience as significant a decline in turnover as projected.[3355] The Parliament Budgetary Office also found that $1.3 billion went to companies whose quarterly turnover doubled, and a further $1.3 billion went to companies whose turnover tripled during the quarter for which they claimed JobKeeper.[3356] This issue was partly addressed in phase 2 of JobKeeper (from 28 September 2020 to 28 March 2021). In that phase, businesses and not-for-profits had to demonstrate that they had experienced an actual decline in turnover rather than submit an estimate of decline.[3357]

Economist Chris Murphy's analysis indicates that a small business operating at 70 per cent of normal turnover, which was the eligibility ceiling for JobKeeper, received payments equal to 193 per cent of lost profits.[3358] Also, his estimates imply that, for the average business, a fall in revenue of 45 per cent would leave the business as well off with JobKeeper as before the pandemic.

JobKeeper on aggregate overcompensated businesses, but the overcompensation was not evenly shared.[3359] Many businesses that were worst hit by the pandemic received little compensation. For example, businesses that were forced to suspend operations completely because of social distancing requirements received no compensation through JobKeeper.[3360] The JobKeeper Evaluation also noted that job losses were largely borne by employees in ineligible businesses and ineligible employees in JobKeeper-nominated businesses, including short-term casuals or temporary visa holders.[3361] For those whose workforce consisted of a large number of temporary migrant workers, this was usually compounded by larger declines in turnover and employment.[3362]

The Australian Council of Trade Unions noted that business overcompensation may have been reduced or avoided altogether had the government built in transparency mechanisms.[3363] *Fault lines: an independent review into Australia's response to COVID-19* (the Fault Lines Report) went further, noting that 'JobKeeper should have had a built-in clawback for businesses that made large profits'.[3364] The JobKeeper Evaluation noted that the decision not to include a clawback mechanism reflected senior officials' concern that it would affect businesses' take-up of the measure. Rather, it concluded that 'a policy design that enabled a switch to retrospective

eligibility sooner, combined with transparency of claimants, would have been a better option to improve targeting of JobKeeper payments'.[3365]

2.2.7. Support measures helped reduce the rate of transmission

The Inquiry heard that during the early months of the pandemic, some workers felt financial pressure to continue working despite testing positive for COVID-19. The Australia Institute noted that over one-third of employed Australians have no access to statutory paid sick leave entitlements. For many others, such as permanent part-time workers, sick pay entitlements could quickly be exhausted given the extended absences that were required to follow public health guidance.[3366] The Fault Lines Report found that most casual and contract workers who did not have sick leave as part of their working conditions were often forced to choose between their incomes and protecting themselves and the community.[3367] The Pandemic Leave Disaster Payment allowed workers with little or no access to paid leave entitlements to isolate or quarantine.

> *Providing all members of society with an income sufficient to comfortably live on is a critical aspect of public health, and during a highly contagious pandemic one of the most effective measures that can be taken is to ensure paid sick leave is available to all. Since isolation payments were discontinued we have all heard many stories of employers forcing covid-positive workers back into the workplace, in spite of their workplace health and safety obligations. – Submission 1203*[3368]

When the COVID-19 Disaster Payment was announced, Australia was well into the recovery stage of the pandemic, and many of the previous supports for individuals and households, such as JobKeeper and the Coronavirus Supplement, had ended. Some criticised this gap, noting the adverse impact of the lack of individual support in this interim period before the COVID-19 Disaster Payment was announced.

> *This is also an accessibility and inclusion issue – removing supports which allowed people to isolate at home has led to workplaces, hospitals, schools, and all manner of public places becoming inaccessible to high risk families. This is utterly unacceptable. – Submission 1203*[3369]

However, we have also heard that the benefit of the disaster payments was that they were more targeted than other payments introduced in response to the pandemic, mostly because the payments had broader eligibility and their duration was tied more closely to the health restrictions.[3370] The impact of the pandemic on insecure workers is explored in Chapter 23: Workers and workplaces.

2.2.8. Support measures increased the welfare of many Australians, but left some residents behind

Research published by the Australian Council of Social Service, in partnership with UNSW Sydney, estimates that income support measures are estimated to have lifted 646,000 Australians, including 245,000 children, out of poverty.[3371] The panel heard that this policy

intervention helped mitigate some of the negative impacts of the pandemic on housing security, mental health and rates of family violence.[3372] The Australian Council of Social Service contends that it gave many long-term income support recipients temporary relief from living in entrenched poverty.[3373] However, the panel also heard that when these policies were ceased many of the gains were unwound.[3374]

The introduction of the Coronavirus Supplement and the disaster payments provided a safety net for individuals who could not work. We heard that the Supplement and JobKeeper payments were designed to be complementary to each other.[3375] These two measures effectively represented a universal basic income for working age Australians during the alert phase of the pandemic.[3376]

Research shows 'that the number of households living in housing affordability stress would have increased by 74 per cent without the income support measures, and the number living with severe housing affordability stress would have increased by 167 per cent'.[3377] The Australian Council of Social Service stipulated that 'income support did more [than other measures in the housing sector] to absorb the income shock of the pandemic, to a significant extent letting housing policy and, especially, landlords, off the hook'.[3378]

The Australian Council of Social Service also noted that the stronger safety net and lifting of lockdowns were associated with reduced financial hardship and psychological distress.

> *Since getting the extra $550 has help me in a lot of ways. Not worrying about when I'm going to eat the next time or falling behind bills and getting kicked out as after being homeless for over 10 years and getting my own flat I never want to go back there as my depression and anxiety ain't good and my mental health was real bad where I just wanted to end my life. – Australian Council of Social Service*[3379]

Some submissions suggested the effective doubling of the income support payment through the Coronavirus Supplement was fiscally irresponsible, but most submissions covering the topic noted the important role that it played in ensuring that those most disadvantaged by the COVID-19 pandemic weathered its impacts.[3380] Single Mother Families Australia noted how beneficial the Supplement was to their members, stating:

> *… we began receiving many messages and photos on our Facebook page from April when the $550 per fortnight Coronavirus Supplement payment started to flow. These messages overwhelmingly showed the positive impact of the payment and we created a campaign to retain the payment: 550 Reasons to Smile. The campaign captured the amount of the fortnightly increase, whilst simultaneously acknowledge that many for the first time could afford dental care. – Single Mother Families Australia*[3381]

An exploration of the impact of the COVID-19 pandemic on inequality in Australia

Income inequality in Australia was relatively stable before the COVID-19 pandemic. The virus and the measures the government took in response led to unusual fluctuations in inequality between 2020 and 2022.[3382]

The Australian Government response, including the Coronavirus Supplement and other income support measures, significantly reduced income inequality during the initial period of the pandemic. The Australian Council of Social Service described the increase to the JobSeeker Payment through the Supplement as 'transformative in its impact; without the Supplement, it is estimated that poverty would have doubled'.[3383] After the pandemic, income inequality increased as the economy recovered and government supports were wound back.[3384]

Sustained or high levels of economic inequality can have negative consequences. Inequality can lead to uneven access to social opportunities, such as health and education, and increase vulnerabilities to economic shocks.

The Productivity Commission's research paper *A snapshot of inequality in Australia* noted that the initial period of the crisis saw a reduction in poverty and income inequality as a direct result of the Coronavirus Supplement and JobKeeper.[3385] The Household, Income and Labour Dynamics in Australia (HILDA) survey shows a decrease in income inequality through the Gini coefficient's movement from 0.304 to 0.289.[3386] However, the Productivity Commission's paper noted that income inequality increased again once the supports ended.

Wealth in Australia has also increased in recent years, with particularly strong growth during the COVID-19 years. The biggest contributor to household wealth was the growth in housing wealth as a result of strong growth in house prices.[3387] It is also partly a result of increased household savings during the crisis. Household incomes grew while lockdown restrictions were in place and consumption of goods and services was lower. This allowed households to build their financial wealth by paying off debts and banking their savings. As a result, wealth inequality declined during the pandemic, particularly for the lower income earners.[3388]

2.2.9. Early access to superannuation had long term-consequences

We have heard from stakeholders that the early access to superannuation is not a measure they would consider adopting for a future public health emergency response because it can have detrimental effects on retirement incomes, particularly those of women (for further details, see Chapter 19: Women).[3389] The Senate Select Committee on COVID-19 stated that 'in the early months of the pandemic the government's scheme led to the Australian economy being supported by "the private savings of people who were hardest hit by COVID-19 restrictions"'.[3390]

On the other hand, analysis by the Grattan Institute found that withdrawing super early would not cost the economy as much as has been publicised, because the lower super balance would be offset by larger pension payments.[3391] We also heard that the measure was aimed at supporting households through use of their own wealth. In particular, it was intended to support those for whom the rate of JobKeeper was lower than what they were earning before the pandemic.[3392] However, one stakeholder also acknowledged that stronger eligibility criteria

should be designed to minimise the risk that the money is used for antisocial activities, such as gambling.[3393]

The Australian Bureau of Statistics reported that data collected up to September 2020 showed 29 per cent of people who accessed their super early mainly used it to pay their mortgage, while 27 per cent used it for household bills.[3394] Another 15 per cent used it to pay credit card or personal debts, while around one in eight people (13 per cent) added it to their savings. The Families in Australia survey concluded that the likelihood of accessing superannuation as part of the early release was higher among those:

- whose income, or that of their partner, had been substantially reduced
- who had experienced a change to their employment
- whose spouse or partner had experienced a change to their employment
- receiving JobSeeker or JobKeeper allowance
- aged 25 to 34 years (compared to those aged 18 to 24 and over 35)
- who did not have a spouse of partner, compared to those who did
- who had resident children under the age of 18, compared to those who did not.[3395]

However, research conducted by the Australian National University, in conjunction with George Washington University and Harvard University, found that, for individuals who had a credit check, the funds from the early withdrawal of super scheme were largely used for immediate, non-durable purchases. Gambling was reported as the third largest discernible category.[3396]

2.2.10. Responsibility for business support measures was split between the states and territories and the Commonwealth

As states and territories made decisions to impose public health restrictions in the vaccine rollout phase of the pandemic, business support payments came to be mostly funded by the states and territories or jointly funded with the Australian Government.

Many of these payments were achieved through bilateral agreements with the states and territories.[3397] Reporting and data-sharing requirements built into these agreements allowed the Australian Government to monitor how and where program money was being used.[3398] However, industry stakeholders noted that the inconsistent protocols, different support measures and their rules of implementation across jurisdictions created much confusion for employers and workers.[3399]

At the Australian Government level, we heard there was a collaborative approach to designing these arrangements.[3400] However, we also heard from stakeholders that there was a lack of clear communication between the states and territories and the Australian Government, creating additional uncertainty for businesses.[3401] We heard that there was an informal understanding that the Australian Government would be responsible for providing support for

individuals and households, whereas the states and territories would be responsible for supporting business and industry.[3402]

A positive aspect of this is that in theory the approach allowed for states and territories to target businesses and industries that most needed the support, reflecting that the impact of the pandemic was not consistent across the country. However, in practice it resulted in duplication of business supports, as was the case with the New South Wales Government's JobSaver. Some stakeholders called for greater coordination between the Australian Government and states when providing support.[3403]

Also, the states and territories noted that it was difficult to access the information and systems they needed to deliver business support payments during the pandemic.[3404] The Omicron wave resulted in location-specific lockdowns across the country, and support should have been targeted to these regions. However, there are system limitations with the provision of targeted location-specific support outside the disaster payment and grants framework at the Commonwealth level.[3405]

3. Maintaining consumer and business confidence

As with any economic shock, the pandemic risked undermining consumer and business confidence and deepening the economic downturn. To maintain confidence, the Australian Government deployed broad-based economic support measures that were separate from those aiming to compensate households and business for direct economic losses.

Early in the pandemic there was extreme uncertainty about what the virus would mean for the global and Australian economy. The risk was that this uncertainty would create additional and long-lasting economic harm. As the pandemic progressed, this uncertainty reduced. However, some uncertainty remained – for example, when restrictions would be lifted or reimposed, the long-term impacts of the virus and how it might evolve, when and how quickly a vaccine would become available and what an economic recovery would look like.

At various stages of the pandemic it was important to maintain consumer and household confidence in the face of these uncertainties. However, this came with a greater risk of either understimulating or overstimulating the economy.

3.1. Response

3.1.1. Unconventional monetary policy measures during the COVID-19 pandemic

Coming into the pandemic, interest rates were at historical lows. As a result, once interest rates were lowered to the effective lower bound on 20 March 2020, the Reserve Bank of Australia turned to its suite of unconventional monetary tools to achieve its inflation and employment objectives. The Reserve Bank of Australia used most of these tools for the first time in its history.

The *Review of the Reserve Bank of Australia: an RBA fit for the future* (Reserve Bank of Australia Review) was an independent review conducted by Dr Gordon de Brouwer, Professor Renee Fry-

McKibbin and Professor Carolyn Wilkin. It noted that each tool was intended to contribute to an overall easing of financial conditions by lowering borrowing costs, improving access to credit and/or contributing to a lower exchange rate than otherwise. The tools supported the fiscal response to the pandemic by lowering government borrowing costs. The tools were designed to complement each other and operate as a package.[3406]

Term Funding Facility

Term funding schemes usually involve providing low-cost, longer-term funding to banks and lending institutions to help reduce funding costs and interest rates for borrowers.[3407] They also often include explicit incentives to bolster the supply of credit to businesses.

The Reserve Bank Board established the Term Funding Facility in March 2020, with an extension to the Term Funding Facility announced in September 2020.[3408] The Term Funding Facility provided three-year funding to banks at a fixed rate of 0.25 per cent (lowered to 0.1 per cent in November 2020). The initial funding allowance for each institution was up to 3 per cent of existing outstanding credit, available until 30 September 2020. It provided an additional allowance for institutions that increased their lending to businesses and was available until 31 March 2021.[3409]

In September 2020, the Reserve Bank of Australia introduced a supplementary allowance of up to 2 per cent of existing lending, available until 30 June 2021, and extended the deadline for the additional allowance to 30 June 2021. The Term Funding Facility closed to new drawdowns on 30 June 2021.[3410]

Forward guidance

Forward guidance is a statement that provides explicit information about the future state of monetary policy, with the intention to influence interest rate expectations. The Reserve Bank Board provided forward guidance in March 2020. This guidance was 'state-based', meaning that it committed to keeping the cash rate unchanged until specific economic conditions were met:

> *The Board will not increase the cash rate target until progress is being made towards full employment and it is confident that inflation will be sustainably within the 2–3 per cent target band.*[3411]

The Reserve Bank of Australia added a 'calendar-based' component to their forward guidance in a speech by the Reserve Bank Governor in October 2020 and in Reserve Bank Board statements from November 2020.[3412] They indicated a time horizon of three years over which the cash rate would be unlikely to change. This language was updated in February 2021:

> *The Board will not increase the cash rate until actual inflation is sustainably within the 2 to 3 per cent target range … The Board does not expect these conditions to be met until 2024 at the earliest.*[3413]

The Reserve Bank Board maintained this calendar-based component of forward guidance until November 2021. It continued state-based forward guidance until May 2022.[3414]

Yield target

A yield target involves setting a target for a term interest rate and pledging to buy (or sell) enough bonds to keep the rate from rising above (or falling below) its target.[3415]

The Reserve Bank Board introduced a target for the yield on three-year Australian Government bonds of around 0.25 per cent in March 2020 (lowered to 0.1 per cent in November 2020).[3416] It viewed the yield target as reinforcing its forward guidance for the cash rate. In practice, this operated as a ceiling on yields.[3417] The Reserve Bank of Australia supported the target through bond purchases in the secondary market when needed. The target focused on the bond that was closest in maturity to three years: the April 2023 bond until October 2020 and the April 2024 bond thereafter. The yield target on the April 2024 bond was discontinued in November 2021.[3418]

The Reserve Bank of Australia Review noted that the Reserve Bank of Australia's use of the yield target was unique in comparison with other central banks, as no other peer introduced one in response to the COVID-19 pandemic.[3419]

Bond purchase program

Asset (or bond) purchase programs involve central banks purchasing assets (usually government bonds) to ease financial conditions by lowering funding costs and influencing the exchange rate.[3420]

The Reserve Bank Board began a bond purchase program in November 2020. The initial commitment was $100 billion of bond purchases to be made over six months, at maturities of around five to 10 years. The bond purchase program was extended on three occasions: in February 2021, when the Reserve Bank of Australia purchased an additional $100 billion; in July 2021, when it announced that it would continue purchases, but at a lower rate of $4 billion a week; and in September 2021, when purchases were extended to February 2022 at the same weekly rate.[3421]

3.1.2. Economic Support Payments

The Economic Support Payments were four one-off cash transfers that the government announced between March 2020 and March 2021. The first payment of $750 was announced as part of the first economic response package on 12 March 2020.[3422] Those receiving social security income support payments (including JobSeeker), family assistance payments, veterans' payments, ABSTUDY payments and Farm Household Allowance, and those holding certain concession and health cards (other than the Low Income Health Care Card), were eligible and automatically received these payments.

The second payment of $750 was paid on 10 July 2020 to the same recipients, apart from those who were receiving the Coronavirus Supplement.[3423] The stimulus payments were administered

by either Services Australia or the Department of Veterans' Affairs (depending on the recipient), with approximately 11.6 million payments and an approximate fiscal cost of $8.8 billion.[3424]

The third and fourth payments of $250 were provided to recipients of specific pensions or holders of certain concession cards.[3425] The government had identified that the third and fourth payments, paid on 30 November 2020 and 1 March 2021, would support around 5 million social security, veteran and other income support recipients and eligible concession card holders. Over half of those who benefited from these payments were pensioners.[3426]

3.1.3. Boosting Cash Flow for Employers

The Boosting Cash Flow for Employers (Cash Flow Boost) measure was announced as part of the first stimulus package on 12 March 2020.[3427] It was significantly expanded in the second package on 22 March 2020, with total payments of $35.9 billion as of 2022–23.[3428]

As part of this measure, the government provided temporary cash flow support (between $20,000 and $100,000) for small and medium businesses and not-for-profit organisations that employed staff during the economic downturn associated with COVID-19. These payments were designed to help businesses' and not-for-profits' cash flow so they could keep operating; pay their rent, electricity and other bills; and retain staff.[3429]

Small and medium-sized businesses and not-for-profit organisations with aggregated turnover under $50 million who employed staff were eligible to receive credits totalling between $20,000 and $100,000 when they lodged their activity statements for tax periods from March 2020 through to and including the September 2020 period. The credits were automatically made against pay-as-you-go (PAYG) tax withholding and GST due in these quarters. Any excess credit was paid directly to the business as a refund.[3430]

3.1.4. Small and medium enterprise loan guarantee schemes

The SME Loan Guarantee Scheme Phase 1, SME Loan Guarantee Scheme Phase 2, SME Recovery Loan Scheme and Show Starter Loan Scheme provided government guarantees to participating lenders to enhance their ability to extend credit to small and medium enterprises (SMEs).[3431] The loan eligibility criteria varied between the schemes. Under Phase 1 and Phase 2 of the schemes, the government provided a 50 per cent guarantee to participating lenders to enhance their ability to extend credit to SMEs.

Phase 1 of the scheme supported unsecured working capital loans for up to $250,000 for terms of up to three years. It included a repayment holiday for the first six months. Phase 1 of the scheme started on 23 March 2020 and ended for loans on 30 September 2020.[3432]

Phase 2 of the scheme supported secured and unsecured loans for up to $1 million for terms of up to five years with a cap on interest rates. Phase 2 of the scheme started on 1 October 2020 and ended for loans on 30 June 2021.[3433]

The SME Recovery Loan Scheme offered loans on an unsecured or secured basis for a maximum size of $5 million for up to 10 years. Under this scheme, the government provided the following loan guarantees:

- 80 per cent for loans written from 1 April to 31 December 2021
- 50 per cent for loans written from 1 January to 30 June 2022.[3434]

The Show Starter Loan Scheme supported loans for up to $5 million for terms of up to 10 years with a cap on interest rates. Under this scheme, the government provided a 100 per cent guarantee to participating lenders. This scheme was designed to help creative economy businesses to access financing for new productions and events that stimulate job creation and economic activity.[3435]

3.1.5. Tax relief measures

The government introduced a range of tax relief measures to assist households and businesses. For example, it extended low and middle income earner tax offsets and brought forward tax cuts under Stage 2 of the Personal Income Tax Plan by two years. It also gave small businesses immediate cash flow relief, including through the Enhancing Instant Asset Write-off, Backing Business Investments, Loss Carry-back Tax Offset and Temporary Full Expensing and other accelerated depreciation measures. Some of these measures are discussed below.

Low and middle income tax offset

Low and middle income earner tax offsets were first announced in the 2018–19 Budget and extended into subsequent budgets throughout the COVID-19 period. As part of the 2020–21 Budget, the government announced that low and middle income earners would receive a one-off additional benefit of up to $1,080 from the low and middle income earner tax offsets.[3436] This, combined with the cost of bringing forward Stage 2 of the Personal Income Tax Plan, was estimated to reduce receipts by $17.8 billion over the forward estimates period.[3437] The offset was further extended in the 2021–22 Budget. Individuals with a taxable income below $126,000 received an additional tax cut in 2020–21 from low and middle income earner tax offsets, whereas individuals with a taxable income over $126,000 did not receive any benefit from low and middle income earner tax offsets, but received tax cuts in Stage 2 of the Personal Income Tax Plan.[3438] The offsets concluded on 30 June 2022.

Enhancing instant asset write-off

From 12 March 2020 to 31 December 2020, the government increased the instant asset write-off threshold below which eligible business entities could access an immediate deduction for eligible depreciating assets (instant asset write-off) from $30,000 to $150,000.[3439] The eligibility was also expanded to include all businesses with aggregated annual turnover of less than $500 million (up from $50 million) until 31 December 2020. This was estimated to allow approximately 5,300 businesses, employing 1.9 million people, to access the write-off for the first time.[3440]

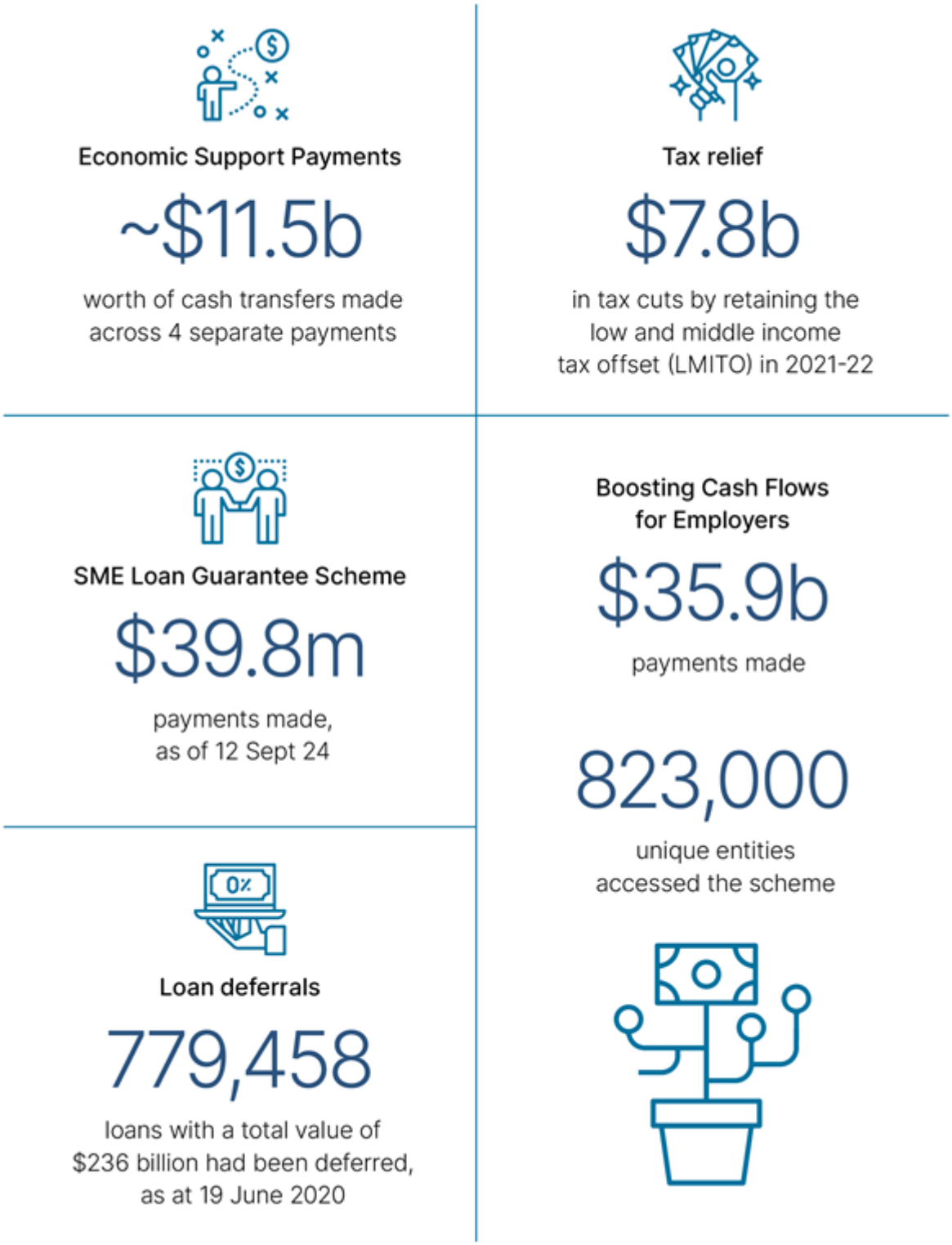
3.1.6. Government and regulatory relief measures

The government, along with state and territory governments, worked with industry and regulators to help households and businesses with regulatory relief measures. These regulatory relief measures were aimed at reducing compliance burdens and providing financial relief. For example, the government put in place rent relief measures, moratoriums on rent increases, free child care and more. The Australian Taxation Office and Services Australia announced a pause on all debt recovery activities from April 2020 in an effort to lower household compliance burdens. These included any Australian Taxation Office debts on hold and Centrelink repayments. Services Australia recommenced debt recovery in mid-2021 and the Australian Taxation Office recommenced it in early 2022.[3441]

Further, the government also worked with the Australian Banking Association, the Australian Prudential Regulatory Authority, the Australian Competition and Consumer Commission, and the banks to allow individuals, households and small businesses to defer their mortgage.[3442] The Australian Prudential Regulatory Authority's role was to monitor banks to ensure that they had sufficient capital and liquidity buffers to enable their customers to defer their payments, while still meeting their short- to medium-term cash flow obligations.[3443]

3.2.Impact

Figure 7: Usage and expenditure of government measures[3444]



3.2.1. Household savings and non-essential spending increased

A record fall in household spending, coupled with government support payments to households (such as JobKeeper, the Coronavirus Supplement, economic support payments, and early access to superannuation) drove a rise in the household saving to income ratio to 19.8 per cent in the June quarter national accounts, the highest since June 1974 (see Figure 8).[3445] Australian Bureau of Statistics analysis indicates that quarterly household deposits in June quarter 2020 increased $33.4 billion and short-term loan liabilities (credit cards and personal loans) by 7.5 per cent.[3446]

Government support measures supported household savings in a number of ways. The government's moratorium on elective surgery and other healthcare services led to a decrease in household spending on health care by 25.6 per cent through the year.[3447] The Early Childhood Education and Care Relief Package reduced households' out-of-pocket expenditure because services that received funding under the package were not allowed to charge families any fees.

Figure 8: Household saving rate[3448]

While overall household consumption fell, household consumption on non-essential goods and services increased. The financial year to June 2020 saw an increase in spending on home improvement projects, garden activity and home offices.[3449] Household spending on tools increased by 29.8 per cent and spending on appliances increased by 21.1 per cent. Australian Bureau of Statistics analysis also indicates that, because most people spent more time at home, there was a 20.9 per cent higher spend on goods for recreation and culture such as audio-visual and exercise equipment. Retail turnover of alcoholic beverages also rose during the period, and was 38.5 per cent higher (seasonally adjusted) during the last three months of the financial year to 2020 compared to the same period in the prior year.[3450]

JobKeeper and the Coronavirus Supplement also had stimulatory effects, but they mainly functioned as a wage subsidy and an income support payment respectively. The Economic Support Payments ($750 one-off payments) were primarily intended to stimulate demand in

the economy, similar in effect to the one-off payments granted during the Global Financial Crisis. We heard from interviewees that at the start of the pandemic the intention was to provide economic certainty during a period of uncertainty. However, with changes to employment and income, movement restrictions and demand constraints, these one-off stimulus measures were more likely to be saved rather than spent. Interviewees acknowledged that, with the introduction of payments such as JobKeeper and the Coronavirus Supplement, the Economic Support Payments were likely unnecessary.[3451]

The increases in household savings and subsequent rapid increase in household consumption over 2021–22 partly contributed to the inflationary pressures of the transition/recovery phase in 2022 (for further details, see Chapter 20: Managing the economy).[3452]

3.2.2. Monetary policy supported the economy during period of heightened uncertainty but was slow to respond to changing circumstances

On the whole, monetary policy was effective at supporting the economy over the pandemic, including by reducing borrowing costs and boosting household cash flows.[3453] Despite being constrained by the effective lower bound and low interest rates going into the pandemic, the combination of conventional and unconventional monetary policy resulted in interest payable on dwellings, as a share of total gross income, declining to its lowest level this century in the March quarter of 2022 (see Figure 9).

Figure 9: Interest payable on dwellings, share of total gross income[3454]

However, the Reserve Bank of Australia has acknowledged that the Reserve Bank Board's focus was on 'providing insurance against very bad outcomes – that ultimately did not eventuate'.[3455] This led the Reserve Bank Board to provide more support and for longer, rather than risk not doing enough.

That said, the Reserve Bank of Australia Review found that the bank's analysis during the pandemic may also have downplayed the burden of high prices and the costs to the economy

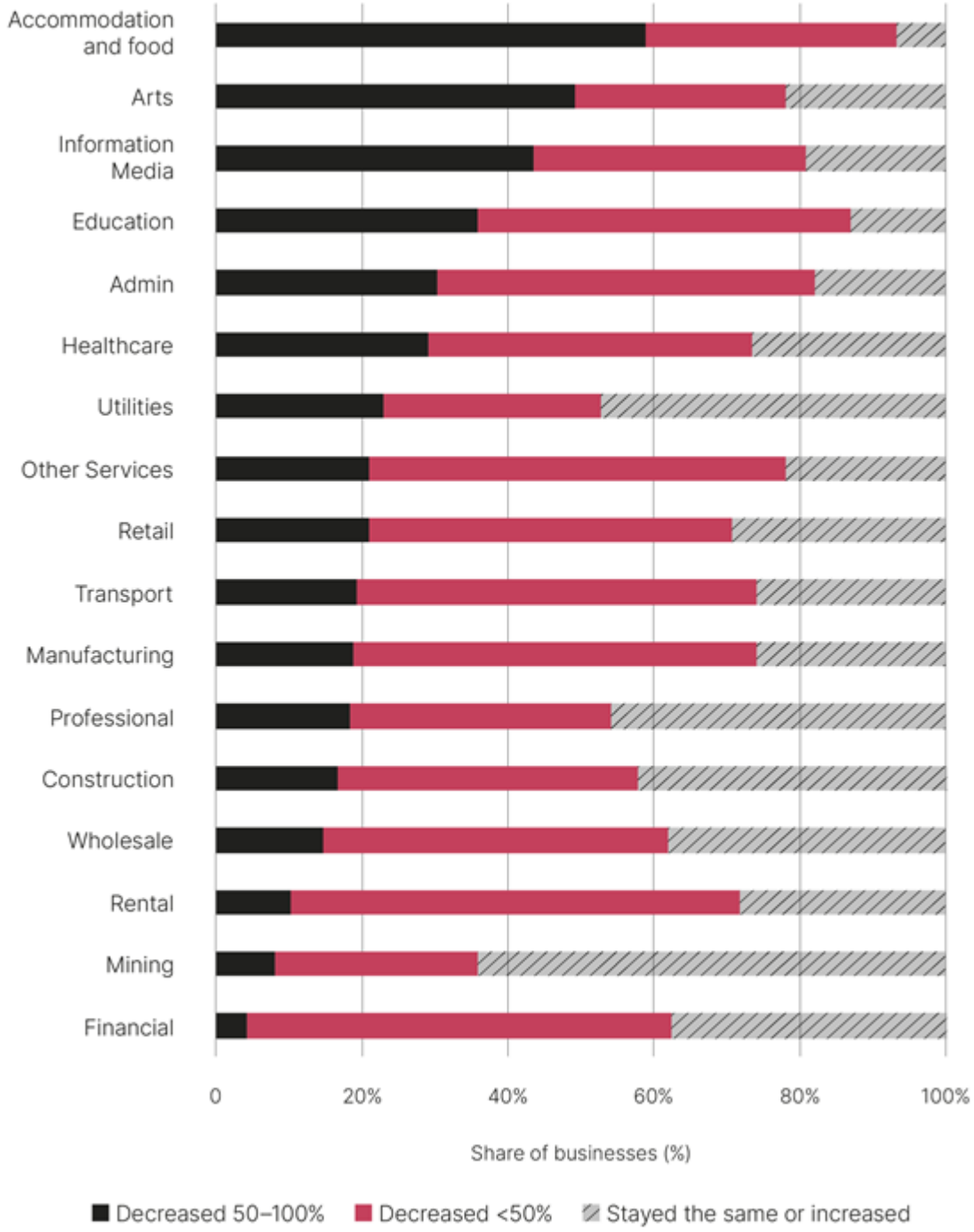
of bringing inflation down when it becomes embedded in expectations. This resulted in upside risks to inflation receiving less attention.[3456]

3.2.3. Support measures were necessary to sustain businesses in a period of uncertainty

Stakeholders told the Inquiry that the broad-based support measures were essential for businesses, especially during the alert phase, when there was little information on how the pandemic would unfold.[3457]

In these early months of the pandemic, the sharp decrease in consumer demand, coupled with the activity restrictions, impacted businesses. Profitability and cash flow became key concerns for businesses across industries. Around 70 per cent of businesses that the Australian Bureau of Statistics surveyed in June 2020 reported a decline in revenue relative to the same time the previous year (see Figure 10).[3458] By June 2020 the gross value added fell by 6.5 per cent in 15 out of 19 industries. The largest of these falls was observed in hospitality and tourism-related industries.[3459] Mirroring this, the industries with the largest job losses were arts and recreation services (16.5 per cent) and the accommodation and food services industry (15.1 per cent).[3460] For further details on the impact of COVID-19 on specific industries, see Chapter 24: Supporting industry.

Figure 10: Changes in revenue by industry, June 2020 – relative to same time last year[3461]



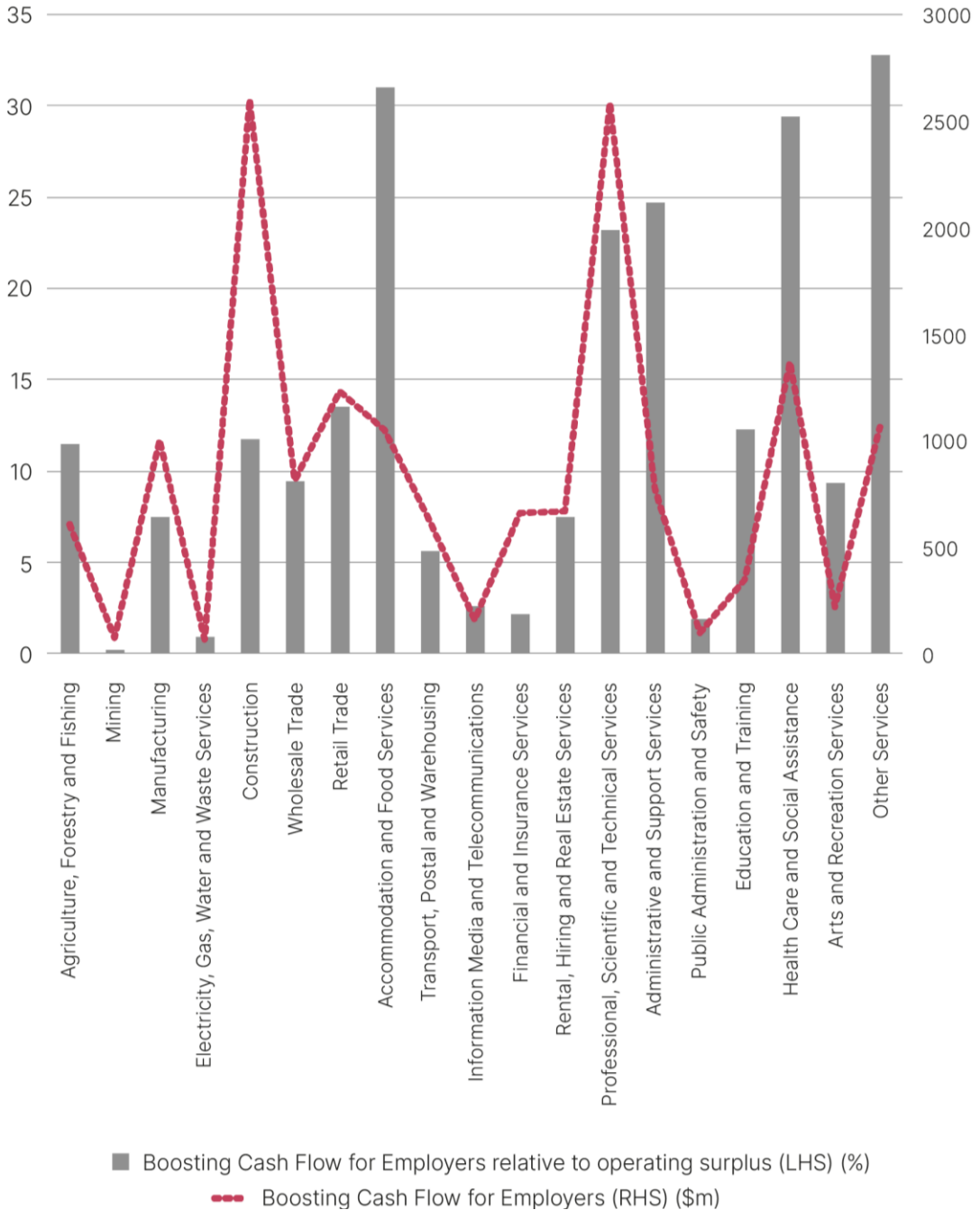
The Cash Flow Boost was the largest stimulus measure until JobKeeper was introduced just over a week later. Analysis indicates that JobKeeper and the Cash Flow Boost acted together to increase business cash flow, support business profitability and lift savings. These two policies had the largest effect, because they alleviated costs and allowed businesses to remain solvent.[3462]

As we heard at our Community Services Roundtable, eligibility for JobKeeper allowed organisations to retain staff. It also enabled some organisations to redeploy staff in areas that became more critical during the pandemic. Without JobKeeper, some organisations (particularly

not-for-profits) would not have been able to continue providing services through the pandemic.[3463]

Australian Bureau of Statistics analysis indicates that industries with a large proportion of small businesses received the most amount of JobKeeper and Cash Flow Boost payments, including construction, health and social assistance, and accommodation and food services.[3464] JobKeeper payments relative to compensation of employees were highest in the industries where most jobs were lost – for example, arts and recreation services, and accommodation and food services. Relative to operating surplus, Cash Flow Boost payments were highest in arts and recreation services and accommodation and food services.[3465]

Figure 11: Boosting Cash Flow for Employers payments by industry, relative to operating surplus[3466]



Further, Reserve Bank of Australia analysis in October 2020 concluded that, without the government's stimulus support, the estimated 3 per cent decline in business revenue in 2019–20 would have resulted in around 1,400 additional business failures, relative to normal times.[3467] Extended decline of business revenue in 2020–21 would have caused annual revenue to decline to 9.5 per cent compared with the previous year, and an additional 5,200 businesses would have been expected to fail.

Experience of small businesses during the COVID-19 pandemic

Small businesses accounted for 97 per cent of all businesses in Australia in 2023.[3468] Small businesses suffered a disproportionate impact because a large number of small businesses were in industries most affected by the pandemic.

Restrictions and lockdowns had a severe impact on many small businesses. A joint survey by the Australian Chamber of Commerce and Industry and the University of South Australia in November 2020 noted that Victorian businesses were twice as likely to face a greater than 80 per cent decline in revenue compared with businesses in New South Wales and other states.[3469] A survey by the Department of Industry, Science, Energy and Resources in 2020 noted that 'ongoing profitability' and 'maintaining cash flow' were among the highest ranked of main stress factors for businesses.[3470]

Reports also suggest that uncertainty during the pandemic was a key challenge for many small businesses and resulted in considerable stress and fatigue.[3471] Small business owners reported that there was an expectation from employees and customers that they would have more information on the pandemic, even though they were operating with the same information as others.

Many small business owners also faced mental health challenges during the COVID-19 crisis. A survey conducted by the Treasury in 2022, which was similar to the one conducted by the Department of Industry, Science, Energy and Resources in 2020, found there had been a shift in the main small business stress factor, from future economic uncertainty to struggling to find balance between the demands of work, health and personal life in 2022.[3472]

Small business respondents felt they had to keep up the appearance of being fine, even when they were struggling with their mental health and wellbeing, because others depended on them. The Treasury findings also noted that, while there were signs that more business respondents were seeking help than in 2020, stigma associated with mental health was still a significant issue in the small business sector. There are also indications that culturally and linguistically diverse (CALD) small business owners responded to challenges differently from non-CALD small business owners.[3473]

Government support alleviated some financial concerns for businesses, particularly during the early phases of the pandemic.[3474] We heard from the Council of Small Business Organisations Australia that financial support was well timed and rolled out relatively efficiently. We also heard that the Boosting Cash Flows measure was important for the small business sector.[3475] However, we also heard that, as support for businesses became decentralised during the latter stages of

the pandemic, it varied considerably between states and territories.[3476] In particular, when programs were implemented, small business owners had to spend many hours interpreting support and grant guidelines.[3477] Members of the Council of Small Business Organisations said that, in future, clearer and more accessibly financial counselling should be provided along with the financial support so that small businesses know how to use the money during a crisis and what programs are available to assist.[3478]

Small businesses also played a role in the enforcement of pandemic restrictions when businesses were able to open. The Australian Small Business and Family Enterprise Ombudsman submission said that, as a condition of reopening, small businesses had to enforce mask mandates, distance between individuals, and the number of people inside and outside venues. In communities or with groups that did not support these health restrictions, small businesses were vulnerable to aggression, abuse and vandalism in person and online.[3479]

Small businesses noted that peak bodies were an important source of information and advice during the pandemic – they acted as the conduit between businesses and governments. State small business ombudsmen performed a crucial role in supporting small businesses through the pandemic.[3480] However, small businesses also noted the importance of clear communication about public health orders, restrictions and eligibility for supports so that they can make informed decisions about their business and successfully remain a source of information to the public.[3481]

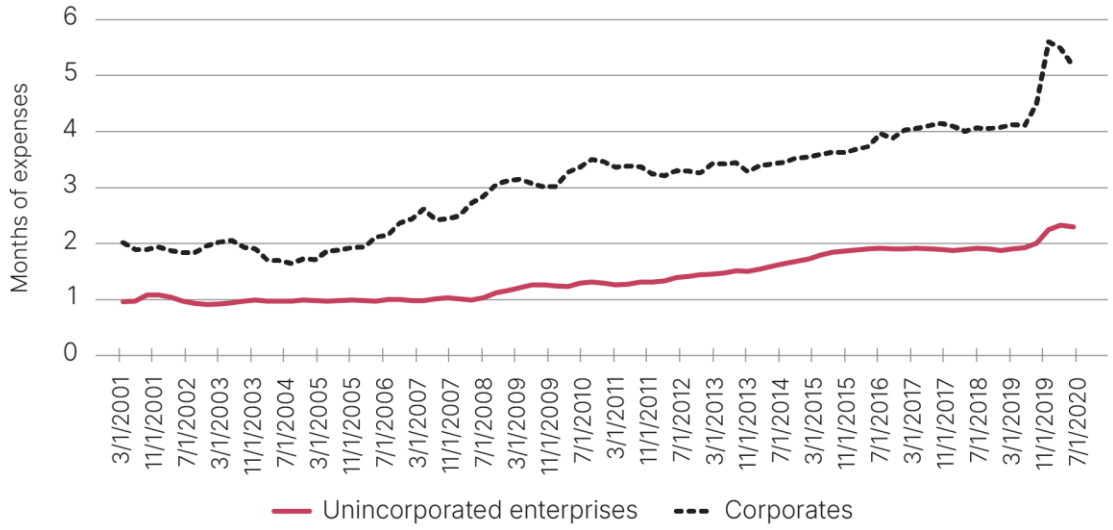
3.2.4. Considerable support measures provided to businesses were associated with high levels of business profitability and savings

During the pandemic, support measures may have overcompensated businesses and allowed them to build up significant cash buffers and savings. Large corporate businesses in particular significantly increased their cash holdings during the pandemic, including by reducing expenses and drawing down credit lines.[3482] The increase in business savings also led to a decreased demand for additional debt.[3483]

Boosting Cash Flows for Employers

The panel heard that the Cash Flow Boost was a successful measure, providing much-needed stability for small businesses at a time of great uncertainty.[3484] We heard that it was provided without conditions to enable businesses to choose the best way to support employment outcomes.[3485] Given that the payment was so quickly overtaken by the JobKeeper Payment, it is difficult to assess its impact and whether it represented value for money for taxpayers. It has also not been subject to a review, so it is difficult to assess its effectiveness.

Figure 12: Cash holdings of non-financial businesses, months of expenses ($m)[3486]



We heard that that the original intention of the measure was that it would act as a form of wage subsidy. However, as mentioned above, businesses did not need to apply and did not need to prove what the payment would be used for (for example, passing it on to employees). These elements, coupled with the drop in consumer demand, meant that businesses mainly used the payment to build their cash buffers. Furthermore, there is some evidence that some businesses restructured their operations to be able to qualify for the measure, including splitting businesses to ensure that their revenues were under $50 million or making up fictitious employees.[3487]

After the last Cash Flow Boost payments in September 2020, the government shifted to providing sector-specific measures during the latter half of the suppression phase and vaccine rollout phase of the pandemic (see Chapter 24: Supporting industry).

3.2.5. Regulatory changes and relief measures eased financial burdens for households and businesses

We heard that the easing of regulatory measures was an important feature of the pandemic's economic response.[3488] It provided households and businesses with temporary cash flow relief as they tried to navigate through the crisis. The tax relief measures outlined above were expected to provide more than 7 million individuals with tax relief of $2,000 or more for the 2020–21 year.[3489]

In relation to the pause in debt collection activities by the Australian Taxation Office and Services Australia and debt deferrals by the banks, we heard that they were important measures to stabilise the economy during the pandemic.[3490] Services Australia's national debt pause commenced on 3 April 2020 and was in place until 30 October 2020. During this time, 650,652 individuals had pauses applied, totalling $3.66 billion.[3491] However, it has been difficult for the Australian Taxation Office and Services Australia to resume their collection activities and they now have significant backlogs.[3492] For Services Australia, this is partially due to the fact that

approximately 36 per cent of outstanding debts are for a value of $500 or lower, but the cost of recovery is considerably higher than $500 per debt.[3493] Furthermore, while debt collection activities were paused by these agencies, debt was still being accrued and individuals were not notified of the accruing debt. This meant that individuals were not able to plan for their own financial circumstances and limit future debt liabilities.[3494]

APRA's monthly data releases show that banks' deferral of loans peaked in May 2020. As at 30 June 2020 data submitted by all banks indicates that $274 billion worth of loans had been granted temporary repayment deferrals.[3495] This is close to 10 per cent of total loans outstanding. Housing loans make up most of the total loans granted repayment deferrals. However, small business loans have a higher incidence of repayment deferral, with 17 per cent of small business loans subject to repayment deferral, compared with 11 per cent of housing loans. However, one stakeholder noted that, while a number of households took up the option for mortgage deferrals, many did not actually defer their payments and continued to pay off their loans.[3496] This may have been because the government announced economic support measures soon after the banks announced the option for deferral.[3497] However, it was noted that these measures provided a form of stability in the interim.

4. Securing the economic recovery

As restrictions started to be lifted in May 2020 the focus of the government turned to the economic recovery. Australia's GDP dropped 6.9 per cent in the June quarter, and there was a focus on rebuilding the lost capacity across the economy and reducing unemployment, which peaked at 7.5 per cent in July 2020.[3498] Many of the policies the government adopted were similar to those that would be used to support economic recovery in a recession caused by a negative shock to demand, including infrastructure spending. However, as outlined in Chapter 20: Managing the economy, the economy recovered much faster than anticipated, with the reopening effectively providing a large positive shock to demand negating the need for government fiscal stimulus.

4.1. Response

4.1.1. Job recovery measures

The government announced the JobMaker Plan in the 2020–21 Budget, with a range of measures to support job growth and recovery as part of the economic recovery plan.[3499] Some key measures of the JobMaker Plan are outlined below.

JobTrainer Fund

As part of the 2020–21 Budget, the Australian Government committed $500 million to partner with state and territory governments to establish a $1 billion JobTrainer Fund (JobTrainer).[3500] An additional $500 million was committed by the Australian Government to extend the program until 31 December 2022. The fund supported free or low-fee training places for job seekers and young people (including school leavers) to upskill or reskill in areas of identified skills need. JobTrainer was established through a National Partnership Agreement. It expected

to support around 463,000 enrolments, including 33,800 aged care training places and 10,000 places in 2021–22 for Australians to gain valuable digital skills.[3501]

An individual was eligible for a JobTrainer-sponsored course if they:

- had not previously completed an Australian Qualifications Framework qualification under JobTrainer
- were an Australian citizen, permanent resident, New Zealand citizen or asylum seeker
- were between 17 and 24 years of age when the course commenced.

The scheme was also open to job seekers of any age ('job seeker' was defined as a person who held a current Health Care Card, Pensioner Concession Card or Veterans Gold Card or was unemployed) or an individual enrolled into a priority program listed in the JobTrainer Funded Programs Report.[3502]

JobMaker Hiring Credit

The JobMaker Hiring Credit scheme was a wage subsidy paid directly to employers to help accelerate growth in the employment of young people during the COVID-19 economic recovery. The scheme, which was also announced in the 2020–21 Budget and began on 7 October 2020, was an incentive for businesses to employ additional job seekers aged 16 to 35 years.[3503]

The JobMaker Hiring Credit was expected to support around 450,000 young Australians finding jobs, at an estimated cost of $4 billion.[3504] Eligible employers could access the JobMaker Hiring Credit for each eligible additional employee they hired between 7 October 2020 and 6 October 2021. To be eligible, the employee must have received the JobSeeker Payment, Youth Allowance (Other), or Parenting Payment for at least 28 consecutive days within the 84 days before the start of employment. Employers were able to receive $200 per week for each additional eligible employee they hired aged between 16 and 29 years old, and $100 per week for each additional eligible employee they hired aged between 30 and 35. The scheme was administered by the Australian Taxation Office and could be claimed by employers in arrears from the Australian Taxation Office. As the scheme was designed to support new employment, employers did not need to satisfy a turnover test (unlike JobKeeper).[3505]

4.1.2. HomeBuilder

On 4 June 2020 the Australian Government launched the HomeBuilder program to support the residential construction sector.[3506] Under the program, between 4 June 2020 and 31 December 2020 eligible Australians received a grant of $25,000 towards renovations or new home builds.[3507] To be eligible, singles had to earn less than $125,000 and couples less than $200,000 per annum. Applicants had to have signed contracts between 4 June 2020 and 31 December 2020 to purchase a house and land package, build a new home on a pre-owned vacant block, knock down and rebuild a home, do a substantial rebuild or renovation of an owner-occupied property, or purchase an off-plan apartment or townhouse. Construction had to have

commenced within three months of the contract date in the original announcement (this was later extended).

On 29 November 2020 the government announced an extension of the program to 31 March 2021.[3508] However, the grant was reduced to $15,000. Contracts had to have been signed between 1 January 2021 and 31 March 2021.

HomeBuilder was implemented through a National Partnership Agreement with the state and territory governments.[3509] It was designed to complement existing state and territory First Home Owner Grants Programs, stamp duty concessions and other grant schemes. Combined with the state and territory schemes, first home buyers in regional Victoria and Tasmania could access up to $45,000 in grants.[3510]

4.1.3. Infrastructure projects

Infrastructure stimulus formed a major part of the government's economic stimulus. The initiatives the government introduced included:

- $1 billion for smaller scale, 'shovel-ready' infrastructure projects and $500 million for Targeted Road Safety Works (from June 2020)
- over $2.8 billion for the terminating Road Safety Program – similarly, for smaller scale projects that could be rolled out quickly (from October 2020)
- $2.5 billion in funding, through the Local Roads and Community Infrastructure program, to every local government area for construction, maintenance or improvement of local roads and council assets as a COVID-19 stimulus program. A further $750 million was allocated to Phase 4 (from 1 July 2023) as an infrastructure development program.[3511]

By May 2021 the government had committed $14 billion in new and accelerated infrastructure projects since the onset of the COVID-19 pandemic. Its stated intention was to boost demand and create jobs.[3512] The 2021–22 Budget included an additional $15.2 billion over 10 years for road, rail and community infrastructure projects across Australia.[3513]

The state and territory governments also engaged in their own stimulus measures during the pandemic, including infrastructure stimulus. The New South Wales Government committed to a guaranteed $100 billion infrastructure pipeline over four years to drive employment growth and help create 88,000 direct jobs.[3514] The Queensland Government announced $52 billion infrastructure pipelines, to be rolled out over four years.[3515]

4.1.4. Gas-fired recovery

Gas-fired development became a central aspect of the government's economic recovery plan on the basis that it would support the manufacturing sector and reduce electricity prices for households and businesses.[3516] The government's National COVID-19 Coordination Commission, set up in March 2020, launched a Manufacturing Taskforce to assess the role of domestic manufacturing, with energy being a key area of focus.[3517] The Manufacturing Taskforce's interim report called for investment in domestic manufacturing and subsidies for

gas development.[3518] In September 2020 the government announced key initiatives to boost gas supply in Australia, boost pipeline and transportation markets and empower gas customers as part of its JobMaker Plan.[3519] In the 2021–22 Budget, the government expanded on this, providing $58.6 million in new measures such as:

- $38.7 million for targeted support of critical gas infrastructure projects to alleviate the forecast gas supply shortfall
- $3.5 million to design and implement the Future Gas Infrastructure Investment Framework to support the Commonwealth's consideration of medium- to long-term critical gas projects identified by future National Gas Infrastructure Plans
- $5.6 million to strengthen the government's energy system planning framework by delivering a further National Gas Infrastructure Plan in 2022
- $4.6 million to develop initiatives empowering gas-reliant businesses to negotiate competitive contract outcomes, including developing a voluntary standardised contract framework
- $6.2 million to continue work to accelerate the development of the Wallumbilla Gas Supply Hub in Queensland.[3520]

4.2. Impact

4.2.1. Outcomes of the jobs recovery measures were mixed

The impact of the government's package of measures to boost jobs recovery, as part of its broader economic recovery package, was mixed. JobTrainer had success in helping young people, job seekers and school leavers access vocational courses. By August 2021, more than 100,000 people in New South Wales had taken up a fee-free course under this program.[3521] At that time, health and individual support, community services, construction, business administration and IT were the most popular types of courses accessed in New South Wales and 94.5 per cent of people said they achieved at least one work-related benefit from the training.

Despite projections, take-up of the JobMaker Hiring Credit was low. It was intended to support around 450,000 jobs at a cost of $4 billion, but evidence indicates that only 8,230 employees had benefited from it.[3522] The Grattan Institute attributed this minimal uptake to the narrow eligibility for both employees and businesses.[3523] We also heard from one interviewee that despite being designed carefully, the JobMaker Hiring Credit was largely ineffective.[3524] The panel notes that during its rollout the economy and labour market were performing strongly, which may explain in part the poor take-up.

4.2.2. Excessive demand for construction services overheated the industry and the economy

The relationship between levels of economic activity and construction output is well established. Economic recessions have traditionally had a significant impact on the construction industry, more so than other industries.[3525] At the same time, infrastructure spending tends to

produce higher fiscal multipliers than other forms of government spending.[3526] As a result the construction sector has featured heavily in government economic stimulus measures in past recessions.

There are clear indications that the infrastructure measures taken – in particular, HomeBuilder – overheated the industry and contributed to inflation in the post-pandemic era.[3527] The program was designed explicitly to stimulate aggregate demand and support the residential construction sector. It acted to stimulate consumption expenditure and lowered the significant household savings built up during the pandemic.[3528] However, the measure failed to appropriately take into account the supply-side effects of the pandemic. The *HomeBuilder National Partnership Agreement Review: stakeholder consultation* report states:

> *It could be said that the HomeBuilder did partially contribute to the constraints in supply of labour, materials and land that resulted from this industry overheating. However, it is critical to note that this would have been just one factor. Broader supply chain issues because of the COVID-19 pandemic were another, and much more impactful, factor. – KPMG 3529*

Existing labour shortages were exacerbated by border closures, and supply chain disruptions led to increased material costs. This contributed to delays with project completions.[3530] Recent media articles have also criticised the HomeBuilder program in particular for favouring middle- to high-income earners rather than lower income earners.[3531] Figure 13 shows that, since September 2021 (inclusive), the contribution of housing (which includes but is not limited to dwelling costs) to quarterly inflation has ranged between 20 per cent and 50 per cent.

Figure 13: Contribution to quarterly inflation[3532] (%)

Groups	*Sep-21*	*Dec-21*	*Mar-22*	*Jun-22*	*Sep-22*
Food and non-alcoholic beverages	0.04	0.12	0.47	0.35	0.55
Alcohol and tobacco	−0.04	0.06	0.08	0.05	0.08
Clothing and footwear	−0.14	0.09	−0.02	0.13	−0.01
Housing	*0.35*	*0.37*	*0.56*	*0.52*	*0.67*
Furnishings, household equipment and services	0.13	0.09	0.09	0.21	0.25
Health	0.00	−0.02	0.15	0.03	0.02
Transport	0.35	0.32	0.48	0.27	−0.05
Communication	−0.01	0.00	0.01	0.00	0.03
Recreation and culture	0.12	0.19	0.08	0.18	0.17
Education	0.00	0.00	0.20	0.00	0.00
Insurance and financial services	0.03	0.06	0.03	0.06	0.07
Total	0.8	1.3	2.1	1.8	1.8

The Treasury estimates of the HomeBuilder program at the time it was implemented indicate that the government underestimated take-up of the program. The government initially announced the program as a $25,000 grant and expected to support 27,000 homes totalling $680 million.[3533] It was later extended as a $15,000 grant to support a further 15,000 homes, at

an estimated cost of $240.9 million in the 2021–22 Mid-Year Economic and Fiscal Outlook. The Treasury data reveal that, as at June 2024, 113,156 applications had been approved and grants payments totalling $2.6 billion had been paid.[3534]
Some HomeBuilder payments were made after pandemic restrictions had eased, including $260.3 million provided in 2022–23.[3535] The extension to HomeBuilder recognised that applicants had entered into financial commitments on the basis they would receive the grant, but through no fault of their own were affected by supply constraints and construction industry delays.[3536] The program is expected to continue to support the construction industry given that existing applicants have until 30 June 2025 to submit their applications.

The HomeBuilder National Partnership Agreement Review found that state and territory governments were not made aware of or consulted on the design or implementation elements of the HomeBuilder program until it was first publicly announced.[3537] This created significant implementation challenges for these jurisdictions. In particular, it was difficult to respond to public queries and meet public expectations. The report indicated that some requirements were not fit for purpose and definitions of substantial renovation, citizenship requirements and other terms lacked sufficient clarity and guidance.[3538]

4.2.3. Public investment in sectors and manufacturing was misplaced

The government's gas-fired recovery plans during the COVID-19 pandemic have been criticised as being short-sighted, expensive and contradictory to Australia's commitment to reduce carbon emissions.[3539] The National COVID-19 Coordination Commission Manufacturing Taskforce's interim report estimated that the proposed reforms could improve the resilience of the Australian economy through diversification and lead to more than 170,000 'well-paid direct jobs in energy-enabled industries' if the manufacturing industry grew by 10 to 20 per cent.[3540] However, as the Grattan Institute noted, gas-fired recovery faced two key challenges.[3541] Firstly, Australia must reduce emissions over time to meet our climate change targets – and gas is not an exception. Secondly, eastern Australia has already burned most of its low-cost gas, and gas prices are now too expensive to be viable. The government's policies were unlikely to reduce prices without significant ongoing cost.

The Grattan Institute also found that 'gas will not fuel a manufacturing renaissance', noting that Australia's truly gas-reliant manufacturers make polyethylene, ammonia and alumina – for those manufacturers, gas makes up more than 10 per cent of input costs.[3542] But these sectors employ only a little more than 10,000 workers and make up just over 0.1 per cent of the national economy. By contrast, more than 750,000 workers are employed in manufacturing sectors where gas makes up less than 1 per cent of input costs on average.[3543]

The Australian Sustainable Finance Initiative, a joint venture of the big four banks, major insurers, super funds, asset managers and financial regulators, argued that it was no longer appropriate to simply throw money at old forms of infrastructure.[3544] It argued that it would be preferable to use infrastructure stimulus spending to solve rather than contribute to the problem of global warming. Researchers at Oxford University noted that economic recovery packages that seek synergies between climate and economic goals have better prospects for

increasing national wealth and enhancing productive human, social, physical, intangible and natural capital.[3545] Some commentators have argued that investing in gas is a jobs-poor outcome because, for every $1 million of output, the gas industry employs around 0.4 people.[3546] The Australia Institute noted that, because these subsidies will not reduce gas prices, they will not create additional jobs in flow-on industries like manufacturing.[3547]

The government and the National COVID-19 Coordination Commission were also criticised for not aligning measures with the Paris Agreement climate targets.[3548] The government was criticised for a lack of transparency or accountability, seemingly furthering the interests of particular groups.[3549] The Manufacturing Taskforce was led by Neville Power, the current Director and Deputy Chair of Strike Energy Limited and former CEO of Fortescue Metals.[3550]

5. Evaluation

Protecting against pandemic losses

The Australian Government was not prepared for a pandemic-induced economic crisis, and had not undertaken any scenario exercises or developed any of the measures necessary to protect households and businesses from losses during a pandemic. That the policies which were implemented were as successful as they were in minimising the economic and social harm of the pandemic was testament to the leadership, agility and innovation of the government and key officials.

The panel carefully considered the notion of when a wage subsidy scheme, like JobKeeper, is appropriate and whether it should be part of a future pandemic response. There were issues with overcompensation which led to excessive savings by businesses and households and unnecessary fiscal costs for government; however, these could be fixed with better policy design in a future pandemic, as outlined in Nigel Ray's JobKeeper Evaluation. While a short-term work scheme (similar to those used in other countries) could be a more appropriate policy response, in the absence of social insurance in Australia, the panel considers that wage subsidies should form part of an economic toolkit for government in a future pandemic response. Overall, JobKeeper performed exceptionally well against its overarching objective of maintaining employment relationships across the economy and protecting households from large falls in income. Indeed in many respects, the JobKeeper program was to the economy what the border closure was to the broader health response.

Notwithstanding the broad success of the economic response, decisions to exclude certain businesses, individuals and organisations from supports – and in ways that were not based on the scale of their losses but, rather, on other criteria, including citizenship status – did not represent equitable treatment and created unnecessary hardship, undermining the broader economic and health objectives of the programs.

In particular, the panel was deeply concerned about the lack of support for temporary visa holders, especially during the alert phase of the pandemic. The panel heard that there was no policy basis for excluding temporary visa holders from JobKeeper. Equitable access to supports would have reduced pressure on community and state-based support services at a time of

significant demand on their collective capacity and avoided significant hardship amongst a relatively young adult population. Also, the exclusions resulted in many temporary migrants leaving Australia. Apart from the reputational damage, this also resulted in significant labour shortages in many sectors (as explored in later chapters), adding to inflationary pressures and undermining Australia's economic recovery from the pandemic.

The panel considers that the COVID-19 income support measures were crucial in ensuring that there was a basic liveable income for most Australians and mitigated some of the negative effects of the pandemic on individual and household welfare. The emergency increases to income support payments were necessary because of the inadequacy of the social security system. This was shown in the rapid decrease in poverty rates when the additional supports were introduced and the rapid increase in poverty rates after they ended. In future, Australia's preparedness for a pandemic will depend on a robust social security system that enables recipients to afford basic necessities.

The disaster payments also alleviated the stress of individuals needing to earn an income and supported people's compliance with public health orders. Combined with income support payments, they increased the welfare of many Australians and were vital in minimising the economic and psychological harm for the most disadvantaged individuals and communities.

We acknowledge the agility of Services Australia and the Australian Taxation Office in providing support measures to millions of Australians during a time of unprecedented demand for government services. We owe much of Australia's success to the ability of agencies such as Services Australia and the Australian Taxation Office to quickly redeploy staff and services as needed.

However, provision of business and industry supports was inconsistent, particularly as the pandemic progressed. This happened because of breakdowns in effective coordination, communication and collaboration between the states and territories and the Australian Government. Provision of economic support to businesses should be clearly delineated and communicated between all levels of government. This will ensure that resources are deployed efficiently across jurisdictions and help preparedness for a future pandemic.

The panel heard a variety of views and conflicting evidence on the early withdrawal of superannuation scheme. Some said it should never be repeated, but others said the scheme was important in allowing individuals to continue to meet their financial obligations. On balance, the panel considers that pre-existing hardship provisions would have been sufficient to meet the scheme's broad objectives and would have minimised the negative impacts on retirement savings into the future.

Maintaining consumer and business confidence

It can be difficult to fully appreciate the level of uncertainty that dominated during the alert phase of the pandemic, when the majority of economic support measures were conceived and implemented. Because Australia was largely unprepared to deal with a pandemic-induced

recession, the government initially provided stimulus measures more like those used during cyclical downturns, such as the Global Financial Crisis.

The Reserve Bank of Australia demonstrated its preparedness in having this toolkit of unconventional measures and showed leadership in utilising these tools (many for the first time) in the face of enormous uncertainty. We note that the Reserve Bank of Australia Review has conducted a thorough review of the bank's measures during the pandemic and has analysed their contribution to the post-pandemic inflationary environment. We agree with the recommendations of the Reserve Bank of Australia Review and note the work that the Reserve Bank of Australia is undertaking to implement these recommendations.

The panel heard views that all of the supports that were deployed were needed to maintain confidence – without them, the economic outcomes would not have been so positive. The panel agrees that the level of economic supports needed to err on the side of being too much, rather than too little, but an approach of doing 'whatever is necessary' in a crisis is not unconditional. With improved planning, more targeted support could have been provided.

The suite of measures to maintain confidence, including the $32 billion Cash Flow Boost paid to all small businesses, regardless of whether they had had an increase or decrease in cash flows, the extension of low and middle income earner tax offsets and the expansionary monetary policy settings all contributed to the overcompensation of businesses and households and an erosion of the government's fiscal position. They led to increases in savings and contributed to the inflationary pressures post-pandemic (as explored in Chapter 20: Managing the economy).

The panel considers that in future pandemic measures that are intended to maintain the confidence of households and businesses need to be carefully designed to ensure that excessive savings do not exacerbate the post-pandemic inflationary pressures and economic harm.

Securing the economic recovery

The government's broad focus on programs to assist with jobs recovery demonstrates its commitment to maximise the employment gains coming out of the pandemic, which resulted in long-term unemployment dropping to its lowest levels in decades. The panel considers this objective was valid as after a pandemic it is important to have the right skills in the economy to support the recovery and to assist people back into work. The JobTrainer Program appears to have been well-directed to supporting the recovery; however, evidence suggests other programs such as the JobMaker Hiring Credit did not achieve their stated aims.

The bigger issue with the transition to recovery after the pandemic recession in mid-2020 came largely from a miscalculation of the nature of the economic recovery from the pandemic, which we now have a much better understanding of. With the benefit of hindsight, many of the measures that were deployed ended up either not being necessary or adding to post-pandemic inflationary pressures. The supply-side effects of support measures during the pandemic, as well as the combined effect of related measures such as international border closures, were poorly considered or evaluated.

There are clear indications that the stimulus measures to support the construction industry – in particular, HomeBuilder – contributed to overheating the industry and partially contributed to inflation in the post-pandemic period. The result was that the industry was significantly under-resourced, with a substantial backlog of construction work that needed to be completed.

The government's 'gas-fired recovery' strategy was also an example of narrowly focused and poorly designed policy with limited benefits for the manufacturing industry and jobs growth. Alternative approaches to infrastructure stimulus, such as investments in green or renewable technology, would have ensured any infrastructure or other stimulus spending would help to solve rather than contribute to the problem of global warming.

These infrastructure stimulus measures aimed at supporting economic recovery were more focused on addressing demand rather than supply, demonstrating the government's poor use of evidence and evaluation. However, demand recovered quickly while supply remained constrained. This added to imbalances in the economy during the recovery. We heard from many industries (see Chapter 24: Supporting industry) that they struggled to increase supply during the reopening due to uncertainty, ongoing restrictions and labour shortages. This failure of planning and preparedness during the pandemic undermined the economic recovery and added to supply-side constraints.

The panel notes that a number of the key fiscal measures have not been evaluated. It considers this to be a missed opportunity. The fiscal measures the government deployed during the pandemic were some of the most significant seen in this country and involved the expenditure of considerable amounts of public money. Review of the key economic measures that have not been subject to an assessment of their effectiveness would promote transparency and trust in government and ensure we are well placed to learn from the pandemic experience. The panel notes that the Reserve Bank of Australia has reviewed most of its extraordinary monetary policy measures, but we agree with the Reserve Bank of Australia Review that it would be better for these reviews to be conducted at arm's length from the organisation.

We must draw the lessons from the design and implementation of these measures and maintain the capacity to model scenarios to improve preparedness for a future public health emergency.

6. Learnings

- The implementation of economic supports needs to mirror the health response and objectives in a pandemic. To facilitate this, economic policy measures should be proportionate to the nature of the shock and be targeted at maintaining an adequate level of income for households and businesses for the economy to withstand the impact of the shock.
- Support for household and businesses should be targeted but broad based. Exclusions based on factors such as residency status can have negative impacts on the economy and social cohesion and should be avoided.

- Measures should also be designed with in-built transparency and evaluation mechanisms to promote public trust and identify lessons for future policy design.
- Policy design needs to consider delivery system constraints and balance the benefits of targeting payments with the need for simplification and rapid deployment in a crisis. Preparedness for future crises should be a factor for departments to consider when making investments in key data, systems and process capabilities.
- A strong social safety net is necessary in a crisis where sectors of the economy are effectively closed and there are limited opportunities for affected workers to find alternative employment. The strength of the social safety net at the onset of a crisis will determine the need for discretionary measures.
- Preparedness for future public health or economic crises requires a well-developed 'economic toolkit' that can be readily deployed. Refer to 'The economic toolkit' below for further details.

6.1. The economic toolkit

All crises differ in some way and therefore the next public health emergency will likely require a different response or combination of responses. The development of an 'economic toolkit', with both fiscal and monetary policy measures, will ensure preparedness for any future public health or economic crises.

6.1.1. Fiscal policy measures

The fiscal policy tools below set out the broad range of measures used during the COVID-19 pandemic. While the panel is of the view not all of these will be appropriate in a similar future public health crisis, it is important that the toolkit includes all measures.

Wage subsidies – In line with the findings from the JobKeeper Evaluation, we note that a national wage subsidy similar to JobKeeper should only be used when there is a need to temporarily 'freeze' the labour market to allow otherwise productive employees and businesses to continue to operate, paving the way for a rapid recovery. It is inappropriate to deploy a wage subsidy in normal economic recessions, as it is not a measure targeted towards addressing aggregate demand in the economy. Further, the design and implementation of a national wage subsidy should consider the findings of the JobKeeper Evaluation and issues raised in this Inquiry to ensure that a wage subsidy can be more appropriately targeted in future.

Note that while a national wage subsidy can be an appropriate method of providing compensation to individuals, it is not as effective in providing compensation to businesses. A short-time work scheme would reduce the uneven compensation for businesses provided by JobKeeper (in favour of zero compensation). However, the JobKeeper Evaluation found that implementing such a scheme was not feasible during the COVID-19 pandemic. Considering the merits and feasibility of implementing either wage subsidies or short-time work schemes should form part of the preparation for a future crisis of a similar nature.

Income support payments – Increases to income support payments are appropriate when significant uncertainty in the economy gives rise to mass unemployment, and there is an expectation for government support to be adequate for households to weather the negative impacts of the crisis. This helps to reduce further job losses from a severe reduction in expenditure from those who become unemployed as a result of economic conditions. It is also vital to ensure that the most financially disadvantaged in our society have a basic liveable income, which will not only help ensure compliance with public health orders but help minimise social and economic harm.

Cash transfers to households and businesses – Cash transfers can be appropriate measures in a future crisis in providing immediate cash flow relief, helping households and businesses reduce their debts and easing financial burden across the economy. However, measures need to be carefully considered in terms of their overall impact on the economy to avoid overcompensating and overstimulating the economy. The COVID-19 pandemic was associated with high levels of precautionary savings, and as such, the impact of measures to stimulate aggregate demand were shown to have negligible contemporaneous effects, but a larger delayed effect. Measures that primarily stimulate aggregate demand in the economy are less appropriate in such crises where demand is already constrained due to public health measures.

Release of superannuation – Blanket early access to superannuation should not be considered as an appropriate policy measure to support individuals in a large temporary shock such as the pandemic, as the loss of future income to the individual typically outweighs the economic benefit gained during the crisis period. Early access to superannuation should be available for individuals through the established financial hardship processes available at the Australian Taxation Office.

Tax relief measures – Tax relief measures can be appropriate in a future crisis to provide immediate cash flow relief and help households and businesses reduce their debts; however, they are generally not as effective as direct payments as a fiscal stimulus. Moreover, tax relief measures should be timed appropriately and must be considered in terms of their overall impact on the economy, especially during a shock that impacts both the demand and supply sides of the economy. Temporary tax relief measures can be difficult to implement because their removal is often interpreted as an increase in tax for households and businesses. These measures need to be implemented with an exit strategy that is clearly communicated to affected individuals and businesses.

Regulatory measures – Regulatory relief may be appropriate in a future crisis in helping households and businesses reduce their debts and ease financial burden across the economy. During the COVID-19 pandemic, the financial and economic regulators played an important role in monitoring and maintaining the financial stability of the economy, whilst also providing relief for financial institutions to help households and businesses through the pandemic. However, as with cash transfers, measures must be considered in terms of their overall impact on the economy. Measures such as debt collection pause policies should be implemented as an 'opt-in' measure, with adequate communication and notification provided to individuals throughout the pause on the amount of (and accrual of further) debt. The lack of appropriate

communication of debt makes it difficult for individuals to adjust their behaviour and plan for their own financial circumstances.

Infrastructure stimulus – Infrastructure stimulus measures in a future public health emergency should be focused on productivity-enhancing public infrastructure to ensure that the economy will reap long-term benefits from government investment. In future crises of similar nature, where the movement of labour and capital is restricted, adequate consideration needs to be given to the supply-side effects of infrastructure stimulus measures.

6.1.2. Monetary policy measures

The economic policy toolkit should also include the monetary policy tools. This includes the unconventional tools deployed by the Reserve Bank of Australia implemented during the COVID-19 pandemic. The use of unconventional monetary policies during a national public health crisis such as a pandemic is appropriate, particularly when conventional monetary policy measures are constrained. However, these unconventional monetary policy measures should in a future crisis of similar nature be more carefully designed and calibrated with risk monitoring, mitigation and exit planning accounted for as part of their design and implementation.

Further, in line with recommendation 3 from the Review of the Reserve Bank of Australia, the Statement on the Conduct of Monetary Policy should acknowledge the importance of both monetary policy and fiscal policy for macroeconomic outcomes. The government (in particular the Treasury) and the Reserve Bank of Australia should commit to:

- continue to regularly share information about the economic outlook, risks and policy constraints
- work together to analyse the impacts of monetary policy decisions on fiscal policy, and the impacts of fiscal policy decisions on monetary policy
- jointly develop scenario analysis that identifies the best combination of policy responses to economic challenges, in ways that do not compromise monetary policy independence
- identify how the RBA's monetary policy framework and the government's fiscal approach can together best support good economic outcomes and acknowledge that fiscal policy may have a larger role in some circumstances – for example, when the cash rate is at its effective lower bound.

7. Actions

7.1. Immediate actions – Do in the next 12–18 months

Action 3: Conduct post-action reviews of outstanding key COVID-19 response measures to ensure lessons are captured, including key economic measures.

- Review the effectiveness of the remaining key economic support measures deployed during the pandemic, to draw lessons for the development of the Economic Toolkit.
- The following significant economic measures that have not been subject to a comprehensive review should be prioritised: Boosting Cash Flow for Employers, the Coronavirus Supplement, HomeBuilder, the Pandemic Leave Disaster Payment, the COVID-19 Disaster Payment, and the Early Release of Super.

Action 6: Develop legislative and policy frameworks to support responses in a public health emergency, including for an Economic Toolkit.

The Economic Toolkit should:

- be developed by Treasury and the Reserve Bank of Australia, in consultation with relevant departments and the states and territories
- include measures that can be tailored to respond to different forms of economic crisis, including a public health emergency, with an appropriate gender lens applied.
- cover the division of responsibilities of the Australian Government and state and territory governments for the development and implementation of economic response measures
- draw on lessons from reviews of significant aspects of Australia's COVID-19 response, including ensuring all residents, regardless of visa status, are supported during the response
- be updated over time to reflect research and reviews of economic settings (see Actions 8 and 22)
- consider the mechanisms for the implementation of measures, and whether these could be enhanced to better support delivery – such as upgrades to existing systems or data-sharing arrangements
- consider the role of transparency mechanisms in promoting public trust.

Action 9: Agree and document the responsibilities of the Commonwealth Government, state and territory government and key partners in a national health emergency. This should include escalation (and de-escalation) triggers for National Cabinet's activation and operating principles to enhance national coordination and maintain public confidence and trust.

This should include:

- greater clarification of roles and responsibilities, including around key areas of shared or intersecting responsibility such as vaccine distribution, health and social care of people with disability, older Australians and the provision of economic support in a national health emergency.

7.2.Medium-term actions – Do prior to the next national health emergency

Action 21: Build emergency management and response capability including through regular economic scenario testing to determine what measures would be best suited in different forms of economic shocks and keep an economic toolkit up to date.

Led by Treasury, this should include:

- a primary coordination role for Treasury and inclusion of state and territory treasuries
- testing a system-wide response, including Treasury, the Reserve Bank of Australia and key economic and financial regulators at the Australian Government level
- drawing on the Economic Toolkit to test the suitability of those measures to respond to different types of economic shocks
- reflecting any learnings from scenario testing exercises in updates to the Economic Toolkit.

Chapter 22 – Supply chains

1. Context

Focusing on supply chains, this chapter explores the impact of the pandemic on the systems, processes and businesses involved in producing, processing and transporting goods to consumers – for import and export. Supply chains are important for everyday life, ensuring we have the goods and services we need, when we need them. In normal times the Australian supply chain sector largely operates independently and smoothly, with the role of government focused on regulating parts of the sector.

The pandemic had an immediate, widespread and largely unanticipated impact on supply chains.[3551] It highlighted our reliance on the 'just-in-time' model of operation and the vulnerabilities of that model,[3552] and disproved the widely held assumption that free flow of goods over borders would continue uninterrupted.[3553] The pandemic also exacerbated existing vulnerabilities in the freight sector.[3554] Combined, this made it difficult for supply chains to deliver goods to Australian consumers and industry without significant delays and disruptions.

Items affected included daily essentials such as medicines and groceries; key products for the functioning of certain supply chains, such as pallets,[3555] building materials[3556] and shipping containers;[3557] and health products critical for Australia's pandemic response, such as personal protective equipment (PPE), ventilators and testing kits.[3558]

Some of the factors causing these challenges were beyond the Australian Government's control:

- limits in overseas production of some essential goods, caused by the shutdown of other economies in response to the pandemic and suppliers prioritising local needs[3559]
- a reduction in international airfreight options, and a spike in demand for sea freight, which contributed to the shortage of shipping containers and resulted in sharp increases in the price of transporting goods[3560]
- unanticipated changes in the domestic demand for goods, with hospitals trying to meet their public health needs and consumers stockpiling critical goods such as food and medicines[3561]
- changes in the global demand for goods, with increased demand for items used as part of the pandemic response (like PPE) and an increase in online shopping.[3562]

However, some issues were within the control of the Australian and state and territory governments. Many of the domestic supply chain challenges were the result of the implementation of public health measures which were developed by governments that had a limited understanding of supply chains and undertook minimal industry consultation ahead of making key decisions.

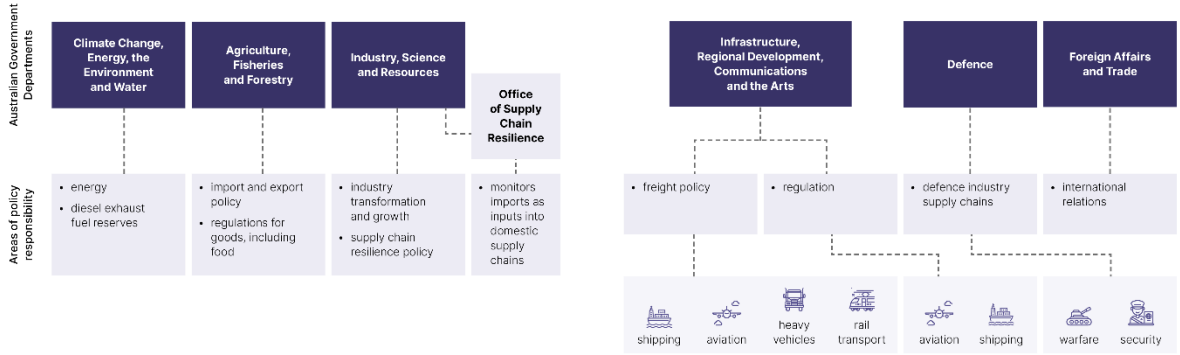
2. Response

The public health measures introduced by the Australian and state and territory governments, as outlined in Chapter 9: Buying time, had a profound impact on domestic and international supply chains. There was no crisis plan for supply chains, and a patchwork of response measures was used to ensure the continued operation of critical supply chains.

2.1. Government roles and responsibilities

The Inquiry heard that government roles and responsibilities for supply chains are complex and fragmented. In part this is because there are so many components to supply chains and supply chain policy includes a broad range of initiatives across these components. Not only are different levels of government responsible for different parts of supply chain policy, but different departments within each level of government are involved.

Figure 1: Supply chain responsibilities[3563]



There are various regulations which relate to important practical aspects of managing supply chains. These regulations are managed at different levels of government. Examples are:

- Curfews – airport curfews are managed at the Australian Government level by the Department of Infrastructure, Transport, Regional Development, Communications and the Arts.[3564] Delivery curfews for heavy vehicles to manage noise in urban areas are managed by local councils.
- Vehicle licensing – registering and licensing road and rail operators, including air and noise emissions requirements, is managed by state and territory governments. Registering aircraft and ships is managed at the federal level by the Civil Aviation Safety Authority and Australian Maritime Safety Authority respectively.[3565]
- Regulatory compliance – national regulators have been established for rail (Office of the National Rail Safety Regulator), maritime (Australian Maritime Safety Authority) and heavy vehicles (National Heavy Vehicle Regulator). Aviation safety is regulated by the Civil Aviation Safety Authority.

During the Inquiry, we heard that despite the sophistication of Australian supply chains, the sector needed Australian Government support to ensure Australians had access to the goods they needed.[3566] International factors which could not be controlled were mitigated through

government response measures. Domestic factors largely needed to be addressed through Australian Government engagement with the state and territories. The response can be broadly grouped into two categories: addressing issues as they emerged, and building long-term resilience.

2.2. Addressing challenges as they emerged

2.2.1. Australian Competition and Consumer Commission authorisations for industry collaboration

Through the pandemic, the Australian Competition and Consumer Commission (ACCC) issued numerous authorisations to enable businesses in key sectors to work together on supply chain issues. The authorisations were necessary to avoid non-compliance with competition law. While not all were supply chain related, the ACCC processed 33 authorisation requests related to the pandemic.[3567] This was approximately as many authorisation applications as the ACCC receives in a typical year, and most of them arrived in a six-week period from mid-March 2020.[3568]

2.2.2. Government taskforces and working groups

One of the earliest challenges to emerge was the shortage of critical medical supplies needed to support Australia's public health response. In March 2020 the then Department of Industry, Science, Energy and Resources reprioritised significant resources to establish three dedicated taskforces to support the procurement of PPE, ventilators and testing kits.[3569] The taskforces collaborated with industry to source, triage and assess offers for supplies with the goal of enabling the Department of Health to boost the National Medical Stockpile.[3570] For more on the procurement for the National Medical Stockpile, see Chapter 12: Broader health impacts. In March 2020, these taskforces were consolidated into the COVID Response Taskforce within the Department of Industry, Science, Energy and Resources. The COVID Response Taskforce facilitated supply of PPE and hand sanitiser to meet industry and community needs, and worked to resolve supply chain challenges.

The Department of Industry, Science, Energy and Resources also established several other taskforces early in the pandemic to address critical supply chain issues as they arose:

- The Business Intelligence and Supply Chains Taskforce was responsible for providing supply chain advice to the Prime Minister and the Minister for Industry, Science and Technology throughout 2020.[3571] It collated business intelligence on Australian supply chain issues, including emerging and ongoing issues experienced by industry sectors. It worked in partnership with AusIndustry and other Commonwealth partners to build a broad understanding of the issues impacting Australian industry.[3572]
- The Food and Grocery Taskforce engaged with industry to gather intelligence on food and grocery supply chains at the height of panic-buying and food supply chain restrictions.[3573] It provided advice and support to the Minister for Industry, Science and Technology and across government on food and grocery supply chains.[3574]

- The Transport and Freight Taskforce helped critical goods manufacturers and suppliers to access freight and logistics support, including by collaborating with Austrade and the Department of Infrastructure, Transport, Regional Development, Communications and the Arts to create the International Freight Assistance Mechanism.[3575] It also mapped real-time flight data, through both Commonwealth and public sources, to facilitate logistics for business and critical supplies, and provided a whole-of-government view on transport and freight issues.[3576]

Other government agencies established taskforces and working groups to address specific supply chain challenges. They were all focused on finding practical solutions to issues and included Australian Government, state and territory and private sector representatives:

- The Supermarkets Taskforce was established on 18 March 2020 to respond to pandemic-related challenges facing supermarkets and to coordinate supermarket responses across Australia.[3577] Challenges included stabilising consumer confidence; maintaining equitable access to food, including in regional and remote communities; and minimising negative impacts, including health risks, for staff and customers.[3578] It was led by the Department of Home Affairs and consisted of government, industry and not-for-profit members.[3579]
- The National Indigenous Australians Agency Remote Food Security Working Group was established in March 2020 to share information and develop responses to the specific food security risks faced by remote Aboriginal and Torres Strait Islander communities.[3580] Participants included state and territory governments, the ACCC, Aboriginal and Torres Strait Islander remote store management companies, and remote wholesale, distribution and freight companies.[3581]
- The National Coordination Mechanism Supply Chains Taskforce was established by the Department of Home Affairs in January 2022.[3582] It aimed to mitigate the consequences of COVID-19 related supply chain crises and disruptions, including food and grocery sector workforce absences and non-health impacts, and help meet the demand for rapid antigen testing (RAT) kits, sanitiser and PPE.[3583] It also managed supply chain crises brought about by flooding in South Australia in February and March 2022; damage to road and rail infrastructure; adverse weather and flooding on Australia's east coast; and global events such as China reducing the export of agricultural urea used to make diesel exhaust fuel additives.[3584]

2.2.3. Initiatives to support domestic manufacturing

The Australian Government established a number of initiatives with the goal of ensuring that critical items, such as PPE, could be manufactured domestically. In April 2020, the Department of Industry, Science, Energy and Resources launched the Australian Manufacturing Fund for PPE to support expanded domestic manufacturing capability for medical supplies, including face masks, face shields and ventilators.[3585]

In March 2020 the Department of Industry, Science, Energy and Resources established the Advanced Manufacturing Growth Centre COVID-19 Manufacturer Response Register. This was an online portal which enabled businesses to collaborate or form consortia to enable them to respond to pandemic demand by producing certain items.[3586] The department also provided domestic manufacturers with free access to product manufacturing standards for PPE.[3587]

2.2.4. Initiatives to promote the movement of goods

The then Department of Infrastructure, Transport, Regional Development and Communications expanded its engagement with industry to address issues associated with the domestic movement of goods. This included establishing the COVID Land Transport Working Group to inform and support decisions taken through National Cabinet and the Australian Health Protection Principal Committee.[3588] The working group consisted of representatives from all jurisdictions, regulators, and key road and rail industry stakeholders.[3589] The Maritime COVID-19 Resource Group Teleconference brought together Australian Government and state and territory health and transport representatives, along with the Australian Border Force, maritime and port industry associations and unions, to address the critical risks and bottlenecks that were developing and to manage the potential consequences for the maritime industry.[3590]

On 9 April 2020, National Cabinet agreed that the Australian Government and all states and territories would implement a consistent and immediate exemption enabling non-cruise maritime crew to transit to and from their places of work, within and across jurisdictions, with agreed documentation.[3591] National Cabinet noted that states and territories could adopt additional protocols in consultation with industry to protect crews on board vessels, and would establish appropriate penalties for companies and individuals found to be in breach of the requirements of the exemption.[3592]

In July 2020, National Cabinet agreed to the national Freight Movement Protocol and Code; in August 2021 this was updated in response to the Delta outbreak.[3593] The Department of Infrastructure, Transport, Regional Development and Communications co-designed the protocol and code with industry, states and territories, and a range of experts to respond to the challenges associated with interstate freight movements. It provided a national framework for the interstate movement of freight workers when domestic border restrictions were in place.[3594] The framework's goal was to allow freight to cross state borders and to promote greater consistency between states and territories in the implementation of border controls, so that it was easier for freight workers to understand their obligations when crossing borders.[3595]

The Department of Infrastructure, Transport, Regional Development and Communications also worked with local councils to enable freight vehicles (B-doubles) to drive through urban areas so that drivers could access testing sites.[3596] The National Heavy Vehicle Regulator worked with state and territory governments to allow B-triple road trains and B-doubles on key freight routes to enable the movement of supplies to South Australia, Western Australia and the Northern Territory.[3597]

The grounding of international flights due to international border closures led to significant issues for airfreight. In April 2020 the Australian Government established the International

Freight Assistance Mechanism.[3598] This program was implemented by Austrade with support from the Department of Infrastructure, Transport, Regional Development and Communications, the Royal Australian Air Force and the Department of Agriculture, Fisheries and Forestry.[3599] It was a collaborative effort between government and industry, whereby government purchased the services of airfreight companies to accelerate delivery of agricultural and fisheries exports and to re-establish global supply chains during the pandemic.[3600] While primarily an export initiative, it was also responsible for importing medical supplies, medicines and equipment to support Australia's response to COVID-19.[3601]

The Therapeutic Goods Administration convened the Medicines Shortages Working Party to monitor and manage shortages of medicines.[3602] Participants included Therapeutic Goods Administration representatives, medical associations, pharmacy associations and pharmaceutical industry representatives.[3603]

2.3.Longer-term measures to build resilience

The Australian Government recognised that many of the supply chain challenges which arose during the pandemic reflected a need to build supply chain resilience. In response, it implemented longer-term measures to achieve this goal. This included establishing the Office of Supply Chain Resilience to proactively monitor Australia's critical international supply chains, assess vulnerabilities and guide whole-of-government efforts to improve supply chain resilience.[3604]

The Office of Supply Chain Resilience worked with departments on issues specific to the pandemic and issues concurrent with the pandemic, such as the potential AdBlue (diesel exhaust fluid) shortage.[3605] It also hosted a Supply Chains Roundtable with industry to gain real-time information and intelligence on supply chains and enable responsive advice and policy development across government.[3606] This was first established during the pandemic but continues to meet to address other challenges and issues as they arise.

In February 2021 the Treasurer asked the Productivity Commission to undertake a study of Australia's resilience to global supply chain disruptions.[3607] The resulting report, *Vulnerable supply chains*, delivered to government in July 2021, developed an analytical framework to identify supply chains that are vulnerable to disruption and applied it to Australian imports and exports.[3608] It also identified strategies to manage supply chain risks and the circumstances under which government might intervene.[3609] The Office of Supply Chain Resilience has built on this framework for its ongoing work program.[3610]

In October 2020 the Australian Government announced the Modern Manufacturing Strategy as part of its JobMaker plan.[3611] This was a 10-year strategy that aimed to increase Australian supply chain resilience by building domestic manufacturing capability in a number of target sectors: resources technology and critical minerals processing, food and beverages, medical products, recycling and clean energy, defence and space.[3612]

Industry-specific measures, such as for agriculture, are discussed in Chapter 24: Supporting industry.

The Supply Chain Resilience Initiative was an international collaboration between Australia, India and Japan to strengthen policy approaches to supply chains by sharing best practices and to foster closer business relationships across the Indo-Pacific.[3613] Joint ministerial statements were released through the Supply Chain Resilience Initiative in 2021 and 2022 on the themes of supply chain resilience and securing Indo-Pacific supply chains respectively.[3614]

3. Impact

The impact of the pandemic (and associated public health measures) on supply chains was unanticipated, being both immediate and significant. The Australian Government was faced with an extremely high risk that many supply chains for essential goods would fail. There were actual supply chain failures within some sectors, which took the form of shortages caused by delays and disruption. The risks of supply chain failure were unequally distributed across Australian communities. In particular, some at-risk groups (such as people reliant on medications and remote Aboriginal and Torres Strait Islander communities) experienced higher risks of not being able to access essential supplies.

3.1. Impact of health restrictions on supply chains

Health restrictions had a major impact on supply chains and posed a range of challenges to their operation.[3615] Direct risks to supply chains were caused by travel restrictions and isolation and testing requirements.[3616] Indirect risks were caused by heightened uncertainty and confusion among industries and the difficulty of operationalising health restrictions.[3617]

3.1.1. Increased risks to supply chains

Travel restrictions, health requirements and activity restrictions all created specific issues for industry to navigate in order to ensure that supply chains continued to function. Travel restrictions affected supply chains reliant on the interstate movement of workers in specialised occupations and small workforces.[3618] Health restrictions, such as the requirement for staff to isolate as close contacts and other 'test, trace, isolate and quarantine' measures, resulted in temporary product shortages and contributed to high rates of absenteeism in some sectors.[3619] Activity restrictions prevented normal logistics operations across the supply chains.[3620]

In addition to sector-specific risks, there were increased risks for regional, rural and remote areas due to their geography. We heard that these communities face barriers which affect their access to and the cost of quality food and essential items, and that these barriers compounded the risk of supply chain disruption during the pandemic.[3621] Their challenges include long and more complex supply chains with limited alternative routes for receiving essential goods,[3622] limited storage capacity, and seasonal isolation.[3623] Consumers in these regions also tended to experience greater inconvenience than those in urban areas when certain supplies were not available.[3624]

Hospital pharmacists told us that, compared to metropolitan hospitals, regional, rural and remote hospitals experienced higher rates of orders that were only partially filled, placed on back order or cancelled.[3625]

> *In one week … 90% of medicine orders for responding to rural and remote hospitals were reported to be on 'backorder'. Notably this was not only key medicines related to ventilation but more broadly across many drug classes. – The Society of Hospital Pharmacists of Australia*[3626]

3.1.2. Confusion and uncertainty caused by a lack of effective government communication

There was limited industry consultation during the development of health measures to ensure they were practical.[3627] In addition to this, governments provided industry with little to no warning regarding upcoming changes in health requirements so that supply chains could be adjusted.[3628] Finally, industry found that public health orders did not clearly set out requirements in plain English, making it difficult for workers to be certain they were complying with them.[3629]

3.1.3. On-the-ground difficulties

Health measures created a range of practical hurdles for workers on the ground, including rail workers, truck drivers and seafarers. Freight workers reported difficulty in navigating definitions of essential workers, which differed between jurisdictions and were often incomplete.[3630]

Workers reported that state governments and their police forces did not have the same understanding of how jurisdiction permit systems for interstate travel should be applied.[3631] This resulted in some rail staff being incorrectly forced into hotel quarantine.[3632] The risk of being 'stuck' across a border due to this issue resulted in many freight drivers refusing to take interstate loads, threatening critical food supply chains.[3633]

Workers also found it difficult to comply with health requirements. Those travelling interstate or working at ports reported delays caused by long queues for testing at borders.[3634] Supply chain workers more broadly reported difficulties accessing polymerase chain reaction (PCR) tests, due to nationwide competition for the same resources.[3635] Maritime workers reported gaps in protocols for international seafarers which affected access to vaccinations and to non-COVID-related medical care.[3636] Requests to go ashore for medical care were often denied based on transmission fears.[3637] The supply chain sector also reported negative impacts of health requirements on the physical and mental health of workers – for example, freight workers experienced nosebleeds and stress due to frequent PCR testing.[3638]

These impacts were compounded by domestic and international crises which occurred in parallel to the pandemic, including Australia's 2020 bushfires, flooding in South Australia in 2022,[3639] and Russia's war in Ukraine.[3640] These crises further strained supply chains, creating additional disruptions and adding to the burden experienced by people and systems.[3641]

3.2.Feedback on the government's reactive response

Feedback on the government's reactive response was largely positive. Despite the challenges imposed by the public health measures and the lack of a plan to manage them, feedback from industry on the government's efforts to respond to subsequent supply chain challenges was largely positive.[3642]

We heard that the ACCC's interim authorisations to allow collaboration in certain sectors were important for maintaining supply chains in certain areas or industries.

- Allowing supermarkets to collaborate significantly assisted in enabling consumer access to products in remote and rural areas.[3643]
- The essential medicines authorisation was described by a key manufacturer as valuable in maintaining supply chains.[3644]

The International Freight Assistance Mechanism reconnected and maintained Australia's connection with 63 international destinations.[3645] It enabled the movement of more than 50,750 tonnes of high-value perishable Australian products to international customers and facilitated the import of nationally important goods, including medical supplies, via over 28,000 flights.[3646]

The National Coordination Mechanism taskforces received largely positive feedback. Representatives from the supply chain sector indicated that the National Coordination Mechanism did an exemplary job of bringing together levels of government and different sectors of industry to develop solutions to both pandemic issues and concurrently occurring crises such as the prospective AdBlue shortage.[3647] However, we also heard that attending National Coordination Mechanism meetings was time-consuming and that participants did not always see how the information they shared was used to inform decision-making.[3648] The National Coordination Mechanism is discussed in more detail in Chapter 6: The Australian Public Service: Responding to a multi-sectoral crisis.

The Remote Food Security Working Group received mixed feedback. A 2020 House of Representatives Standing Committee on Indigenous Affairs inquiry into food security noted the working group's success in addressing some of the key supply-related issues facing remote communities.[3649] The committee also noted the number of submissions that provided positive feedback about the working group and recommended that it continue.[3650] This recommendation has been accepted, and the working group's scope has been expanded to consider remote food security matters.[3651]

However, some stakeholders were more critical of the working group's efforts. We heard that that it was not particularly proactive, and that more effort is required to manage the longstanding food security issues in remote Aboriginal and Torres Strait Islander communities.[3652] Gaps in the provision of food to remote communities meant that in some instances, the community-controlled health sector had to step in to source and deliver food packages to people in remote communities, which is outside their usual remit.[3653]

The Supermarkets Taskforce was described as a critical initiative that helped the sector to navigate through the uncertainty of the pandemic by providing a cohesive industry voice to policymakers.[3654] We heard that it moved quickly to find practical ways to manage issues raised by other unrelated crises which occurred during the pandemic – specifically the 2022 rail outages in Western Australia and the Northern Territory.[3655]

While the Australian Government was not responsible for the measures that supermarkets implemented in response to the pandemic, it did work with the industry to achieve consensus

on measures in support of the pandemic response. One such measure was to impose purchasing limits on certain essential items, such as toilet paper, flour and hand sanitiser.[3656] Focus group respondents told us that these limits caused considerable inconvenience and stress for particular groups, including larger families, people who travelled long distances to visit supermarkets, and people on tight budgets who tended to shop after payday and buy enough to ensure their family could 'eat until their next pay'.[3657]

Purchasing limits for large families

Myra was living with her husband and four children at the time of the pandemic. With a large family to feed, Myra was very nervous when she started hearing news of shortages of grocery supplies and seeing evidence of empty shelves in her local supermarket. She understood why purchasing limits were put in place but felt that they did not consider larger families like hers. Myra reported that they easily got through two litres of milk every day, so she was needing to go to the supermarket once a day while also juggling home schooling, her own work and the stress of a public health emergency. To help reduce this burden, she reported that she and other shoppers would 'trade' supplies depending on what items their family needed and could be purchased under the limits.[3658]

Some shoppers were unable to purchase important items like baby formula, child-friendly foods, specific foods that their children would reliably eat, and over-the-counter health products.[3659]

> *I really struggled with getting baby formula and had to go to multiple supermarkets and chemists … and my youngest son has an eating disorder and only eats one type of chicken nuggets, and I had to drive 30 minutes to buy one type of chicken nugget … it was stressful and not ideal with a baby.* – Focus group participant who uses mental health care, Western Australia[3660]

Furthermore, purchasing limits did not resolve all supply issues. People in regional and remote areas more commonly reported issues than their metropolitan counterparts.[3661]

State and territory government and National Heavy Vehicle Regulator approvals to allow B-triple road trains and B-doubles on key freight routes were critical in ensuring supermarkets could provide essential goods to support affected communities – despite major shortages of truck drivers and of food and groceries.[3662]

The Therapeutic Goods Administration's response to supply shortages was described as impressive.[3663] In particular we heard that there was open access and dialogue with suppliers experiencing supply chain issues, and that responses to these issues were flexible, practical and timely.[3664]

Some efforts to adopt a consistent national approach were hampered by states and territories adopting different approaches to cross-border movements, creating additional complexities for freight workers. In particular the during the panel's consultations the supply chain sector expressed the view that, despite the Freight Movement Protocol and Code and efforts to align requirements across states and territories, freight workers continued to experience difficulties in

moving around the country.[3665] This created further delays in moving freight across borders and caused greater uncertainty for freight workers.[3666]

Managing supply chains is a complex endeavour involving many different groups of policy and industry representatives. Industry is the primary expert in this area, with an understanding of the discrete components of supply chains spanning the various stages of production, transport and distribution. It also has the practical experience and specific skills to ensure that supply chains function. However, the Australian and state and territory governments play a key role in making policies that affect the environment in which supply chains function. Australia's federated system means that a national approach cannot be implemented without the agreement of each state and territory. It also means that states and territories are able to take decisions that differ from a previously agreed national approach.

This was clearly demonstrated in relation to the Freight Movement Protocol and Code. After initially achieving a degree of consistency, this was eroded when states and territories started implementing differing approaches.[3667] Similarly, we heard that after decisions were made through the National Coordination Mechanism that addressed the challenges being faced by a sector, states and territories would then hold their own consultation with different participants and decide on a different course of action.[3668] From an industry perspective, a lack of consultation and communication before health measures were announced and implemented caused increased risks for supply chains.[3669]

3.3.Lack of understanding of supply chains within government

The response suffered from a lack of understanding of supply chains within government. Stakeholders highlighted the gap in government preparedness required to ensure that supply chains would remain resilient in a crisis and the impact of this lack of preparedness on the efficacy of responses. The Inquiry heard that there was a lack of expertise on supply chains and visibility of supply chain work across the Australian Government, including gaps in understanding how the supply chain sector worked and a lack of data.[3670] For example, industry representatives recounted that while government officials considered how to ensure finished medical products like COVID-19 vaccines were imported, they did not consider how to import the critical components for other medical goods until the issue was raised by industry.[3671]

In the Inquiry's Freight and Logistics Roundtable, supply chain sector representatives told us that the government's lack of knowledge of supply chains resulted in government officials making poor decisions regarding health measures.[3672] We heard that the sector had to continually attempt to educate government officials, both at the Australian Government and state and territory level, over this period so that measures could be amended in a way that enabled supply chains to function.[3673]

We heard that the lack of a detailed national crisis response plan for supply chains was one of the main reasons why the sector faced significant and wide-ranging difficulties in moving workers and goods. Industry representatives told us that individual companies do have contingency plans but that, given the importance of supply chains,[3674] there is a need for plans to:

- anticipate issues rather than being reactive
- cover the entire sector and entire supply chain from start to finish, as well as clearly establishing what the key elements of supply chains are and what critical assets are
- involve a coordinated, Commonwealth-led national approach to simplify the requirements that the supply chain sector needs to understand and comply with
- be developed and agreed by the Commonwealth and state and territory governments in advance to avoid gaps and confusion for workers during a crisis
- consider how government can build ongoing relationships with industry representatives through which to share information, address challenges and foster supply chain resilience during a crisis.[3675]

We heard that specific attention should be given to:

- ensuring all appropriate workers and sectors are covered by plans – specifically by:
- identifying all relevant occupations for essential workers lists
- incorporating health and welfare provisions for international supply chain workers like seafarers
- including enabling industries like roadhouses and repair shops
- including provisions for priority sector access to health measures such as vaccination and testing
- establishing a national solution to enable workers to navigate future interstate border closures
- developing a strategy for communicating about issues to the supply chain and the community
- designating a single body for government–industry communication and coordination on supply chains, such as the National Coordination Mechanism, and considering the membership of such a group.[3676]

The importance of a single designated body was echoed by relevant Australian Government departments. We heard from the Department of Industry, Science and Resources that a whole-of-government, nationally coordinated procurement approach to securing the supply of critical products and services would reduce costs, maximise economic efficiency and ease the burden on suppliers.[3677]

Stakeholders told us that a lack of planning also contributed to confusion regarding individual departments' roles and responsibilities during the pandemic. A common theme was that it was unclear which departments should take the lead in responding to specific supply chain challenges. This added to inefficiencies in ensuring the issues were addressed.[3678] We also

heard that central departments – in particular the Treasury – became involved in leading on supply chain issues that should sit with other departments.[3679]

A lack of planning also contributed to the Australian and state and territory governments competing to buy critical supplies, such as PPE, from international sellers and to establish the same manufacturing capabilities.[3680] While governments successfully secured supplies in a globally constrained market, the decentralised approach led to duplicated efforts and added to the burden on industry.[3681]

We heard that exercises are important to ensure that systems and processes function effectively in a crisis and without stress-testing, relationships and structures used during the pandemic would not be as robust in the future.[3682] A number of people told us that national crisis simulations or scenario planning would have helped to coordinate and target the government's pandemic response, and indicated that such exercises should be undertaken over the next six to 12 months.[3683]

The panel heard that while governments did not have a good understanding of supply chains, the cooperation amongst state and territory and Australian Government officials to solve problems was impressive.[3684] We also heard that departments relied on individual relationships between government officials and industry members to solve problems.[3685] Some officials indicated that if anyone had been unexpectedly absent, the government's ability to effectively respond to the pandemic would have been compromised.[3686] However, industry stakeholders told us that informal networks had contributed to good outcomes and that pre-planning would help to build these into the system.[3687]

3.4. Feedback on increased engagement from government

Industry welcomed increased engagement from government but struggled to access health decision-makers.[3688] The Inquiry heard that the Australian Government's approach to solving issues worked for some specific sectors, such as the food and grocery industry. Industry representatives indicated that for this sector there was clear and productive communication between industry and government so that problems were raised, solutions suggested and regulatory changes made where needed.[3689]

The Office of Supply Chain Resilience's Supply Chains Roundtable received positive feedback from some industry representatives. We heard that it had been promptly established, that it provided a forum for government and industry to discuss policy options and actions so that industry could optimise its response to supply chain issues, and that it enabled critical information to be efficiently shared among a range of stakeholders.[3690]
Industry representatives noted that peak bodies played an important role in ensuring information was communicated between businesses and the government. These bodies had the ability to engage with government to obtain answers to questions the sector had, and the relationships with businesses to relay information to them from the government.[3691]
However, we heard there was duplication of committees and taskforces across several Australian Government departments. This resulted in industry representatives repeating the same information to different parts of the government without a tangible change to policy

priorities or service provision.[3692] Some stakeholders indicated that this was an inefficient use of their limited resources.[3693]

A major concern communicated to us was the difficulties that industry faced in communicating to health officials at all levels of government the risks that public health measures posed for supply chains. We heard that the implementation of public health measures created a high risk of supply chain disruption unforeseen by health decision-makers.[3694] We heard from industry that it reached a point where industry were looking at closing the interstate rail network, which would have stopped 80 per cent of goods going to Adelaide and Perth.[3695] At the Freight and Logistics Roundtable we heard that travel restrictions placed the iron ore export industry within two weeks of shutting down, as the helicopter pilots responsible for transporting seafarers between ports and ships could not travel to attend work.[3696] This would have had serious consequences for the Australian economy.

We heard that health officials often did not accept invitations to attend meetings with industry to discuss supply chains. Where officials did attend, they were not decision-makers and there was no tangible outcome of industry's attempts to share information.[3697] Industry representatives expressed frustration that their concerns were not taken seriously by officials.[3698]

Industry roundtable participants told us that these issues stemmed from prioritising health considerations relating to the transmission of the virus over all other potential risks. They recognised that risk-based controls are important but said that decision-makers need to consider the right risk balance when implementing restrictions.[3699] The impact of not doing so led to impractical workarounds being imposed on the supply chains sector and, in some instances, workers circumventing health requirements on the ground so as to ensure goods were delivered.[3700]

3.5.The lasting impact of the pandemic on the supply chain sector

The pandemic has had a lasting impact on the supply chain sector. Industry representatives at a roundtable with Australian Chamber of Commerce and Industry members told us that since the pandemic their operating environment has become more challenging.[3701] They indicated that contributing factors were the overall decrease in trade due to geopolitical tensions and Australia's reduced domestic manufacturing capability.[3702]

Industry representatives indicated that they are undertaking their own preparation for future challenges. This includes undertaking 'war gaming' exercises where they consider the impact of global events on supply chains.[3703] Businesses are also developing contingency plans with a focus on ensuring they can operate despite movement restrictions, reflecting their experience of the pandemic. Despite the cost, they have moved from a 'just-in-time' model of supply chain management, where they hold stocks of as little material as possible, to a 'just-in-case' model, where they hold stockpiles of essential items in warehouses.[3704]

The Inquiry heard that the pandemic had an impact on the workforce that supports supply chains. Workforce shortages are an ongoing issues in the sector, and the higher average age

made these workers more vulnerable to the virus, contributing to supply chain challenges during outbreaks.[3705] We also heard that that ongoing effects from the closure of international borders to migrants during the pandemic have exacerbated the shortage of truck drivers available to transport freight.[3706]

We heard about an increased focus on sovereign (Australian) manufacturing capacity, although views differ between relevant groups. Pharmaceutical companies indicated differences in opinion regarding the need for Australia to develop sovereign manufacturing capabilities to produce medical supplies. In submissions, some companies indicated that government-led development of sovereign manufacturing capabilities for key components of important medical supplies will reduce the impact of future international supply chain disruption.[3707] This includes establishing a National Medical Manufacturing Taskforce as a first step to inform manufacturing policy and determine key areas for future government investment in sovereign manufacturing capability.[3708]

The need for greater focus on sovereign manufacturing was echoed in the recommendations of the Joint Standing Committee on Foreign Affairs, Defence and Trade inquiry into the implications of the COVID-19 pandemic in December 2020.[3709] The panel notes that there has been no government response to this Inquiry.

However, other companies told us that because onshore manufacturing and stockpiling would be costly, Australia needs to remain linked into global supply chains. Very few countries are capable of end-to-end manufacturing of goods like vaccines, and Australia is not one of them.[3710] It is therefore important that Australia spread the risks across different supply chain points rather than relying on domestic supply and manufacturing.[3711]

Post-pandemic, industry appears to have a clearer understanding of what it might need from the government with regard to ensuring supply chains are resilient to future shocks. Key among these needs is leadership. Australian Logistics Council Roundtable participants indicated that individual state and territory governments are developing their own freight and logistics strategies, and that coordination between jurisdictions is necessary to avoid varying requirements across Australia.[3712] Australian Chamber of Commerce and Industry Roundtable participants indicated that in any future crisis the Australian Government must indicate to industry what the manufacturing priorities are, so that industry can effectively pivot production to assist the response – for example, gin distilleries making hand sanitiser.[3713] A common theme we heard from industry stakeholders was the need for national plans and structures to be implemented during a crisis. Australian Logistics Council Roundtable participants also reported that the Australian Government is suffering from an element of 'COVID amnesia': people have forgotten what happened and have returned to pre-COVID ways of thinking and arrangements, even if some of the pandemic arrangements worked well.[3714]

4. Evaluation

There were no comprehensive Australian Government plans in place to respond to supply chain risks, and there were no structures in place to facilitate communication and collaboration with all relevant parties during a crisis. Instead, the government reacted to challenges as they arose and put in place longer-term initiatives where it saw the opportunity to do so.

Overall the Australian Government's response was effective, in that there was no significant, permanent breakdown of key supply chains. In particular the ACCC's interim authorisation process demonstrated agility and was vital to resolving critical, time-sensitive supply chain issues while safeguarding long-term competition.

Despite averting major issues, there were still challenges the Australian Government did not completely overcome which could have been addressed through better planning and preparedness. There is also a high risk that in a future pandemic there will be greater pressure on critical supply chains, leading to greater impacts on the health of the workforce.

Government departments demonstrated leadership by working with representatives from industry and from state and territory governments to share information and develop and implement practical solutions, including establishing a number of key taskforces and working groups. However, the lack of understanding about supply chains undermined the response and contributed to the supply chain challenges.

Australia's federated system also undermined the approach. The need to operate in an ad hoc, reactive manner made it difficult to achieve an enduring, nationally consistent and practical crisis response. Agreement on common definitions and operating protocols between parties before a future crisis would increase the chance of a nationally coherent approach and improve supply chain resilience.

The government is to be commended for establishing new consultation and engagement mechanisms during the pandemic. However, these did not operate without issues, and agreements at the national level were not always implemented at the state level. It is critical to establish clear national consultation and engagement mechanisms to develop and implement successful crisis response measures for a complex area like supply chains. This would be assisted by the development of a modular operational plan for supply chains, which can be deployed in a range of emergencies that pose a risk to supply chains, not just pandemics.

This planning should be supported by ongoing exercises between all levels of government and industry to test and strengthen its response measures. A range of events can compromise supply chains, so the planning should consider a range of different challenges.

The panel's view is that an important complement to emergency planning is building domestic and international supply chain resilience during business-as-usual periods. This is because many of the challenges faced in developing appropriate response measures during the pandemic – such as data gaps – are best addressed through longer-term measures. Additionally, a higher level of resilience will contribute to lower levels of supply chain disruption during a crisis.

We recognise that the Australian Government has begun to link stronger, more resilient supply chains with Australia's overall economic security and resilience and that major policies with a stronger supply chain focus have been implemented since the pandemic.[3715] The National Reconstruction Fund, the Future Made in Australia agenda and the Indo-Pacific Economic Framework demonstrate attempts to foster domestic capability to produce critical goods and increase regional cooperation. In addition to this, the Office of Supply Chain Resilience continues to monitor trade flows, pre-empt potential issues relating to critical imports and facilitate a whole-of-government response to supply chain challenges. Existing policies such as the National Freight and Supply Chain Strategy are also being amended to include reference to resilience.[3716]

Our view is that while this approach indicates progress within government, more must be done to bring this work together into a coherent whole and achieve a degree of alignment across the Australian Government, the states and territories and industry. The panel considers that this would best be done through a whole-of-government plan that focuses on building resilience in critical sectors, addressing supply chain data gaps, and providing for ongoing engagement between the government and industry on supply chain issues.

5. Learnings

- Governments' limited understanding of supply chains and their complexities undermined efforts to support supply chains during the COVID-19 pandemic. An improved understanding of supply chains within governments would better position Australia in a future crisis.
- Australian Government leadership is required to ensure that supply chains continue to function through an emergency. Collaboration across all levels of government and industry is required to effectively deal with large-scale supply chain issues.
- Developing national plans for supply chain disruptions would prevent ad hoc, reactive and inefficient government response measures in a crisis. Scenario exercises between government and industry would improve preparedness for a future crisis.
- A national plan for supply chains should be supported by regular engagement between governments and industry.
- Efficient interstate travel is one of the key enablers of Australia's domestic supply chains.
- Workers across all aspects of supply chains are essential workers.

6. Actions

6.1. Immediate actions – Do in the next 12–18 months

Action 5: Develop updated health emergency planning and response arrangements in conjunction with states and territories, and key partners, including consideration of escalation and de-escalation points, real-time review and a focus on post-emergency recovery.

As part of this, develop:

- Modular operational plans for specific sectors, including high-risk settings, which can be deployed in response to a variety of hazards.

The Supply Chains plan should:

- be developed in consultation with state and territory governments and industry
- consider agreed protocols between Commonwealth and state and territory governments, should state border travel be restricted, to ensure ongoing operation of critical supply chains
- include provision for scenario exercises with industry to simulate responses to supply chain disruptions.

Action 6: Develop legislative and policy frameworks to support responses in a public health emergency, including for essential services and essential workers.

Essential services and essential workers frameworks should include:

- definitions of essential workers and essential services in a national health emergency
- mechanisms to support rapid harmonisation between the Australian Government and state and territory governments where practicable
- a set of agreed principles to guide decision-making, with respect to the movement of essential workers and the continued operation of essential services in a crisis
- a commitment to clear and consistent communication of the definitions and how they will apply
- clearly communicated rationale for localised approaches where required
- arrangements for priority access to vaccination, PPE, and infection, prevention and control training in a national health emergency.

Action 15: Ensure there are appropriate coordination and communication pathways in place with industry, unions, primary care stakeholders, local government, the community sector, priority populations and community representatives on issues related to public health emergencies. Structures should be maintained outside of an emergency, and be used to provide effective feedback loops on the shaping and delivery of response measures in a national health emergency.

- Build and maintain engagement mechanisms outside of an emergency with industry (including businesses and entities across the supply chain).
- Maintain and build on effective structures that were established before or during the COVID-19 pandemic.
- Consult these groups on the development and updating of pandemic plans, and ensure they participate in stress-testing exercises.
- Ensure there are clear mechanisms to feed into decision-making processes in an emergency, and genuinely engage relevant bodies in pandemic preparedness activities and responses to future emergencies.
- Utilise these structures in national health emergencies to provide effective feedback loops on the delivery of response measures.

6.2.Medium-term actions – Do prior to the next national health emergency

Action 22: Develop a whole-of-government plan to improve domestic and international supply chain resilience.

This should include:

- consideration for how resilience can be built across all critical supply chains
- arrangements to collect supply chain data to support decision-making
- engagement structures that encourage ongoing and regular communication between government and industry on the development and implementation of the whole-of-government plan and emerging supply chain issues.

Chapter 23 – Workers and workplaces

1. Context

The COVID-19 pandemic brought sudden and significant change to workplaces across Australia as public health orders placed restrictions on the gathering and the movement of people. In the alert phase employers, employees, business groups and unions all faced uncertainty about the modes of transmission of the virus and what this meant for continuing to work. These uncertainties continued throughout the pandemic as evidence, guidance and the virus itself evolved. Workplaces became a potential vector for transmission, which posed major challenges to existing workplace relations and work health and safety (WHS) systems.

The health restrictions and public health orders imposed throughout the pandemic (largely by state and territory governments) impacted different professions and industries in different ways. Employers and employees were forced to quickly adapt, including by making changes to service delivery, moving processes online, and increasing or decreasing hours of operation. Where the nature of their work permitted, particularly in office-based jobs, many shifted to remote working. Workers in industries that could not transition to working from home often worked reduced hours under changed industrial conditions with new WHS risks, while others were furloughed. The restrictions affecting workplaces changed as risks evolved over the course of the pandemic.

The scale of the pandemic and the varying impacts across the labour market prompted changes to workplace relations legislation to give employers and employees more flexibility to continue to work, where it was safe to do so. Given that many workers were required to continue attending workplaces, the pandemic saw a heightened emphasis on WHS provisions nationwide.

Workers in professions providing essential services had to continue working to keep Australians safe, cared for and fed. Many of the essential workers that Australia relied on could not perform their roles from home and needed specific designation to enable them to go to work. Going to work put them at greater risk of contracting and potentially spreading the virus.

This chapter outlines the challenges faced, and the important changes made by the government, unions and employers to keep Australians safely in work during the pandemic. The chapter addresses the role of workplace relations and financial support, workplace health and safety and the importance of clear definitions of essential workers.

2. Workplace relations and financial support

2.1. Response

On 10 March 2020 the then Minister for Industrial Relations met with unions and employer representatives to discuss COVID-19,[3717] canvassing scenarios Australian workplaces might encounter and corresponding actions the government might consider.

Before any changes affecting the interactions of employers and employees, the Australian Government announced the JobKeeper Payment wage subsidy in response to rising unemployment.[3718] Amendments to the *Fair Work Act 2009* (Cth) enabled employers that qualified for the JobKeeper scheme and were entitled to JobKeeper payments for employees to give certain directions to employees.[3719] Employers could give employees three kinds of directions:

1. A JobKeeper-enabling stand-down, which could require an employee not to work on a day they would usually work, work for a shorter period on a particular day, or work a reduced number of hours overall (which could be nil)
2. A direction to perform other duties, provided they were within the employee's skill and competency
3. A direction to work at a different place, provided it was suitable for the employee's duties. This could include the employee's home.[3720]

Employers qualifying for JobKeeper could also make two kinds of requests of employees, which the employee had to consider and not unreasonably refuse:

1. Work on days or at times that were different from the employee's ordinary days or times but did not reduce the employee's number of hours of work
2. Take paid annual leave, provided the request did not result in the employee having a leave balance of less than 2 weeks.[3721]

Australian Government guidance on these changes indicated that there were protections for employees from employer misuse of these provisions.[3722] The vast majority of the JobKeeper provisions in the *Fair Work Act 2009* (Cth) were repealed on 29 March 2021.[3723]

As case numbers increased in March and April 2020 and further public health orders were introduced, the Fair Work Commission, using powers under the *Fair Work Act 2009* (Cth), made a range of determinations that temporarily varied modern awards to increase flexibility for employers and employees.[3724]

> *Across ensuing months, modern awards were varied by consent to add dedicated COVID schedules for hospitality, restaurants, vehicle repair, services and retail, clerks and other industries. These schedules allowed temporary changes to hours, duties and locations of work, spreads of hours, taking of annual leave or temporary closures,*

options which provided critical support for jobs and workplaces, both prior to and in conjunction with the JobKeeper wage subsidies. – Barklamb[3725]

Applications to vary a number of awards were made between March and May 2020, including the Hospitality Industry (General) Award 2010, the Clerks – Private Sector Award 2010, the Restaurant Industry Award 2010 and the Fast Food Industry Award 2020.[3726] These variations involved inserting new schedules which allowed for greater flexibility in relation to a range of conditions including the duties employees could be required to perform; where duties could be performed; hours of work; annual leave (including employer requests for leave to be taken and twice the length of leave at half pay); and notice periods for close-downs.[3727] Notably many of these applications were made through partnerships between business peak bodies and unions.[3728]

On 8 April 2020 the Fair Work Commission inserted a temporary schedule (Schedule X) into 99 awards on its own initiative.[3729] Schedule X allowed eligible employees to take unpaid pandemic leave if they were prevented from working because of COVID-19.[3730] This was also available to casual workers.[3731] The schedule also gave workers in more industries the flexibility to take twice as much annual leave at half pay.[3732] Schedule X initially operated until 30 June 2020 but was extended by the Fair Work Commission in a number of modern awards throughout 2020 and 2021. The Fair Work Commission extended the operation of only the unpaid pandemic leave element of Schedule X in some modern awards until 30 June or 31 December 2022. The schedule finally ceased on 31 December 2022.[3733]

All of the changes to modern awards made by the Fair Work Commission referenced above were supported by letters and submissions from the Minister for Industrial Relations.[3734] Submissions from the minister often noted that each change was 'a temporary but necessary response' to an 'extraordinary situation'.[3735]

A decision of the Fair Work Commission on 27 July 2020 made paid pandemic leave an entitlement for aged care sector employees covered by the Aged Care Award, the Nurses Award and the Health Professionals and Support Services Award.[3736] This entitlement was inserted into these awards under Schedule Y and applied until 29 March 2021.[3737]

On 16 April 2020 the government added a new regulation to the Fair Work Regulations 2009 which altered the access period for varying enterprise agreements.[3738] This reduced the mandatory notice period to 24 hours, with the goal of improving the speed and simplicity with which employers could vary wages and conditions.[3739] Few employers used the shorter notice periods to vary enterprise agreements.[3740]

As the pandemic evolved and public health measures were revised, workplaces were repeatedly required to adapt, and new means of support were provided. As detailed in Chapter 21: Supporting households and businesses, the Australian Government created the Pandemic Leave Disaster Payment and the COVID-19 Disaster Payment.[3741] These payments were intended to provide financial support so that people would not go to work when they were sick, thereby reducing the spread of infections.

Role of the Office of the Fair Work Ombudsman

Throughout the pandemic, the Office of the Fair Work Ombudsman was tasked with providing guidance and information relating to COVID-19 and the workplace and received additional funding to meet the high levels of demand.[3742]

The Office of the Fair Work Ombudsman established:

- a dedicated *Coronavirus and Australian workplace laws* website, with up-to-date information and an automated translation plug-in that translated website content into over 30 languages

- online tools and resources to help businesses manage their obligations and stand-downs, as well as updated tools and resources to provide guidance on issues like pandemic leave and increased workplace flexibility

- a virtual assistant which provided real-time responses to COVID-19 related questions

- a coronavirus hotline to prioritise callers with COVID-19 related enquiries; this answered 133,000 calls during its operation

- the Temporary Workplace Legal Advice Program, which provided free, tailored legal advice to eligible businesses and workers through a panel of external law firms on referral from the Office of the Fair Work Ombudsman.[3743]

The *Fair Work Amendment (Supporting Australia's Jobs and Economic Recovery) Act 2021* (Cth) came into effect in March 2021. This made amendments to the *Fair Work Act 2009* (Cth) to aid Australia's recovery from the pandemic. It introduced a statutory definition of a casual employee, and a universal casual conversion mechanism as a National Employment Standards entitlement.[3744]

2.2.Impact

2.2.1. Early changes were slow to be agreed due to weak existing engagement mechanisms

Although governments, unions and employer groups were able to constructively engage and compromise on key issues to strengthen the Australian Government's response, this could have been achieved sooner. The Inquiry heard that establishing effective multi-stakeholder engagement took a substantial period of time early in the pandemic, as formal tripartite arrangements between employers, employees (represented by unions) and government had not been in place for a number of years before the pandemic.[3745] We heard that meetings early in the pandemic were characterised by stakeholders advocating their usual workplace relations agenda, highlighting tensions between employers' desire to keep their business running and minimise financial harm, and concerns about the health of their employees.[3746] However, a number of key changes, particularly in relation to modern awards, were driven by collegial and consensus-seeking engagement between stakeholders.[3747] Given the need to rebuild engagement arrangements early in the pandemic, the outcomes achieved in the workplace relations space were notable.

Throughout the pandemic, multi-stakeholder and tripartite approaches facilitated flexibility in awards and proved to be an effective way to manage disruption and change. – Office of the Fair Work Ombudsman[3748]

2.2.2. Workplace relations changes gave businesses flexibility to adapt and were warmly welcomed by most business groups

The workplace relations changes early in the pandemic were an important response to the crisis. The Fair Work Commission noted that labour demand was decreasing and layoffs were increasing as a result of public health orders and that this risked an increase in unemployment.[3749] Stakeholders supported the increased flexibility in relation to working from home, duties that employees could perform, and leave provisions.[3750] Coupled with government support measures such as JobKeeper, the workplace relations measures successfully halted the increase in layoffs and helped to maintain employer–employee relationships. As noted in Chapter 20: Managing the economy and Chapter 21: Supporting households and businesses, maintaining employment relationships is important to minimise the risk of long-term labour scarring.

At the Inquiry's Council of Small Business Organisations Australia Roundtable we heard that changes to legislation supported small businesses to implement workplace health and safety and workforce changes brought about by the pandemic.[3751]

Working from home was a major source of flexibility for many businesses during COVID-19. Although there had been a gradual increase in the percentage of employed people regularly working from home before the pandemic, this figure jumped from 32 per cent in August 2019 to 40 per cent in August 2021.[3752] As at August 2023, the Australian Bureau of Statistics reported that 37 per cent of workers continue to work from home regularly, highlighting how the pandemic prompted a broader shift toward flexible work arrangements.[3753]

2.2.3. Effectively communicating to employers and employees was important

The impact of the pandemic on workplaces and the changes to workplace relations legislation, many of which were significant, made it important to ensure that employers and employees could access reliable information and understand their rights and obligations.

The Office of the Fair Work Ombudsman played an important role in communicating about the changes and providing assistance more generally. From mid-March to June 2020, the average number of calls per day to the Office of the Fair Work Ombudsman's Fair Work Infoline increased by 40 per cent and the number of website views increased by 43 per cent compared to the same period in the previous year.[3754]

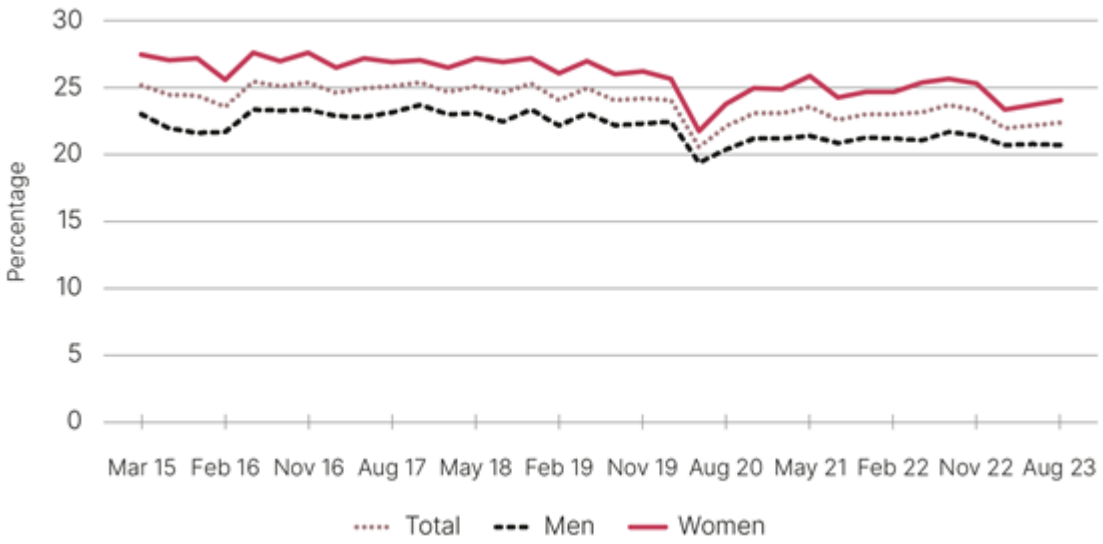
2.2.4. Insecure forms of work were relied on but undervalued

The term 'insecure work' generally encompasses casual work, gig economy work, fixed-term contracts and labour hire arrangements.[3755] Before the pandemic, Australia was one of the Organisation for Economic Co-operation and Development (OECD) countries with the highest

levels of reliance on these kinds of work: 25 per cent of all Australian workers were engaged on a casual basis and there were roughly 250,000 gig economy workers.[3756]

Many of the industries most impacted by the pandemic employed a high share of casual workers, such as accommodation and food services.[3757] The total share of casual employees in the Australian labour market fell sharply from 24.1 per cent in February 2020 to 20.6 per cent in May 2020.[3758] As at August 2023 the level of casual employment remained below pre-pandemic levels, as shown in Figure 1.[3759]

Figure 1: Share of casual employment in Australia[3760] (%)



The panel heard that financial support eligibility requirements presented challenges for many insecure workers, particularly in relation to the exclusion of many casual workers from JobKeeper.[3761] Aligning with the definition of 'long-term casual' under the *Fair Work Act 2009* (Cth), casual workers who had been in their job for less than 12 months were not eligible for JobKeeper.[3762] If they needed income support, they had to rely on the JobSeeker Payment. Casual workers who had been in their job for 12 months or more were eligible for JobKeeper.[3763] The panel heard that there was a view that not every job could be preserved without significantly impacting labour mobility.[3764]

The Independent Evaluation of the JobKeeper Payment concluded that exclusions based on employee characteristics, such as those for short-term casuals and for temporary migrants, compromised the effectiveness of the payment.[3765] Consistent with the analysis in the JobKeeper Evaluation, we heard from a number of union representatives that the 12-month cut-off was perceived as arbitrary.[3766] A key reason for this was that short-term casuals share many similar characteristics to long-term casuals.[3767] The JobKeeper Evaluation found that 45 per cent of short-term casuals and 49 per cent of long-term casuals were earning above $550 per week.[3768] Yet short-term casuals on JobSeeker were financially worse off than the long-term casuals on JobKeeper.[3769]

> *It is estimated around 1.1 million casuals missed out on JobKeeper because they didn't have 12-months' continuous service. This was grossly unfair on casual*

> *workers especially given they are often employed in insecure, precarious work that leaves them with inferior rights such as no access to sick leave, annual leave or long service leave. The fear, vulnerability and powerlessness experienced by casual workers meant living standards and financial independence was severely impacted. – Australian Services Union*[3770]

The panel heard that, given the complexities in financial support for insecure workers, people in these positions became a vector for transmission of COVID-19, as they sometimes felt compelled to work when sick or knowingly a close contact, to avoid financial disadvantage.[3771] The Pandemic Leave Disaster Payment and the provision of unpaid leave for casual workers was a useful means of addressing these concerns.[3772]

> *For the last few years people who work in supermarkets and hotels have faced a dilemma – go to work and risk catching COVID or stay home and not get paid – an impossible choice for many families. – Davis*[3773]

One stakeholder summarised these issues by saying that a person's work was one of the biggest determinants of their experience during the pandemic, including whether they contracted COVID-19.[3774]

3. Work health and safety

3.1. Response

Commonwealth and state and territory regulators are responsible for compliance and enforcement of the WHS laws in their respective jurisdictions. Safe Work Australia is a tripartite national policy body that works to improve WHS and maintain strong WHS laws.[3775]

Workplaces and workers faced significant health and safety risks during the pandemic. Employers and workers faced challenges in identifying how public health requirements and WHS duties intersected and how the WHS framework applied.[3776] We heard from some stakeholders that the general lack of tripartite relationships added to these challenges.[3777]

Safe Work Australia released a statement of regulatory intent on COVID-19 on 2 April 2020.[3778] The statement set out the enforcement approach that the WHS regulators (excluding regulators in the ACT and Victoria, which did not sign up to the statement) would take to ensure compliance throughout the COVID-19 pandemic:

> *WHS Regulators will take into account the unprecedented pressure on industry and employers during the pandemic and apply a common sense and practical approach to interactions with workplaces. Importantly, compliance and enforcement activity will continue; however, consideration will first be on matters that pose a significant and/or serious risk to health and safety. WHS Regulators' responses will be proportionate with a focus on what is reasonably practicable in these exceptional circumstances. – Safe Work Australia*[3779]

On 24 April 2020, National Cabinet released the National COVID-19 Safe Workplace Principles.[3780] The principles were developed in consultation with union representatives, the National COVID-19 Coordination Commission and the Minister for Industrial Relations.[3781] National Cabinet gave Safe Work Australia responsibility for developing nationally consistent and industry-specific WHS guidance on COVID-19.[3782] Safe Work Australia subsequently published guidance on aged care, health care, mining and other industries, setting out employers' responsibility to minimise the risks of COVID-19 in the workplace as far as reasonably practicable.[3783]

Shortly after the release of the National COVID-19 Safe Workplace Principles, Australia began reopening due to decreased case numbers. Safe Work Australia launched an online toolkit to provide detailed guidance for businesses and workers on how to stay safe from COVID-19.[3784] Safe Work Australia's website became a centralised national information hub for WHS guidance on COVID-19.[3785] It provided resources to help build awareness and understanding of WHS best practice in relation to COVID-19, including a business resource kit, links to posters and signage, checklists, fact sheets and infographics.[3786] Safe Work Australia also created a small business hub offering tailored information and animations on key topics such as risk assessments, cleaning and hygiene.[3787] Public fact sheets were made available in 63 languages, translated by the Department of Home Affairs COVID-19 in-language hub.[3788] National Cabinet agreed on 5 May 2020 that Safe Work Australia was the 'single source of information' for workplaces.[3789]

3.2.Impact

Opportunities were missed to utilise the WHS framework to complement public health measures. Many stakeholders told us that Australia has a relatively sophisticated and effective WHS system which could have been better utilised during the pandemic.[3790] Through a risk-based approach, the system provides flexibility for employers in different industries to adapt workplace practices to the WHS environment they face, along with an established legislative framework, guidelines and codes of practice.[3791] However, we heard from some stakeholders that the WHS system was not used to its potential during the pandemic and that governments instead relied on public health orders to manage the changed risk environments.[3792] Public health orders were seen as blunt policy tools that led more industries and workplaces to be closed than would have been needed if Australia had effectively identified and controlled workplace risks.[3793] Public health orders allowed the efficient implementation of critical health measures such as lockdowns, but their withdrawal created challenges from a WHS perspective:

> *Many employers focused on public health orders for guidance on how to manage COVID-19 rather than by conducting risk assessments and implementing the most effective measures to control the hazard in that workplace. This was even more evident as public health orders relaxed, employers took this as the cue to relax workplace control measures which was not necessarily consistent with the risk assessment at the time. – Shop, Distributive and Allied Employees' Association*[3794]

We heard from unions that public health orders failed to consider the practical application of health measures in workplaces.[3795] This view was shared by representatives from the freight and logistics industry.[3796] We also heard that there was no clear voice for workers in the development of public health orders. Public health emergency decision-makers such as the Australian Health Protection Principal Committee engaged unions only occasionally, on very serious health measures, rather than on a routine basis. Mechanisms to provide feedback or consult on measures that required adjustment or clarification were insufficient and stakeholders recommended a single point of contact in a future crisis.[3797]

The Inquiry heard that Safe Work Australia's statement of regulatory intent sought to demonstrate that those regulators which agreed to the statement would not take a heavy-handed approach to compliance and enforcement at a time of such upheaval and uncertainty, instead adopting an educative and pragmatic position.[3798] Regulators were also required to comply with public health orders and had to undertake compliance and enforcement with their available workforce. This involved taking a risk-based approach, focusing on workplaces with the highest risks of transmission or the greatest consequences from infection.[3799] However, we heard that some stakeholders perceived the statement as an indication that regulators were pulling back from the enforcement of WHS requirements in light of public health orders.[3800]

This misunderstanding of the practical application of health measures was particularly prominent in frontline industries, including the health industry. Personal protective equipment (PPE) is discussed in more detail in Chapter 9: Buying time, but access to and use of PPE in the workplace was a WHS issue. Various union surveys pointed to deficiencies in implementation of core public health practices in workplaces.[3801] For example, a United Workers Union survey of 531 cleaners, conducted in May 2020, found that 74 per cent did not have adequate PPE.[3802] The Inquiry heard that workers did not have adequate understanding of or training on using PPE.[3803] We also heard that N95 masks effectively do not fit female faces and that this was known before the pandemic.[3804] The high incidence of COVID-19 among health and social care workers in Victoria in July to August 2020 is evidence of deficiencies in workplace control of COVID-19.[3805]

> *Workplace health and safety must be a priority, with a particular focus on protecting frontline healthcare staff who are at high risk of infection and harm due to their repeated exposure to those who carry infectious diseases. During the pandemic, enforcement of infection prevention and control work health and safety requirements was substandard in many contexts, particularly aged care. Confusing, non-evidence-based, and contradictory guidance, which prioritised last line of defence methods and led to over-reliance on the use of personal protective equipment over more effective forms of protection. – Australian Nursing and Midwifery Federation*[3806]

3.2.1. Safe Work Australia played a valuable role as an information hub on WHS and COVID-19

We heard that Safe Work Australia was a very useful source of relevant and accurate information.[3807] Between March 2020 and September 2024, the COVID-19 content across all

Safe Work Australia websites received 14 million hits, showing that employers knew it was a centralised information hub.[3808] Safe Work Australia has also found an enduring role in engaging and assisting small business as a result of its work in the pandemic.[3809] Its profile was also raised within government as a result of the National Cabinet decision on its role as an information hub.[3810] We heard that this facilitated more productive engagement across government, greater alignment among Safe Work Australia members (governments, worker representatives and employer representatives) and faster decision-making.[3811]

4. Essential workers

4.1. Response

While public health restrictions effectively closed large parts of the economy, it was necessary for some parts to remain open. The government response to managing essential workers evolved throughout the pandemic but largely derived from making exceptions to public health orders for some workers, to ensure that industries necessary to the pandemic response or providing important basic services could continue to operate. The first example of this came on 17 March 2020, when National Cabinet issued advice capping the size of gatherings at 500 but made exceptions for key work environments such as airports, aged care services and correctional centres.[3812]

While National Cabinet later sought consistency across states, workplace restrictions and exemptions for essential workers were predominantly made under state government legislation and public health orders.[3813] In practice, this meant that workers in different states and cities were subject to different rules on isolation and their ability to leave the house for work.

To enable essential workers to attend work, the Australian Government took steps to ensure that children of essential workers could attend early childhood education and care centres and schools during lockdowns.[3814] Australian Government funding for early childhood education and care services required centres to prioritise care for children of essential workers.[3815] This is discussed further in Chapter 24: Supporting industry and Chapter 14: Children and young people.

4.2. Impact

4.2.1. There was confusion about the definition of 'essential workers'

While the terms 'essential', 'frontline' and 'key' worker became part of the everyday lexicon, these terms are not defined in Australian Government legislation or consistently defined or coordinated across jurisdictions. Some states did have legal definitions, but these were not designed for a pandemic.[3816] A survey conducted by the Australian Manufacturing Workers Union in July and August 2021 found that 21 per cent of workers in New South Wales were unsure whether they had been designated an 'authorised worker' under the state's public health orders.[3817]

Minutes from National Cabinet meetings in March and April 2020 released through freedom of information requests contain no references to essential workers or frontline workers.[3818] Instead these concepts were inferred from restrictions and lists of 'non-essential gatherings'. Essential gatherings and essential services were described in general terms rather than defined.

Definitions changed throughout the pandemic in response to changing conditions, but at no point was there a definitive list. When the initial stay-home orders were announced on 25 March 2020, the Prime Minister defined essential workers as all workers who were still able to work under health restrictions.

> *Now if you ask me who is an essential worker? Someone who has a job. Everyone who has a job in this economy is an essential worker. Every single job that is being done in our economy with these severe restrictions that are taking place is essential. It can be essential in a service whether it's a nurse or a doctor or a schoolteacher, or a public servant who is working tonight to ensure that we can get even greater capacity in our Centrelink offices, working until eight o'clock under the new arrangement in the call centres, these are all essential jobs. People are stacking shelves, that is essential. People earning money in their family when another member of their family may have lost their job and can no longer earn, that's an essential job. Jobs are essential. – The Hon Scott Morrison*[3819]

However, some types of essential work failed to meet the relevant definitions. This meant that businesses had to seek approval for exemptions from public health orders. The Inquiry's News Media and the Information Environment Roundtable heard journalists were recognised as essential workers, but not the rest of the full complement needed for production, including technicians and repairs.[3820] Working across borders also posed practical limits on providing news services.[3821]

This became increasingly problematic as lockdowns became geographically based, where only essential workers were permitted to travel between local government areas (LGAs) or greater than a certain distance.

> *The lack of clarity around the definition of essential work meant some people were prevented by police from leaving LGAs to attend work. – University of Sydney Infectious Diseases Institute*[3822]

The confusion about 'essential worker' definitions extended to the different types of essential work. As many types of office work that kept important industries operating could be done from home, the experiences of these workers varied greatly from those of frontline workers who were exposed to the virus on a daily basis – in health or retail settings, for instance.[3823]

4.2.2. Differences between states also created issues for essential workers

As definitions of essential workers were implemented by state governments, this created the potential for differences between jurisdictions. The Inquiry heard from businesses that state government processes for exemptions were relatively well managed. However, the lack of a

single national approach meant that businesses operating nationally or in multiple states had to seek approval and make the case for exemptions from up to eight different governments.[3824] Many stakeholders suggested a more coordinated national approach to essential worker declarations.[3825]

The closure of state borders created a further layer of complexity, particularly for businesses and workers that operate nationally or in border regions, or move between jurisdictions.

Many technicians and specialist workers travel widely to undertake general maintenance and critical repairs on communications and energy infrastructure.[3826] Some types of highly skilled specialist technicians are limited in number and may operate across states and territories, some internationally. This became an issue during the pandemic as border closures and quarantine requirements prevented them from fulfilling their maintenance duties.[3827] The reduction in maintenance of infrastructure increased the risk of failure and made networks less resilient and systems more vulnerable.

The panel heard that the processes for approval to travel across state borders for work were often slow. In some cases, it was easier to source workers from overseas than interstate.

National Cabinet sought to improve interstate travel for essential workers in some key industries, agreeing on a Freight Workers Protocol on 24 July 2020 and an Agriculture Workers Code on 4 September 2020.[3828] The Inquiry heard that these measures helped to address some of the issues but that they were introduced late and after significant disruption, and that there remained differences across states. Other industries continued to face issues with cross-border movement.

> *The patchwork of border controls, exemptions and entry pass systems made the COVID-19 pandemic extremely difficult for businesses that continued to deliver essential services between States and Territories throughout this period, with conditions and requirements for 'essential workers' not often being considered until well after the imposed requirements, causing significant confusion and disrupt to organisations in this category. – Qantas*[3829]

4.2.3. Communication and operationalisation were fragmented

As National Cabinet described but did not define essential services, it was left to states and territories to implement decisions.[3830] They did this within different legislative environments, through public health orders and often complemented by media statements and press conferences.[3831] This resulted in inconsistent protocols across the country, compounded by frequent changes. There was no single method of informing the public about changes to the definition of essential workers – or how they were applied and enforced – and messaging was sometimes confusing and unclear. Differences across states therefore remained a challenge.

As noted in the interim report of the Senate Select Committee on COVID-19:

> *At times, the Prime Minister's attempts to explain the situation only added to the confusion. On 18 March he listed certain 'essential' activities and explained*

> *'everything else is non essential'. However, on 24 March, in response to questions over the meaning of an 'essential worker', he unhelpfully suggested that 'everyone who has a job in this economy is an essential worker'. This was in direct conflict with state leaders' requests for non essential workers to work from home if possible. – Senate Select Committee on COVID-19*[3832]

Many stakeholders noted that this situation caused significant confusion:

> *States and Territories released varying lists of roles that were considered 'essential' … These terms were described rather than defined, derived from the measures implemented by the National Cabinet, being the Prime Minister, the Premiers of the States and the Chief Ministers of the Territories. – Australian Rail Track Corporation*[3833]

> *Confusion reigned within the first stages of industry shutdown as to who could trade. This was a direct result of unclear, conflicting and confusing mandates. This was exacerbated by various state government restriction notices, where terms such as 'restricted or permitted operations' were confusing, and at times impossible to interpret. – Motor Trades Association of Australia 3834*

4.2.4. Essential workers bore the brunt of the pandemic

Essential workers faced heightened risks of exposure to COVID-19 in their workplaces. It was reported that during the second wave of COVID-19 infections around 70 per cent of the healthcare workers in Victoria acquired the illness at work.[3835] In addition to higher risks of contracting the virus, frontline and essential workers were frequently required to work longer shifts. They often did so with inadequate PPE – or inadequate understanding and training on how to use it – and often under additional testing and isolation requirements.[3836]

Many essential workers were unable to access vaccines for many months, despite facing elevated risks.

> *Education employees were regarded as essential workers, and yet access to Covid vaccinations was limited and extremely difficult to access throughout a majority of the pandemic. Priority access to vaccinations should have been confirmed for education workers at the earliest possible stage. – Independent Education Union*[3837]

Essential workers' heightened exposure to the virus raised concerns about bringing COVID-19 into their households, which led many to separate from family members for extended periods of time.[3838] Coupled with witnessing the effects of the virus on the community, this increased the emotional strain on essential workers and contributed to mental distress (discussed further in Chapter 12: Broader health impacts).[3839]

These employees received little compensation for the increased risks they faced. Many were ineligible for JobKeeper or JobSeeker payments, were on low rates of pay and experienced high

rates of housing instability, food insecurity and financial hardship compared to workers in non-essential industries.[3840] We heard that some major companies provided additional remuneration for essential workers. Coles and Australia Post recognised employees with 'thank you' payments.[3841] The Victorian Government gave the state's health and education frontline workers 15,000 free arts festival tickets, and its 'Hotels for Heroes' program allowed the state's 8,000 healthcare workers to self-isolate in hotels at no expense.[3842]

At the same time, many essential workers had to take on additional responsibilities, including enforcement of public health orders such as social distancing requirements or checking vaccination status.[3843] The Inquiry heard that many of these workers faced abuse from members of the public when enforcing public health orders or for product shortages resulting from supply chain issues. This placed extra strain on their mental health.

Essential workers also faced difficulties complying with health restrictions themselves. Requirements to test and isolate were particularly challenging for those who had to move across borders and those in high-risk environments such as health and aged care.

> *During the pandemic, testing requirements became a significant challenge for freight, logistics and transport workers. Drivers crucial to the functioning of the supply chain often had to endure lengthy queues for testing, impacting their ability to fulfil their duties promptly. Compounding this issue, roadhouses and other facilities occasionally restricted drivers from using essential services, ordering food, or taking mandated rest breaks on the premises. – Port of Melbourne*[3844]

We also heard that for many workers, particularly early in the pandemic, testing was conducted outside of work hours or at the employee's expense.[3845]

The Inquiry heard that the toll of these impacts contributed to essential workers leaving their occupations, which led to staff shortages in a number of industries following the pandemic.[3846] We heard that there was much public appreciation for the sacrifice and dedication of frontline workers, including (although to a lesser extent than healthcare workers) those in services not traditionally considered essential, such as cleaners and grocery store workers.

5. Evaluation

Workplace relations

Many employers and employees faced significant uncertainty throughout the pandemic and particularly early in 2020, when lockdowns and other response measures were first implemented. Workers had very real concerns for their health, while businesses had very real concerns about their financial position if work could not be undertaken.

We are not aware of any crisis-specific or pandemic-specific government plans to manage the workplace relations system. This lack of preparation meant that responses tended to be reactive and relied on leadership from key government agencies, unions and business leaders. Establishing effective multi-stakeholder engagement took time early in the pandemic due to weak existing tripartite arrangements. While engagement has improved since the pandemic, more could be done to build and maintain these arrangements to ensure that key parties can come together quickly in a crisis. This would improve agility across government and key stakeholders and could help to resolve other issues, such as confused communication.

Once engagement processes were in place, measures were put in place that helped employers and employees adapt reasonably well. However, we note the diversity of challenges faced by different industries and workplaces nationwide. Large-scale paid leave support served as an important supplement to the health response. Various supports added to the workplace relations system encouraged people to stay home when sick to reduce the spread of infection to other workers.

These changes were made possible by the resolution of rigidities between the Australian Government and the Fair Work Commission. Ministerial input on Fair Work Commission variations to modern awards was rare before the pandemic, but during the pandemic the Minister for Industrial Relations sent letters and submissions to the Fair Work Commission supporting determinations on changes to modern awards. Such engagement has remained a feature of the workplace relations system since the pandemic.[3847]

The panel sees the exclusion of insecure workers from some support mechanisms as an opportunity for improvement in a future crisis. Changing modern awards to provide casual workers with unpaid pandemic leave was a positive step. To minimise harm across the workforce more broadly, support for workers should not be contingent on the nature or type of employment. In addition to improving equity, it would strengthen the effectiveness of the public health response if casual and gig economy workers did not face a loss of income by staying home following exposure to a virus or contracting the virus.

The pandemic highlighted the entitlements that casual workers forgo in return for a casual pay loading. Greater flexibility for workers to stay at home when they are sick would support improved compliance with public health objectives in a future health emergency.

The panel also notes the importance of effective communication in this space. Workplace relations law is complex, making it difficult for many employers and employees to understand their rights and responsibilities when changes are made. While the Office of the Fair Work

Ombudsman provided many Australian employers and employees with guidance on workplace relations changes, simplified communication of the changes, particularly to less unionised industries, would avoid some of the confusion that arose during COVID-19.

The Australian Government has introduced reforms since the pandemic which have broad implications for the workplace relations system. It is too soon to assess how these might play out in a future crisis. We note that a key focus of these reforms has been addressing the prevalence of insecure work in Australia highlighted by the pandemic.

Work health and safety

Safe Work Australia provided leadership and worked with agility through the pandemic to support businesses to fulfil their WHS obligations. COVID-19 revealed a wide variation in understanding of WHS obligations across Australia. Many employers relied on advice from government on the steps they needed to take to operate safely. A key driver of the demand for guidance was confusion about the interactions between the WHS system and public health orders.

As a result of the pandemic, both governments and industry have a better understanding of the WHS framework and the obligations that it imposes.[3848] Safe Work Australia now has a strong base of useful resources for employers and employees on managing the risks associated with viruses and infectious diseases, which will prove helpful in the event of a future public health emergency.

The panel considers that the WHS system should be used better in a future crisis by enabling risks to be assessed more flexibly according to the nature of different workplaces. Where possible, health departments should consult with WHS counterparts on the content of public health orders to ensure that the implications for workplaces are taken into account. Changes to workplace practices should be informed by the best understanding of the risks and available evidence at the time, with appropriate mechanisms to adjust practices as required.

Public health orders should aim to reflect the diversity of Australian industries and workplaces. This requires greater consultation of workplace experts within and outside government. Clearer communication to the community during the next pandemic on public health orders and the interaction between WHS and public health orders would address confusion for employers and employees.

> *It was difficult for workers to navigate public health orders and directions, and there was no clear channel for workers and unions to feed into how the pandemic was managed in their sector and provide advice on how best to implement the public health objectives in different workplaces.* – ACTU[3849]

Essential workers

The unprecedented scale of the pandemic meant that Australia was unprepared for the challenge of managing essential workers at a time when health restrictions were designed to keep people at home. There were few pre-existing definitions or lists of essential workers, and

those definitions that did exist were largely not appropriate to define the types of workers who are essential in a pandemic. This meant that public messaging around restrictions and essential activities was difficult and frequently caused confusion.

Governments demonstrated impressive agility in implementing National Cabinet decisions about non-essential activities and establishing processes for exemptions for essential workers. However, differences between states and the lack of a single source of communication left many unsure as to whether they were essential. In some cases, this led to people moving to the informal economy.[3850]

Stronger national coordination and consistency around definitions of essential activities and essential workers would provide a higher level of certainty for businesses and employees and reduce the amount of bureaucracy required to obtain exemptions. While this may prove challenging under current legislative arrangements, there is value in seeking greater harmonisation between states outside of an emergency setting.

6. Learnings

- An individual's employment status can have a significant impact on their experience during a pandemic, including in relation to their risk of contracting the virus and the nature and quantum of government support they receive. Workers (including casual workers) should have access to appropriate financial support or leave arrangements to ensure they are not placed in a position of having to choose between working to support themselves and their families and complying with health advice during a public health emergency. Access to appropriate financial supports and leave arrangements can support compliance with public health measures.
- Tripartite engagement was critical to delivering necessary workplace relations and WHS pandemic responses. Strong tripartite engagement mechanisms would assist in responding to a future crisis which affects workers and workplaces.
- The government's provision of information and advice regarding workplace relations and WHS issues was heavily relied upon during the pandemic. A centralised information hub model was valuable in informing employers and employees of their rights and responsibilities.
- Clear WHS advice and guidance in times of a public health emergency will assist workplaces to continue functioning safely. This guidance should be updated as new evidence emerges and circumstances and risks change. To avoid confusion, there should be explicit guidance that compliance with public health orders is a separate requirement to WHS obligations, and that compliance with public health orders does not necessarily mean compliance with WHS obligations.
- Inconsistent and changing definitions of essential workers across governments created confusion. National agreement on the definitions of essential workers and essential services would provide clarity for employers and employees in a future crisis.

7. Actions

7.1. Immediate actions – Do in the next 12–18 months

Action 6: Develop legislative and policy frameworks to support responses in a public health emergency, including for essential services and essential workers.

Essential services and essential workers frameworks should include:

- definitions of essential workers and essential services in a national health emergency
- mechanisms to support rapid harmonisation between the Australian Government and state and territory governments where practicable
- a set of agreed principles to guide decision-making, with respect to the movement of essential workers and the continued operation of essential services in a crisis
- a commitment to clear and consistent communication of the definitions and how they will apply
- clearly communicated rationale for localised approaches where required
- arrangements for priority access to vaccination, PPE, and infection, prevention and control training in a national health emergency.

Chapter 24 – Supporting industry

1. Context

Industries across Australia faced enormous challenges during the pandemic. Changing consumer demands disrupted the way industries traded, operated and communicated. Government public health measures, including social distancing, border closures and lockdowns, had a dramatic and immediate effect. Industries wore the impacts of economic uncertainty, supply chain disruptions and workforce challenges. These issues are explored in the preceding chapters in this section.

Even though they faced many challenges, businesses proved to be agile and innovative in the ways they responded to the pandemic. Many changed their business models so they could continue to operate in the face of restrictions. For example, hospitality businesses focused on takeaway service and retail businesses moved to online sales, creating unprecedented national and global demand for e-commerce platforms.[3851] However, during this period, government support was essential to keep many businesses operational and ensure that the economy, and society more broadly, continued to function.

At the outset, a key weakness that was identified in the pandemic response was the lack of established channels for communication between the Australian Government and industry. The National COVID-19 Coordination Commission and the Treasury's Coronavirus Business Liaison Unit helped to address these deficiencies. Communication with industry is discussed further in Chapter 4: Leading the response. These whole-of-government responses were important, but industry-specific responses were also needed to address the individual needs and challenges of different sectors.

The Inquiry heard from representatives of industries spanning a wide cross-section of Australia's economy. All of them faced, and in some cases continue to face, significant challenges. Some industries faced challenges that were unique to their sectors, but the broad themes that came up in interviews, submissions and data were consistent: in crises where the government imposes restrictions that affect businesses, the government should actively engage and support them to help mitigate losses and ensure continued operation.

We heard from industry that government did not always show they understood the impact that border closures and other public health measures would have on different sectors of the economy. Support measures were often ineffective at addressing the challenges that industries were facing. For example, certain sectors were disproportionately affected by the exclusions in the JobKeeper Payment's eligibility criteria. The panel heard that a lack of communication from the government and poorly coordinated implementation of support measures compounded the difficulties experienced by industry.

Key industry stakeholders told the Inquiry that the lag between the announcement of public health orders by governments and the release of detail around their implementation had significant operational business impacts. Industries felt there was a lack of engagement and

guidance from the government, coupled with inadequate support. This meant they experienced disproportionate impacts of the pandemic and their ability to recover from the crisis once the economy reopened was hampered.

This chapter is structured as a series of industry snapshots to fully capture the unique experiences and challenges industries faced. Industries that are covered are agriculture, arts and entertainment, aviation, early childhood education and care, energy and telecommunications, higher education, media, tourism and travel, and vocational education and training (VET). Not all sectors of the economy are covered in detail, but the panel has focused on the sectors that best illustrate the challenges faced in the pandemic. This chapter draws out high-level lessons about industry for a future public health emergency.

2. Support for industry to continue to function during a pandemic

2.1. Agriculture

2.1.1. Context

The agriculture sector was able to continue to operate relatively successfully during the pandemic because of continued domestic and global demand. However, it faced significant workforce, supply chain and regulatory challenges.

2.1.2. Response

Agriculture is an important part of Australia's economy. It supports domestic food security, economic stability, and global trade commitments, and significant disruption would have far-reaching, disastrous implications.

The industry saw early challenges with outbreaks in meatworks. By July 2020 these outbreaks had led to more than 300 COVID-19 cases in Victoria alone.[3852] This issue was also experienced globally.[3853]

The then Department of Agriculture, Water and the Environment had regulatory responsibilities for certification of exports. To protect its staff while still meeting these obligations, it moved to conducting remote regulatory auditing where possible.[3854] This was not always possible and some international trading partners refused to accept Australia's agricultural exports unless a departmental officer verified them in person.[3855] In these instances, the staff who needed to conduct this work were given essential worker status so that abattoirs could continue to operate, supporting a key export market.[3856]

The sector was able to overcome early issues, but one of the biggest challenges it faced during the pandemic was a workforce shortage brought on by the closure of the international border. The agriculture industry had relied on working holiday makers and workers under the Pacific Australia Labour Mobility Scheme (known as the Pacific Labour Scheme from 2018 to 2021) to

supplement its workforce. However, from February 2020 to March 2022, the number of working holiday makers in Australia fell by 87 per cent, from 143,000 workers to 18,600 workers.[3857]

> *The movement of workers, equipment, and stock was heavily impacted by the Federal Government's decision to limit interstate and international travel. Over half of the overseas workers who found work on Australian farm[s] were not allowed to enter the country due to the differing quarantine rules in each state. – National Farmers' Federation*[3858]

Horticulture farms were most severely impacted – they saw a 20 per cent reduction in the number of workers (29,300 workers) between 2019–20 and 2021–22.[3859] Before the pandemic, it was estimated that around 25 per cent to 30 per cent of all working holiday makers were employed in horticulture.[3860] The impacts of COVID-19 on labour markets were less visible in the broadacre cropping and dairy sectors, as these farms typically use far fewer overseas workers.[3861]

The closure of the international border also made it difficult for agricultural exporters to move their goods out of the country. Supply constraints for both air and sea freight, that resulted from the international border closure, reduced the capacity for exporters to ship their goods out of the country. Airfreight is used for time-sensitive and perishable or high-value goods (such as meat and fresh fruit).[3862] With fewer flights in and out of the country, and sea freight heavily congested, there was also a significant increase in the price of transporting goods.[3863] This made it even more challenging for exporters to transport their goods.

In response to the challenges faced by the sector, the Australian Government introduced a number of measures to alleviate agricultural labour shortages, including changes to visa and quarantine requirements for agricultural workers, and incentives to encourage people in Australia to take up short-term farm work.

On April 2020 the government introduced the Pandemic Event (subclass 408) visa to allow temporary migrants to stay in Australia while COVID-19 travel restrictions were in place.[3864] It also established the Pacific Pathways Plan so that fully vaccinated workers from low-COVID-risk Pacific countries could travel quarantine-free to Australia to take up work in the agriculture, meat processing, tourism and care sectors, under the pre-existing Pacific Australia Labour Mobility Scheme.[3865] The government also provided support to agricultural shows and field days through the $52.9 million Supporting Agricultural Shows and Field Days Program.[3866]

The first 136 workers arrived under the Pacific Pathways Plan on 16 November 2021 from Solomon Islands.[3867] They went to work in regional and rural towns such as Tamworth, Wagga Wagga, Junee, Dubbo, Wingham and Casino.[3868] Before the program, Pacific Australia Labour Mobility Scheme participants were subject to a 14-day quarantine period in line with public health advice, as with all other international arrivals. The Pacific Pathways Plan reduced delays and costs for Australian businesses that needed to access urgent labour. In November 2021 there were more than 17,000 Pacific Australia Labour Mobility workers in Australia.[3869]

The Australian Government also established the $17.4 million AgMove program to reimburse the costs of eligible people who relocated to take up short-term agricultural work, including harvest work.[3870] AgMove had two phases:

- Between 1 November 2020 and 4 May 2021, it provided reimbursements up to $6,000 for Australian workers or $2,000 for temporary visa holders with working rights who completed at least 120 hours of work over at least six weeks.
- From 5 May to 31 December 2021, workers were also eligible to receive a subsidy of $2,000 for Australians and $650 for temporary visa holders to complete at least 40 hours of work over two weeks. The 2022–23 Budget provided a further $6.6 million to extend AgMove until 31 December 2022.

The government also put in place policies to restore and protect pandemic-disrupted agricultural supply chains. The Agri-Business Expansion Initiative, announced on 23 December 2020, was an $85.9 million program to help Australian agribusinesses expand and diversify their export markets.[3871] It included the expansion of the Agricultural Trade and Market Access Cooperation grants program, short-term agriculture counsellors, and enhancements to the department's market intelligence capacity. The Busting Congestion for Agricultural Exporters package, part of the 2020–21 Budget, allocated $328.4 million over four years to cut unnecessary red tape to get products to export markets more quickly and support jobs in rural, regional and remote Australia.[3872]

The International Freight Assistance Mechanism was a temporary emergency measure to restore key airfreight routes.[3873] Its primary aim was to support Australian exporters of agricultural items such as seafood and horticulture. See Chapter 22: Supply chains for more detail on the International Freight Assistance Mechanism.

2.1.3. Impact

The agriculture sector was able to manage the impacts of the pandemic relatively well, a testament to the resilience it has built through regularly responding to natural disasters.

The agility of the then Department of Agriculture, Water and the Environment in quickly pivoting its regulatory model was vital to ensuring the ongoing operation of export markets during the pandemic. The Australian and Victorian governments collaborated closely to resolve serious issues in Victoria's meat processing facilities.

Overcoming the workforce challenges was more difficult. Although there has been no formal review of AgMove, the fact that it was fully subscribed, with around 10,000 agreements finalised, indicates that this was a successful program for addressing agricultural workforce shortages.[3874] The panel heard that industry welcomed the renewed focus on the Pacific Australia Labour Mobility Scheme.[3875] At the height of the pandemic, there were more than 14,900 Pacific Australia Labour Mobility Scheme workers on horticultural or agricultural farms.[3876]

Despite labour shortages faced by the sector, Australian horticulture production increased by around 3 per cent from 2019–20 to 2021–22. 3877 This partly reflects favourable growing conditions but it also reflects the efforts of horticulture farms to adapt to labour shortages by adjusting production systems and management practices. This included streamlining roles to increase productivity, increasing the hours worked by the existing workforce, altering crop plantings to lengthen the peak harvest period, or substituting labour for capital, such as using automatic fruit-picking machines and driverless tractors.[3878]

While total horticulture production increased, some farms were negatively impacted by the loss of labour availability. Of farms that experienced crop loss in 2021–22, around 17 per cent reported that a lack of labour was one of the primary causes for the loss.[3879] However, most farms that lost crops indicated that environmental factors were the primary cause.[3880]

2.2.Arts and entertainment

2.2.1. Context

The arts and entertainment sector felt the full and prolonged impact of the pandemic. This was primarily due to public health measures which reduced the sector's capacity to operate effectively. Parts of the sector were further inhibited by their effective exclusion from key economic support.

2.2.2. Response

Australia's arts and entertainment industry plays a vital role in our culture, national identity and economy, contributing an estimated $122.3 billion of GDP in 2019–20.[3881]

While the industry suffered huge losses during the pandemic, Australians relied more than ever on arts and entertainment for their mental health and collective wellbeing.[3882] However, most of the industry was unable to operate – artists were unable to work, live events were cancelled, cultural institutions were effectively shuttered, and businesses were operating at drastically reduced capacity or not at all.[3883] The pandemic significantly reduced the sector's capacity to generate revenue. This affected the ability of artists and other workers in this industry to support themselves, which necessitated swift support from the government.

Funding for policy delivery across the arts and entertainment industry occurs at the Australian Government, state and territory and local government levels, as well as through private engagement and support.

A 2023 report from the Cultural and Creative Statistics Working Group broke up the total estimated 2021–22 public expenditure on cultural activities. For 2021–22, the report estimated $8,317.5 million total expenditure on cultural activities across the three tiers of government:[3884]

- $3,165.2 million (38 per cent of total) from the Australian Government
- $3,325.6 million (40 per cent) from state and territory governments
- $1,826.7 million (22 per cent) from local governments.

Of this, $646.4 million was targeted COVID support for cultural and creative organisations and infrastructure, businesses, individuals, support programs and initiatives.[3885]

Due to the number of sub-industries that fall under the category of arts and entertainment, the experience of the pandemic across this industry was wide ranging. Issues ranged from the obvious loss of income for arts and entertainment workers, to some less obvious impacts such as difficulties in getting insurance for live events and in-person work, as well as the interruption of the International Indigenous Repatriation programs.[3886]

Reflecting the diversity of the industry, a range of different Australian Government initiatives were designed to support it. Among these, JobKeeper provided a welcome lifeline, sustaining eligible businesses and organisations.[3887] However, the majority of artists were ineligible for JobKeeper because of their employment type.[3888]

The $200 million Restart Investment to Sustain and Expand (RISE) Fund, which formed part of the COVID-19 Creative Economy Support Package, was the most substantial industry-specific support administered by the Australian Government. RISE grants supported 541 projects across a range of sub-sectors.[3889]

The government announced the Creative Economy Taskforce in August 2020.[3890] The taskforce's purpose was to provide strategic guidance to help rebuild the arts sector during the pandemic and assist with the implementation of support measures.[3891]

As the industry is expansive, comprising a number of sub-industries, identifying individual programs and grants available across the industry is difficult. There is no single repository that captures Australia-wide data on arts funding and programs.

Australian Screen Production Incentive – an additional $400 million for the Location Incentive

In March 2020, the outbreak of the COVID-19 pandemic caused a near-total shutdown of large-scale film and television drama production in Australia.[3892] The sudden decline in large-budget international screen production filming in Australia affected cast, crew, post-production services, catering and other providers who rely on work created by these large-budget productions. These productions also deliver new job and training opportunities in the industry and are vital for maintaining the sector's workforce capacity.

The Australian Government's Location Incentive was first announced in May 2018, with $140 million in funding to help Australia remain competitive in attracting large-budget international productions. In 2020 the government committed a further $400 million until 2026–27. The additional funding was intended to keep screen productions coming to Australia and create new job and training opportunities for Australians. The then Prime Minister stated that it would 'help back the screen sector's recovery from the impacts of COVID-19'.[3893]

In 2020–21 and 2021–22 the program supported filming in Australia by major international productions such as *Blacklight*, *The Tourist*, *Thirteen Lives*, *Young Rock*, *Joe vs Carole*, *Ticket to Paradise*, *Spiderhead* and *Irreverent*, among many others. The increase in the Location Incentive allowed Australia's screen industry to secure a pipeline of large-budget international

productions to film in Australia. The longer-term assurance of the Location Incentive demonstrated an important understanding of the complexities of the screen industry, where producers require significant cash flow and early investment to get productions off the ground.

Successful cooperation between the Australian Government, state and territory governments and the industry was essential to the industry's success during the pandemic. Australia received global recognition as a pioneer of best practice in screen production, being one of the first jurisdictions to publish and implement industry-wide COVID-safe guidelines.[3894]

An Australian Government evaluation of the Location Incentive program noted that screen drama production spend reached a record $1.9 billion in Australia in 2020–21, a result of increases in both Australian and international productions.[3895] Between 2018–19 and 2020–21, the Location Incentive created an estimated 39,100 jobs, including 27,800 full-time equivalent positions, and supported 13,100 businesses.[3896] While the Location Incentive was not specifically a pandemic measure, the government's decision to provide a further $400 million kept the screen sector afloat during the pandemic and in its aftermath.[3897]

2.2.3. Impact

The Inquiry heard from stakeholders that it took a long time to convey the importance of the industry to decision-makers, which delayed the policy response.

The arts and entertainment industry has a unique workforce, with a high concentration of freelance and casual workers. It has limited pathways to 'secure' employment and, as a result, much of its workforce was ineligible for government support.[3898] Support measures to the industry during the pandemic did not always reach the businesses and workers who needed them the most.

> *I have lost what was full time work as a stage manager and had to take a much lower paying full time role outside the industry. I have had the opportunity to work casually a few hours a week on some creative developments but nowhere near my previous capacity or wage. – Survey respondent, Standing Committee on Communications and the Arts, Inquiry into Australia's creative and cultural industries and institutions*[3899]

Stakeholders told the panel that the government's National Cultural Policy, *Revive: a place for every story, a story for every place*, released on 30 January 2023, has helped the industry regenerate in some areas. However, the industry is still feeling the effects of the pandemic in 2024, with workforce and skills shortages across sectors.[3900]

There was some criticism among industry stakeholders that government funding provided through one of the sector's major support lifelines, the RISE Fund, was not flowing to arts workers as intended. The panel heard that support through RISE did not always trickle down from arts organisations and venues to benefit individual workers, who were the most affected by loss of employment opportunities and income.[3901]

The Inquiry also heard that stakeholders from across the industry did not feel supported by the government. They perceived a lack of targeted support and noted the exclusion of much of the industry's workforce from JobKeeper.

> *The eligibility criteria for the JobKeeper Payment disproportionally excluded sectors like the arts where many workers have multiple employers, are employed as casuals, are sole traders with irregular cash flows; and many arts organisations are local government or university run. – National Association for the Visual Arts*[3902]

> *According to Australian Taxation Office (ATO) data, 25,370 people in the Creative and Performing Arts subdivision of the ANZSIC Arts and Recreation Services Division received JobKeeper payments in April 2020. As at February 2020, there were 45,400 employees in this subdivision, of whom around 40,000 are employed in the private sector. This means that around 63 per cent of employees in this subdivision were in receipt of JobKeeper payments in April 2020 based on employment levels prior to the pandemic. – Bureau of Communications, Arts and Regional Research and Office of the Arts*[3903]

The panel heard positive feedback from stakeholders in the screen sector around its experience of engaging with the government during the pandemic. They were particularly positive about the Temporary Interruption Fund, a measure designed to support local film and television producers to start filming again in circumstances where new productions had been halted by insurers not providing coverage for COVID-19. However, stakeholders noted that the measure excluded some parts of the sector.[3904]

2.3.Aviation

2.3.1. Context

The aviation sector saw an immediate and severe impact from pandemic response measures affecting the transport of workers, tourists and freight.

2.3.2. Response

The aviation sector is important to Australia's economy and quality of life. Supporting this sector during a crisis is vital to maintaining supply chains, supporting trade and facilitating emergency responses. The nature of the COVID-19 pandemic highlighted just how essential aviation is to the economy and society.

In 2018 the aviation sector in Australia employed over 90,000 people and contributed $20 billion to the Australian economy.[3905] The closure of Australia's international borders in March 2020 and the movement restrictions imposed at the outset of the pandemic posed an existential threat to the sector. It was the largest shock in its history, with passenger numbers falling by 97 per cent and one-third of aviation workers stood down, retrenched or exiting the

industry.[3906] This created skills shortages across the aviation workforce, leading to long-term impacts that are still being felt.[3907]

The impact on the industry was twofold. The huge reduction in passenger numbers that resulted from international and domestic border closures translated to significant financial strain for airlines, which still had financial liabilities such as staff salaries, aircraft leases and maintenance.[3908] To reduce the strain, companies stood down or laid off a significant portion of their workforce across various roles.[3909]

Despite the significant disruption, the sector had an essential role to play during the pandemic. Given Australia's location and geography, the continued operation of aviation was vital for international repatriation efforts, the essential movement of people and the continued operation of domestic and global supply chains. Aviation is crucial for high-value, low-volume freight; for the efficient movement of freight in between capital cities; and for regional connectivity. Further discussion on supply chains is in Chapter 22: Supply chains.

There is limited competition in Australia's domestic aviation sector. Aviation is very capital intensive, creating high barriers to entry. If one or more key players in the sector were to fail, this would compromise Australia's ability to have a functioning and competitive aviation industry. This risk was clear early in the pandemic, when Australia was faced with the potential collapse of its second largest domestic airline, Virgin Australia.

Virgin Australia

The Australian Government and the aviation sector more broadly faced an early and significant challenge when, in March 2020, Virgin Australia requested a $1.4 billion bailout from the government to support it through pandemic-related financial difficulties. The government ultimately rejected this request, informed by advice from the specifically established Markets Taskforce within the Treasury,[3910] for two main reasons:

1. With Virgin Australia choosing voluntary administration, it would continue to operate, allowing the market to remain competitive.

2. Virgin Australia's shareholders are primarily based overseas, and the government did not want to bail out a foreign-owned company.

As stated by the then Treasurer: '… the Government was not going to bail out five large foreign shareholders with deep pockets who together, own 90 per cent of this airline'.[3911]

Virgin Australia announced on 21 April 2020 that it would be placed into voluntary administration.[3912] It was purchased by a private company, Bain Capital, later in 2020.

Research into bailout policy published in the *Journal of Transport Policy* in December 2021 looked into the case of Virgin Australia and found: 'The outcome suggests that the private market can provide a solution without government intervention for the case of Virgin Australia, which is consistent with the widely held view that the government should refrain from giving direct financial aid to a failing firm. However, our analysis also shows that if the private sale deal were not realised, the cost would be huge in terms of (for example) the interests of Australian

consumers and regional communities. A minimum level of assistance with conditions can be considered to restore competition in Australian domestic market and maintain air transport connectivity for regional areas.'[3913]

Despite not agreeing to the request from Virgin Australia, the government did provide other support to the industry. This took two forms: financial support and strategic planning for the future of the aviation sector.

Financial support for the aviation sector was delivered through the JobKeeper Payment and through an industry-specific package. The industry received $1.2 billion in support through JobKeeper (see Chapter 21: Supporting households and businesses). Qantas was the largest recipient, receiving $856 million. Virgin Australia and Regional Express received $285.9 million and $29.4 million respectively.[3914]

A number of airports also received significant amounts in JobKeeper, including Sydney Airport ($15.6 million), Brisbane Airport ($11.9 million) and Adelaide Airport ($5.8 million).[3915] Targeted support for regional airports was provided through a new Regional Airports Program ($41.2 million in June 2020, and $29.6 million in July 2021).[3916]

The government's sector-specific expenditure on aviation support measures totalled $2.1 billion (as at 30 January 2022).[3917] The biggest programs were the Australian Airline Financial Relief Package at $641.7 million, and the Domestic Aviation Network Support package at $480.7 million. Both primarily supported domestic airlines to remain financially viable. This sector-specific support spanned the length of the pandemic: the earliest measure was announced on 1 February 2020, and a number of programs continued well into the transition/recovery phase.

The Tourism Aviation Network Support program was announced in November 2021. Its purpose was to drive demand for interstate travel and thereby support jobs, with effects trickling down to accommodation, food and activities in nominated regions. The program provided a 50 per cent subsidy on over 800,000 economy tickets to and from a range of regions.[3918]

In addition to financial support, the Australian Government provided significant strategic support to the sector. It established the Future of Aviation Reference Panel in 2020 to develop a five-year plan for aviation. The panel reported in 2021 with 14 recommendations covering the breadth of issues facing the industry. In response, in December 2021 the government released the Aviation Recovery Framework.[3919] The framework outlined six strategic priorities for the government's future activities to support the aviation sector to recover from the impacts of COVID-19: supporting aviation efficiency; building a sustainable pipeline of workforce skills; optimising airport infrastructure; connecting regional communities; revitalising general aviation; and embracing new technologies.[3920]

To support the sector's reopening and mitigate its growing skills shortages, the International Aviation Support program was introduced from March 2021.[3921] It provided funding intended to maintain a core Australian international aviation capability and ensure Australian airlines could

quickly resume commercial international flights as international restrictions were lifted. This measure included financial support for airlines to use for crew and training.

In response to a 2022 Senate inquiry, the Australian Government published its Aviation White Paper in August 2024. The Aviation White Paper sets out the government's long-term objectives for the aviation sector and the policy initiatives it will adopt to encourage growth and innovation in the sector to 2050.[3922]

2.3.3. Impact

Australian Government support for the aviation sector during the pandemic was important for its survival. Feedback from Australia's aviation industry indicated that the government's financial support measures had ensured that essential air connectivity across Australia continued and that aviation resumed as the economy exited the pandemic.[3923] The ANAO's audit of COVID-19 support to the aviation industry found that 'development of subsequent support measures was timely, with the department generally providing advice to government prior to known events (such as the cessation of the JobKeeper scheme) or soon after unforeseen events'.[3924]

A review of support for the aviation sector analysed the impact of several programs, including the Tourism Aviation Network Support (TANS) program. It found that 'TANS had supported the return of the aviation sector, but lockdowns and travel restrictions had dampened the effect. The [review] suggested that extension of the measure could further stimulate recovery, but timing was important'.[3925] The program was extended to March 2022.[3926]

However, government support for this sector did not alleviate financial pressures entirely. In June 2020, Qantas announced plans to cut at least 6,000 jobs and continue to stand down 15,000 workers to help the company survive impact of the pandemic.[3927] This decision aimed to reduce costs amid the significant decline in revenue for the aviation sector. Qantas announced a further 2,500 cuts in August 2020 to streamline its operations and focus on recovery efforts. This involved outsourcing ground crew at major Australian airports.[3928] In September 2023 the High Court ruled that the sacking of 1,700 ground and baggage workers was illegal.[3929]

There has also been criticism from airports that the government support flowed primarily to airlines. Submissions to the Inquiry highlighted the impacts of international arrival caps and travel restrictions on Australia's five major airports, revealing the increased operating costs associated with turning around international services with exceedingly small numbers of passengers.[3930]

The panel heard the Australian Government's support for the aviation industry did not effectively assist airports, which received only $220 million of the $5.6 billion of aviation industry support.[3931] Sydney Airport had to raise $2 billion in equity in August 2020 as there was concern that it would become insolvent.[3932] In 2019 the Australian airport sector employed over 206,000 Australians and contributed $34.6 billion in value-added economic activity. By 2022 the sector had not fully returned to pre-pandemic levels: it employed over 171,000 Australians and accounted for $27.4 billion in value-added economic activity.

The Australian Airports Association's own analysis of the government's support for the sector found:

> *Of the $5.2 billion in aviation industry support provided between 2020 and 2022, 63.5 cents in every dollar of support (approximately $3.2 billion) flowed to airlines, compared to only 4.4 cents in every dollar ($220 million) for airports … Compared to airlines, the airport sector was left to manage its fixed operating costs (around $4 million a day across all airports) through the pandemic, with only limited direct support. – Australian Airports Association*[3933]

The panel heard from stakeholders at the Travel and Tourism Roundtable that while airports performed an essential service during the pandemic, supporting Australia's sovereign air network and freight, they were not treated as such by the government. Most of Australia's airports are owned and run by local governments, mostly in regional and remote areas. Local government was excluded from JobKeeper, adding to the difficulties experienced in keeping these airports running.[3934]

Efforts to improve skills retention among this workforce were compounded by internal border closures. Industry criticised the inflexible approach to this across governments. Border closures meant that specialist workers (such as air traffic controllers and pilots) were unable to access training facilities to retain the skills necessary to return to work immediately when borders reopened. The panel also heard that the sector had tried to communicate this issue to the government but had received little acknowledgment of the unique skills in this area. The 'blanket approach' to border restrictions remained.[3935] As a result, the workforce was unequipped to service the huge demand once travel restarted.

The panel heard at the Travel and Tourism Roundtable that, in addition to the shortage of pilots resulting from workforce challenges, a significant number of pilots have left Australia to work for airlines in the United States.[3936] This is due to the availability of E3 work visas for speciality occupation workers under the United States–Australia Free Trade Agreement, as well as generous sign-on bonuses.[3937] Reports indicate that air travel continues to suffer the impact of skills shortages, compounded by issues such as aircraft shortages and high airfares.[3938]

Stakeholders also told the panel that insufficient lead times and a lack of guidance for the reopening of borders meant that the industry was unprepared for the resulting demand.[3939] The sudden reopening, without sufficient advance warning, also meant that the industry missed a window for international carriers to start scheduling flights, which resulted in further revenue losses.[3940]

The closure of Australia's internal borders also had a significant impact on the travel and tourism sectors, which is discussed further below.

2.4. Early childhood education and care

2.4.1. Context

Early childhood education and care (ECEC) plays a critical role in the development of children and the lives of their families. Consistent attendance at ECEC is important for child development, and also enables carers to work, which contributes to economic growth and productivity. The ECEC sector was vital to support essential workers during the pandemic but it experienced unique challenges in continuing to operate. Many parents withdrew their children from childcare centres in the alert phase of the pandemic, threatening the viability of businesses and organisations in the sector.

2.4.2. Response

ECEC is an essential service, delivering developmental, learning and wellbeing-enhancing early learning for children and supporting participation in work and study for parents and carers. As outlined in Chapter 14: Children and young people, the challenge that confronted the ECEC sector was the significant temporary decrease in demand, while also being an essential service. This had a significant impact on the operational sustainability of businesses in this sector, which required a specialised policy response from the Australian Government.

> *Despite the early uncertainties surrounding the spread of COVID-19, most ECEC services in Australia remained open. They were considered by the Australian Government to be an essential service – enabling essential workers – doctors, nurses, police officers and so on – to continue to work to keep society and the economy running. – Goodstart Early Learning*[3941]

In the alert phase of the pandemic, many parents withdrew their children from ECEC services to reduce the risk of infection and/or because their work situation changed.[3942] This had a significant impact on the revenue of many businesses in this sector, resulting in the risk of widespread business closures. Childcare facilities are largely reliant on the Australian Government's Child Care Subsidy (CCS), which is paid directly to childcare centres on behalf of families, based on children's attendance.[3943]

The government announced a relief package for the sector in April 2020, which provided free child care for three months.[3944] The package suspended the usual form of childcare assistance provided through the CCS. Instead of receiving payments based on attendance, child care services were subsidised through weekly payments based on fees charged in a reference fortnight in February 2020. This measure gave parents the flexibility to keep their children enrolled in child care, regardless of their physical attendance at the centre, which provided vital financial certainty for businesses.

The relief package required ECEC centres to remain open.[3945] The sector was advised to prioritise care to children of essential workers, vulnerable and disadvantaged children, and previously enrolled children. JobKeeper applied differently across the ECEC sector from 30

March 2020 to 12 July 2020, and many employees were unable to receive JobKeeper from July onwards.[3946]

When the relief package ended on 12 July 2020, ECEC services returned to normal funding arrangements. To provide additional support, from 13 July to 27 September 2020, ECEC services also received a transition payment equal to 25 per cent of the average weekly fees that they charged during a reference fortnight.[3947]

The government then provided a recovery package from 28 September 2020 to 31 January 2021.[3948] This was effectively an extension of access to the transition payment for jurisdictions that faced ongoing pandemic impacts (particularly Victoria). Additional support was available for services that were at risk of imminent closure.

Until 31 January 2021, services in Victoria at high risk of permanent closure due to COVID-19 also had access to funding through the Community Child Care Fund Special Circumstances Grant Opportunity.[3949] From 12 October 2020 to 31 January 2021, services outside Victoria also could apply for this grant opportunity if they were at risk of temporary or permanent closure due to COVID-19 and were operating in or servicing families from disadvantaged and vulnerable communities or operating in a community with limited or no other childcare services.
As lockdowns were introduced across the country in 2021, additional supports were put in place for ECEC services in affected locations. These included:

- 23 June 2021: Additional absence days for child care in Commonwealth-declared hotspots[3950]
- 19 July 2021: Child Care Gap Fee Waiver (NSW), which allowed childcare centres in areas subject to stay at home orders to waive gap fees when parents chose to keep children at home[3951]
- 16 August 2021: Child Care Gap Fee Waiver (COVID hotspots), which allowed childcare centres in Commonwealth-declared hotspots to waive gap fees if a state or territory directed that centres were only open for some children.[3952]

From 23 August to 30 November 2021 the Australian Government introduced a viability support package to maintain the viability of services, retain staff and ensure there was access to child care for those who needed it.[3953] Eligible services in Commonwealth-declared COVID-19 hotspots received a business continuity payment (25 per cent of pre-COVID average weekly fees for centre-based day care, family day care and in-home care services, and 40 per cent for outside school hours care services). Eligible services could also waive gap fees and access additional absences. As at 18 October 2021, $234 million in support was paid to over 6,200 services in Victoria, New South Wales and the ACT.[3954]

After the end of extended lockdowns, some support measures remained in place to help the sector deal with the continued impact of COVID-19. For example:

- services could waive the gap fee when a child was unable to attend care for a COVID-19-related reason
- all families got 10 extra allowable absences per child in 2021–22 and 2022–23
- families could receive CCS for absences when a child had COVID-19
- families could use evidence of a positive COVID-19 test to access additional absences.

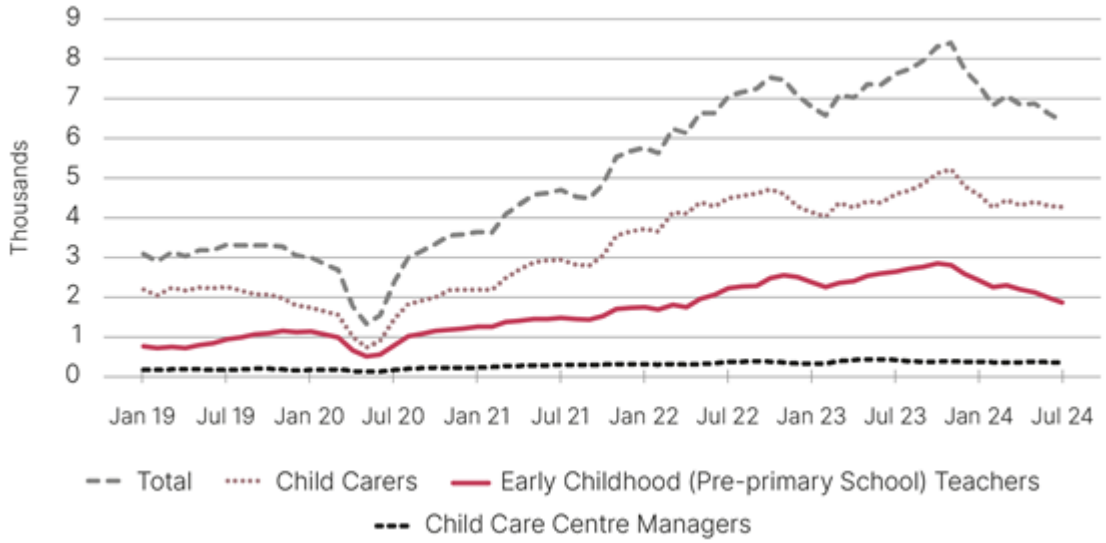
2.4.3. Impact

The panel heard there were concerns that without government support, there would not have been a sector to recover once the economy reopened when public health measures were withdrawn.[3955] However, stakeholders also told the Inquiry that the speed of the government's response at the beginning of the COVID-19 pandemic was hampered by the pre-existing legislative and systems frameworks.[3956]

Stakeholders expressed frustration that sectoral support measures did not take into consideration the different business structures of ECEC services across the sector.[3957] For example, the design of support measures assumed that all services would experience a significant drop in attendance. However, the Inquiry heard that this was not the case for all service types. Family day care services in particular maintained attendance at rates higher than 90 per cent.[3958] The exclusion of services provided by local governments – which operate a significant proportion of ECEC services and are the providers of last resort in many communities – was also raised as a concern.[3959]

The panel heard that the government response did not meet the needs of all providers. They attributed this to the speed at which funding was rolled out, a lack of consultation, and insufficient understanding of the diversity within the sector.[3960] We also heard about inconsistency as to which services could access support, and inflexible approaches.[3961] Participants at the Early Childhood Education and Care Roundtable said that JobKeeper, one of the sector's main safety nets, did not take into account variation in the sector's workforce and many workers were excluded as a result. This contributed to a large number of educators leaving the sector.[3962] Figure 2 shows the increase in monthly job vacancy rates in ECEC settings. High vacancy rates had an ongoing effect on existing staff as they tried to do extra work to compensate.[3963] Attrition rates continued to rise. Educators reported being overworked because of staff shortages and exhausted after two years of pandemic, and feeling their profession to be under-recognised.[3964]

Figure 2: Early childhood education and care job vacancies, January 2019 to July 2024[3965]



Submissions to the Inquiry called for ECEC to be categorised as an essential service, emphasising the importance of access to this service.[3966]

2.5.Energy and telecommunications

2.5.1. Context

The energy and telecommunications sectors experienced changes in demand during the pandemic but they were more affected by their lack of access to critical infrastructure, and restrictions on the movement of workers needed to perform repairs and maintenance.

2.5.2. Response

The energy and telecommunications sectors are critical for most aspects of our daily lives. The 2019 bushfires caused significant disruptions to critical telecommunications and energy infrastructure, followed shortly by the COVID-19 pandemic, which saw a large shift in the patterns of consumption for both services.

The demand on the Australia's telecommunications networks increased significantly as a result of remote working and education, and increased telecommunications usage more broadly. There was a significant increase in data demand over the National Broadband Network (NBN) between 28 February 2020 and late March 2020. Business hours traffic increased by up to 70 per cent over this time.[3967] The pandemic helped to drive rapid growth in Australia's online activity, with an 11 per cent increase in broadband connections in Australia from 2020–21.[3968]

The public health measures had a number of unintended consequences for these sectors. Border closures prevented technicians and specialist workers from crossing borders to undertake general maintenance and critical repairs on communications and energy infrastructure.[3969] This included activities such as fault rectification, network construction and upgrading, and preventive maintenance and assurance. Reduced maintenance on these

networks increased the risk of failure. This made the systems more vulnerable in the event of another crisis, such as a natural disaster.

Early in the pandemic it was clear that keeping these sectors operational, agile and able to meet changing consumer demands would be critical. To facilitate this, the government responded in a variety of ways. It acted early to bolster Australia's access to emergency oil supplies, announcing in March 2020 that it would lease space in the United States Strategic Petroleum Reserve to store and access Australian-owned oil during a global emergency.[3970]

The electricity sector was well placed to continue operating. It was well practised in emergency management procedures and able to use existing structures and pandemic planning that had been undertaken by the Australian Energy Market Operator.[3971] The sector also recognised the impact of the pandemic on consumers. The Australian Energy Regulator releasing a revised Statement of Expectations for energy businesses in March 2020, which set out the operating principles for retailers.[3972] The statement recognised that economic circumstances arising from the pandemic could cause financial hardship affecting people's ability to pay their energy bills. It provided guidance for retailers and customers dealing with financial hardship matters. In August 2020 the Australian Energy Regulator created a mechanism allowing some retailers to defer the payment of network charges to distribution network service providers for six months for customers impacted by COVID-19.[3973]

While total demand for electricity fell by 2.1 per cent in the second quarter of 2020, household electricity consumption increased by 10 per cent, and small business usage declined by 17 per cent in 2020.[3974] Electricity bills increased by 7 per cent for households while falling 16 per cent for small businesses.

For the telecommunications sector, the major government response measures included:

- the *Telecommunications hardship principles for COVID-19* released in April 2020, established in consultation with the industry[3975]
- $150 million financial relief for internet providers to support their residential and small and medium business customers through NBN Co[3976]
- regular meetings of the Communications Sector Group to facilitate information sharing around emerging engineering, security and operational issues[3977]
- a range of competition exemptions authorised by the Australian Competition and Consumer Commission (ACCC).[3978]

2.5.3. Impact

The measures taken by the government, in combination with the sectors' preparedness, were important for sustaining their operational agility during the pandemic. The timing of the final stages of the NBN rollout was fortuitous. Without this, it is unlikely that existing networks would have had bandwidth and resilience to service the increased demand.

The government's swift acknowledgment of these essential sectors and its role in making sure they could continue to operate was an important part of a largely successful response. It is important that we learn from the success of these sectors during the pandemic and use them to inform future crisis responses where possible. The energy sector demonstrated the importance of proactive crisis preparedness, including robust planning, to minimise disruption to critical services.[3979]

The impacts of border closures on our ability to service critical infrastructure exposed the need to engage with sectors to pre-empt unintended consequences of policy. Many decisions made during the pandemic did not recognise the importance of flexibility in relation to the application of stringent public health orders on essential sectors. In future, timely and streamlined cross-border movement for telecommunications and energy technicians and specialist workers should be allowed for in any cross-border restrictions.

2.6.Higher education

2.6.1. Context

The closure of international borders and the flow-on effects to international student numbers had a big impact on the higher education sector.

2.6.2. Response

The closure of the international border on 19 March 2020 (and the earlier closure of the border to China and other countries) coincided with the start of the academic term for many universities, meaning that international students were shut out of the country. To students already in Australia, the message from the Prime Minister in April 2020 was to return home.[3980]

There was a regulatory response from the government that allowed students to continue studying from outside Australia,[3981] but this was not always achievable or desirable. Many students simply deferred or cancelled their studies.[3982]

International students represent an important source of revenue for many universities, and by the end of 2020 the financial health of public universities looked bleak. The sector's net operating result declined from $2.3 billion in 2019 to $669 million in 2020.[3983] This was a result of this steep decline in revenue, universities reduced total expenses, including by cutting staff.

To add to the challenges faced by the higher education sector, public universities were excluded from JobKeeper in line with the government's policy not to provide JobKeeper to institutions that were predominantly publicly funded.[3984] The reasoning was that the primary role of JobKeeper was to help businesses and organisations that were experiencing significant decline in revenue. There was an expectation that public universities would use their existing government funding during the pandemic and not need to rely on additional taxpayer-funded subsidies like JobKeeper.

In early May 2020, the government introduced a six-month turnover test for universities. This extended the usual month or quarter period for the turnover test to account for the lumpy

nature of the payments universities receive from international students. Later in May 2020, privately funded universities were excluded from this requirement, allowing them to receive JobKeeper payments. This was consistent with the government's policy intent to provide JobKeeper support to primarily privately funded businesses.[3985]

2.6.3. Impact

Early in the pandemic, during the alert and suppression phases, the Australian Government provided some support for the higher education sector to help increase university revenue. The 2020–21 Budget estimated that the higher education sector received funding of around $11.4 billion in 2020–21.[3986] This included:

- subsidising short online courses
- changes to the funding and fees for Commonwealth supported domestic students as part of the Job-Ready Graduates Package
- one-off $1 billion in research funding for universities through the Research Block Grants Program and Research Support Program.[3987]

However, the impact of the additional one-off $1 billion was not experienced evenly across higher education providers and may have made it challenging for some universities to build capacity. This is because Research Support Program funding is allocated on a relative performance based methodology, which rewards higher education providers for attracting research income.[3988]

The panel heard that the exclusion of employees of significantly government-funded institutions was an issue during the pandemic. Some stakeholders talked about a misleading perception that jobs in higher education were more secure than those in the private sector.[3989] The Independent Evaluation of the JobKeeper Payment concluded that the exclusion of the public sector, including public universities, was appropriate, as these sectors receive a significant amount of public funding and during the pandemic they needed different arrangements tailored to their specific challenges.[3990] However, the panel heard from stakeholders that the exclusion of universities from JobKeeper had profound and long-lasting impacts on the sector. Submissions to the Inquiry suggested that funding for higher education over the pandemic may not have been adequate.

> *I found JobKeeper was overall good, but unfair. I work in the tertiary sector and universities were not provided with support. The result was a lot of jobs lost and we are still feeling the loss of these staff, and associated morale, today. I and many colleagues have lost trust in the government's support for universities. In the future, universities should be considered in support packages.* – Submission 863[3991]

The sector provided feedback to the Inquiry criticising the Australian Government's treatment of international students. The lack of a government social safety net for international students placed this responsibility on universities, and they were not resourced to provide this support. The Inquiry's focus groups found despite loss of work and income, most international students reported being unable to access income support payments or other financial supports such as

utility freezes due to their visa status.[3992] Many also did not know whether they were protected under tenancy acts. This led a few to drop out of their study entirely and switch to a working visa in order to work and afford living expenses.[3993] Others reported being reliant on families, friends, universities and charity organisations for financial support and felt purposefully 'left-out' by government, 'unwelcome' and 'isolated'.[3994]

The panel heard overwhelmingly that there was concern and disappointment among the sector that the message to international students was simply 'go home'.[3995]

> *Universities, local governments and charities, were forced to fill this gap. The University of Melbourne offered food relief and financial assistance of up to $7500 for students facing financial hardship due to COVID. The University also expanded scholarships for international students, connected with offshore students through Study Hubs in several international cities, and offered further counselling and psychological support. At a time of budgetary constraint, these expenses were critical. – University of Melbourne*[3996]

Surveys conducted in 2020 by the University of Technology Sydney's Institute for Public Policy and Governance looked into the experiences of international students during the pandemic. The surveys found that 61 per cent of respondents who had been employed before the pandemic lost their job, only 15 per cent had managed to find new employment by July 2020,[3997] and 54 per cent reported experiencing financial difficulties.[3998] Only 13 per cent of respondents described the support they had received from the Australian Government as 'good' or 'excellent'.[3999]

> *I lost that one [job] because they said that they didn't need anyone and they have to like shut down their restaurant for that time. And I tried to contact them after the restaurants were open and like I was casual over there and they had their full-time and part-time so they were like, "No, we have to provide shifts to them now [full-time staff], so when we will need you, we will call you". So they are of that attitude. – University student, Sydney*[4000]

The sector rebounded in 2021, recording its largest ever surplus ($5.3 billion).[4001] This resulted from cost containment measures and increased revenue, generated through a combination of increased government funding (including the $1 billion research funding) and improved investment performance. However, the recovery has been uneven across the sector due to different levels of exposure to international students, and different delivery models (including pre-COVID investment in transnational education).[4002] Some universities have seen their balance sheets improve, while others have experienced a slower recovery. It is also difficult to assess the impact of the large-scale staff reductions during the pandemic.

In 2022, both commencing and total domestic student numbers sharply decreased at universities (10.4 per cent), and in specific cohorts: low socio-economic status students (11.7 per cent); regional, rural and remote students (8.1 per cent); and Aboriginal and Torres Strait Islander students (8.0 per cent). The causes of this were strong employment growth, cost

of living pressures, and perhaps a reduction in the number of students finishing year 12 of school.[4003]

2.7.Media

2.7.1. Context

For the media sector, the pandemic accelerated the transformation of the digital landscape. It contributed to a major decline in advertising revenue and impacted the financial viability of media businesses at a time when they were relied on more than ever to communicate news about the pandemic and health restrictions to the public.

2.7.2. Response

The media industry provides a critical service, which became even more apparent during the pandemic. Australians relied on public interest news more than ever to keep up to date on the evolving health situation and the public health orders. An April 2020 survey indicated that during the pandemic, Australians were accessing news media more than usual, as the main source of information about COVID-19.[4004] The panel heard from News Media and the Information Environment Roundtable participants that the media played a vital role in spreading and democratising information on important issues such as border restrictions and vaccine rollouts, and combating misinformation and disinformation around public health measures.[4005]

The pandemic exacerbated existing challenges in the media sector arising from declining revenues, rising costs and an outdated regulatory environment. The economic impact of COVID-19 was particularly pronounced for the traditional news and broadcasting sectors, where advertising revenues fell even more sharply than before.[4006]

In April 2020 the government announced a package of measures to help sustain Australian media businesses. The measures included:

- tax relief in the form of a one-off, 100 per cent rebate of the Commercial Broadcasting Tax in 2020–21
- a $50 million Public Interest News Gathering program to support public interest news journalism in regional newspapers and regional commercial television and radio
- short-term regulatory relief in the form of a suspension of Australian drama, children's and documentary content quotas for broadcasters
- fast-tracking work to harmonise regulation of Australian content.[4007]

2.7.3. Impact

The government support measures helped the media sector to continue to operate during the pandemic. However, despite assistance for commercial television broadcasters, the pandemic significantly accelerated the transition to on-demand video platforms.[4008] The 2020 Media

Consumption Survey revealed that the highest increase in screen consumption was reported for online channels, specifically online subscription services (29 per cent), free video streaming services (23 per cent) and other websites and apps (16 per cent).[4009]

The panel heard that government support for the sector was vital throughout the COVID-19 pandemic but that it could be improved in the future.[4010] Stakeholders emphasised that government assistance was required to address operational challenges for those working in cross-border communities, including in relation to definitions of essential workers.

Stakeholders from commercial free-to-air television were critical of the eligibility criteria for JobKeeper, citing its failure to take into account the casualised and freelance nature of employment for many workers in the media sector.[4011] The panel also heard that JobKeeper's exclusion of local broadcasters owned by international parent companies was seemingly at odds with the broadcasters' role of providing essential news and information services.[4012]

As a result of the suspension of content quotas for commercial free-to-air broadcasters, the amount of children's content being screened across these networks has decreased significantly. Under the old standard, each network had to broadcast a minimum of 260 hours of children's programs annually.[4013] The *Broadcasting Services (Australian Content and Children's Television) Standards 2020* commenced in January 2021.[4014] While the new standards were not strictly a pandemic measure, the timing of their implementation was fast-tracked to mitigate the pandemic's compounding effect on the challenges facing the sector. In 2021 the Nine Network screened 47 hours of children's television and Network Ten screened 40 hours.[4015]

Children's television was able to provide culturally specific education and entertainment during the pandemic, at a time when it was particularly critical to support parents and caregivers.[4016] For example, *Play School* produced a special COVID-19 episode to help answer some of the questions that children might have had about the pandemic.[4017] While the panel acknowledges the government's post-pandemic support for the sector, its view is that cutting content quotas is likely to reduce the sector's ability to perform a similar function in a future crisis.

2.8.Travel and tourism

2.8.1. Context

Being heavily reliant on the movement of people, the travel and tourism industry immediately felt the impact of international and domestic border closures, and had limited opportunities to pivot operations. The challenges faced by the sector were exacerbated by public health measures designed to limit the spread of the virus, such as lockdowns and social distancing.

2.8.2. Response

The tourism industry includes a range of businesses that contribute to Australia's visitor economy. Most businesses in this space align themselves with a specific sector such as accommodation, hospitality, retail or transport.[4018] The travel industry is slightly broader but it does have substantial overlap with the tourism industry. These intersecting areas are both discussed here, and further relevant information is in Section 2.3.

The travel and tourism industries are significant contributors to Australia's economy. Before the pandemic, the travel and tourism industries were thriving: in 2019, tourism expenditure in Australia by short-stay international visitors and domestic travellers was $138.5 billion.[4019]

The travel and tourism industries rely on the movement of people. This meant that when domestic and international border closures were enforced, they were effectively shuttered overnight. As the pandemic unfolded, the vulnerability of sectors that had never had to rely heavily on government support was exposed. This was particularly evident in relation to the workforce, which was significantly reduced. The travel and tourism sectors have a significant proportion of casual and seasonal workers, international students and other migrant workers on temporary international visas.[4020] Many of these workers were ineligible for government support.

The pandemic affected tourism and travel operators differently depending on business characteristics such as size, location, management and ownership style.[4021] The different consumer demands within the sectors (for example, leisure, visiting friends and relatives, conference, business, group, independent, special interest, religious, sport and cultural) also influenced how certain businesses felt the pandemic's effects. Government support was necessary to avoid the collapse of these industries, although the support measures were not universal or equally distributed.

The relatively sudden closure of the international border left many Australian citizens and permanent residents stranded overseas. As part of the initial response to the pandemic, the government provided consular services to help vulnerable Australians by facilitating access to flights to Australia and providing financial assistance where required through the Hardship Program (see Chapter 7: Managing the international border).

The tourism and travel sectors were vital in assisting with these repatriation efforts. Airlines and travel companies worked with the government to organise repatriation flights when commercial flights were suspended.[4022] Travel agencies and tour operators helped to coordinate logistics, such as bookings, transfers and communicating with travellers.[4023] Hotels provided quarantine services to travellers once they returned to Australia (see Chapter 8: Implementing quarantine).

Other than this important but limited essential role, demand for travel services declined dramatically. The panel heard from key stakeholders that the travel sector effectively lost all of its international business during the period between the closure of the border and reopening.[4024]

> *Travel businesses spent the COVID-19 pandemic with no income due to the international travel shutdown, chasing $10 billion in credits and refunds on behalf of customers. They also played a key role in assisting Australians return to Australia and their respective state/territory during changing border restrictions. While many parts of the Australian economy have rebounded, the impacts on the travel industry continue, with international travel still below pre-pandemic levels.– Australian Travel Industry Association*[4025]

Tourism Research Australia reports that as Australians were unable to leave the country, they turned to domestic travel in greater numbers. This strongly benefited various regions, such as Western Australia and tropical Queensland.[4026]

Government support for the travel and tourism industries was broad. It included general business support, such as JobKeeper, and specific programs targeting some of the most vulnerable subsectors, such as hospitality and retail. Recognising the importance of ensuring consumers could rebook their travel, the government implemented the COVID-19 Consumer Travel Support Program, which provided grants to eligible travel agents and tour arrangement service providers.[4027] The $258 million program opened in December 2020 and closed in June 2022.

The Australian Government implemented specific measures to support travel and tourism related sectors (such as transport, agriculture and education) under its $1 billion COVID-19 Relief and Recovery Fund.[4028] One program funded under this was the $50 million Recovery for Regional Tourism Program, designed to help regions reliant on international tourism. Another was a $139.6 million program to help exhibiting zoos and aquariums with the fixed operational costs associated with caring for animals and continuing conservation efforts.

On 11 March 2021 the government announced the $1.2 billion Tourism and Aviation Flight Path to Recovery package.[4029] The package included the Tourism Aviation Network Support program to boost interstate aviation connectivity and the tourism industry by helping to rebuild demand and confidence for interstate travel to regions impacted by the loss of international tourists.[4030] Travellers were offered cheaper fares, which meant that they could spend more on accommodation, tour activities and experiences in the regions. Austrade advised on the regions selected for the program based on tourism data.[4031]

The Australian Government also partnered with states and territories to co-fund specific programs to help the tourism travel sector. For example, $30 million was made available for iconic tourism attractions in Queensland, through grants of up to $4 million to ensure major tourism enterprises remained viable and were ready to scale up as visitors returned.[4032]

In April 2021 the Australian Government established an independent Reimagining the Visitor Economy Expert Panel to provide advice to government and the tourism industry to help drive the economic recovery of the industry.[4033] The expert panel consulted with over 500 stakeholders across industry and all levels of government. Its report provided recommendations for government and industry on how to chart a course for sustainable long-term growth of the visitor economy.

In March 2022 the government released *THRIVE 2030*, the national long-term strategy to rebuild and return the visitor economy to long-term sustainable growth.[4034] *THRIVE 2030* was informed by the Reimagining the Visitor Economy Expert Panel report, whose recommendations formed the basis of the THRIVE 2030 Action Plan.[4035]

2.8.3. Impact

The pandemic's impact on the travel and tourism sectors was felt immediately upon the closure of the international borders. At the end of 2019 there were 757,500 tourism jobs in Australia. By mid-2020 this had reduced to 363,900 jobs, a decrease of 52 per cent, or 393,600 jobs, in six months.[4036]

Figures from Tourism Research Australia indicated a swift recovery from the pandemic for the domestic tourism sector in 2022, with growth moderating in 2023 as international travel recovered and inflationary pressures emerged.[4037] This moderation in domestic travel growth was expected. Its impact has varied across tourism regions and sectors.

Travel to regional areas increased more quickly than travel to capital cities, with travellers preferring to avoid more densely populated areas. The increase in driving holidays was particularly beneficial for regions within two to three hours' drive from capital cities.[4038] The biggest constraint on the recovery in regional, rural and remote tourism was finding enough workers to meet the increased demand. This was exacerbated by the shortage of working holiday makers, who often fill workforce demands in regional, rural and remote areas.[4039]

> *The [Working Holiday Makers] program delivers enthusiastic and mobile workers to regions where labour is most needed, which enables regions and businesses to meet seasonal labour needs thanks to the flexibility of the visa. – Australian Chamber – Tourism*[4040]

A Reserve Bank of Australia report from December 2022 indicated a strong recovery for domestic tourism but highlighted the challenges – largely due to labour shortages and supply chain disruptions – faced by businesses in scaling up to meet this rapid surge in demand.[4041]

Demand in the international tourism sector has had a much slower post-pandemic recovery trajectory. However, Tourism Research Australia forecasts a full recovery of international visitor numbers in 2025.[4042] Despite the recovery in tourism spend in 2023, challenges persist in some parts of the visitor economy. They include:

- ongoing supply constraints, such as workforce and skills shortages, supply-chain disruptions, and rising cost pressures
- moderating domestic visitor demand growth after a major upswing in demand in 2022
- a reduction in discretionary spending in 2023, likely caused by cost-of-living pressures
- the impact of some Australians prioritising overseas trips over domestic trips
- lower numbers of high-value international visitors compared to pre-pandemic years.[4043]

The Business Events Grant Program supported more than 1,500 applicants and, together with matched funding, injected $100 million into the economy.[4044]

The Consumer Travel Support Program was generally regarded as an effective support measure. We heard that it helped many businesses to remain viable.[4045] Industry commentary indicated that the program ensured pre-booked international travel services were ultimately delivered and businesses would remain open:

> *Without [JobKeeper and the Consumer Travel Support Program], many travel agencies and tour arrangement services throughout Australia would not be in business today and the several billions of dollars of consumer credits and refunds from airlines would not have been managed and maintained on behalf of the Australian public for use again when Australia's borders reopened. – Australian Travel Industry Association*[4046]

However, some stakeholders were critical of aspects of the program's design and administration.

Stakeholders in the travel and tourism industries also questioned the government's treatment of different sub-industries. There was a perception that the restrictions were unfairly and arbitrarily applied across travel-related industries such as trains, cruise ships and air travel. The panel heard that the cruise industry was treated unfairly when COVID-19 outbreaks on cruise ships across the world resulted in the government's decision to ban all cruise ships from foreign ports entering Australian ports.[4047]

Stakeholders also noted that there were existing government–industry relationships and forums for engagement but these were not used effectively during the pandemic.[4048] Instead the government established a new industry engagement group during the pandemic, which stakeholders reflected on as being an ineffective and inconsistent channel of communication.[4049] The panel heard that the lack of government engagement with industry around decisions caused significant challenges during the reopening of borders.[4050] In particular, we heard that the lack of guidance and communication ahead of the reopening resulted in business uncertainty and an inability for the industry to adequately prepare.[4051]

The Tourism Aviation Network Support program was well received by industry and the travelling public. The ACCC noted that it 'helped stimulate demand for holiday travel. While Tourism Aviation Network Support only applied to certain routes, Qantas, Jetstar, Virgin and Rex ran a number of overlapping promotions at the same time to encourage more people to fly.[4052]

Phase 1 of the THRIVE 2030 strategy, which ended in May 2024, focused on 'strengthening collaboration, improving data and insights, activities to address workforce and insurance challenges, and building and diversifying domestic and international markets'.[4053] A report on the progress of the strategy noted that the target of a visitor economy spend of $166 billion was exceeded, reaching $207.7 billion for the year ending December 2023.

2.9.Vocational education and training

2.9.1. Context

In the vocational education and training (VET) sector, students were unable to complete the in-person training components of their qualifications. This compromised the skills pipeline and exacerbated workforce shortages across industries.

2.9.2. Response

The Australian Government introduced several skills measures to encourage VET training and apprenticeship employment over the course of 2020 in response to the pandemic and the resulting recession. The measures focused on high-priority occupations identified through the Apprenticeships Incentives scheme, which included aged and disability carers, early childhood educators and enrolled nurses.[4054]

On 30 March 2020 the government announced Supporting Apprentices and Trainees, a wage subsidy program for existing apprentices employed in small and medium businesses.[4055] The program provided a 50 per cent subsidy for wages paid between 1 July 2020 and 31 March 2021. Support was extended to new apprentices from October 2020, through the Boosting Apprenticeship Commencements wage subsidy.[4056] The subsidy was extended to March 2022 at a cost of $3.9 billion.

The JobTrainer Fund was announced in July 2020 to support 340,000 unemployed and young people to study high-demand courses for free or at a low fee.[4057] The first phase of the program cost $1 billion – $500 million from the Commonwealth and $500 million matched by state and territory governments. An additional $1 billion was committed through the same matched funding arrangement when the program was extended to December 2022.

Further details on the wage subsidy and JobTrainer are in Chapter 21: Supporting households and businesses.

2.9.3. Impact

Strong VET systems are vital to meet the skills needs of the Australian economy. A significant proportion of Australian society is engaged in the sector.[4058] The disruption to the VET sector largely stemmed from the imposition of public health orders, which limited access to workplaces for work placements due to social distancing, moved a lot of course delivery online, and led to lower enrolment numbers.

On-the-job training is an essential component of VET courses. More than one in five Australian apprentices and trainees reported that the on-job-training component of their study had been delayed by COVID-19 in 2020.[4059] This was particularly relevant where digital learning alternatives were not practical (for example, trade qualifications could only deliver the theory components online).

The industries that were hardest hit by the suspension in new apprentice and trainee contract commencements early in the pandemic included arts and recreation services; accommodation

and food services; transport, postal and warehousing; retail trade; and agriculture, forestry and fishing.[4060]

Trends in apprenticeship numbers indicate that the wage subsidies provided during the pandemic have contributed to a substantial turnaround in the number of apprentices in training. Data from the National Centre for Vocational Education Research for September 2021 showed there were 352,020 apprentices and trainees in training, which was an increase of 33.2 per cent from the September 2020 figure.[4061] However, the increase may have been slightly offset by increased cancellations and withdrawals, which reached 25,205 in September 2021 – an increase of 51.9 per cent compared with 2020.[4062]

As of December 2022, the JobTrainer Fund supported more than 562,000 enrolments and over 206,000 course completions in areas of skills need.[4063] Skill alignment is an ongoing challenge for the sector; however, while there has been no review of JobTrainer, the panel heard that support through the program was critical.[4064] Further detail on this measure is in Chapter 21: Supporting households and businesses.

Public health measures led to a reduction in VET student enrolments and engagement, although the impact varied over the course of the pandemic. Enrolments declined substantially in the early stages, with an overall decrease of 6.3 per cent between 2019 and 2020.[4065] This had an impact on the financial viability of the sector, as providers rely on students competing their training or meeting major milestones to completion.

> *VET students were incredibly challenged during the pandemic to meet the mandated work placement hours for school or externally delivered VET courses. In New South Wales 2 unit x 2 year VET Frameworks course students are required by the New South Wales Education Standards Authority (NESA) to undertake 70 hours of workplace learning over the two years of the course. For students in lockdown this was incredibly difficult to achieve, particularly in environments such as hospitality and childcare, and added to the challenges they experienced, and not achieving the work placement hours resulted in their Higher School Certificate being held back until the VET requirements were addressed. – Isolated Children's Parents' Association Australia*[4066]

Enrolments rebounded in late 2020 and into 2021 as the sector adjusted to new delivery modes and government initiatives were introduced. Student participation ultimately returned to pre-pandemic numbers by mid-2021.[4067] However, providers reported that enrolments either plateaued or declined in in 2022.[4068]

We heard that the government's efforts to bridge workforce shortages by realigning skills with areas of demand were not as successful as they could have been. Despite VET funding intended to increase student numbers in high-demand sectors like aged care, some have suggested enrolment results have been mixed.[4069]

Research published by the National Centre for Vocational Education Research concluded:

> *Funding support from the Commonwealth and state and territory governments was viewed positively by most of the participating training providers, and it is clear that the various support packages assisted the VET sector to adapt to the turbulent pandemic environment. – Trimboli, Lees and Zhang 4070*

The panel heard that some VET students made important contributions to the COVID response through voluntary and paid work – particularly students in allied health courses – but that this could not count towards placement requirements for accreditation purposes.

3. Evaluation

The Australian Government's decision to close the international border was an important decision which fundamentally altered the course of the pandemic in Australia, protecting it from some of the worst health and economic outcomes experienced globally. This was supported by decisions at all levels of government to implement public health measures and provide broad economic supports to households and businesses. However, it is clear that the response had an acute impact across industries, and not all sectors received the support required to compensate for the losses that came as a result.

While industries welcomed support from government, it was often the case that measures were not appropriately designed or effectively targeted to the relevant sector. For sectors that are too critical to fail, this posed significant risks.

Government should identify which sectors are critical during a pandemic and develop crisis plans for these sectors

During the pandemic, it became evident that governments had not previously considered the sectors critical to the functioning of the economy and society. In order to prepare for a future public health emergency, there would be benefit in the development of a framework to identify which sectors these are and, if they do not already have crisis plans in place, develop plans to strengthen the resilience of these sectors survive during the next crisis.

The energy and telecommunications sectors are recognised as critical sectors by governments and were better prepared to deal with the crisis. The energy sector had comprehensive crisis plans in place, and the Australian Energy Market Operator was one of the few key organisations that had an effective pandemic plan. The telecommunications sector is similarly critical. The large-scale Optus outage in 2023 demonstrated how reliant Australians are on telecommunications, when even a provider-specific outage caused chaos across the country. While the fortuitous completion of the NBN rollout before the pandemic enabled greater connectivity, more planning is essential for future crises.

Australia's large landmass and geographically dispersed population means that a functioning and competitive aviation sector is necessary to move people and goods around the country. Given this, the absence of a comprehensive crisis plan for the aviation sector was a critical oversight. When the sector was faced with an existential crisis, the government quickly realised that it would need to provide support to keep the sector afloat. The lack of planning meant that

decisions around the appropriate level of government support for the industry's survival had to be made quickly at the beginning of the pandemic. A crisis plan for the sector would improve preparedness and agility in the face of a future crisis.

Without access to ECEC services, workers with children or caring responsibilities could not have gone to work and the pandemic response would have been critically undermined. The ECEC sector faces a unique set of challenges during a pandemic, and it came perilously close to collapse. The lack of a functioning ECEC sector would also undermine the functioning of the economy more broadly. For this reason the panel considers that in addition to a crisis plan, the government should develop emergency funding supports for this sector and maintain them as part of the economic toolkit (see Chapter 21: Supporting households and businesses). There are also long-term developmental impacts from a lack of access to ECEC services (explored in Chapter 14: Children and young people) which need to be minimised during a pandemic.

The agriculture sector did not experience a significant decrease in output during the COVID-19 pandemic. However, it is a critical sector for the supply of food and for the economy and should be recognised as such.

While broad-based supports were effective, some sectors require bespoke supports

As discussed in Chapter 21: Supporting households and businesses, the Australian Government implemented a range of broad-based measures to support business through the crisis. In some cases, these measures did not provide equal support, due to specific design features, or were not adequate given the specific challenges faced by some industries. In these cases, bespoke supports were required.

A consistent theme of the government's pandemic support was the failure of some policies and programs to account for diverse employment structures within various sectors. Industries such as arts and entertainment, tourism, and hospitality and retail, where many workers are freelancers or gig workers, or on temporary visas, had significant portions of their workforces excluded from JobKeeper. The panel notes that the design of JobKeeper aimed to preserve mobility in the labour market, which is necessary to help the economy adjust during a crisis. However, the lack of other targeted support measures meant that certain industries were unfairly impacted. For the arts sector, the government developed a bespoke package of supports because JobKeeper was not as effective and the industry was significantly impacted by the pandemic.

The higher education sector is another example of a sector that required bespoke support. As international students represent an important revenue stream, universities were faced with a considerable crisis at the outset of the pandemic. Despite this, public universities were excluded from JobKeeper. In response to the needs of the sector, the government provided an additional $1 billion in research funding, but the panel considers this response to be manifestly inadequate. The higher education sector is critical for both the economy and the pipeline of skilled and qualified workers, and more support should have been provided to help it through the crisis. Similarly, the VET sector is critical for Australia's skills pipeline. It too needed a tailored support package to help it through the crisis.

Some sectors were unable to operate at all during the pandemic, or could only operate in a limited way. Their challenges extended beyond the provision of broad-based support measures. For example, the travel and tourism sectors were unable to effectively operate until most of the public health measures had been relaxed and the international borders reopened. These sectors received a range of targeted supports, which was appropriate, as government measures restricted their ability to operate. Both sectors are important for the economy and provide important services more broadly. For future crises, it is important to consider additional supports for sectors like these which face challenges extending beyond the term of the broad-based supports.

A sound understanding of sectors is important for understanding how to target support in a crisis

To understand which sectors may need support in a crisis, and then to appropriately target support measures to those sectors, government need a sound understanding of the profile of those sectors. This includes factors such as sources of revenue, workforce profile, key markets, and vulnerabilities.

For example, having a detailed understanding of the workforce profile of the arts sector, with its high degree of casualisation and gig workers, would have helped the government to understand that JobKeeper would not meet the needs of the sector. If it had understood this at the time, it might have developed more appropriate supports for the sector.

The experience of the media sector also demonstrates the importance of understanding a sector when targeting support. By delivering its support through a mix of financial measures, regulatory relief and reform initiatives, the government aimed to support the sector through the crisis while also improving its ongoing viability.

The panel heard from the travel sector that the government had an insufficient understanding of the sector, and that this compromised the design of one of its key support measures. The Consumer Travel Support Program was an important and beneficial measure overall, but some elements of its design and administration should be reconsidered in a future crisis requiring similar support. Stakeholders reiterated the need for greater consultation with industry in the design of support measures, as well as greater understanding within government of the sector that it is seeking to support.

It is the panel's view that, to improve preparedness for a future crisis, governments need to have a better understanding of the profile of key sectors of the economy. This will allow them to quickly identify which sectors are likely to be most impacted in a future crisis, the needs of those sectors, and how best to tailor supports for them. It could also work as a protective factor against rent-seeking behaviour from companies and sectors, as a fuller understanding of a sector would help government to more easily identify genuine need and target support to that need.

4. Learnings

- In crises where the government imposes significant restrictions that impact businesses, industries should be supported to help mitigate losses incurred as a result of those restrictions.
- Establishing ongoing relationships and regular communication between government and industry would help improve the response to a future public health emergency.
- Depending on the nature of the crisis, different sectors (and the various kinds of businesses within those sectors) will be impacted in different ways. Careful consideration of the unique operating environments and workforce compositions of industries will allow the government to determine which sectors are likely to be the most vulnerable in a particular crisis. This should underpin decisions regarding which sectors need tailored supports and inform their design.
- Certain sectors that are strategically critical and potentially vulnerable to the impact of a public health emergency, such as aviation, require additional planning to avoid delays in the government's response.
- During a crisis, early planning by the government to address the logistics of easing public health measures is essential to allow for industries to prepare for the recovery phase.

5. Actions

5.1. Immediate actions – Do in the next 12–18 months

Action 5: Develop updated health emergency planning and response arrangements in conjunction with states and territories, and key partners, including consideration of escalation and de-escalation points, real-time review and a focus on post-emergency recovery.

As part of this, develop:

- An enhanced National Health Emergency Plan (updated National Health Emergency Response Arrangements) and updated National Communicable Disease Plan. These updated plans should align with the Australian Government Crisis Management Framework
- Management plans under the National Communicable Disease Plan for priority populations
- Modular operational plans for specific sectors, including high-risk settings, which can be deployed in response to a variety of hazards.

The series of plans should:

- have clearly defined scope, ownership and accountability, including a clear legal basis and defined roles for Commonwealth bodies (including the CDC), states and territories, and industry partners
- incorporate feedback from community, industry and academia into plans and response measure adjustments.

Action 15: Ensure there are appropriate coordination and communication pathways in place with industry, unions, primary care stakeholders, local government, the community sector, priority populations and community representatives on issues related to public health emergencies. Structures should be maintained outside of an emergency, and be used to provide effective feedback loops on the shaping and delivery of response measures in a national health emergency.

- Build and maintain engagement mechanisms outside of an emergency with industry (including businesses and entities across the supply chain).
- Maintain and build on effective structures that were established before or during the COVID-19 pandemic.
- Consult these groups on the development and updating of pandemic plans, and ensure they participate in stress-testing exercises.
- Ensure there are clear mechanisms to feed into decision-making processes in an emergency, and genuinely engage relevant bodies in pandemic preparedness activities and responses to future emergencies.
- Utilise these structures in national health emergencies to provide effective feedback loops on the delivery of response measures.

Appendices

Appendix A: Terminology

1. Acronyms

Short form	Description
ABS	Australian Bureau of Statistics
ACCHS	Aboriginal and Torres Strait Islander Community Controlled Health Services
ACT	Australian Capital Territory
Aged Care Royal Commission	Royal Commission into Aged Care Quality and Safety
AHPPC	Australian Health Protection Principal Committee (to 6 May 2024)
AHPC	Australian Health Protection Committee (from 7 May 2024)
AHPRA	Australian Health Practitioner Regulation Agency
ANAO	Australian National Audit Office
APS	Australian Public Service
ATAGI	Australian Technical Advisory Group on Immunisation
ATO	Australian Taxation Office
CALD	Culturally and linguistically diverse
CDC	Centre for Disease Control
CHO	Chief Health Officer
CMO	Chief Medical Officer
DFAT	Department of Foreign Affairs and Trade
Disability Royal Commission	Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
ECEC	Early childhood education and care
GDP	Gross domestic product
GP	General practitioner
GPRC	General Practitioner Respiratory Clinics
H1N1	2009 H1N1 swine flu pandemic
ICT	Information and communications technology
ICU	Intensive care unit
IPC	Infection prevention and control

Short form	Description
JobKeeper	JobKeeper payment, a COVID-19 support measure
JobSeeker	JobSeeker payment, a financial support measure for those looking for work
LGA	Local government area
LHD	Local health district
MBS	Medicare Benefits Schedule
MP	Member of Parliament
mRNA	Messenger ribonucleic acid vaccines, used to reduce the severity of COVID-19
NACCHO	National Aboriginal Controlled Community Health Organisation
National Cabinet	Forum attended by the Australian Prime Minister, Premiers and Chief Ministers
NCCC	National COVID-19 Coordination Commission (to July 2020)
NCC	National COVID-19 Commission Advisory Board (from July 2020)
NCH	National Coronavirus Helpline
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NMS	National Medical Stockpile
NPA, COVID-19 NPA	National Partnership on COVID-19 Response
NSW	New South Wales
NT	Northern Territory
OECD	Organisation for Economic Co-operation and Development
PCR	Polymerase chain reaction – testing method used to detect the SARS-CoV-2 virus
PDLP	Pandemic Leave Disaster Payment
PHN	Primary Health Network
PHO	Primary Health Organisation
PM&C	Department of the Prime Minister and the Cabinet
PPE	Personal protective equipment
QLD	Queensland
RAT	Rapid antigen test – home use test to detect the SARS-CoV-2 virus
RBA	Reserve Bank of Australia
SA	South Australia

Short form	Description
SARS	Severe acute respiratory syndrome, 2003 outbreak
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2, virus that causes COVID-19
SITAG	Science and Industry Technical Advisory Group
TAS	Tasmania
TGA	Therapeutic Goods Administration
TIC	Traveller with Illness checklist
TTIQ	Test-trace-isolate-quarantine
VET	Vocational education and training
VIC	Victoria
WA	Western Australia
WHM	Working Holiday Maker
WHO	World Health Organization

2. Glossary

Term	Definition
2019-nCoV	Novel coronavirus was the initial name given to the virus by the International Committee on Taxonomy of Viruses, used in World Health Organization reporting 23 January until 11 February 2020.[4071]
Acute disease	A medical condition that comes on suddenly and lasts for a limited time.[4072]
Acute mental health units	Acute mental health units provide voluntary and involuntary short-term in-patient management and treatment during an acute phase of mental illness, until the person has recovered enough to be treated effectively and safely in the community.[4073]
Aggregate demand	Aggregate demand is a term used in macroeconomics to describe the total demand for goods produced domestically, including consumer goods, services, and capital goods.[4074]
Airborne transmission	Airborne transmission is defined as the spread of an infectious agent caused by the dissemination of droplet nuclei (aerosols) that remain infectious when suspended in air over long distances and time.[4075]
Allied health	There is no one definition of allied health. Different definitions are used internationally and across Australia. Generally, the Australian Government recognises allied health professions that have a university qualification accredited by a relevant national accreditation body, a national professional organisation with clearly defined membership criteria, clear national entry-level competency standards and assessment processes, autonomy of practice and a clearly defined scope of practice.[4076]
Ancestral strain	The original strain or variant of SARS-CoV-2 that was first reported in Wuhan, China, in December 2019.[4077]
Animal reservoirs	The reservoir of an infectious agent is the habitat in which the agent normally lives, grows, and multiplies. Reservoirs include humans, animals, and the environment. The reservoir may or may not be the source from which an agent is transferred to a host.[4078]
Antenatal	The antenatal period covers the time from conception until birth.[4079]

Term	Definition
Antiviral medications	Antiviral medications help your body fight off harmful viruses. These drugs can ease symptoms and shorten the length of a viral infection.[4080]
Asymptomatic	Experiencing a disease with no symptoms.[4081]
Auslan	Auslan is Australian Sign Language, the language of the Australian Deaf Community.[4082]
Automatic stabilisers	Refers to certain types of government spending and revenue that are sensitive to changes in economic activity, and to the size and inertia of government more generally.[4083]
Behavioural science	Behavioural science is an interdisciplinary approach that encompasses the study of human behaviour and the design of strategies to change it.[4084]
Carer	Carers are people who provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, or alcohol or other drug issue, or who are frail aged.[4085] Informal carers provide care to those who need it within the context of an existing relationship, such as a family member, a friend or a neighbour.[4086]
Case surveillance	A surveillance case definition is a set of uniform criteria used to define a disease for public health surveillance. Surveillance case definitions enable public health officials to classify and count cases consistently across reporting jurisdictions.[4087]
Casual employees	Employees who do not have certain paid leave entitlements or guaranteed hours of work, and whose employment can end without notice unless notice is required by a registered agreement, award or employment contract. In the context of JobKeeper, short-term casuals are casual employees who have been employed in their job for less than 12 months. Long-term casuals are casual employees who have been employed in their job for more than 12 months.[4088]
Chronic disease	Long-lasting condition with persistent effects.[4089]
Clinical factor	An element that contributes to the assessment and treatment of a patient.[4090]

Term	Definition
Committee of Cabinet	Cabinet Committees provide the forum for detailed consideration and discussion of issues before full Cabinet consideration, with officials available to assist ministers if the Cabinet Committee wishes. The Prime Minister determines the membership, Chair, Deputy Chair and terms of reference of each Cabinet Committee. Cabinet Committees are usually established either around a subject area, such as national security, or around a general function of government, such as expenditure and taxation.[4091]
Communicable diseases	Communicable diseases are diseases that can spread from person to person.[4092]
Community Controlled Health Service	A Community Controlled Health Service (CCHS) is controlled by community members (through a locally elected board), so it can address the comprehensive health and wellbeing needs of its local community. CCHSs are independent and not controlled by the government.[4093]
Comorbidities	The occurrence of two or more health conditions in a person at one time.[4094]
Contact tracing	Contact tracing is the process of identifying, assessing, and managing people who have been exposed to someone who has been infected with the COVID-19 virus.[4095]
COVID-19	Coronavirus disease (COVID-19) describes the infectious disease caused by the SARS CoV-2 virus, used by the World Health Organization from 12 February 2020, and in this report.[4096]
COVID-19 pandemic	Worldwide outbreaks of COVID-19 were characterised by the World Health Organization as a pandemic on 11 March 2020.[4097]
Data linkage	The method by which information about people, places and events from different data sources is brought together.[4098]
Delta	The variant of SARS-CoV-2 that was first reported in India in December 2020.[4099]
Demand	Demand is the quantity of a good that consumers are willing and able to purchase at various prices during a given time.[4100]
Disability Liaison Officer	Disability Liaison Officers provide support so that people with disability can access health care.[4101]

Term	Definition
Disallowance	Disallowance is a form of repeal of disallowable instruments initiated by the Parliament. The Parliament, with a majority vote in either House of the Parliament, may disallow a disallowable instrument in part or in full. This may result in an instrument ceasing to have effect and reviving an earlier instrument. If an instrument is disallowed, generally the rule-maker may not make an instrument similar in substance for six months.[4102]
Disinflation	Disinflation is a temporary slowing of the pace of price inflation and is used to describe instances when the inflation rate has reduced marginally over the short term.[4103]
Disinformation	False or inaccurate information spread deliberately to manipulate the opinions or actions of others.[4104]
Easy Read	Easy Read is a way of writing to present information so that it is easier for people with low literacy to read.[4105]
Elective surgery	Elective surgery is planned surgery that can be booked in advance as a result of a specialist clinical assessment.[4106]
Epidemic	The occurrence in a community or region of cases of an illness, specific health-related behaviour, or other health-related events clearly in excess of normal expectancy.[4107]
Epidemiologist	Someone who studies diseases and how they are found, spread, and controlled in groups of people.[4108]
Epidemiology	The study of the patterns and causes of health and disease in populations.[4109]
Excess mortality	The difference between the observed number of deaths in a specified time period and the expected numbers of deaths in that same time period.[4110]
Extraordinary/unconventional monetary policy	Unconventional monetary policy occurs when tools other than changing a policy interest rate are used. These tools include forward guidance, asset purchases, term funding facilities, adjustments to market operations and negative interest rates.[4111]
Fiscal policy	The use of government spending and taxation to influence the economy.[4112]
Flattening the curve	A strategy to slow the infection rate so that, even if infections could only be delayed and not avoided, case numbers would be contained to levels where those who were sick could receive optimal care.[4113]

Term	Definition
Freedom of association	The right to freedom of association protects the right of all persons to group together voluntarily for a common goal and to form and join an association.[4114]
Full employment	Full employment is an economic situation in which all available labour resources are being used in the most efficient way possible. Full employment embodies the highest amount of skilled and unskilled labour that can be employed within an economy at any given time.[4115]
Fully vaccinated	A person is fully vaccinated if they have received all the vaccine doses recommended for their age and individual health needs.[4116] The number of doses that qualified as fully vaccinated changed over time.
Furlough	A period of unpaid leave.[4117]
Genomic sequencing	A laboratory method to determine and map the entire genetic makeup of a specific organism or cell type.[4118]
Genomic surveillance	Genomic surveillance is the process of constantly monitoring pathogens and analysing their genetic similarities and differences.[4119]
Gross domestic product	The total market value of the goods and services produced by a country's economy during a specified period of time.[4120]
Gross value added	An economic productivity metric that measures the contribution of a corporate subsidiary, company, or municipality to an economy, producer, sector, or region.[4121]
Henderson Poverty Line	As defined in the 1973 Commonwealth Commission of Inquiry into Poverty, it is the standard by which poverty is measured in Australia. It presents the minimum income levels required to avoid a situation of poverty, presented for a range of family sizes and circumstances.[4122]
High-risk settings	High-risk settings include health care, residential care, and other settings where both a high proportion of people are at high risk of severe disease and there is an increased risk of SARS-CoV-2 transmission.[4123]
Household disposable income	Household disposable income is the sum of household final consumption expenditure and savings.[4124]
Income support payments	An income support payment is a regular payment from the Australian Government to help with living costs.[4125]

Term	Definition
Incubation period	The time between exposure to an individual infected with the virus during their infectious period and the first appearance of symptoms.[4126]
Infection prevention and control	Procedures and practices to prevent the transmission of diseases, such as hand hygiene, personal protective equipment, cleaning.[4127]
Infectious period	The time where an individual infected with the virus is contagious and can pass on infection to other people.[4128]
Inflation	Inflation is the rate of increase in prices over a given period of time.[4129]
In-reach	The provision of care and support from external staff, such as hospital nurses and doctors, to people living in residential aged care homes.[4130]
In-vitro diagnostic devices	Tests that detect disease, conditions and infections and are done with equipment such as test tubes.[4131]
Isolation	Physical separation of a person with a transmissible disease from other people, including those in the same household, to stop the spread of the disease.[4132]
Just-in-time model	A form of inventory management that requires working closely with suppliers so that raw materials arrive as production is scheduled to begin, but no sooner. The goal is to have the minimum amount of inventory on hand to meet demand.[4133]
Labour market scarring	A negative effect of unemployment that reduces a worker's chance of re-entering employment, or has long-term impacts on income even once re-employed.[4134]
Labour mobility	The ease with which workers are able to move around within an economy and between different economies.[4135]
Legislative instruments	Laws on matters of detail made by a person or body authorised to do so by the relevant authorising legislation. Examples include regulations, rules and determinations.[4136]
Lockdown	A temporary condition imposed by authorities in which people must stay at home unless they need to go out for certain reasons, such as going to work, buying food, or taking exercise, and limit their activities outside the home.[4137]
Medicalise	Treat in medical terms.[4138]
Misinformation	False or inaccurate information spread without malicious intent, although its effects can still be harmful.[4139]

Term	Definition
Modern awards	A modern award is a document which sets out the minimum terms and conditions of employment on top of the National Employment Standards.[4140]
Monetary policy	Monetary policy involves influencing interest rates to affect aggregate demand, employment and inflation in the economy.[4141]
Monoclonal antibody treatments	Monoclonal antibodies act like your body's own antibodies to help stop the symptoms of COVID-19. Monoclonal antibodies do not replace a COVID-19 vaccine. They are intended as a treatment for COVID-19, not as a preventive measure.[4142]
mRNA	A type of RNA found in cells, messenger ribonucleic acid (mRNA) molecules carry the genetic information needed to make proteins.
National Aboriginal Community Controlled Health Organisation	The National Aboriginal Community Controlled Health Organisation (NACCHO) is the national leadership body for Aboriginal and Torres Strait Islander health in Australia.[4143]
National Disability Insurance Scheme	Scheme jointly governed and funded by the Australian, state and territory governments to provide funding to eligible people with disability to access the services and supports they need.[4144]
National Medical Stockpile	The National Medical Stockpile is a strategic reserve of drugs, vaccines, antidotes and personal protective equipment for use in national health emergencies.[4145]
National minimum wage	All employees working in Australia are entitled to a minimum wage. This is the minimum amount an employee can be paid for the work that they are doing.[4146]
Net operating balance	An accrual measure that shows whether the government has to borrow from financial markets to cover its operating activities.[4147]
Net overseas migration	The net gain or loss of population through immigration to Australia and emigration from Australia.[4148]
Non-accelerating inflation rate of unemployment (NAIRU)	The lowest unemployment rate that can be sustained without causing wages growth and inflation to rise.[4149]
Non-disallowable instrument	An instrument that does not allow for disallowance (see definition of disallowance).
Non-pharmaceutical interventions	Strategies that are used to control the spread of transmissible diseases and do not depend on drugs, vaccines or other specific medical interventions. Also known as 'public health and social measures'.[4150]

Term	Definition
Not-for-profit	Not-for-profit (NFP) organisations are organisations that provide services to the community and do not operate to make a profit for members (or shareholders, if applicable).[4151]
Omicron	The variant of SARS-CoV-2 that was first reported in South Africa and Botswana in November 2021.[4152]
Outbreak	An epidemic limited to localised increase in the incidence of a disease, e.g., in a village, town, or closed institution.[4153]
Overcrowding	Overcrowding is a situation where a household does not have enough space to accommodate all its members adequately or where this results in occupants experiencing stress of various kinds.[4154]
Pandemic	An epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people.[4155]
Particulate filter respirators	Particulate filter respirators (PFRs) are designed to reduce the wearer's respiratory exposure to airborne contaminants such as particles, gases or vapours. PFRs are appropriate for use for respiratory protection as part of the personal protective equipment (PPE) required for airborne precautions applied in healthcare facilities (for both clinical and non-clinical healthcare workers).[4156]
Pathogen	Any kind of infectious organism that causes disease.[4157]
Perinatal	Pertaining to or occurring in the period shortly before or after birth (usually up to 28 days after).[4158]
Personal protective equipment	Equipment used to protect the wearer from infection and other hazards.[4159]
Point-of-care testing	Clinical laboratory testing conducted close to the site where patient care or treatment is provided.[4160]
Polymerase chain reaction (PCR) testing	A highly sensitive laboratory-based system for testing for COVID-19. PCR tests pick up minuscule amounts of ribonucleic acid or RNA, a single-stranded chain of cells that processes protein and may carry the genetic information of a virus like COVID-19. PCR testing is relatively expensive and can take hours or days to yield a result.[4161]

Term	Definition
Precautionary principle	Under this principle, the pandemic situation is assessed, evidence is collected and tailored measures are implemented to manage domestic case numbers. The precautionary principle allows action to be taken before there is robust evidence regarding risk, or of the effectiveness of specific interventions is available.[4162]
Primary care	Primary care is health care people seek first in their community, such as from GPs, pharmacies and allied health professionals.[4163]
Primary Health Networks	Primary Health Networks (PHNs) are independent organisations that the Australian Government funds to coordinate primary health care in their region.[4164]
Priority populations	Populations who may be at greater risk in a pandemic. These populations may experience inequitable burden of disease and disparities in health and economic outcomes.[4165] This may stem from inequities in social determinants of health, including education, employment, socio-economic status and access to health care and other government services.[4166] People may also experience intersecting layers of inequality and social disadvantage.[4167] In the context of a pandemic, priority populations may face increased health risks or disproportionate impacts from pandemic response measures.
QR code	QR codes (or Quick Response codes) are two-dimensional codes that you can scan with a smartphone. The code contains information, usually a website address, and once you scan it, the code connects you with a resource on the web.[4168]
Quarantine	Separation and restriction of movement of people who may have been exposed to a transmissible disease to stop the spread of the disease.[4169]
'Rally around the flag' effect	During crises, particularly international crises which may represent an existential physical threat to a country, trust in government – irrespective of partisanship and policy outlooks – increases dramatically. This surge in public support for the government has been referred to as the 'rally around the flag' effect, with citizens looking to the authorities – and especially to a single national leader – to guide them through the crisis.[4170]
Rapid Antigen Test (RAT)	A quick test which detects the presence of specific proteins of the virus. It is simple enough to be performed by individuals at home or in the workplace without supervision. RATs are less accurate than the laboratory-based polymerase chain reaction (PCR) tests but are generally considered reliable when used to test symptomatic individuals.[4171]

Term	Definition
Remote learning	Remote learning is an educational process in which the teacher and student are not physically in a traditional classroom environment.[4172]
Rent-seeking	Rent seeking is defined as any practice in which an entity aims to increase its wealth without making any contribution to the wealth or benefit of society.[4173]
Repatriation	The act of sending or bringing someone, or sometimes money or other property, back to the country that they or it came from.[4174]
Restrictive measures (restrictions)	Public health measures which aimed to reduce community infection through restrictions on social interaction.[4175]
Restrictive practices	Restrictive practices involve the use of interventions and practices that have the effect of restricting the rights or freedom of movement of a person with disability.[4176]
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2 is the virus name used throughout this report. It was announced by the International Committee on Taxonomy of Viruses on 11 February 2020, chosen because the virus is genetically related to the coronavirus responsible for the SARS outbreak of 2003.[4177]
Sequelae	A result or condition that follows from a disease or illness.[4178]
Single Touch Payroll (STP)	Single Touch Payroll is an Australian Government initiative to streamline employers' reporting of payroll information to government agencies.[4179]
Social determinants of health	Social determinants of health are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.[4180]
Social distancing	Reducing the number of close physical and social contacts we have with one another.[4181]
Social insurance system	Social insurance provides insurance against economic risks such as unemployment, illness and disability.[4182]
Social security payments	Used interchangeably with income support payments.
Strain	When a variant of a virus has different functional properties to the original virus and becomes established in a population.[4183]
Supply	Supply is the quantity of a good that producers are willing and able to sell at various prices during a given time.[4184]

Term	Definition
Supported accommodation	Supported accommodation refers to housing options that give NDIS participants a high level of support. Supported accommodation can be either supported independent living (SIL), where supports come into the participant's home and help them living independently; or specialist disability accommodation (SDA), where participants with high support needs live in a specially designed house and receive support there.[4185]
Supported decision-making	The process of providing support to people to make decisions to remain in control of their lives.[4186]
Systemic advocacy	When groups or individuals are working for long-term social change to make sure legislation, policies and practices support the rights and interests of all people with disability.[4187]
Test positivity rate	The percentage of all tests reported that are positive.[4188]
Turnover / Business turnover	The amount of business that a company does in a period of time.[4189]
Unemployment rate	The percentage of people in the labour force that are unemployed.[4190]
Vaccine hesitancy	Vaccine hesitancy refers to delay in acceptance or refusal of safe vaccines despite availability of vaccination services.[4191]
Vaccine mandate	Can be defined as interventions imposing consequences for non-vaccination. There are many forms a vaccine mandate can take, but the most common used in Australia for COVID-19 were exclusion from public settings, exclusion from travel or exclusion from employment.[4192]
Variant	Where a virus has mutated and contains at least one new genetic change compared to the original virus strain.[4193]
Variants of concern	Multiple COVID-19 variants of concern and variants of interest have been designated by the World Health Organization based on their assessed potential for expansion and replacement of prior variants, for causing new waves with increased circulation, and for the need for adjustments to public health actions.[4194]
Wage subsidies	Wage subsidies provide financial incentives to employers to hire and retain eligible participants in ongoing and sustainable positions.[4195]

Term	Definition
Wastewater testing	Wastewater or sewage includes blackwater from toilets plus greywater from baths, showers, sinks and washing machines. Wastewater surveillance for Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) involves the systematic and targeted sampling and testing of wastewater to detect the SARS-CoV-2 virus, and interpretation of results.[4196]
Wraparound support	Ensures individuals receive integrated and coordinated services that work together to meet their needs.[4197]

Appendix B: Background on the Inquiry

1. Terms of Reference

The purpose of the Commonwealth Government COVID-19 Response Inquiry (the Inquiry) is to identify lessons learned to improve Australia's preparedness for future pandemics.

1.1. Scope

The Inquiry will review the Commonwealth Government's response to the COVID-19 pandemic and make recommendations to improve response measures in the event of future pandemics. It will consider opportunities for systems to more effectively anticipate, adapt and respond to pandemics in areas of Commonwealth Government responsibility.

The Inquiry will adopt a whole-of-government view in recognition of the wide-ranging impacts of COVID-19 across portfolios and the community. Specific areas of review may include, but are not limited to:

1. Governance including the role of the Commonwealth Government, responsibilities of state and territory governments, national governance mechanisms (such as National Cabinet, the National Coordination Mechanism and the Australian Health Protection Principal Committee) and advisory bodies supporting responses to COVID-19.
2. Key health response measures (for example across COVID-19 vaccinations and treatments, key medical supplies such as personal protective equipment, quarantine facilities, and public health messaging).
3. Broader health supports for people impacted by COVID-19 and/or lockdowns (for example mental health and suicide prevention supports, and access to screening and other preventive health measures).
4. International policies to support Australians at home and abroad (including with regard to international border closures, and securing vaccine supply deals with international partners for domestic use in Australia).
5. Support for industry and businesses (for example responding to supply chain and transport issues, addressing labour shortages, and support for specific industries).
6. Financial support for individuals (including income support payments).
7. Community supports (across early childhood education and care, higher education, housing and homelessness measures, family and domestic violence measures in areas of Commonwealth Government responsibility).
8. Mechanisms to better target future responses to the needs of particular populations (including across genders, age groups, socio-economic status, geographic location,

people with disability, First Nations peoples and communities and people from culturally and linguistically diverse communities).

The Inquiry will consider the findings of previous relevant inquiries and reviews and identify knowledge gaps for further investigation. It will also consider the global experience and lessons learnt from other countries in order to improve response measures in the event of future global pandemics.

The following areas are not in scope for the Inquiry:

- Actions taken unilaterally by state and territory governments.
- International programs and activities assisting foreign countries.

1.2. Independent Panel

The Prime Minister has appointed an Independent Panel of three eminent people to conduct the Inquiry. The Independent Panel will consult with relevant experts and people with a diverse range of backgrounds and lived experience.

1.3. Taskforce

A Taskforce within the Department of the Prime Minister and Cabinet will support the Independent Panel.

1.4. Public consultation

Public consultation will be completed during the Inquiry on the substance of the issues outlined in the Terms of Reference. The Independent Panel may invite and publish submissions and seek information from any persons or bodies. Consultation will take place across Australia with:

- Key community and other stakeholders reflecting a diversity of backgrounds
- Experts
- Commonwealth Government and state and territory government agencies
- Members of the public

1.5. Final Report

The Independent Panel will deliver a Final Report to Government including recommendations to the Commonwealth Government to improve Australia's preparedness for future pandemics by the end of September 2024.

2. Panel biographies

Ms Robyn Kruk AO, Chair

Ms Robyn Kruk AO has significant senior executive experience in the health and social care sectors and whole-of-government policy and operational areas including emergency management. Robyn has led state and Australian Government agencies, including New South Wales Health and Department of Premier and Cabinet, the Commonwealth Department of the Environment, Water, Heritage and the Arts, and the National Mental Health Commission. Robyn has chaired a range of independent reviews, most recently the 2023 Independent Review of Overseas Health Practitioner Regulatory Settings, and the 2022 New South Wales Health COVID-19 System Response Debrief. In 2005, Robyn was appointed a Member of the Order of Australia for service to public administration in New South Wales. In 2018, Robyn was appointed Officer of the Order of Australia for 'distinguished service to public administration, particularly through mental health reform, to environmental protection and natural resource management, and to food standards'. Robyn has a Bachelor of Science in Psychology (Honours) and a Masters degree in Administration.

Professor Catherine Bennett

Professor Catherine Bennett's infectious disease epidemiology career cuts across health, university and government sectors, including outbreak preparedness and response with NSW Health and the Australian Government. Catherine is currently an Alfred Deakin Distinguished Professor. Catherine joined Deakin as Chair in Epidemiology in 2009 after eight years with the University of Melbourne as Deputy Chair of the Academic Programs Committee in the Faculty of Medicine, Dentistry and Health Sciences, and Director of Population Health Practice in the Melbourne School of Population Health. Prior to that, Catherine worked with the New South Wales and Victorian Governments in a variety of senior positions, including Olympic Public Health Coordinator for Northern Sydney. Catherine was also the founding Chair and President of the Council of Academic Public Health Institutions Australia. Catherine's international research collaborations focus on community transmission of superbugs and antimicrobial resistance,

as well as pandemic-related projects. Catherine has been a prominent public analyst during the COVID-19 response, keynote speaker, and advisor to industry, governments, and institutions globally.

Dr Angela Jackson

Dr Angela Jackson is a health economist and the Lead Economist at Impact Economics and Policy. Starting her career at the Commonwealth Department of the Prime Minister and Cabinet, Angela has worked across tax, fiscal and social policy, including as Deputy Chief of Staff to the Australian Minister for Finance. Angela is a part-time Commissioner at the Commonwealth Grants Commission, member of the Victorian National Heart Foundation Advisory Board, member of the Economic Inclusion Advisory Committee and National Chair of the Women in Economics Network. Angela holds a Masters in International Health Policy (Health Economics) with Distinction from the London School of Economics and Political Science, a Bachelor of Commerce (Hons) from the University of Melbourne, and a Bachelor of Economics from the University of Tasmania. In 2021, Angela was awarded her PhD on the Economics of Disability in Australia from Monash University. Angela has authored a number of high-profile reports and published articles in peer-reviewed journals on health, aged care, disability, housing and gender policy.

Appendix C: Stakeholder engagement

We wanted as many people as possible to be able to share their lived experience of the COVID-19 pandemic. It was critical that we heard from experts and international counterparts and could apply and evaluate their ideas. With this in mind, we provided the following different ways for people and organisations to be contribute to the Inquiry.

1. Public submissions

The Inquiry called for submissions between 6 November 2023 and 15 December 2023. We continued to consider late submissions until 30 April 2024. We received and analysed 2,201 submissions, of which 305 were from organisations, 1,829 from individuals, and 67 preferred not to say. Where we had permission to do so, we published submissions on the Inquiry's website.

2. Consultations

On 26 October 2023 we began our engagement. We met with current and former decision-makers including the former Prime Minister of Australia, premiers and chief ministers, ministers, first secretaries from the Commonwealth and states and territories, Commonwealth government secretaries and agency heads. We also met with a wide range of stakeholders from all levels of government, community groups, industry and business, unions, and experts across a range of fields. Consultations were particularly helpful in giving us insights into the government response and providing a mechanism for testing our thinking. In total we hosted more than 250 stakeholder consultation sessions.

3. Focus groups

To supplement individual views received in submissions, we commissioned a series of focus groups and interviews in May and June 2024 to capture the lived experience of individuals, including from priority populations. A total of 176 people participated in these meetings.

The results are captured in ORIMA's *Final report on qualitative research with specific cohorts on their lived experiences with the COVID-19 pandemic*.[4198] The report identified the following key messages:

- Individual experiences of the pandemic were highly negative, and some impacts have continued.
- Perceptions and experiences of the government response to the pandemic changed over time.
- Pandemic information and measures often did not meet the needs of Australia's heterogenous population.

- There was expectation of greater federal government oversight of a pandemic response.
- Negative experiences during the pandemic have disrupted some factors contributing to the social fabric of Australia.

4. Community input survey

We commissioned a community input survey to ensure we heard from individuals who reflected the diversity of Australian society. The survey was conducted in June 2024. The 2,126 Australians who participated provided insights on pandemic management approaches, the effectiveness of public communications during the pandemic, and how public sentiment may inform future responses to pandemic management. The final report, prepared by SEC Newgate, includes the finding that on balance the pandemic had a negative impact on the majority of Australians.[4199] In total, just over half of all those surveyed felt that the Australian Government's response during the pandemic was appropriate.

5. Roundtables

A series of 27 roundtables held between May and July 2024 explored the impact of the pandemic on key sectors and communities. In these roundtables, we were able to confirm that we understood the pandemic experiences and priorities of the sector or community. Summaries were published on the Inquiry's website.

May 2024

- The economic response roundtable brought together a range of economic experts from across academia and industry to discuss the effectiveness of the Australian Government's economic response during the pandemic.
- The freight and logistics roundtable brought together a range of participants from industry, peak bodies and unions to discuss the experiences of the freight and logistics sector during the pandemic.
- The health modelling roundtable brought together a range of participants from academia and research groups to discuss their experiences modelling infectious diseases during the COVID-19 pandemic.
- The health research roundtable brought together health research representatives to discuss areas where the Australian Government did well in generating and using evidence, and key concerns identified in submissions where improvements can strengthen the use of research in future crises.
- The higher education and VET roundtable brought together a range of participants from the higher education and vocational education and training (VET) sectors, including peak bodies and unions.

- The impacts on health services roundtable brought together a range of participants from the health sector, peak bodies and unions to discuss how access to and delivery of health services changed during the pandemic and highlight priorities to enhance pandemic preparedness.
- The pandemic response logistics roundtable brought together a range of participants from the health sector, peak bodies and unions to discuss their experiences of pandemic response logistics.

June 2024

- The community service providers roundtable brought together a range of participants from the community services providers sector to discuss the experiences of the sector during the pandemic.
- The Council of Small Business Organisations Australia (COSBOA) roundtable brought together a range of representatives from COSBOA and its membership to discuss the experience of small businesses during the COVID-19 pandemic.
- The experiences of culturally and linguistically diverse communities roundtable brought together a range of participants including multicultural community leaders, industry peak bodies, public health and medical experts, and Commonwealth, state and territory governments.
- The experience of older Australians roundtables brought together members of government advisory bodies relevant to the experience of older Australians, including individuals in aged care.
- The experience of people with disability roundtables brought together members of key standing advisory groups to government including people with lived experience.
- The human rights and trust in government roundtable brought together participants from human rights and civil liberties advocacy groups and academia.
- The mental health roundtable, convened and chaired by Carolyn Nikoloski, Chief Executive Officer of Mental Health Australia, brought together a range of Mental Health Australia members, including lived experience and carer representatives, to discuss the impacts of the pandemic on mental health.
- The news media and the information environment roundtable brought together news media, media peak bodies, and media and communications experts.
- The travel and tourism roundtable brought together a range of participants from the travel and tourism industries, including peak bodies, organisations and private enterprise, to discuss the experiences of the travel and tourism sectors during the pandemic.

- The experience of First Nations people roundtables brought together key stakeholders from a range of First Nations organisations across Australia to discuss the experiences of Aboriginal and Torres Strait Islander people during the pandemic.

July 2024

- The Australian Council of Trade Unions (ACTU) roundtable brought together representatives from a range of ACTU-affiliated unions.
- The Australian Logistics Council (ALC) roundtable brought together representatives from the ALC and its members, including ALC councillors.
- The early childhood education and care roundtable brought together a range of stakeholders from the early childhood education and care sector.
- The schools, children and young people roundtable brought together a range of participants from peak bodies, advocacy groups and academia related to the education and health of children and young people.
- The Australian Chamber of Commerce and Industry (ACCI) roundtable brought together a range of members from the ACCI to discuss the experiences of their industries during the pandemic.
- The science communication and the role(s) of experts roundtable brought together communication experts, including some directly involved in communicating complex science and risk messages to the public during the pandemic, to discuss their experiences and suggestions.

6. Stakeholders

Our Inquiry has heard from many stakeholders with diverse experiences and perspectives. Lists of government stakeholders, organisations and individuals consulted are on the following pages.

We consulted across all levels of government

the former Prime Minister of Australia

current and former Commonwealth ministers

current and former premiers and chief ministers

current and former chief health officers

Ministerial Councils and inter-jurisdictional forums, including Health Ministers Meeting, Health Chief Executives Forum, First Secretaries Group, and First Deputies Group

the Australian Local Government Association

current and former members of the Secretaries Board

current and former government officials from all levels of government

We consulted a number of independent advisory groups to government

Advisory Committee for the COVID-19 Response for People with Disability

Aged Care Advisory Group (Australian Health Protection Committee subcommittee)

Aged Care Council of Elders

Australian Technical Advisory Group on Immunisation

Culturally and Linguistically Diverse Communities Health Advisory Group

Early Childhood Education and Care Reference Group

Independent Advisory Council to the NDIS

National Aboriginal and Torres Strait Islander Health Protection (Australian Health Protection Committee subcommittee)

National Aged Care Advisory Council

Pharmaceutical Benefits Advisory Committee

We consulted a wide range of community and industry groups

including peak bodies, unions and businesses

We consulted subject matter experts and academics

with a diversity of experience and research interests relevant to the Inquiry

We consulted international counterparts

Finnish Institute of Health and Welfare

Global Health Security Conference 2024 attendees including from Finland and South Africa

NZ Royal Commission COVID-19 Lessons Learned

The Independent Panel for Pandemic Preparedness and Response (World Health Organization)

Government stakeholders

Aboriginal Affairs NSW

ACT Health

Aged Care and Quality Safety Commission

Attorney-General's Department

Austrade

Australian Border Force

Australian Bureau of Statistics

Australian Competition and Consumer Commission

Australian Federal Police

Australian Health Practitioner Regulation Agency

Australian Human Rights Commission

Australian Institute of Health and Welfare

Australian National Audit Office

Australian Prudential Regulation Authority

Australian Public Service Commission

Australian Securities and Investments Commission

Australian Taxation Office

Chief Minister, Treasury and Economic Development Directorate, ACT

Commission for Children and Young People, Victoria

Creative Australia

Department of Agriculture, Fisheries and Forestry

Department of Climate Change, Energy, the Environment and Water

Department of Communities and Justice, NSW

Department of Customer Service, NSW

Department of Defence

Department of Education

Department of Employment and Workplace Relations

Department of Finance

Department of Foreign Affairs and Trade

Department of Health and Aged Care

Department of Health and Wellbeing, SA

Department of Health, Tasmania

Department of Health, Victoria

Department of Health, WA

Department of Home Affairs

Department of Industry, Science and Resources

Department of Infrastructure, Transport, Regional Development, Communications and the Arts

Department of Parliamentary Services

Department of Premier and Cabinet, Victoria

Department of Social Services

Department of the Chief Minister and Cabinet, NT

Department of the Premier and Cabinet, Queensland

Department of the Premier and Cabinet, SA

Department of the Premier and Cabinet, Tasmania

Department of the Premier and Cabinet, WA

Department of the Prime Minister and Cabinet

Department of the Treasury

Department of Transport, NSW

Department of Veterans' Affairs

Multicultural NSW

National Disability Insurance Agency

National Emergency Management Agency

National Heavy Vehicle Regulator

National Indigenous Australians Agency

NBN Co

NDIS Quality and Safeguards Commission

NSW Department of Health

NSW Police Force

Office of the Australian Information Commissioner

Office of the Chief Scientist

Office of the Cross-Border Commissioner, NSW

Office of the Inspector-General of Aged Care

Office of the National Rural Health Commissioner

Productivity Commission

Reserve Bank of Australia

Safe Work Australia

Services Australia

The Cabinet Office, NSW

The Premier's Department, NSW

Treasury, NSW

Organisations

We would like to thank and acknowledge the organisations listed below that consented to be identified. We would also like to extend our thanks to those organisations that contributed to the Inquiry but wished to remain anonymous.

Aboriginal Health and Medical Research Council

Aboriginal Health Council of Western Australia

Accommodation Australia

Accord Australasia

Adult Learning Australia

Airlines for Australia and New Zealand

Anglicare Australia

Aspen Medical

Association for Business Restructuring and Turnaround

Australian Academy of Health and Medical Sciences

Australian Academy of Science

Australian and International Pilots Association

Australian and New Zealand Paediatric Infectious Diseases Group

Australian Associated Press

Australian Banking Association

Australian Chamber of Commerce and Industry (and Australian Chamber – Tourism)

Australian Childcare Alliance

Australian College of Nurse Practitioners

Australian College of Nursing

Australian Council of Social Service

Australian Council of State School Organisations

Australian Council of Trade Unions

Australian Cruise Association

Australian Curriculum, Assessment and Reporting Authority

Australian Federation of Air Pilots

Australian Federation of Disability Organisations

Australian Foodservice Advocacy Body

Australian Hairdressing Council

Australian Healthcare and Hospitals Association

Australian Industry Group

Australian Library and Information Association

Australian Manufacturing Workers' Union

Australian Multicultural Health Collaborative

Australian Nursing and Midwifery Federation (Federal Office and Victorian Branch)

Australian Pathology

Australian Psychological Society

Australian Research Alliance for Children and Youth

Australian Science Communicators

Australian Technology Network of Universities

Australian Traditional Medicine Society

Australian Travel Industry Association

Australian Youth Affairs Coalition

Biotext

Bipolar Australia

Board of Airline Representatives Australia

Burnet Institute

Capital Health Network

cohealth

Communications and Information Technology Training

Community and Public Sector Union

Community Broadcasting Association of Australia

Community Colleges Australia

Community Early Learning Australia

Consumer Health Forum of Australia

Continuity of Care Collaboration

Council of Small Business Organisations Australia

Council on the Ageing Australia

Croakey Health Media

Cruise Lines International Association

Disability Advocacy Network Australia

Early Learning Association Australia

Economic Justice Australia

Ecotourism Australia

Empowered Communities

Enterprise Registered Training Organisation Association

Family Business Association

Family Day Care Australia

Federation of Ethnic Communities' Councils of Australia

Forcibly Displaced People Network

Forum of Australian Services for Survivors of Torture and Trauma

Free TV Australia

Freight and Trade Alliance

Gayaa Dhuwi (Proud Spirit) Australia

Health Services Union

Homelessness Australia

Housing Industry Association

Human Rights Law Centre

Hunter Travel Group

Illumina

Independent Schools Australia

Institute of Certified Bookkeepers

International Transport Workers Federation / Maritime Union of Australia

Isolated Children's Parents' Association Australia

Junior Adventures Group

Kirby Institute, UNSW

KU Children's Services

Liberty Victoria

Lifeline Australia

Local and Independent News Association

Lowitja Institute

Massage and Myotherapy Australia

Mental Health Australia

Mission Australia

Multicultural Centre for Women's Health

Murdoch Children's Research Institute

National Aboriginal Community Controlled Organisation

National Catholic Education Commission

National Centre for Epidemiology and Population Health

National Centre for Immunisation Research and Surveillance Australia

National COVID-19 Clinical Evidence Taskforce / Australian Living Evidence Collaboration

National Mental Health Consumer Carer Forum

National Rural Health Alliance

National Shelter

National Transport Insurance

National Union of Students

National Well-Being Alliance

Neami National

Orygen

Outside School Hours Council of Australia

People with Disability Australia

Primary Health Networks

Public Health Association of Australia

Public Pathology Australia

Qantas Airways

Queensland Alliance for Mental Health

Ramsay Health Care

ReachOut

Redfern Legal Centre

Relationships Australia

Royal Flying Doctor Service

Settlement Council of Australia

Shipping Australia

Skylight Mental Health

Sleep Health Foundation

South Australian Business Chamber

Special Broadcasting Service

St Vincent's Hospital, Sydney

Sydney Infectious Diseases Institute

TAFE Directors Australia

Tasmanian Small Business Council

Telethon Kids Institute

The Newsagents Association of NSW and ACT

The Pharmacy Guild of Australia

The Royal Australian College of General Practitioners

The Salvation Army

The Smith Family

United Workers Union

Victorian Aboriginal Community Controlled Health Organisation

Victorian Automotive Chamber of Commerce

Voyages Indigenous Tourism Australia

Individuals

We would like to thank and acknowledge everyone who voluntarily participated in our consultations, including the individuals listed below who have consented to be identified. We would also like to extend our thanks to those who contributed to the Inquiry but wished to remain anonymous.

Jody Anderson, First Assistant Secretary, Department of Employment and Workplace Relations and Member, Safe Work Australia

Anna Booth, The Fair Work Ombudsman

Professor Jeff Borland, Truby Williams Professor of Economics, The University of Melbourne

Kevin Brahim, Deputy Chief Executive Officer, National Indigenous Australians Agency

Jody Broun, CEO, National Indigenous Australians Agency

Michele Bullock, Governor, Reserve Bank of Australia

Matiu Bush, PhD Candidate, Nurse Practitioner, School of Health and Social Development, Deakin University

Alistair Campbell PSM, Minister-Counsellor (Economic), Department of the Treasury

Michael Campbell, Group Manager, Fair Work Ombudsman

Christopher Carter, CEO, North Western Melbourne Primary Health Network

Dr Kerry Chant AO PSM, Chief Health Officer and Deputy Secretary, NSW Ministry of Health

Dr Nicholas Coatsworth, Former Deputy Chief Medical Officer, Department of Health and Aged Care

Senator the Hon Richard Colbeck, Former Minister for Senior Australians and Aged Care Services and Minister for Sport

Professor Mark Cormack, Independent Reviewer, Scope of Practice Review

Emeritus Professor Rosalind Croucher AM, Former President, Australian Human Rights Commission

Sarah Cruickshank, Deputy Secretary, NSW Department of Customer Service

Christine Dacey, Former Deputy Secretary, Department of Infrastructure, Transport, Regional Development and Communications

Professor Margie Danchin, Murdoch Childrens Research Institute, The University of Melbourne and Royal Children's Hospital

Shane Dexter, Branch Manager, National Indigenous Australians Agency

Professor Helen Dickinson, School of Business, UNSW Sydney

Laureate Professor Peter Doherty, Patron of the Doherty Institute

Emeritus Professor Stephen Duckett AM, Health Economist

Professor Ben Edwards, Centre for Social Research and Methods, Australian National University

Nicholas Elmitt, Policy Manager Medical Practice, Australian Medical Association

Saul Eslake, Economist, Corinna Economic Advisory

Angelene Falk, Former Australian Information Commissioner

Vikki Fischer, Assistant Secretary, Department of Agriculture, Fisheries and Forestry

Dr Jan Fizzell, Senior Medical Advisor, NSW Health

Martin Fletcher, CEO, Australian Health Practitioner Regulation Agency

Anthony Fogarty, Executive Director, Fair Work Ombudsman

Dr Catherine Foley AO PSM, Australia's Chief Scientist

Professor Gigi Foster, School of Economics, UNSW Sydney

Lieutenant General John Frewen, AO, DSC (Retd), Former Coordinator General, National COVID-19 Vaccine Taskforce, Department of Health and Aged Care

The Hon Josh Frydenberg, Former Treasurer

Philip Gaetjens, Former Secretary, Department of the Prime Minister and Cabinet

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Dr Phillip Gould, First Assistant Secretary, Department of Health and Aged Care

Dr David Gruen AO, Australian Statistician

Stephanie Haagen, General Manager, Mission Australia

Adam Hawkins, Assistant Secretary, Department of the Treasury

Dr Robert Herkes, Chief Medical Officer, Ramsay Health Care Australia

Karl Herz, Co-Founder and Managing Director, Biointelect

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Associate Professor (Lyndal) Claire Hooker, Sydney Health Ethics, The University of Sydney

Professor the Hon Greg Hunt, Former Minister for Health and Aged Care

Rosemary Huxtable AO PSM, Former Secretary, Department of Finance

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Crissa Kyriazis, General Manager, Biocelect

Dr Irene Lai, Global Medical Director, International SOS

Professor Julie Leask AO, School of Public Health, Faculty of Medicine and Health, The University of Sydney

Craig Limkin PSM, Secretary, Department of State Growth, Tasmania

Dr Clare Looker, Chief Health Officer, Department of Health, Victoria

Dr Philip Lowe, Former Governor, Reserve Bank of Australia

Dr Isis Maitland-Scott, Senior Medical Advisor, NSW Health

Patricia Malowney OAM, Member, Independent Advisory Council to the NDIS

James Manders, Member, Independent Advisory Council to the NDIS

Precious Matsoso, Director, Health Regulatory Science Platform, University of the Witwatersrand and Co-chair of the Intergovernmental Negotiating Body to Draft and Negotiate a WHO Convention (Pandemic Prevention)

Catherine McAlpine, CEO, Inclusion Australia

Professor Emma McBryde, Infectious Diseases Modelling and Epidemiology, James Cook University

The Hon Mark McGowan, Former Premier of Western Australia

Bettina McMahon, CEO, Healthdirect Australia

Dr Danielle McMullen, Vice President, Australian Medical Association

Professor Jodie McVernon, Director of Doherty Epidemiology, Peter Doherty Institute for Infection and Immunity

Professor George Milne, School of Physics, Maths and Computing, Computer Science and Software Engineering, The University of Western Australia

Professor Brett Mitchell AM, Nursing, Avondale University

Natasha Moore, Aboriginal Family Legal Services

Professor Mark Morgan, Chair, Expert Committee – Quality Care, The Royal Australian College of General Practitioners

The Hon Scott Morrison, Former Prime Minister of Australia

Chris Murphy, Visiting Fellow, Crawford School of Public Policy, ANU

Associate Professor Michael Murray AM, Member, National Aged Care Advisory Group

Dr Shane Oliver, Chief Economist, AMP

Sam Paior, Member, Independent Advisory Council to the NDIS

The Hon Annastacia Palaszczuk, Former Premier of Queensland

The Hon Dominic Perrottet, Former Premier of New South Wales

Associate Professor Melissa Petrakis, Director of Social Work Innovation, Transformation and Collaboration in Health (SWITCH) Research Group, Monash University

Dr Nalini Prasad, School of Economics, The University of Sydney

Laura Pyszkowski, Director, Officer of the Secretary, Department of Health, Tasmania

Glen Ramos, Director, Australian Health Promotion Association

Nigel Ray PSM, Independent Reviewer, Independent Evaluation of the JobKeeper Payment

Dr Sue Regan, Deputy CEO, Volunteering Australia

Associate Professor Leonora Risse, Canberra School of Politics, Economics and Society, University of Canberra

Chris Robertson, Executive Director, Strategy and Policy, Australian Health Practitioner Regulation Agency

Mark Roddam, First Assistant Secretary, Department of Health and Aged Care

Professor Kim Rubenstein, Faculty of Business, Government and Law, University of Canberra

Professor Fiona Russell, Group Leader / Senior Principal Research Fellow, Murdoch Children's Research Institute

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Associate Professor Nick Scott, Head, Modelling & Biostatistics, Burnet Institute

Associate Professor Holly Seale, School of Population Health, Faculty of Medicine and Health, UNSW Sydney

Professor Peter Shergold AC, Independent Reviewer, Fault lines: an independent review into Australia's response to COVID-19

Hayley Solich, Member, National Mental Health Consumer and Carer Forum

Professor Steve Robson, Federal President, Australian Medical Association

Adjunct Professor Ruth Stewart, Former National Rural Health Commissioner

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Jennifer Travis, Director, Customer Engagement and Delivery, Transport for NSW

Edward Valenta, Manager Government Policy, Ramsay Health Care Australia

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Rachel Volzke, Group Manager and Chief Counsel, Fair Work Ombudsman

Professor Euan Wallace AM, Secretary, Department of Health, Victoria

Margaret Walsh, Member, Aged Care Council of Elders

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The Hon Graham West, CEO, St Vincent de Paul Society

Matthew Williams, First Assistant Secretary, Department of Health and Aged Care

Professor Andrew Wilson AO, Co-Director, Menzies Centre for Health Policy and Economics, The University of Sydney

Professor James Wood, School of Population Health, UNSW Sydney

Peter Woolcott AO, Former Australian Public Service Commissioner

The Hon Ken Wyatt AM, Former Minister for Indigenous Australians

Ian Yates AM, Acting Inspector-General of Aged Care

Professor Sally Young, School of Social and Political Sciences, The University of Melbourne

Appendix D: Master chronology

Date	Event
2003	SARS-CoV-1 (SARS) coronavirus outbreak.[4200]
2006	Australian Health Protection Committee was formed.[4201]
2006	National Pandemic Influenza Exercise (Exercise Cumpston).[4202]
2008	Exercise Sustain 08 (test of non-health sector responses to a pandemic).[4203]
2009	Security Sensitive Biological Agents Regulatory Scheme commenced.[4204]
2009	H1N1 (swine flu) pandemic.[4205]
2011	Department of Health and Ageing published the *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009: lessons identified*.[4206]
2011	Australian Health Protection Committee developed the National Health Emergency Response Arrangements.[4207]
2012	MERS-CoV (MERS) coronavirus outbreak.[4208]
2013	Australian Health Protection Principal Committee conducted a capability audit of national response capability for health disasters.[4209]
2013-2016	EBOV (Ebola virus) epidemic.[4210]
2014	Department of Health – Communicable Diseases Network Australia developed the National Framework for Communicable Disease Control (the CD Framework).[4211]
2014	National Action Plan for Human Influenza Pandemic was reviewed by the Australian Local Government Association, seven states and territories and 10 Australian Government agencies. A new whole-of-government pandemic response plan was drafted (and was finalised in 2018 as the National Communicable Diseases Plan).[4212]
April 2014	Department of Health substantially updated the Australian Health Management Plan for Pandemic Influenza to reflect recommendations of the 2009 H1N1 Pandemic response review.[4213]
2015	Department of Health ran one scenario exercise with federal agencies.[4214]
14 May 2015	*Biosecurity Act 2015* (Cth) was passed by Parliament.[4215]
2015–2016	Zika virus epidemic.[4216]
16 June 2016	*Biosecurity Act 2015* (Cth) entered into force.[4217]

Date	Event
September 2016	Department of Health (Australian Health Protection Principal Committee) developed and published the Emergency Response Plan for Communicable Disease Incidents of National Significance (Communicable Diseases Plan).[4218]
2016	Department of Health ran six internal emergency management exercises.[4219] Department of Health reviewed the capability and capacity of laboratories across Australia to diagnose notifiable diseases and other agents.[4220]
2017	Department of Health ran four internal exercises, two scenario exercises with federal and state agencies, and nine disease and plan familiarisation exercises.[4221]
June 2017	Australian National Audit Office audited the Department of Health's coordination of communicable disease emergencies.[4222]
December 2017	Australia underwent a joint external evaluation of International Health Regulations core capacities.[4223]
2018	Department of Health ran three internal emergency management exercises, two scenario exercises with other federal agencies and 14 internal plan and disease familiarisation exercises.[4224]
2018	Department of Home Affairs ran a pandemic planning 'stress test' with other federal agencies, including 'Exercise Wontok' to test communications.[4225]
May 2018	Emergency Response Plan for Communicable Disease Incidents of National Significance: National Arrangements (National Communicable Diseases Plan) was finalised and published.[4226]
December 2018	Australia's National Action Plan for Health Security 2019–2023 was developed to implement the recommendations from the 2017 joint external evaluation of International Health Regulations core capacities. To date, 20 recommendations have been fully completed, and the majority of the remainder have commenced.[4227]
2019	Department of Health ran three internal emergency management exercises, one scenario exercise with federal and state government agencies, and nine internal plan and disease familiarisation exercises.[4228]
August 2019	Australian Health Management Plan for Pandemic Influenza was updated and published.[4229]
31 December 2019	Cluster of pneumonia of unknown aetiology in Wuhan, China, reported to the World Health Organization.[4230]
1 January 2020	National Incident Room began monitoring the cluster in Wuhan.[4231]

Date	Event
10 January 2020	Communicable Diseases Network Australia held its first meeting to discuss the Australian public health response to the cluster in Wuhan.[4232]
11 January 2020	World Health Organization received the genetic sequence of SARS-CoV-2, which allowed for the rapid development of diagnostic tests for COVID-19 in Australia and the start of COVID-19 vaccine development.[4233]
19 January 2020	Australian Government communications on the 'novel coronavirus' began with a statement from the Commonwealth Chief Medical Officer.[4234]
20 January 2020	Communicable Diseases Network Australia recommended the novel coronavirus be a Listed Human Disease under the *Biosecurity Act 2015* (Cth).[4235]
21 January 2020	Director of Human Biosecurity (the Chief Medical Officer (CMO)) added 'Human coronavirus with pandemic potential' to the Biosecurity (Listed Human Diseases) Determination 2016 to enable the use of certain powers in the *Biosecurity Act 2015* (Cth).[4236] First media conference was held by the then CMO, Professor Brendan Murphy.[4237] Enhanced screening methods for passengers arriving directly from Wuhan region were put in place.[4238] National Incident Centre (formerly National Incident Room) was activated.[4239]
23 January 2020	Communicable Diseases Network Australia (CDNA), a subcommittee of the Australian Health Protection Principal Committee (AHPPC), published the first of a series of COVID-19 National Guidelines for Public Health Units.[4240] Public Health Laboratory Network, a subcommittee of the AHPPC, released national guidance on laboratory testing for SARS-CoV-2.[4241] The Australian Prime Minister, the Hon Scott Morrison MP, made his first comments on COVID-19 in a press conference.[4242] AHPPC and CDNA started meeting daily.[4243]
25 January 2020	Australian Government publicly confirmed Australia's first case of COVID-19.[4244]
29 January 2020	First Australian Health Protection Principal Committee statement was published (containing advice on self-isolation for close contacts of confirmed cases and travellers from Hubei province).[4245] Australian Government announced the release of masks from the National Medical Stockpile to support general practitioners and other health workers as well as frontline border, isolation, surveillance and case-tracing workers.[4246]

Date	Event
30 January 2020	World Health Organization declared the global outbreak to be a Public Health Emergency of International Concern.[4247]
1 February 2020	Based on updated advice from the Australian Health Protection Principal Committee, the Australian Government announced that all foreign nationals (excluding permanent residents of Australia) who were in mainland China from 1 February 2020 would not be allowed to enter Australia for 14 days. Australian citizens, permanent residents and their immediate families (spouses, legal guardians or dependants only) returning from China would have to self-isolate for 14 days.[4248] Support for the aviation industry through the Australian Airline Financial Relief Package began.[4249]
3 February 2020	241 Australians evacuated from Wuhan arrived on Christmas Island and were placed in quarantine for up to 14 days.[4250]
7 February 2020	Australian Government announced that Australian citizens and permanent residents aboard a second assisted departure flight out of Wuhan would 'spend 14 days in quarantine in the Howard Springs Accommodation Facility on the outskirts of Darwin'.[4251] Department of Health finalised the Australian Health Sector Emergency Response Plan for Novel Coronavirus (the COVID Plan).[4252]
11 February 2020	'Human coronavirus with pandemic potential' was temporarily listed on the National Notifiable Disease List under subsection 12(1) of the *National Health Security Act 2007* (Cth) for up to six months.[4253] World Health Organization (WHO) Director-General said the development of vaccines and therapeutics would take time and it could be 18 months before the first vaccines would be ready.[4254] WHO named the disease caused by SARS-CoV-2 as COVID-19.[4255]
13 February 2020	Australian Government extended the entry ban for foreign nationals who had been in mainland China by a further seven days from 15 February 2020.[4256]
18 February 2020	Australian Government Department of Health declared COVID-19 a Communicable Disease Incident of National Significance.[4257] Australian Government released the Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19 Plan) to inform the approach to minimising disease spread while information about the virus was gathered.[4258]

Date	Event
20 February 2020	Australian Government announced that people who had been in contact with someone confirmed to have coronavirus had to self-isolate for 14 days (quarantine).[4259] Australian Government extended the entry ban for foreign nationals who had been in mainland China by a further seven days from 22 February 2020.[4260]
25 February 2020	Australian Government's $2 million Medical Research Future Fund grant opportunity supported research into development of a novel coronavirus (COVID-19) vaccine.[4261] Emergency Response Plan for Communicable Disease Incidents of National Significance: National Arrangements (National Communicable Diseases Plan) was activated along with associated emergency communication activities and coordination arrangements.[4262]
26 February 2020	Chief Medical Officer wrote to aged care providers on the need to plan and be prepared for a change to circumstances and shared reference material.[4263]
27 February 2020	Prime Minister announced the National Security Committee decision to activate the Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19 Plan), anticipating that the world would probably soon enter a pandemic phase.[4264]
29 February 2020	Australian Government issued an entry ban from 1 March 2020 for foreign nationals (excluding permanent residents of Australia) arriving from Iran, and a 14-day self-isolation requirement for Australian citizens, permanent residents and their immediate families from the day they left Iran.[4265]
1 March 2020	Western Australian Government announced the first COVID-19 related death in Australia (in Western Australia).[4266]
2 March 2020	Australian Government announced that 'people returning from Italy and South Korea need to monitor their health for the following 14 days after their arrival and practice good hygiene. Healthcare or residential aged care workers should not attend work for 14 days and practise social distancing'.[4267] Aged Care Quality and Safety Commissioner sent a letter to give aged care providers 'updated advice' on COVID-19.[4268] First case in Australia of 'local transmission' (where a person without a travel history is infected by the virus) was confirmed.[4269]
3 March 2020	Dorothy Henderson Lodge outbreak began, ending on 7 May 2020.[4270] Reserve Bank of Australia reduced the cash rate from 0.75 per cent to 0.5 per cent.[4271]

Date	Event
4 March 2020	Australian Health Protection Principal Committee advised that it no longer believed that international border measures could 'prevent importation of COVID-19' and that it did not support 'widespread application of travel restrictions to the large number of countries that have community transmission'.[4272] Minister for Health announced that self-isolation requirements for people travelling from Iran would extend to any person who arrived from 19 February 2020 onwards.[4273]
5 March 2020	Australian Government issued an entry ban for foreign nationals (excluding permanent residents of Australia) arriving from South Korea, and a 14-day self-isolation requirement for Australian citizens, permanent residents and their immediate families arriving from South Korea.[4274] Following a National Security Committee decision, the Prime Minister commissioned the National Coordination Mechanism (NCM), led by Emergency Management Australia through Department of Home Affairs. The NCM took a sector-based approach to stakeholder engagement, convening collaborative forums (sector meetings) as needed to address the specific impacts of a national crisis.[4275] Aboriginal and Torres Strait Islander Advisory Group on COVID-19 was established.[4276]
6 March 2020	Minister for Aged Care and Commonwealth Chief Medical Officer convened the Aged Care COVID-19 Preparedness Forum.[4277]
11 March 2020	Australian Health Protection Principal Committee advised that travel restrictions and self-quarantine measures implemented by the Australian Government had been successful in reducing the number of cases detected in Australia and delaying the onset of community transmission. It recommended that the government maintain strict border measures and travel restrictions for people arriving from China, South Korea, Iran and Italy.[4278] Australian Government issued an entry ban for foreign nationals from Italy (excluding permanent residents of Australia), and a 14-day self-isolation requirement for Australian citizens, permanent residents and their immediate families arriving from Italy.[4279] Australian Government announced the $2.4 billion COVID-19 health package.[4280] World Health Organization declared COVID-19 a worldwide pandemic.[4281]

Date	Event
12 March 2020	Australian Health Protection Principal Committee recommended the exclusion from work of health care workers, including all persons working in the health and aged care sectors, who were close contacts of confirmed cases of COVID-19.[4282] Australian Government announced the first economic support package of $17.6 billion for households and businesses in response to the growing uncertainty stemming from the pandemic. The package included the following elements: • $1 billion to support those sectors, regions and communities that were disproportionately affected by the economic impacts of the pandemic, including those reliant on industries such as tourism, agriculture and education • time-limited 15-month investment incentive to support business investment and economic growth over the short term, by accelerating depreciation deductions • Boosting Cash Flow for Employers measure, providing up to $25,000 for eligible small and medium-sized businesses between 1 January 2020 and 30 June 2020 • first $750 Economic Support Payment to pensioners; social security, veteran and other income support recipients; and eligible concession card holders • increase to the instant asset write-off threshold and expansion to its eligibility until 30 June 2020 • wage subsidy for apprentices and trainees of 50 per cent of their wages to support the jobs of around 120,000 apprentices and trainees for up to 30 September 2020.[4283]
13 March 2020	Australian Health Protection Principal Committee recommended limiting non-essential gatherings to 500 people. National Cabinet endorsed this recommendation on 15 March 2020.[4284] Communicable Diseases Network Australia National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia were released.[4285] Council of Australian Governments agreed to establish a National Cabinet to coordinate Australia's coronavirus response. National Cabinet held its first meeting.[4286] National Cabinet established a new intergovernmental agreement, the National Partnership on COVID-19 Response, between the Commonwealth and states and territories to cover the period the COVID-19 Plan remained active.[4287]

Date	Event
14 March 2020	Governor-General appointed the Prime Minister, the Hon Scott Morrison MP, to administer the Department of Health, out of concern that the Minister for Health could become incapacitated, and a senior minister should be responsible for the exercise of the Minister for Health's extraordinary powers under the *Biosecurity Act 2015* (Cth). The appointment was known to the Minister for Health, the Attorney-General and the Chief Medical Officer. The Prime Minister did not exercise any statutory powers.[4288]
15 March 2020	*Customs Act 1901* (Cth) provisions were used to ban cruise ships from entering Australia.[4289] Prime Minister announced that from midnight a universal precautionary self-isolation requirement on all international arrivals to Australia would come into effect. All people coming into Australia would be required to self-isolate for 14 days.[4290] Government established a Coronavirus Business Liaison Unit in Treasury.[4291]
16 March 2020	Reserve Bank of Australia announced that it would expand its purchases of Australian Government bonds in the secondary market and expand its repurchase agreements operations to provide liquidity to Australian financial markets.[4292]
17 March 2020	Australian Health Protection Principal Committee (AHPPC) published first guidance on risks in schools and early childhood education and care.[4293] ANZAC Day ceremonies and events were cancelled.[4294] National Cabinet endorsed AHPPC's advice (17 March) on strengthening restrictions and limiting non-essential gatherings of more than 100 people, stressing the importance of maintaining 1.5 metre distance between people.[4295] The National Cabinet appointed AHPPC (which, before the pandemic, was a cross-jurisdictional decision-making entity in public health emergencies) as a National Cabinet advisory committee. This meant AHPPC could report directly to National Cabinet and would be subject to Cabinet confidentiality.[4296]

Date	Event
18 March 2020	Australian Health Protection Principal Committee advised there was 'no longer a strong basis for having travel restrictions on only 4 countries and that Government consider aligning restrictions with the risk. This could involve lifting all travel restrictions, noting the imposition of universal quarantine and a decline in foreign nationals travel, or the imposition of restrictions on all countries, while small numbers of foreign nationals continue to arrive'.[4297] Governor-General declared a human biosecurity emergency. This gave the Minister for Health expansive powers to issue directions and set requirements in order to combat the outbreak.[4298] Minister for Health used these expansive powers for the first time by formalising the cruise ship ban made on 15 March 2020 through a determination under the *Biosecurity Act 2015* (Cth).[4299] National Cabinet agreed to restrictions on visitor entry into residential aged care facilities.[4300] National Cabinet agreed to risk mitigation measures for non-essential indoor gatherings of fewer than 100 people.[4301]
19 March 2020	Passengers disembarked in Sydney from the cruise ship *Ruby Princess* without restrictions. This event was ultimately linked to more than 900 COVID-19 cases.[4302] Prime Minister announced the closure of Australia's international borders to all non-citizens and non-residents entering Australia from 9:00 pm on 20 March 2020, with limited exemptions.[4303] The Australian Energy Market Operator enacted its pandemic plan.[4304] Reserve Bank of Australia announced a package of measures to support the economy, including: • a reduction in the cash rate from 0.5 per cent to 0.25 per cent • setting the interest rate corridor system on exchange settlement balances to 10 basis points, rather than zero • the introduction of a target on three-year Australian Government bond yields of 0.25 per cent • the provision of a Term Funding Facility to lower costs for the banking system.[4305]

Date	Event
20 March 2020	JobSeeker scheme created, replacing Newstart Allowance, Bereavement Allowance and Sickness Allowance.[4306] Council of Australian Governments Energy Council agreed to a comprehensive approach to identifying and managing the impacts of the pandemic on the energy sector, including the convening of the Energy Coordination Mechanism.[4307]
21 March 2020	Australian Government announced a $13 million grant to support rapid development of safe and effective treatment options for COVID-19.[4308] First two General Practitioner Respiratory Clinics were opened, one in New South Wales and the other in Queensland.[4309]

Date	Event
22 March 2020	Following Australian Health Protection Principal Committee advice, National Cabinet announced Stage 1 restrictions. They were expected to be in place for six months. Restrictions impacted pubs, clubs, licensed clubs, gyms and indoor sporting venues, restaurants, entertainment venues and religious gatherings.[4310] Government announced the second economic package, providing an additional $66.1 billion, which included the following elements: • Coronavirus SME Guarantee Scheme – government to guarantee 50 per cent of new loans issued by eligible lenders to small and medium enterprises • Coronavirus Supplement of $550 per fortnight to both existing and new recipients of the JobSeeker Payment, Youth Allowance (job seeker), Parenting Payment, Farm Household Allowance and Special Benefit • Early Release of Superannuation for individuals in financial stress to access up to $10,000 of their superannuation • enhancements to the Boosting Cash Flow for Employers measure, under which employers received a payment equal to 100 per cent of their salary and wages withheld • second $750 Economic Support Payment to social security and veteran income support recipients and eligible concession card holders, except for those eligible to receive the Coronavirus Supplement • temporary reduction to superannuation minimum drawdown rates announced for account-based pensions and similar products by 50 per cent for 2019–20 and 2020–21 • temporary relief for financially distressed businesses, including temporarily increasing the threshold at which creditors could issue a statutory demand on a company and the time companies had to respond to statutory demands they received. Temporary relief for directors from any personal liability for trading while insolvent was also included.[4311]

Date	Event
23 March 2020	Australian Government began a paid advertising campaign to inform overseas Australians of the risks of COVID-19.[4312] Coronavirus Economic Response Package Omnibus Bill 2020, containing eight bills to respond to the economic impacts of the coronavirus, passed both houses.[4313] Australian Government activated the domestic emergency response plan (COMDISPLAN) to provide Australian Government assistance to states and territories to manage the impacts of COVID-19 on the Australian community.[4314]
24 March 2020	Coronavirus Supplement eligibility criteria expanded to include Australians receiving student support payments.[4315] Prime Minister announced a ban on overseas travel for Australian citizens and permanent residents, with limited exemptions, through a determination under section 477(1) of the *Biosecurity Act 2015* (Cth). The ban had been agreed by National Cabinet and was enforced from 25 March 2020.[4316] Weddings restricted to five guests, funerals to 10.[4317]
25 March 2020	Prime Minister announced the formation of the National COVID-19 Coordination Commission to coordinate advice to government on actions to anticipate and mitigate the economic and social effects of the pandemic.[4318] National Health Emergency Crisis Payment was introduced.[4319]
26 March 2020	Restrictions on movement to or from some remote communities were introduced through the Emergency Requirements for Remote Communities Determination under subsection 477(1) of the *Biosecurity Act 2015* (Cth).[4320] National Cabinet agreed to temporarily suspend all non-urgent elective surgeries.[4321]
27 March 2020	Prime Minister and state and territory First Ministers, via National Cabinet, agreed that by 29 March all travellers arriving in Australia would be required to undertake 14 days of mandatory quarantine at designated facilities. This would be implemented under state and territory legislation, and states and territories would meet the costs and determine any contributions required from travellers arriving in their jurisdiction.[4322] Australian Energy Regulator released a revised Statement of Expectations for energy businesses, which set out the operating principles for retailers.[4323]
28 March 2020	State and territory governments announced mandatory 14-day quarantine arrangements at designated hotels within their jurisdictions, from 29 March 2020.[4324]

Date	Event
29 March 2020	Nationwide lockdown was agreed at National Cabinet. States and territories could choose to mandate and/or enforce this requirement. State and territory restrictions began to ease across the country around late April and May 2020.[4325] Hotel quarantine began. All passengers who arrived in Australia went into mandatory 14-day hotel quarantine.[4326] National Cabinet advised seniors and people with existing health conditions to self-isolate at home to the maximum extent practicable.[4327] National Cabinet agreed to nationally consistent eviction moratoriums for a period of six months.[4328] Australian Government announced a $1.1 billion package to boost mental health services, domestic violence support, Medicare assistance for people at home and emergency food relief.[4329] Tighter public gathering restrictions were introduced: no more than two people (some exceptions).[4330]

Date	Event
30 March 2020	Third economic package announced, including the JobKeeper payment. The government also announced a temporary relaxing of the partner income test to ensure that an eligible person could receive the JobSeeker Payment, and associated Coronavirus Supplement.[4331] Australian Health Protection Principal Committee advised that states and territories could introduce additional measures to further control community transmission.[4332] Australian Competition and Consumer Commission authorised the Australian Banking Association to introduce mortgage deferral arrangements.[4333] National Cabinet granted exemption for international flight crew and maritime crew from mandatory 14-day quarantine requirements.[4334] Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19) – Management Plan for Aboriginal and Torres Strait Islander Populations released.[4335] Governor-General appointed the Prime Minister, the Hon Scott Morrison MP, to administer the Department of Finance to enable him to exercise the Minister for Finance's significant powers were they unavailable to do so. The Prime Minister also wished to have capacity to make decisions about financial support for states and territories in real time in National Cabinet meetings. This appointment was not disclosed, including to the Finance Minister. The Prime Minister did not exercise his statutory power.[4336] Minister for Health, the Hon Greg Hunt MP, and principal medical advisor, Professor Michael Kidd, announced the expansion of Medicare-subsidised telehealth services for all Australians until 30 September 2020.[4337] Virgin Australia Airlines requested $1.4 billion bailout from the Australian Government due to rapid downturn in revenue. This request was later rejected.[4338]
1 April 2020	Exemption from the general closure of rest stops for heavy vehicle drivers to safely manage fatigue was released.[4339] Australian Health Practitioner Regulation Agency and National Boards announced a pandemic sub-register to fast-track the return to the workforce of experienced and qualified health practitioners.[4340] Council on Federal Financial Relations held its first meeting to discuss COVID-19 issues and policy responses.[4341]
3 April 2020	Advisory Committee on the Health Emergency Response to COVID-19 for People with Disability first convened.[4342]

Date	Event
4 April 2020	Australian Government committed up to $10 million to support CSIRO's work to help secure a vaccine for COVID-19.[4343] Minister for Health, the Hon Greg Hunt MP, announced that the National COVID-19 Clinical Evidence Taskforce would receive $1.5 million to develop 'living guidelines' on the clinical management of patients with suspected or confirmed COVID-19 infection.[4344]
6 April 2020	COVID-19 funding arrangements for the early childhood education and care sector and free early childhood education and care commenced.[4345]
7 April 2020	Australian Government Department of Health contracted the Kirby Institute to implement the COVID-19 Point-of-Care Testing program in remote Aboriginal and Torres Strait Islander communities.[4346]
9 April 2020	Prime Minister announced agreement by National Cabinet to exemption from quarantine for non-cruise maritime crew to travel to and from their places of work, and to updated advice for aircrew quarantine exemptions.[4347]
11 April 2020	Newmarch House outbreak began, ending on 15 June 2020.[4348]
15 April 2020	Department of Foreign Affairs and Trade developed an online Traveller Registration System to monitor and report on the status of returning Australians.[4349] Government announced a package of measures to help sustain Australian media businesses. The measures included tax relief, in the form of a one-off rebate of the Commercial Broadcasting Tax in 2020–21; a $50 million Public Interest News Gathering program, to support public interest news journalism in regional newspapers and regional commercial television and radio; short-term regulatory relief, in the form of a suspension of content quotas for broadcasters; and fast-tracking work to harmonise regulation of Australian content.[4350]
16 April 2020	National Cabinet agreed to continue the suppression/elimination strategy.[4351] Remote point-of-care testing was officially announced to deliver rapid and accurate pathology testing for COVID-19 in rural and remote Aboriginal and Torres Strait Islander communities.[4352]
17 April 2020	NBN Co announced $150 million financial relief and assistance fund to help internet providers to support their residential and small and medium business customers affected by the COVID-19 pandemic.[4353] Management and Operational Plan for COVID-19 for People with Disability released.[4354]

Date	Event
20 April 2020	Communicable Diseases Network Australia National Guidance for remote Aboriginal and Torres Strait Islander communities for COVID-19 released.[4355]
21 April 2020	Australian Government announced that elective surgery restrictions would begin to ease from 27 April 2020.[4356] Australian Government introduced the Pandemic Event (subclass 408) visa to allow temporary migrants to stay in Australia while COVID-19 travel restrictions were in place.[4357] Virgin Australia entered into voluntary administration.[4358]
23 April 2020	Senate Select Committee on COVID-19 commenced public hearings, taking evidence from the Chief Medical Officer and the Acting Secretary of the Department of Health.[4359] Australian Government launched the Critical Health Resource Information System for timely information on intensive care units.[4360]
24 April 2020	National Cabinet provided in-principle support for the coronavirus tracing app COVIDSafe and national principles for safe workplaces.[4361] National Cabinet received updated advice from the Australian Health Protection Principal Committee confirming that the one person per 4 square metre rule and the 1.5 metre social distancing rule were not appropriate or required in classrooms.[4362] Australian Government announced the $1 billion COVID-19 Relief and Recovery fund. Programs funded under this included the Recovery for Regional Tourism Program, a $50 million program designed to help regions reliant on international tourism, as well as a $139.6 million program to assist exhibiting zoos and aquariums with the fixed operational costs associated with caring for animals.[4363]
26 April 2020	COVIDSafe App was launched for voluntary use.[4364]
May 2020	Communications Strategy for People with Disability was released.[4365]
1 May 2020	National Cabinet endorsed the Pandemic Health Intelligence Plan, and the Australian National Disease Surveillance Plan for COVID-19.[4366]
4 May 2020	Attorney-General released draft legislation to codify protections for individuals' data collected by the COVIDSafe app that had been established by a determination from the Minister for Health under the *Biosecurity Act 2015* (Cth).[4367]
8 May 2020	National Cabinet approved the '3 Step Framework for a COVIDSafe Australia' (COVIDSafe Plan) to ease restrictions.[4368] There was no national timeframe for the implementation of this plan, and states and territories agreed to move at different times based on local conditions.

Date	Event
12 May 2020	Parliament passed the *Privacy Amendment (Public Health Contact Information) Act 2020* (Cth) to support the COVIDSafe app and ensure user privacy.[4369]
13 May 2020	First Deputy Chief Medical Officer for Mental Health was appointed at the Australian Department of Health to strengthen the coordinated medical and mental health response and decision-making relating to the COVID-19 pandemic.[4370]
14 May 2020	Australian Health Protection Principal Committee released a statement on the utility of testing for COVID-19 to reduce the requirement for 14 days of quarantine.[4371] Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) Declaration 2020 was extended until 17 September 2020 (this followed in-principle agreement by the National Security Committee of Cabinet).[4372]
15 May 2020	National Cabinet endorsed the National Mental Health and Wellbeing Pandemic Response Plan.[4373] Australian Government announced a new round of its $22.3 million Biomedical Translation Bridge Program to support COVID-19 related research projects.[4374]
26 May 2020	First COVID-19 point-of-care test was conducted in Western Australia.[4375]
29 May 2020	National Cabinet agreed to the cessation of the Council of Australian Governments model and formation of the National Federation Reform Council (comprising National Cabinet, the Council on Federal Financial Relations, and the Australian Local Government Association) to focus on priority federation reform issues of national significance. National Cabinet continued to meet regularly and be briefed by experts, such as the Australian Health Protection Principal Committee.[4376] Principles for COVID-19 Public Transport Operations released.[4377]
June 2020	Restart Investment to Sustain and Expand (RISE) Fund announced at $75 million to help the 'arts and entertainment sector to reactivate'.[4378]
2 June 2020	Australian Government invested another $33 million from the Medical Research Future Fund into coronavirus-related research, which brought the total investment to $66 million.[4379]
4 June 2020	HomeBuilder program announced, providing all eligible owner-occupiers (not just first home buyers) with a grant of $25,000 to build a new home or substantially renovate an existing home.[4380]

Date	Event
25 June 2020	Qantas announced plans to cut at least 6,000 jobs and continue to stand down 15,000 workers to help the company survive the impact of the pandemic.[4381]
26 June 2020	National Cabinet agreed to a new plan for Australia's public health capacity and COVID-19.[4382] National Cabinet met to discuss the Victorian outbreak and recommitted to the strategy of suppression of COVID-19 and to the three-step plan announced on 8 May 2020.[4383]
29 June 2020	*First 24 hours – managing COVID-19 in a residential aged care facility*, published by the Australian Department of Health.[4384]
2 July 2020	Victorian COVID-19 Hotel Quarantine Inquiry was established in response to community cases of COVID-19 found linked to a breach in hotel quarantine infection control.[4385]
7 July 2020	Victoria announced that Stage 3 'stay at home' restrictions were reinstated across metropolitan Melbourne and Mitchell Shire (north of Melbourne) for a minimum of six weeks.[4386]
8 July 2020	St Basil's Home for the Aged outbreak began, ending on 31 July 2020.[4387]
9 July 2020	Principles for COVID-19 Private Bus Industry Operations released.[4388]
10 July 2020	National Cabinet agreed that states and territories would start moving towards charging returned overseas travellers for hotel quarantine.[4389] National Cabinet announced international passenger arrival caps to manage and maintain quarantine arrangements in jurisdictions which had been placed under added pressure by the restriction of international passenger flights to Victoria after the outbreak that began there in June 2020.[4390] The caps were intended to reduce the pressure on state hotel quarantine programs in certain capital cities outside Victoria.[4391] Prime Minister announced that National Cabinet had agreed to a national review of hotel quarantine.[4392] Therapeutic Goods Administration provisionally approved Veklury® as the first treatment option for COVID-19.[4393]
12 July 2020	Free early childhood education and care period concluded.[4394]

Date	Event
13 July 2020	Australian Health Protection Principal Committee released a statement supporting a review of quarantine arrangements. It stated that the review should advise on many operational issues, including staff training, infection and prevention control standards, and support services for different cohorts.[4395] Australian Government mandated the use of surgical masks by aged care workers in residential aged care facilities and those who provided home care support in Victoria's lockdown zones.[4396] Transition payment for the early childhood education and care (ECEC) sector began, aiming to provide additional support to ECEC services equal to 25 per cent of the average weekly fees that they charged during a reference fortnight from 13 July to 27 September 2020.[4397]
16 July 2020	JobTrainer Fund announced, aiming to support 340,000 unemployed and young people to study high-demand courses for free or at a low fee. This included the expansion of the Supporting Apprentices and Trainees program.[4398]
19 July 2020	Victoria announced that people living in metropolitan Melbourne and Mitchell Shire would be required to wear a face mask when leaving their home from 11:59 pm on 22 July 2020, and that the state of emergency was extended until 16 August 2020.[4399]
20 July 2020	Epping Gardens outbreak began, ending on 3 September 2020.[4400]
21 July 2020	JobKeeper Payment and Coronavirus Supplement were extended.[4401]
24 July 2020	National Cabinet agreed the Protocol for Domestic Border Controls – Freight Movements[4402]
27 July 2020	Australian Government established the Victorian Aged Care Response Centre to manage and respond to the outbreak of COVID-19 in aged care facilities.[4403] This was an Australian Government led response, supported by the Victorian Government. Prime Minister announced that the National COVID-19 Coordination Commission would move to its new mode – going forward, it would concentrate on creating jobs and stimulating the economy and minimise its role in coordination. The commission's name was changed to the National COVID-19 Commission Advisory Board.[4404]
2 August 2020	Australian Government announced a $7.3 million commitment to provide 10 additional Medicare-subsidised psychological therapy sessions from 7 August for people in lockdown.[4405] Victorian Government declared a state of disaster in Victoria and announced the implementation of Stage 4 restrictions in Melbourne.[4406]

Date	Event
3 August 2020	Pandemic Leave Disaster Payment was announced to assist people who were self-isolating or quarantining as a result of a direction by a health official or who were caring for someone with COVID-19.[4407]
5 August 2020	Communicable Diseases Network Australia and Public Health Laboratory Network published a joint statement which advised a 10-day isolation period from onset of symptoms.[4408]
7 August 2020	Freight Movement Code for the Domestic Border Controls – Freight Movement Protocol was released.[4409]
10 August 2020	'Human coronavirus with pandemic potential' was permanently listed on the National Notifiable Disease List under subsection 12(1) of the *National Health Security Act 2007* (Cth).[4410]
16 August 2020	Department of Health established the Science and Industry Technical Advisory Group to advise on COVID-19 vaccines and treatments for Australia.[4411]
17 August 2020	Australian Government announced $31.9 million in support to establish 15 new adult mental health centres, branded HeadtoHelp.[4412]
18 August 2020	Australian Government published Australia's COVID-19 Vaccine and Treatment Strategy.[4413]
21 August 2020	Aged Care Advisory Group established as a subcommittee of the Australian Health Protection Principal Committee.[4414] National Aged Care Emergency Response began.[4415] Agreement reached on the resumption of recruitment under the Seasonal Worker Programme and Pacific Labour Scheme for Pacific and Timorese workers to travel to Australia to work in the agriculture and meat processing industry (subject to a 14-day quarantine period paid for by the employer).[4416]
24 August 2020	Newmarch House COVID-19 Outbreak Independent Review report published.[4417]
25 August 2020	Qantas announced a further 2,500 cuts to streamline its operations and focus on recovery efforts. This involved the company outsourcing ground crew at major Australian airports.[4418] Review of Dorothy Henderson Lodge COVID-19 Outbreak report published.[4419]
28 August 2020	Australian Government published the first COVID-19 Common Operating Picture, which displayed a traffic light report of the COVID-19 situation across Australia.[4420]

Date	Event
1 September 2020	Reserve Bank of Australia announced the extension and expansion of the Term Funding Facility, with the latest maturity of three-year funding available extended from September 2023 to June 2024.[4421] The focus of the yield target was also changed from the April 2023 bond to the April 2024 bond.[4422]
2 September 2020	June quarter national accounts released, which showed a fall of 7.0 per cent in the June quarter, the largest quarterly fall on record.[4423]
2 September 2020 to March 2022	Australian Government administered the Special Overseas Financial Assistance (Hardship) Program to help vulnerable Australians to secure flights and return to Australia. Approximately half of the 10,000 Hardship Program applications were approved, at a total cost of $44.54 million.[4424]
3 September 2020	Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) Declaration 2020 was extended to 17 December 2020.[4425]
4 September 2020	National Cabinet agreed in principle that the Commonwealth would work with state and territory governments to develop a new plan to 'reopen' Australia by Christmas.[4426] Department of Health and Australian Technical Advisory Group on Immunisation (ATAGI) established the ATAGI COVID-19 Working Group to advise government on COVID-19 vaccines.[4427]
7 September 2020	Australia entered into a $1.7 billion vaccine supply and production onshore manufacturing agreement, with 33.8 million doses of University of Oxford/AstraZeneca vaccine and 51 million doses of University of Queensland/CSL vaccine, to produce more than 84.8 million vaccine doses for the Australian population.[4428]
20 September 2020	Announcement of the Recovery Package for the early childhood education and care sector, which ran from September 2020 to January 2021 and was effectively an extension of access to the Transition Payment for jurisdictions that faced ongoing pandemic impacts (only for Victoria).[4429]
23 September 2020	Australian Government committed $123.2 million to be part of the purchasing mechanism of the COVAX facility.[4430]
October 2020	Updated Australian Government Crisis Management Framework was published.[4431]
1 October 2020	Australian Health Protection Principal Committee endorsed the governance framework for national genomics surveillance of SARS-CoV-2 in AusTrakka.[4432] Royal Commission into Aged Care Quality and Safety special report on COVID-19 was tabled in parliament and published online.[4433]

Date	Event
6 October 2020	2020–21 Budget was announced, after being deferred from May. It included $115.5 billion to deliver essential health services needed under the Long Term National Health Plan. It also included $5.7 billion to be spent on mental health in 2020–21.[4434]
16 October 2020	Australia–New Zealand one-way quarantine-free travel zone commenced.[4435]
20 October 2020	Howard Springs was formalised as Australia's first Centre for National Resilience, to prioritise the return of Australians stranded overseas, with capacity to accommodate 500 people a fortnight.[4436]
23 October 2020	National Cabinet (except Western Australia) agreed in principle to a three-step framework for 'National Reopening Australia by Christmas'.[4437] National Cabinet commissioned the new Health National Cabinet Reform Committee to deliver a new National Mental Health and Suicide Prevention Agreement and advised on implementation of the National Mental Health and Wellbeing Pandemic Response Plan.[4438] National Review of Hotel Quarantine final report presented to the Australian Government, which accepted the recommendations.[4439] Review of COAG Councils and Ministerial Forums (Conran Review) final report delivered to the Australian Government.[4440]
26 October 2020	Victoria announced that as Melbourne had recorded zero COVID-19 cases, it would move out of lockdown and into the third stage ('stay safe') from 28 October 2020.[4441]
3 November 2020	Reserve Bank of Australia announced that it would purchase bonds issued by the Australian and state and territory Governments on the secondary market under a $100 billion bond purchasing program.[4442] Cash rate was cut from 0.25 per cent to 0.10 per cent.[4443]
5 November 2020	Australia secured 10 million doses of Pfizer's vaccine and 40 million doses of Novavax's vaccine with their first advance purchase agreements.[4444]
11 November 2020	New South Wales announced that customer check-in at businesses must be completed using electronic methods, e.g. a QR code, from 23 November 2020.[4445]
12 November 2020	Visitation guidelines for residential aged care facilities, including escalation tiers and aged care provider responses, were released.[4446]

Date	Event
13 November 2020	National Cabinet endorsed the Framework for National Reopening. All National Cabinet members agreed except Western Australia, which did not agree to the domestic border and international arrival proposals. Under the framework, Australia was to reopen to a state of 'COVID normal', wherever it was safe to do so, by December 2020.[4447] Australian Government published Australia's COVID-19 Vaccination Policy, endorsed by National Cabinet.[4448]
16 November 2020	Announcement of the $56 million Business Events Grants Program, which provided delegates, including buyers and sellers, with financial support to attend and participate at exhibitions, conferences and conventions. The initiative aimed to provide better assurance for the business events sector and encourage businesses to return to the event forum.[4449]
17 November 2020	Australian Health Protection Principal Committee released a statement on routine testing of hotel quarantine workers.[4450]
24 November 2020	Northern Territory announced a new app to help local businesses and organisations with the new COVID-safe check-in system using a QR code.[4451]
30 November 2020	Victoria announced the introduction of a QR code check-in system for businesses.[4452] Updated National COVID-19 Aged Care Plan released.[4453]
1 December 2020	Australian Government required all residential aged care facilities to have a dedicated on-site clinical infection prevention and control lead with specialist training.[4454] South Australia introduced the mySA GOV app for QR code check-in at businesses.[4455]
8 December 2020	Culturally and Linguistically Diverse Communities COVID-19 Health Advisory Group established.[4456]
10 December 2020	Australian National Audit Office published the *Planning and governance of COVID-19 procurements to increase the National Medical Stockpile* performance audit report.[4457] Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) Declaration 2020 was extended until 17 March 2021.[4458] Communicable Diseases Network Australia National Guidance for Urban and Regional Aboriginal and Torres Strait Islander Communities for COVID-19 released.[4459]
11 December 2020	Minister for Health announced the University of Queensland's vaccine would not proceed to phase 3 clinical trials.[4460]

Date	Event
12 December 2020	Future of Aviation References Panel was formed and instructed to engage with senior aviation industry leaders with the objective of providing advice to the Australian Government on policy options to shape the future of aviation in Australia.[4461]
14 December 2020	Round One of the COVID-19 Consumer Travel Support Program was launched to provide a one-off payment to assist travel agents and tour arrangement service providers who had been disproportionately impacted due to the COVID-19 pandemic.[4462] In total $98.6 million in grant funding was paid under Round One.[4463]
18 December 2020	Chief Medical Officer declared the first hotspot for the purpose of provision of Commonwealth support (Northern Beaches Local Government Area).[4464]
19[4465] December 2020	New South Wales announced new COVID-19 restrictions for Greater Sydney following an outbreak in the Northern Beaches area. The restrictions included stay-at-home orders for the northern zone of Sydney.
21 December 2020	Independent review of COVID-19 outbreaks at St Basil's and Epping Gardens aged care facilities report published.[4466]
23 December 2020	Agri-Business Expansion Initiative announced, an $85.9 million program to help Australian agribusinesses expand and diversify their export markets.[4467]
24 December 2020	Australian Health Protection Principal Committee released a statement on Australia's national hotel quarantine principles.[4468] The statement outlined best practice advice for managed quarantine and committed to a process of review and continuous learning. Australian Health Protection Principal Committee released a statement on mandatory quarantine for aircrew who were not local residents.[4469]
7 January 2021	Australia's COVID-19 vaccine national rollout strategy was released.[4470]
8 January 2021	National Cabinet mandated use of face masks on all flights and in airports in Australia.[4471]
10 January 2021	New South Wales ended three-week lockdown and stay-at-home orders associated with the Northern Beaches cluster.[4472]
14 January 2021	First National Health and Medical Research Council (NHMRC) COVID-19 vaccine forum was jointly hosted by the Department of Health, the Australian Technical Advisory Group on Immunisation and the National COVID-19 Health and Research Advisory Committee.[4473]
25 January 2021	Quarantine-free travel arrangement with New Zealand suspended.[4474] Therapeutic Goods Administration provisionally approved Pfizer's COVID-19 vaccine Comirnaty® for use in individuals aged 16 years and over.[4475]

Date	Event
31 January 2021	Quarantine-free travel arrangement with New Zealand resumed.[4476]
2 February 2021	Reserve Bank of Australia announced the bond purchasing program would be expanded by a further $100 billion when the initial program was completed.[4477]
8 February 2021	Australian Health Protection Principal Committee endorsed the Testing Framework for COVID-19 in Australia.[4478]
12 February 2021	Australian Technical Advisory Group on Immunisation published the first version of the *Clinical guidance for COVID-19 vaccines in Australia.*[4479]
13 February 2021	COVID-19 Vaccination Program – Culturally and Linguistically Diverse Communities Implementation Plan released.[4480]
15 February 2021	Quarantine-free travel arrangement with New Zealand suspended.[4481] Therapeutic Goods Administration provisionally approved AstraZeneca's COVID-19 vaccine Vaxzevria® for use in adults aged 18 years and over.[4482]
22 February 2021	Australia's vaccine rollout began.[4483]
1 March 2021	Final report of the Royal Commission into Aged Care Quality and Safety tabled.[4484]
2 March 2021	Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) Declaration 2020 was extended until 17 June 2021.[4485]
5 March 2021	Howard Springs quarantine capacity increased to 2,000 people a fortnight from May 2021.[4486]
9 March 2021	COVID-19 Vaccination Program – Aboriginal and Torres Strait Islander Peoples Implementation Plan released.[4487] Department of Health published the COVID-19 Vaccination – Aged Care Implementation Plan.[4488]
11 March 2021	Announcement of a $1.2 billion support package for tourism and the aviation sector.[4489]
16 March 2021	First Australian Technical Advisory Group on Immunisation (ATAGI) Statement on COVID-19 Vaccines was published. Between March 2021 and October 2023, ATAGI made 42 statements relating to COVID-19 vaccines. From April 2021, it published a weekly meeting summary.[4490] It also released ongoing updates to clinical advice documents, consent documents, and advice for the public.
25 March 2021	Restart Investment to Sustain and Expand (RISE) Fund increased by $125 million.[4491]
28 March 2021	JobKeeper Payment ended.[4492]

Date	Event
31 March 2021	Coronavirus Supplement ended.[4493]
15 April 2021	Governor-General appointed the Prime Minister, the Hon Scott Morrison MP, to administer the Department of Industry, Science, Energy and Resources so that he had the capacity to exercise particular statutory powers unconnected to the pandemic. He exercised these powers once.[4494]
17 April 2021	HomeBuilder program extended.[4495]
19 April 2021	Australia–New Zealand two-way quarantine-free travel zone commenced.[4496]
22 April 2021	COVID-19 vaccine rollout strategy was updated.[4497]
26 April 2021	Australian Government invested more than $114 million to extend telehealth services to the end of 2021.[4498]
27 April 2021	Delta, a new strain of COVID-19, declared in India.[4499] COVID-19 Consumer Travel Support Program opened, with $258 million for providing grants to eligible travel agents and tour arrangement service providers, helping businesses rebook travel using existing COVID-related credits.
30 April 2021	Minister for Health made a determination under the *Biosecurity Act 2015* (Cth) banning entry to Australia's territory of anyone who had been in India within 14 days of their flight to Australia.[4500] Known as the 'India Travel Pause', this was the only period in which Australian citizens and permanent residents were banned from entering Australia, without exception. The India Travel Pause lasted for 14 days.
2 May 2021	Round Two of the COVID-19 Consumer Travel Support Program was launched. In total $19.5 million in grant funding was paid under Round Two.[4501]
3 May 2021	Prime Minister announced that the National COVID-19 Commission Advisory Board would be disbanded, without a review.[4502]
5 May 2021	AgMove support announced with workers eligible to receive a subsidy of $2,000 for Australians and $650 for temporary visa holders to complete at least 40 hours of work over two weeks.[4503]
6 May 2021	The Governor-General appointed the Prime Minister, the Hon Scott Morrison MP, to administer the Department of the Treasury and the Department of Home Affairs to give himself the capacity to exercise particular statutory powers unconnected to pandemic. He did not exercise these statutory powers.[4504]
11 May 2021	2021–22 Budget released.[4505]

Date	Event
13 May 2021	Australia secured 25 million doses of Moderna's vaccine with its first advance purchase agreement.[4506]
27 May 2021	Australian National Audit Office published the *COVID-19 procurements and deployments of the National Medical Stockpile* performance audit report.[4507]
28 May 2021	Victoria statewide lockdown.[4508]
3 June 2021	Temporary COVID-19 Disaster Payment announced to assist people who were unable to work due to state or territory public health orders for restricted movement in a Commonwealth-declared COVID-19 hotspot.[4509]
4 June 2021	Prime Minister agreed to establish a purpose-built quarantine facility at Mickleham in Melbourne (Centre for National Resilience Melbourne).[4510]
7 June 2021	Australian Health Protection Principal Committee published national quarantine principles for international travellers.[4511]
8 June 2021	Operation COVID SHIELD was established.[4512]
10 June 2021	Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) Declaration 2020 was extended until 17 September 2021.[4513]
17 June 2021	Australian Technical Advisory Group on Immunisation recommended Pfizer as the preferred vaccine for under 60s, over AstraZeneca.[4514]
25 June 2021	Greater Sydney and other parts of New South Wales entered lockdown.[4515]
28 June 2021	National Cabinet endorsed the introduction of mandatory COVID-19 vaccinations for workers in residential aged care facilities, with limited exceptions by mid-September 2021.[4516] National Cabinet noted the establishment of indemnity arrangements for COVID-19 vaccinations, to provide assurance and confidence to patients and health professionals during the COVID-19 vaccine rollout.[4517]
29 June 2021	Australian Health Protection Principal Committee published a statement on minimising the risk of transmission from high-risk international travellers in managed quarantine facilities.[4518]
July 2021	Updated Australian Government Crisis Management Framework was published.[4519]
July 2021	Prime Minister agreed to establish a purpose-built quarantine facility at Pinkenba in Brisbane (Centre for National Resilience Brisbane).[4520]
6 July 2021	Reserve Bank of Australia announced that the bond purchasing program would be continued from September to at least mid-November 2021, but with the pace of purchases slowed to $4 billion a week (from $5 billion). The yield target of 0.1 per cent was maintained for the April 2024 bond, but not extended to the November 2024 bond.[4521]

Date	Event
9 July 2021	Australian Health Protection Principal Committee (AHPPC) published a statement on national principles for infection prevention and control in quarantine.[4522] National Cabinet agreed that all disability support workers would be encouraged to be vaccinated.[4523] National Cabinet agreed to the AHPPC's advice strongly encouraging vaccination in sectors with high mobility, such as aviation, resources and freight.[4524]
13 July 2021	Commonwealth announced 50/50 cost sharing for New South Wales's business support packages. Similar arrangements were negotiated with all states and territories by the end of August.[4525]
19 July 2021	South Australia made mask wearing mandatory in all indoor public spaces.[4526]
23 July 2021	National Cabinet commissioned a second review of quarantine arrangements in Australia.[4527] Australia–New Zealand two-way quarantine-free travel zone suspended.[4528]
August 2021	Prime Minister agreed to establish a purpose-built quarantine facility at Bullsbrook in Perth (Centre for National Resilience Perth).[4529]
2 August 2021	Aboriginal and Torres Strait Islander children aged 12 to 15 years and all children aged 12 to 15 years with specific medical conditions or living in remote communities recommended for COVID-19 vaccination.[4530]
3 August 2021	Operation COVID SHIELD National COVID Vaccine Campaign Plan was published.[4531]
6 August 2021	National Cabinet agreed to and released the National Plan to Transition Australia's National COVID Response to open up Australia's international border and progressively remove jurisdiction-level COVID-19 community control measures.[4532]
9 August 2021	Therapeutic Goods Administration provisionally approved Moderna's COVID-19 vaccine Spikevax® for use in adults aged 18 years and over.[4533] Western Australia issued a public health order stating that aged care workers must have received one dose of a COVID-19 vaccine by 17 September 2021.[4534]
11 August 2021	South Australia issued a public health order stating that aged care workers must have received one dose of a COVID-19 vaccine by 17 September 2021.[4535] This mandate was extended to healthcare workers on 1 November 2021 and police officers on 15 November 2021.[4536]

Date	Event
12 August 2021	Australian Capital Territory entered an initial seven-day lockdown, which continued until 14 October 2021.[4537]
15 August 2021	Tasmania introduced a vaccine mandate for all aged care workers.[4538] This was extended to healthcare and quarantine transport workers on 12 November 2021.[4539]
17 August 2021	Therapeutic Goods Administration provisionally approved Xevudy®, a monoclonal antibody treatment, for COVID-19 treatment in adults and adolescents (aged 12 years and over).[4540] Queensland introduced a vaccine mandate for all aged care and disability workers.[4541] This was extended to the education, corrections and airport sectors on 30 November 2021.[4542]
19 August 2021	Northern Territory introduced a vaccine mandate for all aged care workers.[4543] A more far-reaching vaccine mandate introduced on 13 October 2021 required healthcare, emergency service and disability (among many other) workers to be vaccinated against COVID-19 in order to work.[4544] One in two eligible Australians had received at least one vaccine dose.[4545]
22 August 2021	Creative Economy Taskforce announced, to assist in the implementation of the government's $250 million JobMaker plan for the creative economy and provide strategic guidance to build the sector as Australia looked to emerge from COVID-19.[4546]
24 August 2021	Australian Capital Territory introduced a vaccine mandate for all healthcare, disability, aged care, school and early childhood education and care workers.[4547]
26 August 2021	New South Wales introduced a vaccine mandate for all aged care workers. Vaccine mandates for healthcare, disability, school and early childhood education and care workers followed.[4548]
27 August 2021	All children aged 12 years and older recommended for COVID-19 vaccination.[4549]
28 August 2021	Minister for Health announced the COVID-19 Vaccine Claims Scheme.[4550]
2 September 2021	Australian Health Protection Principal Committee published national quarantine principles for international travellers.[4551] Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) Declaration 2020 was extended until 17 December 2021.[4552]
14 September 2021	Plans to accelerate vaccinations for Aboriginal and Torres Strait Islander people in an initial 30 priority areas announced.[4553]

Date	Event
7 September 2021	Reserve Bank of Australia announced the bond purchasing program would be extended until 'at least mid-February 2022' because of the delay in the economic recovery and increased uncertainty associated with the Delta outbreak.[4554]
13 September 2021	All children aged 12 years and older were approved for vaccination by this date.[4555]
17 September 2021	National Cabinet endorsed National Code on Boarding School Students.[4556]
29 September 2021	Government announced winding-down of COVID-19 Disaster Payment.[4557]
1 October 2021	Australian Government announced that Australia was ready to move to Phase B and then Phase C of the National Plan to Safely Reopen Australia. In Phase B, states and territories that were ready could implement: • seven days of home quarantine for Australian citizens and permanent residents who were fully vaccinated with a vaccine approved for use in Australia or 'recognised' by the Therapeutic Goods Administration • 14 days of managed quarantine for anyone who was not vaccinated or was vaccinated with a vaccine not approved or recognised by the Therapeutic Goods Administration.[4558] National Cabinet noted the Australian Health Protection Principal Committee's recommendation of mandatory vaccinations for all workers in healthcare settings.[4559] Victoria introduced a mandate for all 'general' workers to be vaccinated with at least one dose in order to work 'on-site'.[4560]
12 October 2021	National Review of Quarantine delivered its report to the Prime Minister.[4561]
29 October 2021	Minister for Health announced the $180 million package to support primary care to support cases of COVID-19 at home and in the community (Living with COVID).[4562]
November 2021	Pacific Pathways Plan allowed fully vaccinated workers from low-COVID-risk Pacific countries to travel quarantine free to Australia to take up work in the agriculture, meat processing, tourism, and care sectors.[4563]

Date	Event
1 November 2021	Australian Government allowed fully vaccinated (i.e. received two doses) Australian citizens and permanent residents to travel overseas.[4564] The Overseas Travel Ban Determination under the *Biosecurity Act 2015* (Cth) was amended to allow exemptions for 'persons who have received an accepted course of vaccinations'.[4565] Exemptions on travel to Australia expanded to include the parents of Australian citizens and permanent residents.[4566] Independent Review of COVID-19 Outbreaks in Australian Residential Aged Care Facilities report published.[4567] Minister for Health and Aged Care announced that Australian citizens, permanent residents and immediate families with two doses of COVID-19 vaccines would not be required to quarantine either at a hotel or at home when arriving into Australia. Unvaccinated international arrivals were still required to undertake 14 days of hotel quarantine.[4568] One-way quarantine-free travel from New Zealand to participating states and territories in Australia resumed.[4569]
2 November 2021	Reserve Bank of Australia announced that the yield target was discontinued after stronger than expected Australian Consumer Price Index and a rise in bond yields.[4570]
5 November 2021	Over 80 per cent of Australians over 16 years of aged had received double vaccination.[4571]
8 November 2021	Australian Government began a vaccine booster program, for people to receive an additional dose of vaccine to provide additional protection, initially targeted to priority groups most at risk.[4572]
10 November 2021	Australian Health Protection Principal Committee recommended mandatory vaccination of disability workers who were providing intensive supports to National Disability Insurance Scheme participants, as well as for in-home and community aged care workers.[4573]
16 November 2021	First workers arrived under the Pacific Australia Labour Mobility scheme from Solomon Islands.[4574]
21 November 2021	Australia allowed quarantine-free travel for fully vaccinated Singaporeans travelling from Singapore to Australia.[4575]
24 November 2021	National Aged Care Advisory Council established.[4576]
26 November 2021	World Health Organization classified SARS-CoV-2 variant B.1.1.529 (known as Omicron) as a variant of concern.[4577]

Date	Event
1 December 2021	Australia opened to fully vaccinated people who held an eligible student visa or a humanitarian, working holiday maker or provisional family visa.[4578] Fully vaccinated citizens of the Republic of Korea (South Korea) and Japan were able to travel to Australia (to participating states and territories) under quarantine-free travel arrangements.[4579]
7 December 2021	Australian Health Protection Principal Committee published a statement on national principles for end-to-end best practice managed quarantine arrangements for international travellers.[4580]
9 December 2021	Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) Declaration 2020 was extended until 17 February 2022.[4581]
13 December 2021	COVID-19 Vaccine Claims Scheme opened for claims.[4582] Australian Government announced a $106 million investment to strengthen Australia's primary care health system and build permanent telehealth services for Australian patients.[4583]
20 December 2021	Australian Government released the Aviation Recovery Framework.[4584]
24 December 2021	Aged Care Council of Elders established.[4585]
30 December 2021	National Cabinet agreed to the Australian Health Protection Principal Committee's advice to reset test, trace, isolate and quarantine requirements to align with changes in the transmissibility of variants circulating, standardised isolation periods for COVID-19 positive cases to seven days (South Australia continued with a 10-day period), and noted the wider use of rapid antigen tests (RATs) in domestic border crossing testing.[4586]
31 December 2021	First stage of accommodation became available at the Centre for National Resilience Melbourne.[4587]
21–31 December 2021	Tasmania, the Australian Capital Territory, Victoria, New South Wales and the Northern Territory introduced mask mandates for all indoor public spaces, including hospitality, retail and public transport settings.[4588]
January 2022	Victorian Government began operating the Centre for National Resilience Melbourne.[4589] Department of Social Services Portfolio COVID-19 Response Taskforce established to respond to the Omicron wave.[4590]
2 January 2022	Queensland introduced a mask mandate for most indoor settings.[4591]
10 January 2022	All children aged 5 to 11 years were approved for vaccination.[4592]

Date	Event
13 January 2022	National Cabinet reaffirmed National Plan to Transition Australia's National COVID-19 Response.[4593] National Framework for Managing COVID-19 in Schools and Early Childhood Education and Care agreed.[4594] National Cabinet agreed to the final arrangements for the RAT Concessional Access Program, funded jointly by the Commonwealth and states and territories.[4595] Over 95 per cent of people aged 16 or over had received at least two vaccine doses.[4596]
14 January 2022	National Framework for Managing COVID-19 in Schools and Early Childhood Education and Care released.[4597]
18 January 2022	Therapeutic Goods Administration provisionally approved oral COVID-19 treatments Lagevrio® and Paxlovid® for adults aged 18 years and over.[4598]
19 January 2022	Therapeutic Goods Administration provisionally approved Novavax's Nuvaxovid® for use in adults aged 18 years and over.[4599]
20 January 2022	Australian Health Protection Principal Committee proposed the use of rapid antigen tests (RATs) as a diagnostic alternative to polymerase chain reaction (PCR) tests for use in the broader community to manage outbreaks and to detect cases early in high-risk settings.[4600]
24 January 2022	COVID-19 Rapid Test Concessional Access Program was established.[4601]
1 February 2022	Reserve Bank of Australia announced its decision to cease further purchase under the bond purchasing program, with final purchases on 10 February.[4602]
11 February 2022	Interim guidance on managing public health restrictions on residential aged care facilities was published and endorsed by National Cabinet.[4603] Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) Declaration 2020 was extended until 17 April 2022.[4604]
21 February 2022	Australia's borders opened to fully vaccinated visa holders, including tourists, business travellers and other visitors.[4605] On this day, the proportion of people over the age of 16 fully vaccinated was 94.2 per cent.[4606] Western Australia introduced a mask mandate for all indoor public spaces.[4607]
3 March 2022	Western Australia ended hotel quarantine for vaccinated people travelling to Australia.[4608]
29 March 2022	2022–23 Budget released.[4609]

Date	Event
17 April 2022	Human Biosecurity Emergency Declaration relating to COVID-19 lapsed.[4610]
22 April 2022	Health authorities warned on spread of BA.2 Omicron subvariant.[4611]
3 May 2022	Reserve Bank of Australia increased the cash rate from 0.10 per cent to 0.35 per cent.[4612]
12 May 2022	First Australian-made COVID-19 mRNA vaccine dose was given to a clinical trial patient.[4613]
16 May 2022	First stage of accommodation became available at the Centre for National Resilience Perth.[4614]
21 May 2022	Federal election resulted in a change of Australian Government.[4615]
6 July 2022	Australia's borders opened for all eligible visa holders regardless of vaccination status.[4616]
13 July 2022	First stage of accommodation became available at the Centre for National Resilience Brisbane.[4617]
3 August 2022	Children aged 6 months to 5 years at risk of severe illness from COVID-19 recommended for COVID-19 vaccination.[4618]
16 August 2022	Minister for Health and Aged Care issued a determination that the COVIDSafe app was no longer required. This was the Privacy (Public Health Contact Information) (End of the COVIDSafe data period) Determination 2022.[4619]
17 August 2022	Australian National Audit Office published *Australia's COVID-19 vaccine rollout* performance audit report.[4620]
31 August 2022	National Cabinet agreed to reduce isolation periods for COVID-19 positive cases from seven to five days following a positive test. This came into effect from 9 September.[4621]
1 September 2022	Australian Government established the National Emergency Management Agency as a single, enduring agency to better respond to emergencies, help communities recover, and prepare Australia for future disasters.[4622] Minister for Health and Aged Care, the Hon Mark Butler MP, referred the matter of long COVID to the House of Representatives Standing Committee on Health, Aged Care and Sport.[4623]
27 September 2022	Review of COVID-19 Vaccine and Treatment Purchasing and Procurement report by Professor Jane Halton AO PSM, was released by the Department of Health and Aged Care.[4624]
28 September 2022	More than 95 per cent of people aged 16+ had received at least two doses of a COVID-19 vaccine.[4625]

Date	Event
30 September 2022	Communicable Diseases Network Australia released updated National Guideline for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (Including COVID-19 and Influenza) in Residential Care Homes.[4626] Pandemic Leave Disaster Payment ended.[4627] National Cabinet agreed to end mandatory isolation requirements for cases effective 14 October.[4628] Australian Government deactivated the domestic emergency response plan (COMDISPLAN).[4629] National Cabinet agreed to abolish the National Federation Reform Council.[4630] New High Risk Settings Pandemic Payment announced.[4631]
1 October 2022	Crisis Payment for a National Health Emergency ended.[4632]
24 November 2022	Australian Government published the National COVID-19 Community Protection Framework.[4633]
25 November 2022	The Hon Virginia Bell AC handed down the final report of the Inquiry into the Appointment of the Former Prime Minister to Administer Multiple Departments[4634] to the Prime Minister. The inquiry confirmed the Solicitor-General's conclusion that the appointments were constitutionally valid. Justice Bell found the secrecy around the appointments undermined public trust in government.
13 December 2022	Australian Government published the National COVID-19 Health Management Plan for 2023.[4635]
31 March 2023	High Risk Settings Pandemic Payment ended.[4636]
28 April 2023	National Cabinet endorsed the Strengthening Medicare Taskforce recommendation to explore barriers and incentives for all health practitioners to work their full scope of practice.[4637]
5 May 2023	World Health Organization Director-General announced that COVID-19 was no longer considered a Public Health Emergency of International Concern.[4638]
24 May 2023	Australian Government published the *Evaluation of COVID-19 point-of-care testing in remote and First Nations communities*.[4639]
25 July 2023	Australian Government published the Post-Acute Sequelae of COVID-19 Research Plan under the Medical Research Future Fund.[4640]
16 October 2023	Office of the Inspector-General of Aged Care established.[4641]

Date	Event
20 October 2023	Australian Chief Medical Officer declared that COVID-19 was no longer a Communicable Diseases Incident of National Significance.[4642]
13 November 2023	Australian Chief Medical Officer determined that COVID-19 was no longer considered to be a 'human coronavirus with pandemic potential', having the effect that COVID-19 was no longer considered to be a Listed Human Disease.[4643]
23 January 2024	Unleashing the Potential of our Health Workforce – Scope of Practice Review – Issues Paper 1 published.[4644]
15 February 2024	Australian Government published a National Post-Acute Sequelae of COVID-19 Plan.[4645]
16 April 2024	Unleashing the Potential of our Health Workforce – Scope of Practice Review – Issues Paper 2 published.[4646]
18 September 2024	New version of the Australian Government Crisis Management Framework was published, based on the 2023 review.[4647]

Appendix E: Key actions delivered by the Australian Public Service relating to COVID-19

Note: This outline is based on current portfolios and department functions. There have been a number of changes since the pandemic.

Agriculture, Fisheries and Forestry

Department of Agriculture, Fisheries and Forestry

- Developed a dedicated COVID-19 information hub for information and advice about the impacts of COVID-19 on agriculture, trade and the environment.
- Negotiated an Agricultural Workers Code under National Cabinet with state and territory governments to enable cross-border movement of workers, to ensure continuity of agricultural industry and food supply chains.
- Implemented temporary changes in undertaking its regulatory functions for agricultural imports and exports to allow electronic certificates to be used and, where possible, for remote auditing.
- Dedicated staff deployment to enable faster border clearance of imported grocery items for supermarkets, some of which experienced high demand during the COVID-19 pandemic.
- Undertook regular analysis of the agricultural trade implications of COVID-19, such as price changes, the role of imports in our food production, and changes to supply chain.
- While the international borders were still closed, worked with the Northern Territory Government to run a trial to bring horticultural workers into Darwin, which tested health and quarantine settings for the resumption of seasonal worker programs.
- Supported the Department of Health and Aged Care through the *Biosecurity Act 2015* (Cth) to implement health measures for travellers and to facilitate timely and efficient import of key supplies, such as vaccination supplies, rapid antigen tests (RATs) and personal protective equipment (PPE).

Attorney-General's

Attorney-General's Department

- Supported the continued functioning of the Australian legal system and legal assistance sector, and worked with federal, state and territory courts and correctional services to ensure the continued operation of criminal and civil justice systems.

- Provided international law advice to government relating to pandemic response measures.
- Used existing levers to support businesses and taxpayers through administrative flexibility on form lodgements, debt collection and audit activity.
- Provided identity verification services to support state, territory and Commonwealth applications and programs that delivered economic initiatives and helped manage the health impacts of the pandemic.

Australian Federal Police

- Assisted the Australian Border Force in its implementation of international travel restrictions.
- Established the Joint Intelligence Group as the central coordination point for intelligence.
- Established Taskforce Lotus as a targeted, scalable response to potential criminal threats to the COVID-19 vaccine rollout.
- Established the COVID-19 Counter Fraud Taskforce to support Commonwealth efforts to mitigate serious and complex fraud targeting Australian Government COVID-19 economic stimulus measures.
- Bolstered its community policing in the Australian Capital Territory (ACT) by establishing a dedicated COVID-19 Taskforce in July 2020 to ensure a centralised, coordinated response to business continuity, safeguarding community health outcomes and enforcement action. ACT Policing's resources were bolstered in response to the 12 August 2021 lockdown.

Australian Human Rights Commission

- Developed educational materials for government, committees, and organisations to ensure measures protected human rights.
- Developed reports on the risks and impacts of COVID-19 human rights issues for specific populations.
- Published information on COVID-19 and human rights.
- Handled 3,070 COVID-19 related complaints and 14,310 COVID-19 related enquiries. A majority of the complaints related to mask-wearing requirements, vaccination requirements and travel restrictions both domestically and internationally.

Climate Change, Energy, the Environment and Water

Department of Climate Change, Energy, the Environment and Water

- Maintained its core functions to coordinate responses and provide advice on energy market supply emergencies and disruptions under existing mechanisms, which incorporate supply of electricity, gas and liquid fuels (including jet fuel).
- Monitored developments in energy markets and provided briefing during supply emergencies to departmental executives, relevant ministers and the Commonwealth emergency management apparatus.
- Participated in the National Coordination Mechanism and the Australian Government Crisis and Recovery Committee in relation to energy matters.
- Worked with the Australian Energy Market Operator to enact its pandemic plan to ensure the sector was well placed to continue operating.
- Supported the Council of Australian Governments Energy Council's approach to identifying and managing the impacts of the pandemic on the energy sector, including the convening of the Energy Coordination Mechanism.
- Supported the measures for gas-fired development as part of the government's initiative for economic recovery.
- Supported regulatory responses in relation to energy efficiency which to helped reduce the burden on industry.

Defence

Department of Defence

- Established the Defence COVID-19 Taskforce to provide advice to the government on options and capabilities to provide Defence Force assistance to the civil community.
- Established Joint Taskforce 629 to deploy military resources required to support state and territory governments and emergency services.
- Led Operation COVID Shield to accelerate the vaccination rollout, in partnership with the Department of Health.
- Supported a number of initiatives via the Integrated Investment Program to support the economy, including a $1 billion Defence Economic Stimulus package to boost Australia's defence industry and support thousands of jobs across the country.
- Joint Health Command developed and continued to review and reform a Pandemic Plan that formed the basis of the campaign plan for the health element of the Defence response.

Department of Veterans' Affairs

- Ensured continuity of services to veterans and families and outreach to the most vulnerable in the veteran community.

- Open Arms Veterans and Families Counselling offices remained open with phone counselling available 24/7 and regular website updates for important self-help resources, including COVID-specific resources.
- Ensured access to the DVA Veterans' Access Network via telephone and introduction of COVID-safe in-person appointments by appointment while offices remained closed.
- Supported whole-of-government coordination of continuity of services to the Australian community, such as the implementation of COVID-19 economic support payments, education support and Coronavirus Supplement to DVA clients. This also included specific initiatives for vulnerable cohorts such as accessing rapid antigen tests using veteran health cards, and arrangements with supermarkets for allocated time slots for grocery shopping for veterans.
- Commemorated the service and sacrifice of Australians in defence of our nation, including Anzac Day 2020, which saw historic domestic participation in a range of community commemorations including supporting 'Light up the Dawn'.
- Delivered a COVID-safe nationally televised service to mark the 75th anniversary of the end of the Second World War.

Education

Note: During the pandemic the Education portfolio was under the Department of Education, Skills and Employment.

Department of Education

- Supported the early childhood education and care sector through a variety of measures, including legislative amendments, funding packages and grants, establishing and leveraging governance structures, and data collection and research.
- Developed a variety of frameworks, codes and guidelines to support schools, in consultation with states and territories and the sector.
- Designed and delivered a variety of initiatives to support schools to manage the impacts of COVID-19, such as the School Hygiene Assistance Fund, Student Wellbeing Boost, and early access to recurrent funding entitlements.
- Developed the National Teacher Workforce Action Plan, to address workforce shortages that developed due to COVID-19.
- Designed and delivered a variety of initiatives to support the higher education and research sector – for example, funding for short courses, funding to safeguard the university research sector, and Higher Education Loan Program charging measures.
- Developed a number of initiatives to assist international high school and university students, such as an agreement to allow international students on a student visa to

study online, and a travel-ban exemption process for Year 11 and 12 international students.

Employment and Workplace Relations

During the pandemic the Employment portfolio was under the Department of Education, Skills and Employment. Workplace Relations came under the Attorney-General's Department.

Department of Employment and Workplace Relations

- Designed and delivered a variety of initiatives to support apprentices and trainees, such as wage subsidies, additional in-training support, and a new Australian Apprenticeships Incentive System.
- Administered temporary amendments to the *Fair Work Act 2009* (Cth) to help with the implementation of the JobKeeper Payment, providing employers with increased flexibility to help manage their business.
- Supported five tripartite (government, unions and employer representatives) COVID-19 workplace relations working groups focused on economic recovery.
- Supported increased government engagement with the Fair Work Commission on changes to modern awards and Safe Work Australia on its role as a central information hub.
- Implemented a range of programs and initiatives to support job seekers and communities, such as reimbursement of relocation costs to take up short-term agricultural work, reskilling, upskilling and providing employment pathways to assist people to move back into jobs as the economy recovers.

Fair Work Commission

- Established a 'Coronavirus updates and advice' webpage to centralise information about how to engage with the Fair Work Commission on COVID-19 specific processes or application types.
- Varied modern awards and enterprise agreements, including varying 99 awards on its own initiative to provide unpaid pandemic leave and greater flexibility for annual leave for employees under many awards.
- Assisted employers and employees through the resolution of disputes about the temporary JobKeeper amendments to the *Fair Work Act 2009* (Cth).
- Considered the differing impacts of the pandemic across industries, published relevant research and varied modern award minimum wages on a staggered basis in the 2019–2020, 2020–2021 and 2021–2022 Annual Wage Reviews.
- Ensured that all conferences and hearings could be held remotely and reallocated resources to manage increases in application volumes.

Safe Work Australia

- Promoted the National COVID-19 Safe Workplace Principles, as agreed to by National Cabinet.
- Developed nationally consistent work health and safety guidance for COVID-19, in accordance with the Safe Workplace Principles.
- Safe Work Australia's website became a centralised national information hub for work health and safety guidance on COVID-19.

Fair Work Ombudsman

- Developed materials to help employees and employers understand their rights and responsibilities at work amidst the pandemic, including the dedicated 'Coronavirus and Australian workplace laws' webpage and guidance on managing JobKeeper obligations.
- Operated a coronavirus hotline.
- Established a temporary Workplace Legal Advice Program that provided free, tailored legal advice to eligible businesses and workers through a panel of external law firms on referral from the Fair Work Ombudsman.

Finance

Department of Finance

- Provided policy advice to government and other agencies on options for the response, and agreed costs and variations to estimates for relevant programs across agencies.
- Provided enhanced reporting to government on COVID-19 expenditure and payments, providing a comprehensive picture of data from across the Australian Government.
- Provided input and advice on special appropriations and related spending powers, including the *COVID-19 Disaster Payment (Funding Arrangements) Act 2021* (Cth).
- Led the design and delivery of three purpose-built quarantine facilities, known as Centres for National Resilience, including engagement with the Victorian, Western Australian and Queensland governments.

Foreign Affairs and Trade

Department of Foreign Affairs and Trade (DFAT)

- Coordinated facilitated commercial flights, DFAT-enabled departures, and flights chartered for targeted evacuation operations (assisted departures).
- Updated Smartraveller travel advisories and information (including digital channels) to provide advice to Australians overseas.

- Developed the Traveller Registration System, which recorded individual registrant details and supported DFAT's monitoring and reporting on the status of returning Australians.
- Developed the Special Overseas Financial Assistance (Hardship) Program to support vulnerable Australians to secure flights and return to Australia.
- Provided support to contracted parties delivering Australia's International Development Program to continue operation.
- Continued consular support to help repatriate Australians offshore.

Austrade

- Delivered the International Freight Assistance Mechanism to reconnect and maintain essential airfreight supply lines throughout the height of the global pandemic.
- Developed and delivered the Agribusiness Expansion Initiative to help Australian farming, forestry and fishing exporters to expand and diversify their export markets.
- Implemented the Export Supply Chain Service to coordinate supply chain insights while connectivity to international markets remained volatile, capacity diminished and rates expensive.
- Administered a suite of tourism programs, including the Business Events Grants program, Recovery for Regional Tourism program, COVID-19 Consumer Travel Support Program and Supporting Australia's Exhibiting Zoos and Aquariums Program, to support the visitor economy.
- Supported an independent review of the visitor economy (*Reimagining the Visitor Economy Expert Panel Report*), which informed development of the visitor economy strategy THRIVE 2030.

Health and Aged Care

Department of Health and Aged Care

- Developed a framework and plans to protect Australia in pre- and post-vaccination settings, including the Australian Health Sector Emergency Response Plan for COVID-19, the National Plan to Transition Australia's National COVID-19 Response, and the three-step Framework for a COVIDSafe Australia.
- Convened, established and supported the work of health-specific advisory bodies, including the Australian Health Protection Principal Committee and its subcommittees, the Australian Technical Advisory Group on Immunisation, and the Science and Industry Technical Advisory Group, to provide advice and recommendations on key public health decisions and COVID-19 response pathways.

- Supported older Australians and aged care providers through funding packages and grants; on-site vaccinations; guidance on infection prevention and control; visits to aged care homes; daily monitoring and case management; regular on-site polymerase chain reaction (PCR) testing; the provision of surge workforce, personal protective equipment, rapid antigen tests (RATs) and oral antiviral treatments; regular communication with the aged care sector on outbreak preparedness and management; and establishment of the Aged Care Advisory Group under the auspices of the Australian Health Protection Principal Committee.
- Supported the aged care, disability, Aboriginal and Torres Strait Islander, and culturally and linguistically diverse communities through a variety of measures, including through funding packages and grants; provision of vaccination workforce; establishing and leveraging governance structures; identifying and managing existing and emerging issues, including liaising directly with health services, peaks and other organisations; and data collection and research.
- Developed a variety of frameworks, guidelines, and plans to support health and aged care workers, frontline workers and the public in minimising COVID-19 spread in collaboration with states and territories. This includes but is not limited to the National Guidance on Laboratory Testing for SARS-CoV-2, COVID-19 National Guidelines for Public Health Units, living guidelines on the clinical management of patients with suspected or confirmed COVID-19 infections, and the Testing Framework for COVID-19 in Australia.
- Activated the National Incident Room (renamed the National Incident Centre), providing incident management architecture including Australian Medical Assistance Team (AUSMAT) deployments as well as scaling-up of the National Medical Stockpile to support jurisdictions and key stakeholders in the procurement and deployment of essential medical supplies and COVID-19 treatments.
- Procured, assessed and distributed COVID-19 vaccines and treatments to all Australians through the National COVID-19 Vaccine Program and Operation COVID Shield, in partnership with the Department of Defence.
- Procured, assessed and distributed COVID-19 rapid antigen tests to support Australians, in partnership with states and territories.
- Implemented the Living with COVID package including HealthDirect support for COVID-19 triage, personal protective equipment for primary care settings delivered through Primary Health Networks, support for general practices to provide continuing care, COVID community pathways, and updated clinical guidance for general practice through HealthPathways.
- Supported health research communities through funding packages and grants.
- Supported the mental health and wellbeing of all Australians through a variety of measures, including the National Mental Health and Wellbeing Pandemic Response

Plan, funding packages and grants for mental health initiatives, the HeadtoHelp and Head to Health pop-up programs, and mental health support via telehealth and digital platforms.

- Supported ongoing essential healthcare through a variety of measures, including bolstering Pharmaceutical Benefits Scheme funding, e-prescription, expansion of telehealth services, a National Coronavirus Helpline, and General Practitioner Respiratory Clinics.
- Supported development of the National Partnership on COVID-19 Response, to financially support the states and territories with additional costs incurred in their health systems. This included a viability payment for private hospitals.
- Developed plans to support those experiencing long COVID, including the Long-Term National Health Plan, the Post-Acute Sequelae of COVID-19 Research Plan, and the National Post-Acute Sequelae of COVID-19 Plan.
- Developed communication strategies and provided communication products to support states and territories, health and aged care workers, priority populations, stakeholder groups and all Australians. This included thousands of direct communications with the community, health practitioners, other sectors and government/non-government workers via daily press conferences, webinars and social media posts, web content, national communication campaigns, and tailored information; and funding for priority population specific communication channels such as First Nations Media.
- Developed and improved existing data capabilities, including the establishment of the COVID-19 Register; integration of Australian Immunisation Register data, Medicare Benefits Schedule data and Pharmaceutical Benefits Scheme data into the Person Linked Integrated Dataset; and a national dashboard of intensive care unit activity.
- Provided epidemiology data through surveillance and reporting of COVID-19 cases at the Commonwealth level. Developed the national epidemiology workforce through the COVID-Net epi program, which funded an epidemiologist for states and territories.
- Designed the emergency and other health-related legal instruments used during the pandemic, including measures banning cruise ships entering Australia and measures protecting remote communities.

Therapeutic Goods Administration

- Supported the government in the procurement, assessment and regulation of COVID-19 vaccines, treatments, diagnostics (including rapid antigen tests) and other medical supplies such as personal protective equipment.
- Supported health and medical professionals through regular updates on clinical information and eligibility criteria.

- Assessed and regulated COVID-19 vaccines and treatments under provisional approval pathways, without compromising on clinical effectiveness or safety data requirements.

Aged Care Quality and Safety Commission

- Supported older Australians and the aged care sector through the development of online infection prevention control training modules and tools, and expanded infection prevention control spot checks.
- Heightened communications to aged care communities through regular bulletins, engagement with service providers and direct mail-outs to providers.

Australian Commission on Safety and Quality in Health Care

- Developed resources and guidelines for the community and health services on how to reduce the risk of COVID-19 exposure and infection, including advice on infection prevention and control, managing medications and mask wearing.
- Implemented provisions to enable hybrid and virtual accreditation assessments, for both acute and primary care service organisations, where on-site assessments were not possible.

Home Affairs

Note: Emergency Management Australia was previously a division within Home Affairs and became a portfolio agency from 2022 as the National Emergency Management Agency.

Department of Home Affairs

- Managed the international border, exemptions, import and export controls, and sourcing of quarantine facilities.
- Supported crisis management and pandemic planning, including the National Coordination Mechanism, COVID support payments (COVID-19 Disaster Payment and Pandemic Leave Disaster Payment), measures to address supply chain issues, and joint taskforces with the Department of Defence.
- Administered vaccine requirements for non-citizens intending to enter Australia.
- Worked on visa and regulatory changes to support the labour market and critical skills shortages, including shifting its network of global visa processing officers to surge priority caseloads and prioritise onshore processing of applicants in critical sectors.
- Engaged with key community stakeholders through community liaison officers to address issues relating to COVID-19 and to provide support and information to communities.

National Emergency Management Agency

- Implemented the National Coordination Mechanism process, which brought together the Australian Government, state and territory governments, industry and not-for-profit stakeholders to address specific impacts of the crisis.

Industry, Science and Resources

Department of Industry, Science and Resources

- Provided support to industry to establish new domestic capability for manufacturing medical supplies through subsidised loans, grants, and brokering industry and academic partnerships.
- Helped secure access to personal protective equipment (PPE) and essential medical supplies for the National Medical Stockpile, by working with industry to source, triage and assess offers of supplies for the Department of Health to procure.
- Supported domestic manufacturers with free access to product manufacturing standards for PPE and establishing new domestic product testing capabilities through the National Measurement Institute (NMI). NMI provided critical assurance that Australian-sourced supplies and testing were fit for purpose.
- Monitored and advised government on critical supply chain risks, including through a dedicated area called the Office of Supply Chain Resilience.
- Established a number of taskforces early in pandemic to address critical supply chain issues as they arose.

Infrastructure, Transport, Regional Development, Communications and the Arts

Department of Infrastructure, Transport, Regional Development, Communications and the Arts

- Implemented infrastructure investment measures as part of the Commonwealth's economic stimulus response to COVID-19.
- Facilitated freight movements – including through the establishment of the COVID Land Transport Working Group to inform and support decisions taken through National Cabinet and the Australian Health Protection Principal Committee, comprising representatives from all jurisdictions, key industry stakeholders and regulators.
- Facilitated freight movements – including through the establishment of the COVID Maritime Response Group to inform and support decisions taken through Cabinet and the Australian Health Protection Principal Committee, and to facilitate resolution of issues with the potential to disrupt sea freight, comprising representatives from all jurisdictions, key industry stakeholders, unions and regulators.
- Regulated international airline timetable approvals (capping international passenger arrivals) in support of Commonwealth and state health and quarantine policies.

- Designed and delivered a $5.6 billion suite of aviation support measures to maintain essential domestic and regional air connectivity, and preserve a core international aviation capacity to allow the sector to restart after the pandemic.
- Leveraged the Communications Sector Group, one of the critical infrastructure sectors in the Trusted Information Sharing Network, to distribute information to decision-makers from jurisdictional agencies.
- Developed a paper on how COVID-19 restrictions could be modified to ensure the communications industry continued to operate whilst protecting workers and the community.
- Provided a package of measures to support Australian media businesses through the early stages of the pandemic, including tax and regulatory relief and additional funding.
- Administered a range of initiatives through the $1 billion COVID-19 Relief and Recovery Fund, aimed at supporting regional industries, sectors and communities that were disproportionately affected by the pandemic.
- Managed the response to the pandemic in Australia's non-self-governing territories. Facilitated access as early as possible to antiviral treatments and vaccinations for the external territories of Christmas Island, Cocos (Keeling) Islands and Norfolk Island.
- Provided a range of targeted supports to the arts and entertainment sector.

Prime Minister and Cabinet

Department of the Prime Minister and Cabinet

- Served two Prime Ministers, supported their Cabinets and supported National Cabinet.
- Provided whole-of-government coordination and advice.
- Utilised existing and new interdepartmental and Commonwealth–state structures, such as the Secretaries Board, First Secretaries Group, COVID Deputies, First Deputies Group and Chief Operating Officers Committee.
- Established taskforces such as the COVID-19 Risk Analysis and Response Taskforce (which developed the National Plan) and a cross-agency COVID-19 Transition Taskforce, co-led with the Department of Health and Aged Care.
- Established the Vaccine Strategy Integration Group.
- Supported the National COVID-19 Coordination Commission.

Australian Public Service Commission

- Performed a stewardship role in central coordination committees, including as deputy chair of the Secretaries Board and the Chief Operating Officers Committee, and participated in other subcommittees.

- Established taskforces such as the COVID-19 Taskforce on COVID-related workforce matters to support Australian Public Service business continuity, and the Workforce Management Taskforce to stand up a temporary workforce to deploy over 2,300 employees to critical functions.
- Worked with state and territory public service commission equivalents to share information on common workforce management issues.
- Provided whole-of-government monitoring of employee movements, including data on work-from-home arrangements and surge deployment.
- Delivered workplace relations reforms to support public sector arrangements.

National Indigenous Australians Agency (NIAA)

- Worked with other agencies, state and territory governments, peak organisations and Aboriginal and Torres Strait Islander leaders to support their engagement with, and responses to, Aboriginal and Torres Strait Islander peoples and communities regarding COVID-19, including supporting the rollout of COVID-19 vaccinations.
- Worked with NIAA-funded organisations to ensure service viability, and to adapt delivery to meet needs while complying with physical distancing and travel restrictions.

Social Services

Department of Social Services

- Led the portfolio response for people with disability and coordinating efforts across the NDIS Quality and Safeguards Commission and the National Disability Insurance Agency, including establishing the Portfolio COVID-19 Response Taskforce.
- Negotiated improved data reporting of impacts on people with disability.
- Provided supports for people with disability, including delivering rapid antigen testing kits to people in supported independent living and to disability support providers, and expanding the relevant assistive technology lists.
- Provided financial support for individuals, support for communities, and support for industry and businesses, including the COVID-19 Disability Worker Leave Grant.
- Provided funding to states and territories under the National Partnership on COVID-19 Domestic and Family Violence Responses.
- Introduced flexible grant management arrangements to address the impact of COVID-19 on delivery activities.
- Established the sector-led National Coordination Group to monitor the impact of the pandemic and provide advice on Community Support Package funding needs.

- Supported communication with people with disability, working closely with the Department of Health and Aged Care and Services Australia, including providing information and support through Disability Gateway on COVID-19, vaccination and testing.

Services Australia

- Implemented 50 policy changes to 20 payments on behalf of numerous departments, including expanding eligibility to some payments, waiving waiting periods and asset tests for certain payments, and applying exemptions from mutual obligations.
- Paid a number of new payments during the pandemic, including the Crisis Payment for National Health Emergency, economic support payments, the Coronavirus Supplement and the Pandemic Leave Disaster Payment.
- Ensured vaccination providers were able to report COVID-19 vaccinations to the Australian Immunisation Register, and delivered the design and rollout of the COVID-19 Digital Vaccination Certificate.

National Disability Insurance Agency

- Brokered vaccinations in local pharmacies for people with disability with the Pharmacy Guild of Australia.
- Contracted Aspen Medical and GenU to provide clinical first response and provider workforce support services from 2020 to January 2023.
- Distributed accessible information about COVID-19 to participants and providers.
- Enabled flexible use of plans to ensure COVID-19 safety was implemented, including allowing participants to use funds from their existing plan budgets to purchase low-cost assistive technology, rapid antigen test kits and personal protective equipment and to fund one-off deep cleaning of residences.
- Provided support of up to $1,200 per day per household for a COVID-positive participant in supported independent living.
- Paid $75 per participant and $100 per disability support worker to providers who assisted participants or workers to receive an off-site vaccination.
- Provided financial assistance to National Disability Insurance Scheme (NDIS) providers, to support financial viability and assist in retaining staff.

NDIS Quality and Safeguards Commission

- Provided regular advice to registered NDIS providers and provider alerts that included important information about COVID-19.
- Providers were required to notify the NDIS Commission if a support worker or NDIS participant was confirmed to have COVID-19.

- Handled complaints about the safety of NDIS services.
- Required notification where an NDIS participant died with an association to COVID-19.

Treasury

The Treasury

- Increased its economic analysis, advice and reporting to government, providing frequent updates on the global and domestic economic impact of COVID-19 and the associated policy response.
- Led the design and implementation of many COVID-19 measures, including JobKeeper, Boosting Cash Flow for Employers and the HomeBuilder program.
- Worked closely with regulators to monitor and address issues that arose across the financial system.
- Increased engagement with stakeholders, including Australian businesses, state and territory governments, the global economic community, and health organisations such as the Doherty Institute.
- Provided whole-of-government coordination and information sharing.
- Funded the National Partnership on COVID-19 Response, to financially support the states and territories with additional costs incurred in their health systems.

Australian Taxation Office

- Administered many COVID-19 measures, including JobKeeper and Boosting Cash Flow for Employers.
- Shifted its regulatory focus from debt collection to assisting businesses and the community experiencing challenges because of the pandemic.

Reserve Bank of Australia

- Conducted monetary policy operations to lower funding costs and support the supply of credit to the economy, including a number of extraordinary monetary policy tools which it had not previously used.
- Worked closely with the Australian Government, the Australian Treasury and Australia's financial regulators on the coordinated response to COVID-19.

Australian Bureau of Statistics

- Leveraged new data sources to increase the speed of its reporting, including introducing new preliminary releases and surveys.

Australian Competition and Consumer Commission

- Adjusted processes and analysis to more quickly grant urgent interim authorisations for cooperation amongst competitors, where it was in the public interest.

Australia Securities and Investments Commission

- Provided temporary regulatory relief for companies, including enabling certain lower documentation offers to be made to investors and extended periods for lodging financial reports.
- Introduced measures to ensure the equity market remained effective and resilient.

Australian Prudential Regulation Authority

- Provided temporary regulatory relief, including adjusting bank capital expectations and changed reporting obligations.
- Delayed its 2020 supervision and policy priorities.

Appendix F: Acknowledgements

We acknowledge the many people who enabled the completion of the inquiry within our 50-week timeframe. We are grateful to the groups and individuals who gave generously of their time and insights by participating in stakeholder consultations, interviews, meetings, roundtables, focus groups and surveys, and preparing detailed submissions and supporting evidence. The Inquiry would not have been possible without your diverse voices.

We extend our thanks to the COVID-19 Response Inquiry Taskforce, who provided ongoing support throughout the Inquiry. The taskforce was led by Pauline Sullivan with support from Lauren Le Cerf and Alexander Abel, and the following team members:

Trent Alleyne

Dr Jessica Almine

Sarah Bellinger

Matthew Bennett

Leila Bieleny

Michael Carter

Mackenzie Cox

Jessica De Block

Margot Deegan

Paul Ferlitsch

Kim Flanagan

Dr Kate Goasdoué

Zoe Grant

Phil Hastings

Laura Hill

Jessica Holder

Kate Husband

Vaishnavi Karnik

Christopher Laksana

Tracey Langron

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Andrew Pfeiffer

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Charity Rentsch

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Anna Sloan

Alexander Tashevski-Beckwith

Gemma Tuddenham

Mehak Vohra

Matthew Willett

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