Submission to Commonwealth Government Covid-19 Response Inquiry

From Professor the Hon. Greg Hunt

To Commissioner Robyn Kruk AO, Chair of the Inquiry

Date: 23 April 2024

1. Introduction

All countries in the world, including Australia, were impacted by the Covid-19 pandemic, which began in January 2020, with immense suffering and human loss. However, few countries responded and achieved the twin objectives of limiting loss of life and maintaining livelihoods, more effectively than Australia. Perhaps the clearest measure of Australia's Health outcomes was that during 2020 and 2021, when global life expectancy dropped by 1.6 years on average, in Australia it rose by 0.2 years, a difference from the global mean of 1.8 years in average life expectancy.

Nevertheless, there are important learnings as to what can be done in the future to manage the ongoing burden of disease, future outbreaks, and new pandemics.

While the immediate threat to the sustainability of global and Australian health systems has subsided, the human tragedy, economic challenges, and health system threats remain ongoing from what is now an endemic disease. It is also a disease for which the causative virus has continued to mutate. In that context, while world-leading early vaccination rates, lower virulence due to virus mutation and widespread exposure to the disease make the death of any recently infected individual less likely, high prevalence and transmissibility, coupled with declining vaccination rates in the last 18 months leave Australia open to deep harm and the risk of significant mortality from further mutations or the inevitable next round of a major pandemic.

Indeed, as at 27 March 2024, over two-thirds of recorded Covid related deaths in Australia have occurred since 21 May 2022. In the period from January 2020 to 21 May 2022, during the height of the pandemic, there were 8,077 officially recorded deaths, one of the lowest per capita rates in the world. From 21 May 2022 to 27 March 2024 there have sadly been 16,279 reported Covid related deaths in Australia.

In terms of Australia's response, given my role as the Minister for Health and subsequently Health and Aged Care, I will focus largely on the health challenges, response and recommendations based on first-hand learnings from this period and observations of the subsequent period beyond my direct involvement as Minister.

I have also attached approximately 1700 pages of materials that were provided to me before I retired from Parliament – at my request – by the Department of Health and Aged Care for the purposes of any future inquiry or other reference needs. These are **attached** in **Appendices 1-11**. They include potentially valuable timelines prepared by the Department of Health. None of the materials are confidential and some may already be within the possession of the Inquiry, however my hope is that a comprehensive record of timelines, statements, releases, and summaries from within the Health response may be of assistance to the Commission.

The central observation of Australia's pandemic Health response is that Australia achieved one of the lowest rates of loss of life, one of the highest vaccination rates at 98% double vaccination for over 18 year old Australians, and one of the most resilient economic outcomes in the world.

The Primary reasons for these outcomes were essentially fourfold:
1. Pre-pandemic preparation and planning.
2. A comprehensive strategic national response coupled with rapid and focused decision making and constant Cabinet level review of developments and therefore new actions to be taken or to be considered.
3. A willingness to follow the medical advice at a national level including early closure of the borders with China on 1 February 2020.
4. Provision of significant financial resources both for health and mental health resources as well as for national and individual economic well-being.

As at the 29 March 2022, Federal Budget $45 billion had been invested in the Covid-19 Federal health response including a further $4.2 billion allocated in that Budget.

1.1 Health Outcomes

In terms of comparative outcomes as at April 2022, Australia was one of only two OECD countries, along with Japan, to have a whole of population double vaccination rate of over 80% (82.8% at that time), cumulative death rate from Covid of under 300 per million (253.1 at that time) and an unemployment rate of 4.0% or below.

The Global Burden of Disease Study into international Covid deaths published in the Lancet on 11 March 2024 concluded that Australia was one of only a small number of countries to have an increasing rather than a decreasing life expectancy during 2020 and 2021.[1] The Lancet Report attributes 15.9 million deaths to Covid during 2020 and 2021 globally.

In particular the Global Burden of Disease review concludes that from 204 countries and jurisdictions, Australia was one of only 32 countries to record an increase in life expectancy from 2019 to the end of 2021. Global life expectancy was 73.3 in 2019, the year before the pandemic. It subsequently fell by 1.6 years to 71.7 in 2021. By comparison, in Australia life expectancy rose from 83.2 in 2019 to 83.4 years in 2021. US average life expectancy declined by 2 years over the same period.[2]

Perhaps most significantly, the initial Doherty Institute modelling which helped inform the Government's actions indicated a potential loss of life in Australia of up to 150,000 in an unmitigated scenario.[3] It is against this background that the Government took unprecedented steps and actions to limit the spread of the disease and to boost capacity within the health system while also supporting economic activity and individual livelihoods.

1.2 Health Strategic Objective: Containment and Capacity Twin Health Strategy

The fundamental goal of the health response was to save lives and to prevent the health system from being overwhelmed. Systems were in fact overwhelmed or catastrophically stressed in comparable countries or cities such as Italy, Spain, parts of the UK, France, and in particular New York in March and April of 2020 for example.

The simple objective was that every Australian who needed care, and in particular ventilation, would be able to receive that care. That goal was widely known as "flattening the curve". This meant reducing the rate of infection and serious illness below the capacity of the hospital and health system to treat all patients.

In order to achieve that outcome, the medical advice and the clear view of myself, the Government, and the Prime Minister was that we therefore needed a strategy based on two fundamental objectives, each of which contained 4 pillars.

First, the objective was to reduce or contain the rate of infection while capacity was being built. The second was to build that capacity for potentially catastrophic needs in the health system. This twin strategy therefore involved containment and capacity.

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[1] The Lancet, *Global age-specific mortality, life expectancy, and population estimates in 204 countries and territories and 811 subnational locations, 1950–2021, and the impact of the COVID-19 pandemic: a comprehensive demographic analysis for the Global Burden of Disease Study 2021* (Report, 11 March 2021), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(24)00476-8/fulltext.

[2] Charis Chang, 'How Australia bucked a global COVID-19 life expectancy trend', *SBS News* (online, 12 March 2024) <https://www.sbs.com.au/news/article/how-australia-bucked-a-global-covid-19-life-expectancy-trend/thpl96aw4>.

[3] Dana McCauley, 'Australia prepares for 50,000 to 150,000 coronavirus deaths', *The Sydney Morning Herald* (online, 16 March 2020) <https://www.sbs.com.au/news/article/how-australia-bucked-a-global-covid-19-life-expectancy-trend/thpl96aw4>.

Both strategies are set out in real time in my contemporary 13 May 2020 Ministerial Statement on the Health response to Covid-19[4] and updated in the 29 March 2022 Joint Media Release on Australia's overall Health Budget of that date.[5] I draw from both these documents as contemporary records in the early and late stages of my time in helping to manage Australia's response to the pandemic.

2. Containment

The Containment Strategy was based on 4 pillars.

2.1 Borders

First, the closure of the borders to minimise the spread of Covid-19 into Australia.

On 21 January 2020, after consultation with myself, the then Chief Medical Officer Professor Brendan Murphy listed "human coronavirus" as a disease of pandemic potential under the Biosecurity Act. This enabled the Government to prepare for early use of enhanced border measures which were backed by early meetings and preparation for such an eventuality through the National Security Committee of Cabinet and other bodies and agencies of Government. This was well ahead of the WHO which did not declare the novel coronavirus to be a "public health outbreak of international concern" until 30 January 2020.

The most significant action was the early closure of the border with China on 1 February 2020. This faced criticism from China, the WHO, and various domestic actors, and was seen by some other like-minded countries (who subsequently had significantly worse outcomes) as not a decision they were willing to take at that stage.

However, it is arguably the most important peace time decision taken by any Australian Government since the Second World War and along with subsequent decisions was critical to saving lives and making space for vaccination and therapeutic programs along with building health system capacity.

Borders were subsequently closed to Iran, Italy after hesitation from some within the AHPPC, although not Professor Murphy, and South Korea, before closure to all foreign nationals and the introduction of mandatory quarantine for returning citizens and permanent residents.

A major concern was the vulnerability of Indigenous communities and in close consultation with and only where there was the dual support of both State or Territory Governments and traditional owners, restricting access to remote Aboriginal and Torres Start Islander communities. One of Australia's most important achievements was that by May 2022, Australia had one of the lowest rates of infection and loss of life among Indigenous communities of any nation as advised by the Department of Health. For a period of over 2 years, Dr Lucas De Toca of the Commonwealth Department of Health and others worked closely with Indigenous communities on continuous protection and response measures for both remote, rural and urban Indigenous communities.

A ban on cruise ships from foreign ports was also put in place under the Biosecurity Act.

The Government was aware that ultimately it would be impossible to prevent the entry into Australia of Covid-19 and its spread, given the medical advice. However, the clear medical advice and our conclusion was that time to mitigate the effects and build system capacity was critical to saving lives and protecting lives. In addition, the objective was not just to build capacity, but as far as possible, to delay the spread of the disease until individual medical protections such as vaccines or therapeutics had been developed and disseminated. Although there was no certainty of effective vaccines or therapeutics or effective treatments being developed, in fact, the strategic

[4] The Hon. Greg Hunt MP, 'COVID-19', (Ministerial Statement, House of Representatives, 13 May 2020).
[5] The Hon. Greg Hunt MP, Senator the Hon. Richard Colbeck, The Hon. Dr David Gillespie MP, The Hon. David Coleman MP, 'Record Investment in the Future Health of Australia's Health System' (Media Release, 29 March 2022).

assumptions were overwhelmingly accurate, with Australia having achieved comprehensive vaccination by the end of October 2021, two months ahead of schedule and largely in advance of the Global spread of the highly contagious and transmissible Omicron strain.

2.2 Testing

The second pillar of our containment strategy was Covid testing. Testing was identified early as a critical component of limiting the spread of the disease. The procurement of reliable PCR tests in high volume and the establishment of a national testing network was a priority which involved enormous and intense effort by the Department of Health and supporting agencies at Federal, State and local levels. This occurred at a time of massive global shortage and intense competition for such tests. Australia was identified by the London School of Hygiene and Tropical Medicine in April 2020 as having one of the most accurate testing networks in the world.

The testing strategy was underpinned by two elements. Firstly, access to supplies of high-quality reliable PCR tests at a time when there was a massive global shortage.

The Department of Health in conjunction with an Industry Department taskforce and multi-departmental support unit including the Attorney-General's Department, Finance, and the ADF established a specific focus on maintaining continuous flows of tests. The relationship with providers was monitored daily with tests passing 1 million PCR delivered by mid-May 2020 and had grown to over 60 million tests by May 2022.

Secondly, establishment and maintenance of testing sites and throughput capacity.

In late January and early February of 2020, planning was undertaken with the States for rollout of mass testing clinics, known as respiratory clinics, which could then become vaccination clinics. By 13 May 2020, 436 respiratory or testing clinics were in operation, including over 100 GP Respiratory Clinics approximately two weeks ahead of the initial goal for that figure.

On the basis of medical advice, the TGA subsequently began to test and approve Rapid Antigen Tests in advance, but in anticipation of AHHPC support for RAT tests as a supplement or alternative to PCR tests. The Commonwealth also forward ordered large volumes of RAT tests for use in Aged Care facilities and provided a continuous supply of RATS from August 2021 when they were approved for use in aged care facilities. As at 20 May 2022, the Commonwealth had supplied 45 million RATS to aged care facilities and 44.4 million RATS to Concession Card holders. As at 29 March 2022, the Commonwealth had supplied 19.7 million RATS through other channels including to Indigenous communities, Supported Individual Living and Disability care. Over $1.6 billion was allocated to the program including forward provision for the Concession Card Holders Scheme. The Concession Card Holders Rapid Test Access Scheme was discontinued by the subsequent Government.

The findings of the London School of Hygiene and Tropical Medicine underlined how important the comprehensive procurement of tests and delivery through over 400 sites was, in terms of identifying early cases, allowing for isolation and enabling comprehensive tracing to limit the spread of Covid.

2.3 Tracing

Tracing of Covid contacts was identified early as an essential tool for limiting the spread. Public Health systems in all States took the primary lead from late January 2020 on identifying and following case contacts. This was coordinated through the National Incident Centre under Deputy CMO Professor Paul Kelly and Celia Street but conducted by the States. In particular, NSW was seen as having a world standard contact tracing system following a multi-year program of developing public health capability.

Victoria's system suffered extreme overload in June and July of 2020. The Commonwealth was subsequently able to embed the Chief Scientist of Australia Professor Alan Finkel within the Victorian system to assist in automating many of their manual processes and also to embed Dr Sonia Bennett from Queensland to provide medical advice and leadership in contact tracing. In

addition, an ADF contingent led by Commodore Mark Hill was accepted to provide support to the Victorian Department of Health and Human Services in contact tracing, data management, logistics and planning. As at 31 July 2020, Commodore Hill led a contingent of 300 as part of a broader ADF Covid support contingent in Victoria of approximately 1,400 personnel.

The Department of Health has confirmed that the COVIDSafe App had 7.9m registered users and identified 2,829 potential close contacts of those with positive cases.

One potential role for the proposed Centre for Disease Control would be to assist in ensuring that all States and Territories develop their contact tracing reserve capabilities to the level and standard of NSW.

2.4 Public Health and Social Measures (PHSM)

Fourth, a range of Public Health and Social Measures (PHSM) were introduced to reduce disease transmission. The most important of these, social distancing was progressively introduced largely through the co-ordination of the National Cabinet and subsequently through the unilateral decisions of some States.

National Cabinet developed a series of step-up and step-down distancing measures as part of the Covid Roadmap. This included nationally agreed restrictions on gatherings following medical advice.

Subsequent unilateral decisions of some States outside of the National Cabinet framework, such as Victoria's curfews or 5km movement restrictions were not the subject of Commonwealth advice and nor to the best of my knowledge has the medical advice for such restrictions been either released or affirmed at State level.

The philanthropically funded Shergold Review was, in particular, critical of some of the unilateral distancing measures. Given the strong presumption of individual freedom and liberty that underpins our nation and the risks to educational attainment and mental health, my strong forward recommendation is that all States and Territories adopt a uniform national code for pandemic management which mandates medical advice be published for any restrictive measures. Although this was not a legal requirement under the Biosecurity Act, it was nevertheless a practice that we adopted and which I would also recommend be included in amendments to the Commonwealth Biosecurity Act.

Other important PHSM measures that were supported by the National Cabinet and strongly promoted by the Commonwealth included the widespread community use of face masks and a strong focus on hand hygiene, with the widespread availability of hand sanitiser.

3. Capacity

From January of 2020, the threat of catastrophic system collapse – and loss of life – as subsequently occurred in many comparable countries meant that containment alone was not enough. Nor was it compatible with the early and continuous medical advice that Covid-19 would ultimately become endemic in all nations. It was therefore vital to run a parallel strategy of building health system capacity to meet the simple goal of providing care to every patient who needed support.

The strategy to increase health systems capacity was itself based on 4 pillars.

3.1 Primary Care and Mental Health

First, strengthening Primary Health and Mental Health Care.

The Primary Care and Mental Health response included PPE, Telehealth, training of medical personnel, access to medicines and delivery of a comprehensive mental health package.

Critical to Australia's outcomes was the continued provision of PPE during a global collapse in supply and a spike in demand that saw massive shortages in PPE in many countries.

During February, March and April 2020, the world suffered an extreme shortage of PPE relative to need and demand.

Although there were inevitable stresses, the catastrophic international shortages were not however the case in Australia where the Government established a national PPE purchasing program in February 2020. This was overseen by the Departments of Health and Industry which secured over 2 billion units of material for the National Medical Stockpile including surgical masks, N95 masks, gloves, gowns, goggles, swabs, tests, vaccines and other items, based on medical advice from the Chief Medical Officer and requests from States and Territories.

This procurement process was one of the earliest, strongest, and most successful in the world. It helped save lives and protect lives.

By May of 2020 over 100 million units had been received, 75 million masks had been deployed with forward pipelines of all others, and over 100 million more had been ordered. This grew to a total of 1.8 billion units of PPE, swabs, vaccines and other medical items purchased by May of 2022.

In the Auditor-General Report No. 22 2020-21, the ANAO concluded at paragraph 10:

> *"Health's and DISER's NMS procurement planning and governance arrangements in response to the COVID-19 pandemic were effective. Both entities had elements of a plan for meeting the requirement, established fit for purpose governance arrangements and considered risks."*

In addition, in the Auditor-General Report No. 39 2020-21, the ANAO also reported:

> *"Suppliers passing an initial triage stage underwent due diligence checks by procurement taskforces in both departments."*

The ANAO also noted:

> *"At the peak of procurement activity, 35 full time equivalent staff were working on the procurements at Health and at DISER 173 full time equivalent staff were diverted to the taskforces supporting Health.*
>
> *DISER's role in the procurements included: identifying areas of supply chain vulnerabilities: sourcing, triaging and assessing offers to supply PPE and other medical supplies to the NMS: conducting due diligence on some offers of assistance: and drafting some contracts, which it then referred to Health."*

The March 2022 Budget also included a further $1.1 billion for securing additional PPE to continue support for RACFs and other frontline health services via the National Medical Stockpile.

The Government recognised in early 2020 that a national Telehealth system was critical to keeping both GPs, nurses, and patients safe from infection and to keeping General Practices operating while providing services to patients in isolation or lockdown.

The Government previously had a plan to progressively adopt Telehealth over the course of a decade and this was foreshortened to approximately 10 days in late March 2020 under the leadership of Penny Shakespeare and her team within the Department of Health. The adoption of Telehealth was something I considered to be a deep personal commitment and objective. It followed discussion with the AMA, RACGP and individual doctors and observation of the catastrophic losses to medical personnel in Italy, Spain and New York.

Telehealth was rolled out on a national basis with an initial investment of $669 million. By the time of my Ministerial Statement of 13 May 2020, over 9 million consultations had been delivered via Telehealth, underpinned by a double bulk billing incentive. The transformation of Australia's Primary care delivery system to allow for the whole of population Telehealth has become an

abiding and permanent change to Primary Health in Australia. The delivery of over 169 million services via Telehealth following its introduction in March 2020 is arguably the single most significant transformation in Medicare since its introduction in 1984.

I note that from 30 June 2024, it is proposed to discontinue Telehealth measures for:

- Long telephone consultations for eligible patients' assessments for suitability of Covid-19 oral antiviral medicines; and
- Patients with a recently confirmed Covid-19 diagnosis or suspected infection requiring confirmation via PCR pathology tests who can currently access MBS Telehealth services from any available GP.

I would recommend that given the ongoing high prevalence of Covid-19 within the community, existing Telehealth Services for oral antiviral suitability and for PCR confirmation be extended for 12 months, to 30 June 2025 and reviewed for further extension at that time.

The national Telehealth system was underpinned by acceleration of the electronic scripts system, continuous dispensing and establishment of a medicines home delivery system. By May of 2020 over 302,000 deliveries had been made from over 3,600 pharmacies.

The Department of Health advised that as at 31 December 2023, over 191 million electronic prescriptions had been issued Australia wide. This represents a fundamental and enduring reform in the prescription and delivery of medicines to patients.

A significant and important part of the national capacity response throughout Covid was the establishment of a National Mental Health Pandemic Response Plan and support program developed under the leadership of Dr Michael Gardner from my office and Deputy Secretary Tania Rishniw from the Department of Health. This included a 24 hour Beyond Blue pandemic support line, dedicated programs for frontline health workers, and additional support for organisations such as Lifeline, Headspace, and Kids Help Line.

An important initiative was the appointment of a Deputy Chief Medical Officer for Mental Health, Dr Ruth Vine. Dr Vine subsequently oversaw the creation of the Head to Health network for children and adults to complement headspace for youth. After an initial roll out in Victoria in 2020, this was funded as part of the National Mental Health and Suicide Prevention Plan released in 2021 and which by March of 2022 had $1.8 billion allocated for treatment programs including Head to Health.

The final element of the Primary Care capacity plan was recruiting and retraining medical staff. Initiatives were established to recruit new staff and upskill staff. By May of 2020, over 655,000 medical workers had completed infection control training for example, including 120,000 aged care workers and 61,000 disability workers.

All of these items were funded as part of an initial $1.1 billion Community Health and Mental Health Program which was continuously upgraded and funded through to and by the March 2022 Budget forward allocations.

3.2 Aged Care Capacity

From the outset of the pandemic, planning began to support aged care residents and elderly Australians who were deemed vulnerable to the new coronavirus. Building capacity in aged care was a foundation priority of the pandemic response and was itself based across three areas: PPE including infection control, workforce including surge capability and vaccination.

Around the world, including Australia, there was immense hardship for families, staff and providers in aged care, with tragic and painful loss of life globally as well as in Australia. As at 29 March 2022, the advice of the Department of Health and Aged Care was that Australia had one of the lowest rates of loss of life in aged care of any nation, and had the highest known rate of staff vaccination and one of the highest rates of resident vaccinations.

One concern is that despite Covid-19 having transitioned from pandemic to endemic status, in the period from 19 May 2022 to 21 March 2024 resident deaths in aged care have increased by 3,947 or 163%. This indicates the need for ongoing and continuing support in the form of PPE, infection control and training, workforce support and vaccination support for both staff and residents. I

would therefore recommend that there be a new 5 year Aged Care Covid and Flu support plan and package – to be reviewed annually.

In terms of PPE provision for Aged Care, as at 19 May 2022 the National Medical Stockpile had provided 298.8 million units of PPE to residential aged care including 45 million RATS and over 200 million masks, gloves, gowns, goggles, face shields and other equipment.

In addition, as at 15 May 2022 the Commonwealth had distributed 44.4 million RATS to 5.1 million Concession Card Holders.

In relation to workforce, the Commonwealth through the leadership of the Chief Nursing and Midwifery Officer Alison McMillan and the Deputy Secretary in charge of Aged Care Michael Lye oversaw a comprehensive training program in infection control commencing in early 2020. By 13 May 2020 over 120,000 aged care staff had completed infection control training. This program continued throughout the pandemic. In the March 2022 Budget, a further $37.6 million was allocated for ongoing RACF infection prevention and control training for nursing and care staff.

A vital part of the workforce program was ensuring strong support for staffing presence at aged care facilities. This itself involved three major parts.

First, a retention bonus was developed to ensure continuity of care staff. This bonus was first announced in March 2020 and included payments of $800 for RACF workers and $600 for Home Care workers. The initial allocation of $234.9 million was subsequently extended on a number of occasions including an allocation of $215.3 million in the March 2022 Budget bringing the total workforce bonus payments to $657.5 million as at that date.

Second, surge workforce support was put in place with 101,440 shifts having been provided by the Commonwealth as at 20 May 2022. The Department of Health has advised that by February of 2024, over 188,000 shifts had been covered in aged care services as a result of Covid-19 workforce requirements.

Third, ADF personnel were also made available to support facilities where there was particular need. As at 19 May 2022, 190 ADF personnel were deployed to support residential aged care facilities. A total of 542 facilities were supported by the ADF before the deployment was discontinued on 30 September 2022. As at 21 March 2024, there were 186 active outbreaks of Covid-19 in aged care facilities.

Vaccination was also a critical part of the aged care capacity and protection plan. As at 20 May 2022, the aged care vaccination double dose rate was 99.2% for workers and 92.5% for residents. These were respectively the highest known and one of the highest rates of vaccination in aged care facilities globally as advised by the Department at the time. The current vaccination rates are not included in the 21 March 2024 Commonwealth Aged Care update. It could be valuable if these were updated and released.

While every country experienced agonizing aged care loss, the fact that Australia had one of the lowest rates of loss of life in the world is due to a combination of the immense work and dedication of the aged care nurses, carers and other staff, the diligence of providers and the measures outlined above. I note again the significant increase in recorded Covid-19 deaths in the subsequent 22 months since May 2022 and strongly recommend a 5 Year Aged Care Plan be developed for managing Covid-19 in the endemic phase.

3.3 Hospital Capacity

The central goal of building hospital capacity was to ensure that every patient who needed support was able to access care. This was set as an objective in February 2020 by the Prime Minister and endorsed by the NSC on the basis of advice provided by myself and Professor Murphy (non-classified as discussed publicly). In particular, hospital systems around the world suffered enormous degradation of capacity as staff and patients were devastated by Covid during February, March and April of 2020 and in subsequent waves over the coming years.

This goal was pursued through the three programs of building ventilator capacity, supporting public hospitals and supporting private hospitals.

In terms of ventilator capacity, CMO Brendan Murphy and subsequently DCMO Dr Nick Coatsworth and Acting Secretary Caroline Edwards oversaw the program to increase ventilator capacity from 2,200 to 7,500 units to meet projected peak demand in an uncontrolled outbreak. By 13 May 2020, Australia had reached the objective of 7,500 units of ventilator capacity. This was underpinned by the launch of the Critical Health Resource Information System so as to share live data nationwide on ICU beds and equipment.

The ventilator program involved both Resmed and Grey Innovations producing locally made equipment to assist with supply in a globally constrained environment. Australia was also able to supply ventilators to neighbours in the Asia Pacific – at a critical time of humanitarian need.

Public Hospital capacity was built through creation of an initial $500 million Covid-19 National Partnership with the States and Territories. This included covering 50% of the costs for testing, diagnosing and treating people with Covid-19, 50% of the costs for vaccination clinics, free provision of vaccines and 100% of the costs for aged care infection control and response.

The National Partnership was subsequently extended and in the March 2022 Budget an additional $1 billion was allocated to extend the Partnership to 30 September 2022.

A significant part of this work was nursing workforce training and upskilling. This program was developed in conjunction with the ANMF and the Australian College of Nursing under the leadership of Professor Kylie Ward. By May of 2020, 2,377 former registered nurses had received refresher training in what was a fully subscribed re-entry program. Similarly, by May 2020 over 5,500 nurses had completed skills upgrade courses for helping to manage Covid.

Private Hospitals faced a grave threat to their viability and sustainability with the banning of elective surgery by the AHPPC in March 2020. The Commonwealth responded by establishing a Private Hospitals partnership with the public sector and allocating $1.3 billion to support the viability of the Private Hospitals in return for integration with the Public Hospital system, where needed, for pandemic support. My Statement of 31 March 2020 included the following detail:

> "The Australian Government has partnered with the private hospital sector to ensure the full resources of our world class health system, are ready and focused on treating patients as required, through the coronavirus pandemic.
>
> Our Government has guaranteed the viability and capacity of the private hospital sector, in an agreement that will ensure over 30,000 hospital beds, and the sector's 105,000 skilled workforce, is available alongside the public hospital sector.
>
> This will strengthen our Australian COVID-19 response, and preserve the sector's capacity to resume hospital services after the epidemic.
>
> The Commonwealth will offer agreements to all 657 private and not-for-profit hospitals to ensure their viability, in return for maintenance and capacity during the COVID-19 response.
>
> State and Territory governments will also complete private hospital COVID-19 partnership agreements in the coming days.
>
> In an unprecedented move, private hospitals, including both overnight and day hospitals, will integrate with State and Territory health systems in the COVID-19 response."

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.

I would recommend that a standing Private Hospital's Partnership template be adapted for future use in the event of subsequent major national threats to health or health system viability.

Most importantly, Australia achieved the central goal of ensuring that every Australian patient who needed access to ICU or ventilation support through Covid was able to access that support. I particularly want to thank our nurses, doctors, support workers, administrators and manufacturers,

be they public or private, State or Commonwealth for their work in achieving this outcome. I also want to acknowledge and thank Kylie Wright from my office who developed the idea of the Viability Guarantee and partnership at a time of critical national need and risk.

3.4 Research, Vaccination and Treatment Capacity

In the first weeks of the pandemic, the Government identified research, vaccine and therapeutic capacity as being vital to the long-term protection of life as well as the sustainability of our health and health systems. This program was driven by the three themes of research, vaccines and therapeutics.

Throughout the pandemic, Australia played a critical role in global research and development and indeed in late January of 2020 it was the Doherty Institute that first sequenced and made available the data on the emerging coronavirus for global use.

Prior to Covid-19 there had never been a coronavirus vaccine. It was not known whether a vaccine could be developed, how long it would take or whether effective treatments would be developed.

In that context and on the basis of medical advice from the CMO, DCMO and DOH, the Government established a national research program. This in turn led to the opening of the first Medical Research Future Fund (**MRFF**) grant round for Covid vaccines on 18 February 2020, and a subsequent expansion to $30 million on 11 March 2020 for vaccine, anti-viral and respiratory medicine research.

Further rounds of research followed over the coming two years on multiple aspects of Covid-19. This research aided in patient management, care and the selection of vaccines and treatments. Examples of this research included funding for the National Covid-19 Clinical Evidence Taskforce to deliver living guidelines for the care and management of patients with confirmed or suspected Covid in April 2020 which was updated continuously through to May 2022.

On 2 June 2020, the Government lifted research funding to $66 million for Covid-19 including support for the Queensland Molecular Clamp vaccine, 9 anti-viral candidates, and 7 clinical trials for respiratory medicines. On 20 August 2020 cumulative funding for research increased to $91 million and continued with ongoing investments to May 2022. The Department of Health has advised that the MRFF supported 85 research projects across 29 grant rounds.

From the outset of the pandemic the Government, through the leadership of the CMO, began continuous scanning for and planning for vaccine purchasing, manufacturing and delivery. This scanning was further informed with the creation of a Vaccines and Treatments Scientific and Technical Advisory Group (**SITAG**). SITAG had independent responsibility for recommending individual vaccines and antiviral therapies based on safety, efficacy and early access.

It was clear that given the tragic and mass deaths from Covid which were enveloping Europe and the United States that there would be limited or no early supply available at scale coming from those jurisdictions.

In that context, the Government set about ensuring large early volumes of supply by pursuing a dual track strategy of ordering all available early supplies while commencing vaccine manufacturing in Australia.

The decision to manufacture vaccines in Australia via an Agreement with Astra Zeneca and CSL was one of the most important decisions and actions taken by the Australian Government during the course of the pandemic. It was initially considered impossible within the time frame sought, by some senior officials in both Astra Zeneca and CSL. However, through intense joint planning and negotiations a Letter of Intent was released with Astra Zeneca on 19 August 2020 and Production and Supply Agreements were announced with Astra Zeneca and CSL on 7 September. I would particularly like to thank Sam Develin from my office for his role in early and constant engagement with the Department, SITAG and vaccine suppliers and in helping to ensure creation of an Australian vaccine manufacturing partnership between CSL and AstraZeneca.

The subsequent refitting of CSL's vaccine manufacturing facility led to production of 50 million units of vaccine and access at a time that countries around the world were struggling with supply.

The scale of the task and the completion of the manufacturing within a matter of months was arguably one of Australia's most significant peacetime national achievements.

Subsequent agreements were struck with Pfizer, Moderna and Novavax.

The Government announced the National Roll out strategy on 7 January 2021 with the goal of all Australians who sought vaccination to have access in 2021. Ultimately this goal was reached two months early by 31 October 2021 when there was sufficient vaccine and outlets for all Australians who wished to have been vaccinated to be vaccinated.

The most important decision in the vaccination program beyond Australian manufacturing, was to run a dual distribution program using both Primary care and State based clinics. Although there were some who wanted to have a small number of large State based clinics, the Commonwealth was clear in both its medical advice and judgment that full utilization of GP and Pharmacy distribution networks, alongside State mass vaccination channels, was vital to achieving both reach and the capacity of 300,000 vaccinations a day which were achieved during periods of mass vaccination. Over 9,000 points of presence meant that Australians in rural and remote communities had vastly less waiting time and better access to vaccines than in a large clinic only program.

As at the March 2022 Budget, the Australian Government had invested $17 billion in all aspects of the vaccination program. I am not aware if any additional contracts for purchase have been subsequently completed.

I note that the new Government commissioned the Halton Review of Covid-19 Vaccine and Treatment Purchasing and Procurement (September 2022) which found that "Australia's procurement activities were consistent with other high-income countries. A portfolio and redundancy approach was adopted to mitigate risks and ensure supply."

Ultimately Australia achieved a 98% double dose vaccination rate for over 18's. This is one of the highest rates in the world. Of particular importance was the 99% vaccination rate in aged care staff and 92.5% rate for aged care residents. Despite a strong disinformation campaign, intense community level information and support contributed to one of the world's leading Indigenous double dose rates of over 81.3% by May 2022. By 21 May 2022 over 58,750,000 vaccine doses had been administered. In the subsequent 22 months that figure has grown by approximately 13 million doses.

It is a matter of concern that our booster rates have dropped since mid-2022 and I would recommend a strong and renewed public information vaccination campaign to lift booster rates. It is a matter of particular concern that Indigenous booster rates have fallen significantly since mid-2022 and this should be a matter of high priority in any renewed vaccination campaign.

This is consistent with the finding and warning set out in the Halton Review in September 2022: "Australia has been successful at achieving high rates of primary course vaccination and maintaining a low death rate, but relative performance is beginning to wane."

Ultimately, I particularly want to thank Lisa Schofield who led the Vaccines Taskforce within the Department of Health and all those who helped achieve one of the world's leading vaccination rates, especially in aged care and Indigenous Australia.

4. Conclusion and Recommendations

4.1 Principles

The key strategic objectives and strategies of containment and capacity were underpinned by a commitment to three clear principles:

First, follow the medical advice.

It was the Government's role to test and seek additional information, such as when some in AHPPC expressed a predisposition not to have further border closures after Iran in their 4 March 2020 statement of reasons. Under the guidance of Professor Murphy, AHPPC subsequently recommended closures for specific and then all countries. While this example demonstrates why

the Government reserved the right to test and seek additional information, the Federal Government consistently and continuously followed the medical advice of its Chief Medical Advisers.

Given the high quality of this advice, such as the recommendation to close the borders with China, this was fundamental to helping Australia achieve one of the lowest rates of loss of life globally.

The second principle was constant Cabinet review – through the Cabinet, National Security Committee (**NSC**) and other decision-making bodies such as the Expenditure Review Committee (**ERC**) – of developments with the disease and a clear commitment to early action. As an example, in my own case my records indicate that I participated in approximately 50 high-level decision-making meetings relating to Covid in March 2022. This includes 21 Cabinet or Cabinet sub-committee meetings in fora such as NSC or ERC, and a further 29 major meetings including Health Ministers Meetings, the Governor General, Departmental Senior Executive or the Government leadership group.

These continuous decision-making processes allowed for contestability and rigour, while providing a format for considered whole of Government decision making.

The formation of the National Cabinet added further co-ordination to the process and was an important addition to pandemic decision making and governance. While some States did make unilateral decisions, such as Victoria's decision not to accept ADF support for Hotel Quarantine, National Cabinet overwhelmingly helped resolve problems and provide a common roadmap.

I would therefore recommend that an MOU be signed between the Commonwealth and States in which there is a commitment to future pandemic management through continuous Cabinet decision making and continuous use of the National Cabinet.

I would also recommend that States commit not to take unilateral decisions against National Cabinet decisions unless there is published and signed medical advice to the contrary at Deputy Chief Health Officer level or above.

The third principle was continuous communication. This was agreed with the Prime Minister early. In March 2022, for example, my own records show 65 press conferences or interviews. We realized early that the public were seeking facts, analysis, actions and hope. In that context, we sought wherever possible to draw on the knowledge of medical leaders such as the Chief Medical Officer, Deputy CMO Kelly (subsequently CMO), Deputy CMO's Professor Michael Kidd and Dr Nick Coatsworth, Chief Nursing and Midwifery Officer Alison McMillan and the head of the TGA Professor John Skerrit. States adopted a similar approach and the State and Territory Chief Health Officers were also an overwhelmingly effective and reassuring presence.

I would like to commend both the Department and the communications team led by James Perrin in my office for their role in, anticipation of, and in response to the public and media requests for detail, developments, facts and information about Covid-19 and the national response. My office advised me in May of 2022 that, as of that time, they had received and answered over 40,000 media inquiries or approximately 50 per day through the pandemic.

4.2 Key Decisions

In review, despite a clear strategy of containment and capacity and clear principles to govern the conduct of the pandemic, the agony of many other countries shows that the final element needed was a willingness to make major decisions in the face of uncertainty.

In that context, arguably the four most important decisions or actions taken by the Government were:

First, the decision to close the borders with China.

Second, the linked decisions to establish universal Telehealth and to develop a national strategic partnership between the public and private hospitals in late March 2020. These in turn underpinned the stability and continuity of the primary care and hospital systems at a time when we saw global pressure on and, in some cases, catastrophic collapse of such systems.

Third, the decision to establish a national vaccine manufacturing program. This was supported by the decision to run a dual vaccination channel program of GP and primary health distribution supported by State based mass vaccination clinics.

Fourth, the decision to underpin the health advice with economic support in the form of Job Keeper and Job Seeker. I particularly acknowledge the Prime Minister, Treasurer Frydenberg and Minister Cormann for their work in providing the economic resources both for the health program but also these two and other social support programs. These programs not only provided individual economic support at a time of immense vulnerability, but also meant that there was greater willingness to participate in the health response through vaccination and general public support for national measures. This is particularly so when compared with the public response in some other advanced economies.

4.3 Recommendations

In light of the above and drawn from my submission I make the following recommendations for National Health Management of any future pandemics or similar health crises:

1. My strong forward recommendation is that all States and Territories adopt a uniform national code for pandemic management which mandates medical advice be published for any restrictive measures.
2. The Commonwealth Biosecurity Act be amended to ensure that any determinations made by the Minister under a Biosecurity emergency determination be published with reasons, and must be accompanied by signed and published medical advice from the Chief or Deputy Chief Medical Officer of the Commonwealth.
3. I recommend that given the ongoing high prevalence of Covid-19 within the community, existing Telehealth Services for oral antiviral suitability and for PCR confirmation be extended for 12 months to 30 June 2025 and reviewed for further extension at that time.
4. I note the significant 163% increase in recorded Covid-19 deaths in the subsequent 22 months since May 2022, and strongly recommend a 5 Year Aged Care Plan be developed and maintained for managing Covid-19 in the endemic phase.
5. I recommend that a standing Private Hospital's Partnership template be adapted for future use in the event of subsequent major national threats to health or health system viability.
6. It is a matter of concern that our booster rates have dropped since mid-2022 and I would therefore recommend a strong and renewed public information vaccination campaign to lift booster rates.
7. It is a matter of particular concern that Indigenous booster rates have fallen significantly since mid-2022 and I would recommend that this be a matter of high priority in any renewed vaccination campaign.
8. I recommend that an MOU be signed between the Commonwealth and States in which there is a commitment to future pandemic management through continuous Cabinet decision making and continuous use of the National Cabinet.
9. I recommend States should also commit not to take unilateral pandemic health decisions against National Cabinet decisions unless there is published and signed medical advice to the contrary by the jurisdictional Chief Health Officer or Deputy Chief Health Officer.

Ultimately, Covid-19 was a global pandemic with immense pain, suffering and loss, both within Australia and globally. No country escaped unharmed, however very few countries emerged with a lower loss of life and less economic damage than Australia.

The findings of the March 2024 Global Burden of Disease Study which showed Australia increased life expectancy in 2020 and 2021 by 0.2 years while the global average decreased by 1.6 years is the single most important and telling assessment of how Australia fared relative to other countries. It is a tribute to our health professionals, administrators, leaders at all levels and the extraordinary spirit of Australians everywhere who looked out for each other.

In May 2020 I said in my Ministerial Statement that “This has been our most difficult year in 75 years but arguably it has been our finest year in 75.”

With the passage of time, I believe that statement still to be correct, with one amendment. I now believe both 2020 – and 2021 – were together our finest peace time years since 1945.

There are however important lessons for future pandemics and we should strive for continuous improvement. In that respect I hope that this submission may provide some guidance and thoughts for the next generation who face such a crisis.

I want to reserve a special thanks for my staff. My office, led by Wendy Black and Joanne Tester, worked individually and collectively to levels and under pressure that in hindsight is almost unfathomable. I could not be more thankful to all of my dedicated staff who were committed to the health of the nation and made enormous sacrifices.

Finally, I want to thank my family above all others. For two years my children Poppy and James barely knew their father. Despite, or perhaps because of this, they have prospered. That is a credit to them and their mother. I am immensely proud of them both. My ultimate thanks is to my wife Paula. She not only raised our children as a solo Mum, she was my rock during the inevitable low and difficult times when I was absent, isolated or struggling. As a surgical nurse responsible for infection control, she kept a copy of Laurie Garrett’s The Coming Plague by her bedside. This led her to give me the most important advice of the pandemic in January 2020. “This could be the big one. Go hard, go early.” Thank you Mumma.