Commonwealth Government

COVID-19 Response Inquiry Report

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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.

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