Queensland Aboriginal and Islander Health Council (QAIHC) is a leadership and policy organisation. QAIHC was established in 1990 and is the peak organisation representing all Aboriginal Community Controlled Health Organisations in Queensland at both a state and national level.

Thank you for the opportunity to provide feedback for the independent inquiry into Australia's response to the COVID-19 pandemic.

On behalf of QAIHC, we have liaised with our Member services and prepared the following submission.

Governance

The Member services who participated in COVID-19 advisory bodies found that early consultation with the local Aboriginal community-controlled health organisation (ACCHO) service in disaster management and communications meetings was beneficial in organising resources in the community. The ACCHOs were critical in promoting early public messaging, with easy-to-read factsheets and organising incentives for vaccinations.

Key health response measures

Generally, ACCHOs had good access to quality and timely **personal protective equipment (PPE)** through nearby Member services or through their local Primary Health Network (PHN). Some services reported difficulties with vaccine cold chain and with timeliness when ordering **COVID-19 vaccines** through the central pharmacy but were able to work with their local Hospital and Health Service (HHS) to cover gaps in stock. There was also mixed feedback with COVID-19 **antiviral access** with some reporting adequate supplies, while others reported high costs, delayed deliveries and complexity with side effects and medication interactions.

There was widespread disapproval of **vaccine mandates** with staff members facing verbal, and even physical abuse. The repercussions of these mandates included a reduction in childhood immunisation rates, and a negative impact on the relationship between people and their primary health care provider. Services recommended encouragement and positive messaging to promote vaccinations, rather than vaccine mandates, in the future. The vaccine mandates also resulted in a loss of staff during the pandemic, on top of the already existing workforce shortages in the ACCHO sector.

Majority of patients isolated at home if they contracted COVID-19, but those that were required to stay in **quarantine facilities** reported they were "not First Nations friendly". There was a lack of communication between the primary health care sector and state services about patients in quarantine facilities, with no real coordination of patient needs.

There were generally positive remarks about **COVID-19 public health messaging**, with good collaboration with local public health units but there was a recommendation to have early culturally appropriate messaging for First Nations people. There was also a mention of the importance of contact tracing, particularly in remote communities where people may be mobile and move from house to house.

Broader health supports for people impacted by COVID-19 and/or lockdowns

Due to the COVID-19 lockdowns, people were not able to move back to their homes or communities without permission from local council. This was triggering for many First Nations people as it drew parallels with needing permits to move between locations in the past.

The lockdowns also impacted health services financially and regarding continuity of care, with some still recovering from these impacts now. Services were able to adapt to the change in circumstances by providing health services via telehealth and video conferencing, as well as continuing face-to-face consultations with strict screening protocols in place. However, they did note the contact episodes for preventative health care reduced significantly. Not all patients were able to access telehealth or video conferencing services, and so there were several patients with a deterioration in their chronic conditions due to lack of access to face-to-face services.

The number of MBS claims related to 715 health checks and chronic disease care declined during the pandemic when compared to the pre-pandemic period. These MBS claims have since increased to near pre-pandemic levels in the first half of this year. However, concerns remain regarding the underutilisation of preventive care based on need, given workforce shortages that are inarguably worse than prior to the pandemic. The reasons for the medical workforce shortages post-pandemic are unclear but are being felt broadly across general practices and ACCHOs in rural and remote locations.

Support for industry and businesses

Workforce shortages are already a longstanding concern in the ACCHO sector, but services reported a further loss of staff due to burnout, as well as due to the vaccine mandates. The remaining staff worked throughout the pandemic, with flexibility in work arrangements allowing some to work from home. Services in remote areas had restrictions on staff flying in and out, which meant strict testing protocols and some staff members living away from home for extended periods of time.

Financial support for individuals

There was limited knowledge about financial support services for patients. Our Member services recommended better public messaging and collaboration with primary health care services to assist patients in accessing these supports.

Community supports

There are already longstanding issues with access to housing faced by a lot of communities serviced by our Member services. Services reported a worsening of these issues (e.g., delays in actioning housing applications).

Mechanisms to better target future responses to the needs of First Nations people

The local ACCHO is best placed to serve the needs of their community. Close and early collaboration with these services is essential to put the community in the best position when facing a pandemic of this nature. This optimal placement was somewhat confounded during the pandemic period as ACCHOs were provided with resources from external agencies, rather than using their pre-existing effective strategies around communication, education, and engagement with their own community.