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COVID-19 revisited – is a national pandemic plan possible?

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ABSTRACT

As we review health governance during the COVID-19 pandemic, we have an opportunity to reflect on these processes and ensure that future challenges might be managed in a more collaborative and whole of system response. This 'Perspective' reviews COVID-19 responses in Australia, reflects on a number of potential solutions that have been developed by organisations over the past two decades and proffers a governance framework for a Communicable Disease and Pandemic Management Authority that might assist health responses to future challenges.

Keywords: CDC framework, coordination of health responses, COVID-19 responses, national frameworks for disease control, pandemic governance solutions.

The coronavirus disease 2019 (COVID-19) pandemic has highlighted the weaknesses within Australia's health systems to reliably detect, prevent and respond to mass disease outbreaks in a timely, effective and efficient manner.

The first indication of the lack of a national, coordinated response was the confusion and indecision about quarantine measures and the inconsistent infection control protocols. Without clear national policy direction, legislation and the requisite national leadership, state governments quickly moved to fill these gaps. Major quarantine breaches followed and uncertainty, confusion, blame laying and political gaming have continued throughout the course of the pandemic.

Without clear role delineation between jurisdictions, the States continued to build on and increase their local decision-making powers while the Commonwealth increasingly played a passive role in regard to national leadership and responsibility for the pandemic management.

There was a failure to recognise the urgency to manage the national purchase, supply and distribution of protective equipment, vaccines and rapid antigen tests (RAT) as they became available, but perhaps the most disquieting failure at the Commonwealth level was in residential aged care facilities where there were a significant and disproportionate number of deaths. It is tragic that this occurred following on from the Royal Commission report into Aged Care Quality and Safety ('Neglect'), which made many recommendations for sweeping change within Commonwealth governance and the aged heath care industry generally.[1] The report and recommendations have been largely ignored.

Despite the early chaos and confusion, Australia has managed to get through the pandemic with fewer casualties and social discord than experienced by many other nations. In retrospect there is a reasonable argument that the pandemic has 'ended relatively well', lessons have been learnt, all the jurisdictions are now much better prepared and little needs to change.

The counter argument is that Australia was fortunate but may not be so lucky next time around. It begs the question – can Australia afford to maintain the federal relinquishment of leadership and continue to rely on a patchwork of processes driven by nine independent pandemic responses next time? In a Federation it is difficult to get universal agreement on reform but it would now seem sensible to at least begin the discussion on how to develop and build a national pandemic management plan.

Some planning issues and components

It would appear self-evident that early detection, identification and surveillance of all communicable diseases within the Australian population would be generally beneficial

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with regard to public health interventions, clinical treatment and better patient outcomes. Clearly a national communicable disease surveillance and control framework would also improve the likelihood of better pandemic management.

Awareness of this need is not new but the required changes and resourcing have never been seriously considered or resourced.

In 2014, a paper entitled 'National Framework for Communicable Disease Control'[2] was presented to the Department of Health via the Office of Health Protection.

The paper described the disconnected state of communicable disease reporting in Australia and the lack of a national policy framework to better detect, respond to, coordinate and manage communicable disease outbreaks. It provided a series of discussion points and recommendations to achieve a lucid and logical national framework and policy. The authors did not underestimate the magnitude of the task or the difficulties of implementation. They emphasised the need for national coordination and integration, requiring support and engagement across all levels of government, the private sector, the community and health professionals generally. Successful implementation would be dependent upon appropriate funding and finally, and somewhat ironically, the paper comments

> An integrated, coordinated and resourced CD control system strengthens Australia's capacity to detect, prevent and respond to communicable diseases, driving improved health outcomes for the community.[2] (p. 27)

Similarly, in 2017 the Australian Medical Association (AMA) published a discussion paper and position statement which strongly supported 'the National Framework for Communicable Disease Control and the goal of a national implementation plan' and furthermore:

> The AMA calls for the immediate establishment of an Australian National Centre for Disease Control (CDC), with a national focus on current and emerging disease threats engaging in global health surveillance, health security, epidemiology and research.[3] (p. 1)

A recent review and analysis of the international response to the pandemic published in *The Lancet*[4] reinforces many of the points made above and provides some telling observations and comments. It stresses the lack of interconnectivity and 'self-protecting silos' of health specialties in health systems and often poor communication and collaboration between institutions. The review makes four essential recommendations – integration, financing, resilience, and equity to reimagine governance, policies, and investments for better health towards a more sustainable future.

As outlined above, the implementation of any national framework is a very difficult exercise. The question is how to drive national, cross-jurisdictional review, reform and structural change which requires whole of government support and a determination to systematically address and implement the recommendations arising from a review process. Surely as a nation we should be able to find ways to balance self-interest, challenge embedded power and the spectrum of politics; as well as addressing the inevitable lack of trust and suspicion of motives by all incumbents. There are any number of approaches and models that could be considered if this sort of framework is to be implemented.

The AMA position statement (2017) describes a new national body and recognises some of the challenges. And there are other existing interjurisdictional models that might be considered in the context of the implementation of a national CDC. For example, the Australian Institute of Health and Welfare (AIHW) is a Commonwealth Government statutory authority with a Board reporting through the Minister of Health to the Australian Parliament. It was established in 1987 with its composition, functions, powers and obligations set out in its enabling legislation, the *Australian Institute of Health and Welfare Act 1987*.[5]

The role of the AIHW is to collect, manage, collate, analyse and distribute data and reports on health and welfare issues to state, territory and federal government agencies, universities, research centres, and non-government organisation though it probably does not have the legislative power to direct interjurisdictional procedures if required.

Another model could be the National Blood Authority.[6] In many ways the current situation is similar to the problems that beset the blood supply, distribution and management arrangements of the past century.

The report by Mackay and Wells about blood services in 1995[7] cited a highly dysfunctional set of jurisdictional arrangements in Australia. Each jurisdiction had its own supply and distribution arrangements for blood and blood products, there were no clear and consistent ordering or receipting processes, hundreds of millions of dollars for blood and blood products were paid to suppliers without routine or formal audit of proof of delivery or usage. There was also a lack of any national framework for reviewing usage and clinical outcomes.

The increasing lack of transparency in supply arrangements, cost of products, absence of ordering and receipting records, uncertainty of appropriateness of clinical usage of products and the ongoing sovereign risk of the Red Cross/CSL duopoly finally forced all jurisdictions to agree to a national framework and the signing of the National Blood Agreement in 2003.[6]

It was a decade in the making but the Agreement provides for the implementation of a National Blood Authority and assigns roles and responsibilities. The Agreement also describes its relationship with key federal and jurisdictional bodies in order to streamline communication and decision making across the governmental framework.

Nothing is perfect but this model has worked reasonably well and generally assigns responsibility to where it best fits.

It is not a totally centralised system as all stakeholders have a clear and important role in managing the blood supply matrix. There is now limited overlap in function and much more transparency in supply arrangements. Cost and sovereign risk has been contained through a more open market place with international supply contracts signed and all parties have good data to review clinical use and treatment outcomes.

So what to the future

As the pandemic eases, there is a need to review and reform the relationships, functions and responsibilities of all current high-level intergovernmental cabinets, committees and councils. A review would also provide a potential for renewal; to remove outdated, overlapping procedures and processes and provide a focus for more flexible, nimble, informed and constructive decision making. It is possible that a revised structure could be adapted and used to provide a governance framework for a Communicable Disease and Pandemic Management Authority.

Perhaps none of this is possible in these times of increasingly partisan and destructive politics. No doubt there would be fierce debate over which model was best, what state and federal legislation needed to be adopted, changed or created and how any changes would be resourced, but why not at least TRY?

Even so, structural change of this significance would take many years and would need consistent bipartisan vision, leadership and resourcing over a number of electoral cycles.

Finally, there can be no progress without adequate resourcing of all aspects of the journey, i.e. review, negotiation and implementation. It is worth considering that the total combined annual budgets of the AIHW, the National Blood Authority and the Therapeutic Goods Administration is less than that proposed to be spent on Commonwealth grants for sporting facilities and municipal car parks.

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