Government of **Western Australia**
Department of **Health**

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Contact:

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Dear Premier

CONTROLLED BORDER TRANSITION ARRANGEMENTS

On 28 October 2020, I provided advice on proposed changes to closed border requirements and on easing of restrictions beyond Phase 4. The advice also outlined risk-based trigger points for reviewing border controls. On 14 November 2020, the 'Controlled Border for Western Australia Directions' came into force and Western Australia (WA) transitioned from a closed border arrangement to a controlled border arrangement to allow for safe travel into WA from interstate and New Zealand. These controls were predicated on the high effectiveness of border controls at both international and state levels, along with public health, mass gathering and physical distancing measures, in preventing COVID-19 outbreaks in WA. Modelling at the time showed that WA remained the most susceptible to a major outbreak of all the States, only surpassed by the Northern Territory, due to the increased numbers of people moving around in our society and the mixing between non-family groups. The re-introduction of COVID-19 back into the WA community from interstate travellers was expected to lead to substantial outbreaks.

On 16 August 2021, I wrote to the State Emergency Coordinator (SEC) regarding the controlled border arrangements for WA. At that time, New South Wales (NSW) was experiencing a significant and ongoing outbreak of the Delta variant strain of disease. Modelling at the time showed that WA, which had removed the final restrictions on physical distancing and significantly increased the numbers and mixing at high risk venues, including at bars, nightclubs, music venues and events, was the most susceptible of all the larger jurisdictions to a major outbreak. This susceptibility had continued to increase in recent modelling. The emergence of the highly transmissible Delta variant had increased this susceptibility further, particularly among household and work groups. After reviewing the controlled border arrangements issued under the *Emergency Management Act 2005,* I made a series of recommendations to the SEC for more stringent, but more graduated, measures.

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My recommendations of 16 August 2021 included introducing a new requirement for travellers from 'high' and 'extreme' risk jurisdictions to provide proof that they had received at least one dose of a Therapeutic Goods Administration (TGA) approved COVID-19 vaccine prior to entry into WA. I noted, at that time, that both the Pfizer and AstraZeneca vaccines were readily available in all jurisdictions for eligible groups. Since this time, the Moderna vaccine has been approved by the TGA and this is also readily available in all jurisdictions. Other measures, including the requirement to provide proof of a negative COVID-19 PCR test in the 72 hours prior to departure and a mandatory requirement to use the G2G Now App on arrival in WA, were also recommended and introduced. On 21 October 2021, I recommended that all travellers arriving in WA from 'medium', 'high' or 'extreme' risk jurisdictions must provide evidence that they have received both doses of an approved COVID-19 vaccine unless ineligible or medically exempt. This requirement will come into effect from 05 November 2021. It was further recommended that all travellers arriving into WA from 'low' risk jurisdictions must have received both doses of an approved COVID-19 vaccine unless ineligible or medically exempt, which will come into effect from 15 November 2021.

CURRENT SITUATION

On 30 July 2021, National Cabinet met to discuss the 'National Plan to Transition Australia's National COVID-19 Response' (the National Plan). The National Plan provides a graduated pathway to transition Australia's COVID-19 response from its current pre-vaccination settings, which are focused on continued suppression of community transmission, to post-vaccination settings that are focused on prevention of serious illness and fatalities, and are consistent with the public health management of other infectious diseases. The National Plan sets out four phases to facilitate this transition, with each phase being triggered by the achievement of vaccination thresholds. WA is currently in Phase A of the National Plan, where the Commonwealth and jurisdictions are required to continue to strongly suppress the virus to minimise community transmission. Several jurisdictions (NSW, Victoria and Australian Capital Territory) are now in Phase C (80% fully vaccinated over 16 years) of the National Plan and have commenced removing restrictions and opening international borders.

The Doherty Institute provided the original epidemiological modelling used by National Cabinet in July 2021 to determine vaccination coverage thresholds. After large outbreaks occurred in New South Wales, Victoria and ACT, the Doherty Institute revised its modelling in September 2021 and found that, at 80% vaccination coverage with thousands of cases already in the community, there would be more cases and an earlier peak than originally projected. Experience in other countries has also demonstrated that 80% coverage alone is insufficient to contain spread of the Delta variant.

WA remains in an excellent position with no recent COVID-19 cases and no current active cases, either in hotel or home quarantine. The current border arrangements and WA's response to previous outbreaks have been highly successful in preventing importation and community spread, with no significant outbreaks since the small outbreak at the end of June 2021. WA has not been required to implement physical

distancing, capacity limits, mask requirements or other restrictions since it returned to Phase 5 on 12 July 2021. With the 'COVID Safe (Phase 5) Directions' in effect, WA's susceptibility to a future sustained outbreak has risen significantly. The current modelling shows WA is the most susceptible of all the jurisdictions to a major outbreak, due to the increased numbers of people out in the community, movement around the community and the mixing between non-family and non-employment groups. While vaccine uptake is starting to reduce this susceptibility, WA's susceptibility to a major outbreak is expected to remain very high over the next two months until an appropriate level of vaccination is achieved.

WA's fully vaccinated rate over 12 years of age has increased from 9.2% on 12 July 2021 to 63.3% on 04 November 2021. While this remains lower than jurisdictions that have had major outbreaks, WA remains on track to reach 70% fully vaccinated in mid-November and 80% fully vaccinated by mid-December 2021. In addition, mandatory vaccination requirements are being progressively implemented for workforces that are at higher risk of exposure, have a greater potential to transmit to vulnerable populations or are themselves critical to the functioning of our society. These currently include hotel quarantine staff, healthcare and health support workers, mission critical police staff, port workers, freight and logistics workers, resources workers and primary and community health workers. Further groups will be required to receive initial vaccine doses by 01 December 2021 (Group 1) and 31 December 2021 (Group 2), based on my advice provided on 19 and 22 October 2021, respectively.

TRANSITION PLAN

The current border arrangements have been highly effective in reducing the numbers of potential cases who have travelled from interstate or overseas. There have, however, been significant social, societal and mental health impacts, as work, compassionate and family travel have all been adversely affected. These impacts are expected to be mitigated by reopening of the controlled borders.

While the National Plan envisaged removing internal domestic travel restrictions for vaccinated people in Phase C (80% fully vaccinated over 16 years of age) and commencing reopening of limited international travel for vaccinated people, this was largely based on those jurisdictions that had established community transmission where such measures were not anticipated to add significant additional risk.

Opening domestic and international borders will introduce COVID-19 cases into WA, with consequent community spread. For jurisdictions with no community cases, such as WA, the risks of a significant outbreak, particularly when that jurisdiction is highly susceptible to such an outbreak and the required response to such an outbreak would involve the potential imposition of lockdowns or major restrictions, need to be considered. Such lockdowns and major restrictions have significant physical, psychosocial and mental health impacts on people, as well as major impacts on productivity, employment and the WA economy.

Vaccination

The pivotal role that vaccination plays in transitioning from a pandemic phase of 'suppression of community transmission' to one of 'living with COVID' (endemic disease) is well understood. Key to a successful and safe transition is ensuring that a high rate of vaccination is achieved, both collectively and in vulnerable cohorts within the community, and, importantly, that no group or individual is left behind. WA has been fortunate to have had relatively few cases of COVID in the community and to have been able to rapidly control the few small outbreaks during the pandemic; however, this situation has also led to complacency and hesitancy with regards to vaccination. This complacency and vaccine hesitancy is understandably most marked in areas that have had the least cases, including remote and rural areas, and remote Aboriginal Communities. A gradual introduction of cases into the State, achieved through a very high vaccination rate, will further increase the uptake of vaccination in areas of WA that have low vaccine coverage currently, but are more likely to respond to the threat of COVID cases within the State.

The likely impacts of prematurely opening borders on the number of cases, hospitalisations, critical care requirements and deaths also need to be a factor in any re-opening decision. While the current generation of vaccines do not provide sterilising immunity, and will not prevent all vaccinated people becoming infected, they do significantly reduce both transmission and spread, even after one dose and with the Delta variant. The reduction of infection rates of vaccinated people is estimated to be between 44 and 79%, depending on the vaccine, and the reduction of subsequent spread is between 50 and 65%[1,2]. The vaccines are highly effective, however, in preventing hospitalisation and deaths, even after one dose, with 92-96% effectiveness once fully vaccinated, which greatly assists in reducing the demand on the WA health system in the event of an outbreak.

High vaccination rates alone are insufficient to manage outbreaks. Modelling from WA Health, the Doherty Institute, the Grattan Institute[3] and the University of Western Australia[4] have consistently found that the Delta variant will not be eliminated solely by high vaccination rates. WA Health found that, even at 90% vaccination coverage with no other measures, there would be 43,108 cases, 937 hospitalisations, 106 ICU bed stays, and 117 deaths within 360 days. Both internationally and within Australia, there is an abundance of evidence that Public Health and Social Measures (PHSMs), testing, tracing, isolation and quarantine (TTIQ) and resilient health system capacity are required to manage cases within the community. This will be critical as COVID-19 transitions from an epidemic disease to an endemic disease.

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[1] Elliott P, Haw D, Wang H, Eales O, Walters C, Ainslie K, Atchison C, Fronterre C, Diggle P, Page A, Trotter A. REACT-1 round 13 final report: exponential growth, high prevalence of SARS-CoV-2 and vaccine effectiveness associated with Delta variant in England during May to July 2021.

[2] Doherty Modelling Report (Revised 10th August 2021), Technical Appendix, pp. 23. https://www.doherty.edu.au/uploads/content_doc/DohertyModelling_NationalPlan_and_Addendum_20210810.pdf

[3] Duckett, S., Wood, D., Coates, B., Mackey, W., Crowley, T., Stobart, A. (2021), *Race to 80 our best shot at living with COVID*, Grattan Institute, 29 July. Available from: https://grattan.edu.au/report/race-to-80/

[4] University of Western Australia (2021), *National COVID plan puts too many lives at risk*, 24 August. Available from: https://www.uwa.edu.au/news/article/2021/august/national-covid-plan-puts-too-many-lives-at-risk.Modelling: https://osf.io/6j4rd/.

The WA Health model is built for the unique context of WA and provides state-level insights, as opposed to the Doherty Institute model which provides a national view. The September 2021 Doherty modelling, while highlighting the ongoing importance and benefits of TTIQ and PHSM, does not specifically look at the differences between 80 and 90% full vaccination. As WA is one of the few jurisdictions that will transition from zero COVID-19 disease at a high vaccination rate, modelling is useful for planning and preparing for any subsequent outbreak. WA Health has modelled the likely impact of 80% and 90% full vaccination rates (over 12 years of age) where there are medium TTIQ measures and low-level PHSMs, such as indoor use of masks, 2 square metre density requirements, and capacity limits, in place. Vaccination coverage at 80% results in substantially worse outcomes with 61,143 additional cases over a 12-month period compared to 90% coverage, and significantly more hospitalisations (2,921 compared to 937). ICU bed requirements drop from 32 beds at the peak with 80% vaccination to 8 ICU beds with 90%. Vaccination coverage at 90% also delays the onset of epidemic growth, and substantially delays the time to the peak as well as reducing the number of cases at the peak. At 90% vaccination coverage, 117 deaths are projected compared to 313. The public health advantages are both direct (from reduction in COVID disease) and indirect, as the reduced burden on the hospital and primary health care system means that other health priorities will be less adversely impacted.

Focusing purely on the overall vaccination rate, however, can fail to recognise the risks of transitioning prior to adequate vaccination rates being achieved across all cohorts in the WA society, particularly disadvantaged and vulnerable groups. The current vaccination rates of WA's Aboriginal population over 12 years of age is 38.6% for dose 1 and 24.8% for dose 2, both significantly below the general population rates of 79.1% and 63.3%. Of similar concern is the poor vaccination rates in some regional areas, with the Pilbara having a first dose rate of only 45% and the Kimberley and Goldfields' regions being just above 60%. The transition plan needs to ensure that all cohorts within our State are protected and that no groups are left behind due to hesitancy or lack of access or opportunity. There is evidence that other vulnerable groups also have low vaccination uptake rates, but these rates are more difficult to quantify. Aiming to achieve a high overall vaccination rate will better ensure that other groups, such as people from Culturally and Linguistically Diverse (CALD) groups and other vulnerable cohorts, will achieve a vaccination coverage that is consistent with the general population.

WA's mandatory vaccination policy, for which I provided advice on 19 and 22 October, aims to ensure that the workforce is protected, particularly those workers who are most at risk of exposure to COVID, and/or those who are working in an environment in which transmission is likely. It also seeks to protect critical workforces and infrastructure by achieving very high vaccination rates in those workforces. This approach to workforce vaccination has commenced, but will take some time to implement to a level that best protects those workers, with the final mandates to commence implementation by 1 January 2022. Delaying commencement until late January 2022 when 90% vaccination is expected to be achieved will ensure that most workers will have completed their full vaccination course while there are still no community cases.

Testing, Tracing, Isolation and Quarantine (TTIQ)

TTIQ involves testing, tracing and isolating people who may be infected to reduce the risk of transmission. Modelling conducted by the Doherty Institute and WA Health assumes TTIQ is vital to respond to COVID-19 at high levels of vaccination coverage. However, it is a resource intensive operation, and requires widespread asymptomatic testing, identification and quarantine of cases and isolation of close and casual contacts.

The Doherty Modelling paper notes that optimal 'test, trace, isolate, quarantine' measures should be applied to further reduce the epidemic curve when there is transmission in the community. While the exact requirements for the 'optimal TTIQ' in various jurisdictions are still under development, work is being undertaken at a national level to put parameters in place around suitable testing regimes and optimal quarantine times. WA is currently observing the effectiveness of a variety of new testing regimes (for example, testing school children in Albury) and quarantine period variations (for example, no quarantine for fully vaccinated international travellers), many of which have not been trialled in 'real world' settings in which the population vaccination rate is high. Within the optimal TTIQ settings, the role of contact tracing is expected to reduce as vaccination rates near 90%. Contact tracing can and will continue to be used to inform who is most likely to become infected based on exposure to another case and this information will be used to further reduce the spread of the disease and to protect the most vulnerable.

In WA, the approach to contact tracing should reflect WA's public health objectives. TTIQ can result in the total or partial capture of all those who may have been exposed to the virus and may require quarantine or isolation, noting these TTIQ measures can be titrated to meet the demands exerted by an increasing number of COVID cases in the community and the impact that is having on the WA health system. Lessons learned from variations to contact tracing models being used in other jurisdictions will continue to inform changes to optimal TTIQ and a new national guideline for contact tracing is currently under consideration. Again, a slowly rising epidemic curve in WA will allow WA to best utilise its resources to ensure that the most appropriate and judicious choices are made when it comes to optimal TTIQ.

Public Health and Social Measures

The transition to the effective management of endemic COVID-19 disease, or 'living with COVID', is contingent on the continued use of various Public Health and Social Measures. PHSMs refer to the risk mitigation strategies that are applied across the population to reduce the chance of transmission events and propagation of infection throughout the community. The PHSMs include measures such as face mask use, contact registration at venues, density and/or capacity limits on venues, COVID safety plans for venues/events, testing at point of entry to areas/events, and restriction of access to areas/events to vaccinated individuals. The National and State modelling has shown that PHSMs form a useful adjunct to TTIQ and vaccination for reducing the rate of spread and flattening the epidemic curve of COVID in the jurisdiction.

As with TTIQ, it is expected that the PHSMs can be titrated according to the number of cases in the community, the pressure within the health system and capacity of the State to respond to all outbreaks and all emergency situations. Predetermined measures may be implemented as part of the Transition Plan, from a baseline level of measures, with the ability for the State to increase measures to meet increasing transmission in the community and pressure on the health system. The key measures likely to be considered are outlined below.

1. Mask Use

As outlined in previous advice, SARS-CoV-2 is mainly transmitted by close personal contact (via respiratory droplets or aerosols) or via contaminated surfaces. The World Health Organization (WHO) advises that the virus spreads mainly between people who are in close contact with each other, typically within 1 metre (short-range). A person can be infected when aerosols or droplets containing the virus are inhaled or come directly into contact with the eyes, nose, or mouth. Masks are disposable or reusable devices that create a physical barrier between the mouth and nose of the wearer and potential contaminants in the immediate environment. If worn properly, a mask helps to block large-particle droplets that may contain viruses and bacteria, keeping it from reaching the wearer's mouth and nose. Masks may also help reduce exposure of the wearer's saliva and respiratory secretions to others. Therefore, the wearing of masks helps to mitigate or eliminate exposure to COVID-19. The benefit forms the basis of the mask mandates that are required during lockdowns or at various levels of restrictions.

While immunisation remains the most effective intervention for prevention of disease, the use of a mask is a simple and effective way to reduce the risk of contracting COVID-19. Masks should always be used as part of a suite of measures to suppress transmission, such as physical distancing and maintaining good hand hygiene. As a baseline measure within WA Transition Plan, I would recommend that mask use be considered for indoors in high risk, poorly ventilated areas, where physical distancing may be difficult, such as on public transport, or when people are interacting with our most vulnerable cohorts, such as in hospitals, residential aged care and disability services settings. A graduated approach can then be implemented as further PHSMs are needed, such that for higher control, masks could be recommended indoors at all public venues.

2. Public Venue Restrictions

From numerous outbreaks, it is recognised that crowds and gatherings increase the likelihood of COVID spread. Where such an event occurs indoors, especially in poorly ventilated areas, the risk of transmission of COVID is very much higher[5]. A step-wise approach to risk of transmission through public gatherings should be implemented within the Transition Plan, with a graduated approach from a baseline of very limited restrictions to more restrictive measures, as needed when transmission in the

[5] Bulfone, Malekinejad, Rutherford and Razani. 2021. Outdoor transmission of SARS-CoV-2 and Other Respiratory Viruses: A Systematic Review. https://academic.oup.com/jid/article/223/4/550/6009483

community is such that pressure is exerted on the hospital system impacting on broader public health.

At baseline, I would recommend the following:

- contact tracing registration – at all venues (as currently implemented);
- health pass required to attend events with capacity above 1000 people or in high risk venues, such as nightclubs, which specifies full vaccination status;
- mandatory vaccination in place for many workplaces and for visitors to congregate living facilities that are high risk;
- COVID safety plans in workplaces and schools; and
- restricted entry to Remote Aboriginal Communities, as necessary.

The above measures could be increased to 'step up' options, that make the requirements more stringent, such as enhanced enforcement of contact registers, health pass (full vaccination status) required for entry to more events/venues, a negative rapid test for entry to some events/venues, more restrictive density and capacity limits for indoor events/venues and possibly outdoor events, rapid testing at some workplaces, work from home advice, and restrictions/health pass approval required for movement intrastate into/out of restricted locations.

Border Measures

1. Domestic and international arrivals

As community COVID cases increase, the relative risk of incursion of cases into the WA community from domestic and international travel will change. For some low prevalence countries and jurisdictions, the risk of incursion into WA from travel from that area is very low, for other areas it will be high. The requirement for full vaccination for travellers will greatly reduce their chance of being COVID positive on arrival and in the subsequent 14 days. In addition to requiring full vaccination, testing both prior to departure and on arrival to WA should be considered, as another layer of mitigation and reassurance. The WA Health modelling also looked at the impact of removing quarantine requirements and caps on international arrivals for vaccinated travellers, which had minimal impact on the number of cases observed. Testing (pre-departure and post-arrival), however, is highly effective and the additional number of imported cases is minimal, particularly if vaccinated.

As WA transitions to 'living with COVID', the concern regarding additional seeding from travellers will diminish as WA is able to manage cases and hospitalisations. As WA opens the domestic and international borders, it is recommended that a 'low restriction' policy be implemented with no quarantine requirements, and pre-departure and post-arrival testing. The testing requirements should be reviewed after 4 weeks to ascertain their ongoing benefit.

2. Unvaccinated arrivals

Unvaccinated arrivals present a much higher risk of bringing with them COVID infection and then of onward transmission into the WA community. The approach to unvaccinated arrivals should include pre-departure testing, 14 days of hotel quarantine, testing as required in hotel quarantine and a cap on the numbers of such arrivals. Future consideration could be given to allowing home quarantine when these people come from low risk settings.

Impact on the health system

Moving to 90% vaccination with appropriate TTIQ and PHSM measures will mitigate but not remove the need to manage serious cases of COVID-19. WA Health continues to review its readiness in preparation for any outbreak. This includes increasing its bed capacity to cover both COVID cases and the general increase in demand. It is currently opening and staffing 332 beds with approximately 170 already opened, with an additional 270 beds (including 40 additional ICU beds) recently announced, all of which will be opened by August 2022. In addition, there is a surge plan in place that still can be used to increase public and private capacity, which includes spaces that are not ordinarily used for inpatient beds. In addition, non-elective work would be cancelled to support the surge physical bed and workforce capacity in the event of a major outbreak. However, once the 90% full vaccination goal is reached, WA Health is planning to provide clinical care to COVID-19 patients without disrupting business as usual activities in either the public or private health sector, through a combination off the original 332 and now 270 additional beds.

RECOMMENDATIONS

Based on the current evidence available, including observations of other Australian jurisdictions and impacted countries, scientific literature, general modelling and modelling customised to the WA context, I recommend, as the Chief Health Officer, that WA should implement a range of border and public health changes when 90% of the WA population 12 years and over are fully vaccinated against COVID-19.

Under these proposed measures, and on reaching the 90% target, I further recommend that WA should:

- fully open its domestic borders to fully vaccinated travellers, remove all quarantine requirements but continue to require pre-flight and on arrival testing (within 48 hours) for at least a month prior to review;
- allow uncapped inbound international arrivals for all vaccinated persons, without quarantine but subject to pre-flight and on arrival testing (within 48 hours);
- ensure appropriate TTIQ arrangements are in place for any subsequent outbreaks;
- implement the minimum baseline PHSMs required to mitigate seeding and community spread, including mask use on public transport and in vulnerable areas, and ‘Health pass’ full vaccination requirements to attend events with capacity above 1000 people or in high risk venues, such as nightclubs.

- implement the minimum step-up PHSMs required to minimise cases in any subsequent outbreaks without requiring lockdowns; and
- continue hotel quarantine only for high risk unvaccinated overseas travellers.

Proposed settings for international travellers are reflective of those announced by other jurisdictions. As WA may be the final jurisdiction to transition its border arrangements, these settings will likely be further refined closer to the date.

On present estimates, WA is expected to reach 90% fully vaccinated coverage in late January 2022. It is recommended that these measures be implemented on or after the 90% threshold being achieved. As this date may move, either forwards or backwards, depending on hesitancy, supply and uptake, it is further recommended that a final date be confirmed when the 80% fully vaccinated threshold is reached.

Yours sincerely

Dr Andy Robertson
CHIEF HEALTH OFFICER

04 November 2021