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

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Dear Premier

COVID-19 RESPONSE IN WESTERN AUSTRALIA

On 16 March 2020, in response to the emerging COVID-19 pandemic, the then Minister for Health declared a Public Health State of Emergency in Western Australia (WA), pursuant to section 167 of the *Public Health Act 2016* (the Act), with effect from 12 am on 17 March 2020. The Public Health State of Emergency has subsequently been renewed on a fortnightly basis to enable the emergency powers, which are contained within Part 12 of the Act, to be used to manage the pandemic response.

The response to COVID-19 in WA has been guided by the National Cabinet and the Australian Health Protection Principal Committee (AHPPC). As Chief Health Officer, I have continually monitored the cases of COVID-19 observed throughout Australia, New Zealand and the world, and provided advice based on the data, information and epidemiological modelling available. The WA response to COVID-19 in 2020 and 2021 enabled WA to largely prevent the introduction of COVID-19 into the state, while rapidly managing and eliminating the spread from the small Alpha and Delta outbreaks of COVID-19 that occurred. In turn, this response allowed WA to ease restrictions in a way that supported the economy, while building up the vaccine protection with minimal risk to the community's health.

Since the Omicron outbreak began in WA in January 2022, WA Health has been managing COVID-19 outbreaks related to the Omicron BA.2, BA.4 and BA.5 subvariants, using the public health levers of Testing, Tracing, Isolation and Quarantine (TTIQ), COVID vaccinations and Public Health and Social Measures (PHSMs), including masks and visitor restrictions in high risk settings. WA implemented a range of PHSMs in a staged approach during the BA.2 outbreak and has been transitioning these measures to ‘living with COVID’ during the subsequent BA.4/BA.5 outbreak.

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A review of the COVID-19 data shows that WA reached its peak of COVID cases on 16 May 2022, when over 16,900 confirmed cases were reported. Since then, daily and overall active case numbers have been declining slowly, with the average number of cases dropping from 10,436 per day at the peak, to 1,042 per day last month[1] and 679 per day for this month[2]. The average number of active cases per day has dropped from 59,529 active cases daily at the peak, to 5,652 active cases[3] for the previous month and 2,508 for this month.

While WA has experienced hospitalisations and intensive care unit (ICU) admissions due to COVID-19, the ICU admissions have been significantly below the expected numbers from the modelling data. Hospitalisations peaked on 20 July 2022, with 459 cases in hospital, including 22 in ICU, and these numbers have also steadily declined. As of 24 October, 163 cases required hospital care, with 9 cases in ICU, though none required ventilation. There have been 683 deaths due to COVID, which have been highest in the 80-90 age group. The lower than expected rate of serious disease leading to hospitalisation and death in the population is, in large part, due to WA's very high vaccination rates, particularly the third dose booster rate of over 83%.

Future management of COVID-19

Future waves of COVID-19 are likely and WA needs to be prepared to respond to these in a measured and proportionate way. Management of future waves will need to consider the particular subvariant circulating in the community, its severity, likelihood of spread and the expected population protection afforded by previous and future vaccination efforts and prior infections. In the case of a future variant of concern, which is highly contagious and causing severe disease that threatens to overwhelm the capacity of WA's health system, reintroduction of PHSMs and other restrictions may be necessary.

The PHSMs, when combined with TTIQ requirements, have been highly effective in mitigating the impact of COVID-19 by reducing transmission in the community and protecting those most vulnerable to severe disease. Given the profound effect of PHSMs across the whole of society, including restrictions on gatherings, access restrictions, vaccination requirements and mask use, these measures should be mandated only when strictly necessary and proportionate on public health grounds.

With case numbers and hospitalisations now reduced, and any anticipated rises in cases well within the WA hospital capacity, WA has now reached a point in the pandemic where it is appropriate to review the use of the emergency powers under the Public Health State of Emergency, and the related Directions. To maintain community confidence in public health measures, these measures should be constantly reviewed and only used when strictly necessary. Should the situation change, and the reintroduction of PHSMs or other measures to protect the community

[1] Figure is the mean of the 7-day average number of cases between 21 August – 20 September 2022
[2] Figure is the mean of the 7-day average number of cases between 21 September – 20 October 2022
[3] Note: the isolation period changed from 7 days to 5 days on 09 September 2022 which would affect (reduce) the active case numbers reported in September and October.

be needed, there will be greater public understanding and likely compliance if they know that such actions are taken only when absolutely required.

There are some indications that WA may be in the early stages of another wave, with increases in cases, hospitalisations and health worker furloughing figures over the last week. Whole genome sequencing surveillance data does not show any significant spread of new highly virulent subvariants and WA's recent experience of a high caseload setting provides confidence that any anticipated rises due to the currently circulating subvariants will be within the capacity of the WA health system to manage.

Public Health State of Emergency

Under section 3(2) of the *Public Health Act 2016*, actions taken to control a public health risk should be proportionate to that risk. With these factors in mind, I am satisfied that the Public Health State of Emergency powers are no longer required to manage the pandemic in WA. On this basis, and in accordance with section 171 of the Act, I intend to recommend to the Minister for Health that the Public Health State of Emergency be revoked on or after 04 November 2022, which will move Western Australia out of its active response phase and into the recovery phase.

In recommending the revocation of the Public Health State of Emergency, consideration has been given to the powers that may be necessary to control or abate the ongoing risk presented by COVID-19. In accordance with section 152 of the *Public Health Act 2016*, the Chief Health Officer may, for the purposes of preventing, controlling or abating a serious public health risk, authorise an authorised officer to exercise any of the serious public health incident powers (Part 11 powers). A serious public health risk is defined in the Act as a public health risk involving potential harm to public health that is irreversible, of a high impact or on a wide scale. There is no statutory requirement to declare that a serious public health risk has occurred or may occur.

The serious public health incident powers are similar to the State of Emergency powers used to date, but have more restrictions on their use. These powers include enabling an authorised officer to close any premises, to prevent any person or class of persons from entering any premises, to direct any person to undergo medical examination and to direct any person to remain quarantined from other persons for up to 24 hours. Should it be necessary to require people to quarantine for a longer period, an Infectious Disease Extreme Circumstance (IDEC) declaration can be considered and issued by the Minister. At this time, I recommend that these powers are not required, as the COVD-19 pandemic will not represent a serious public health risk, as defined in the Act, at the time that the Public Health State of Emergency is revoked. If, however, a further major outbreak occurs, or a new highly virulent strain emerges, consideration will be given to the use of these powers. In that event, the new *Emergency Management Amendment (Temporary COVID-19 Provisions) Act 2022* will also allow for the reintroduction of other levers of control to ensure WA can protect the community, particularly those most vulnerable members.

Vaccination Mandates

As the Public Health State of Emergency ends, consideration must be given to the COVID-19 management Directions that are currently in place and whether there is a public health need for them to continue. Currently, the Visitors to Residential Aged Care Facilities Directions (No 13) and the mandatory vaccination directions for health workers, primary healthcare workers, residential aged care facility (RACF) workers and disability support accommodation workers remain extant under the *Public Health Act 2016*.

The rollout of the Australian COVID-19 vaccination program commenced in February 2021 with priority populations, including RACF residents and staff, in the first priority group for access. On 28 June 2021, National Cabinet agreed that the COVID-19 vaccination would be mandatory for all residential aged care workers from 17 September 2021.[4] National Cabinet agreed this would be mandated for workers as a condition of working in an aged care facility through shared state, territory and Commonwealth authorities and compliance measures. This requirement was introduced in Western Australia by way of a direction issued under the *Public Health Act 2016.*

At its meeting of 09 July 2021, National Cabinet agreed that the COVID-19 vaccination should be mandated for residential disability support workers from 31 October 2021. National Cabinet noted advice from the AHPPC that many people with disability have a higher risk of developing severe illnesses from COVID-19 and that ensuring high vaccination rates among residential disability workers will help protect people with disability.[5] Disability support workers providing services to people with disability in residential settings were in Phase 1a of the vaccine rollout and other disability support workers, providing care for individuals with disability in private homes, were prioritised for vaccination in category 1b. This requirement was also introduced in WA by way of Directions issued under the *Public Health Act 2016*.

On 6 August 2021, I provided advice that, given the serious public health risk posed to staff, patients and other users of the health care system from COVID-19, the availability of a safe and effective vaccine and the proportionate nature of such a mandate, the benefits of mandatory vaccination of health care workers outweighed the risks and that this should be implemented as soon as practicable. This was implemented in a staged manner, with staff in high risk areas in public or private hospitals or in COVID testing or prevention specific settings, such as COVID clinics or vaccination centres, required to have had a COVID-19 vaccination (first dose) by 01 October 2021. Two further tiers were implemented on 01 November 2021 and 01 December 2021, which applied more broadly to the hospital system and wider health services.

[4] covid-19-vaccination-mandatory-vaccination-of-residential-aged-care-workers-covid-19-vaccination---mandatory-vaccination-of-residential-aged-care-workers.docx (live.com)

[5] https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-mandating-vaccination-among-residential-disability-support-workers

On 1 October 2021, the AHPPC published a Statement recommending that COVID-19 vaccinations should be mandated for all workers in health care settings, including those working in primary health care and community settings[6]. The AHPPC Statement provided a national definition of relevant health care settings, which included those in private provider facilities, such as general practitioners, private nurse offices and consulting offices, pharmacies, dental centres, allied health facilities and private pathology centres. This Statement was considered and endorsed by National Cabinet on 1 October 2021. I subsequently wrote to you on 8 October 2021 and recommended that mandatory vaccination should be introduced in WA for all health workers in primary health and community settings, and that the first dose of this mandatory vaccination should be implemented by 01 November 2021, to align it with the Tier 2 requirement for hospital staff. This was again implemented by way of Directions issued under the *Public Health Act 2016*.

Each of these workforces represent a critical workforce, whose role in preventing disease, treating illness and optimising health in our community must be safeguarded. Due to frequent interactions with a large population base in the community, the primary health and community health workforce were, and continue to be, at high risk of exposure and may be exposed to COVID-19 cases either knowingly or inadvertently. Transmission of COVID-19 in primary health and community health settings also has the potential to cause serious illness in the staff, major disruption to the provision of services, particularly if staff become unwell or are required to furlough, and transmission of COVID-19 to members of the community who attend these setting for health care. Health workers in community settings work closely with vulnerable groups, including the elderly, and those with chronic disease or who are immunocompromised; these vulnerable groups are at high risk of serious sequelae from COVID-19 infection and include people who may not be able to be vaccinated themselves.

In recognition of these risks, a requirement for visitors to hospitals and residential aged care facilities to be vaccinated against COVID-19 was introduced and the requirement for a booster dose of COVID-19 vaccine was mandated for all eligible workers to which a vaccine mandate applied. All those eligible were required to receive a booster dose by 5 February 2022 and those who subsequently became eligible were required to have the booster dose within one month of becoming eligible. These timeframes were implemented to allow the workers enough time to get the booster dose and employers adequate time to check and record the booster dose.

In my advice at the time, I advised that there were good public health grounds for mandating the COVID-19 vaccine as outlined above, if there was a serious public health risk, there was a safe and effective vaccine, and mandating the vaccine was proportionate to that risk. Mandated medical interventions, such as vaccination, are never imposed capriciously; however, patient contact involves unavoidable risks and special obligations. Although voluntary compliance by health and community care professionals and visitors were preferable to mandates, the lack of uptake of the vaccine at that time left limited options. Unvaccinated workers and visitors to high risk facilities, who may spread COVID-19, can cause tremendous harm, particularly when

[6] AHPPC Advice https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-mandatory-vaccination-of-all-workers-in-health-care-settings

caring for vulnerable patients. Patients should expect that their service providers will take every reasonable precaution to protect them from developing a new disease that they did not previously have. With COVID-19, vaccination is the best way to meet this expectation.

The consideration of the revocation of the Public Health State of Emergency represents an appropriate time to review whether the mandates have had the desired public health effect and if these mandates are still required for some or all groups for any longer. I have previously provided advice on 27 May 2022 recommending the removal of vaccination mandates from other groups not managing high risk patients or residents from 01 June 2022.

On public health grounds, the serious public health risk remains, but is significantly reduced. The COVID-19 pandemic remains primarily an Omicron pandemic, with outbreaks due to various subvariants. The vaccines remain safe and effective, particularly in preventing serious disease up to 6 months after a booster dose. The protection against symptomatic disease and subsequent transmission, however, is less, waning to 52-53% protection 12 weeks after the third booster dose.[7] At this time, all health, aged and community care workforces that were mandated to receive their COVID-19 vaccination have been vaccinated with their booster doses.

The question of proportionality is more complex, given the wide range of groups being considered. With over 98% of the population over 11 years having received 2 doses of vaccine and 83.8% of the population having received 3 doses, the risk posed by unvaccinated and partially vaccinated people to the general population is now negligible, particularly as the protection against infection and onward transmission of the Omicron variant is less in two dose and booster vaccinated people than with Delta and other previous variants. Many of the unvaccinated and the partially vaccinated have now been infected during the Omicron outbreak, which will provide some protection against further infection and transmission. The vaccination mandates have made a significant contribution to increasing the vaccination coverage rates, which remain some of the highest in Australia. However, with a third (booster) dose rate of nearly 84%, the public health need to continue mandates, including in high-risk settings, is no longer present. With regards to influenza vaccination, the visitor to RACF requirements provided some protection against the potentially devastating effect that a concurrent influenza spread outbreak may have had in an RACF, but are no longer required as influenza rates have returned to inter-seasonal levels.

Given the high rate of vaccination achieved in WA, and the high number of people already exposed to COVID-19, the mandatory vaccination Directions are now no longer proportionate to the current public health risk. These mandated workplaces and facilities initially had a higher risk of exposure to COVID-19, and the vaccination mandates were put in place to protect those workforces and their patients from exposure. The WA population now has a mixed level of immunity due to both vaccination and natural infection, and vaccination coverage rates underestimate the

[7] Gram MA, et al. (2022) Vaccine effectiveness against SARS-CoV-2 infection or COVID-19 hospitalization with the Alpha, Delta, or Omicron SARS-CoV-2 variant: A nationwide Danish cohort study. PLoS Med 19(9): e1003992. https://doi.org/10.1371/journal.pmed.1003992

true state of community immunity. While the priority of WA's pandemic control must remain protection of the most vulnerable, all workplaces and individuals have been given the opportunity to ensure that mitigation measures, including vaccination, continue to be used to do this.

Given WA has experienced major peaks of infection due to Omicron, which has giving our population a mixed immunity due to vaccination and natural infection, and case numbers, hospitalisations and outbreaks in RACF have all receded, the need for vaccination mandates to protect our workforces in high risk settings, and, in turn, the patients and residents within these settings, can no longer be considered proportionate to the public health risk. It is therefore, my recommendation, as Chief Health Officer, that, when the Public Health State of Emergency is revoked:

- all remaining worker vaccination mandates, including the booster vaccine Directions, be revoked;
- the Proof of Vaccination Directions (No.7) under the Emergency Management Act, which require visitors to residential aged care services and hospitals to be vaccinated or medically exempt to visit such facilities, be revoked; and
- the Visitors to Residential Aged Care Facilities Directions (No 13), which provide that persons must not enter or remain on the premises of a Residential Aged Care Facility unless they have received an up to date influenza vaccine, are asymptomatic for COVID-19 and have not been advised that they a close contact of a known COVID-19 case in the preceding 7 days, be revoked.

Emergency Management Act 2005 **Directions**

In addition to the Proof of Vaccination Directions (No. 7) already discussed, two other health related Directions issued under the *Emergency Management Act 2005* remain extant. These Directions are the COVID Transition (Face Covering) Directions (No 10) and the Department of Fire and Emergency Services Ambulance Service Assistance Directions.

The COVID Transition (Face Covering) Directions (No 10) provide that a person must always wear a face covering while they are at a hospital, aged care facility, residential care facility (including disability care facilities and mental health residential facilities) and health care settings, unless an exception applies. Based on the information provided above, specifically that the COVID-19 case numbers in Western Australia have been declining and a high rate of vaccination has been achieved, these Directions are no longer required, and I recommend that they are revoked. All these facilities can, if required, impose mask or other requirements as a condition of entry to their facilities.

The Department of Fire and Emergency Services Ambulance Service Assistance Directions provide that the Fire and Emergency Services Commissioner must make fire service personnel available to St John Ambulance for the purposes of and to undertake relief ambulance services. This Direction was made on 20 May 2022, when the Omicron outbreak was at its peak and furloughing of staff threatened the provision of services by St John Ambulance. As the COVID-19 case numbers in Western Australia have declined from over 16,900 per day at the time the Directions were

made, to under 1000 cases per day at the current time, the Directions are no longer required, and I recommend that these Directions are revoked. These revocations do not preclude an employer or a facility from having a policy position that may require some or all these previously mandated requirements to continue.

I will continue to monitor the situation and will re-consider the above advice should there be significant changes to the public health situation.

Yours sincerely

Dr Andrew Robertson
CHIEF HEALTH OFFICER

26 October 2022