T R A N S C R I P T

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into the Victorian Government's Response to the COVID-19 Pandemic

Melbourne—Tuesday, 12 May 2020

Members

Ms Lizzie Blandthorn—Chair
Mr Richard Riordan—Deputy Chair
Mr Sam Hibbins
Mr David Limbrick
Mr Gary Maas
Mr Danny O'Brien
Ms Pauline Richards
Mr Tim Richardson
Ms Ingrid Stitt
Ms Bridget Vallence

WITNESS

Associate Professor Julian Rait, OAM, President, Australian Medical Association Victoria *(via videoconference)*.

The CHAIR: Thank you for joining us today, and I am sorry that we have kept you waiting. We welcome you to the public hearings for the Public Accounts and Estimates Committee's Inquiry into the Victorian Government's Response to the COVID-19 Pandemic. The Committee will be reviewing and reporting to the Parliament on the responses taken by the Victorian Government, including as part of the national cabinet, to manage the COVID-19 pandemic and any other matter related to the COVID-19 pandemic. We have asked that all mobile phones be turned to silent.

We let you know that all evidence taken by this Committee is protected by parliamentary privilege, Therefore you are protected against any action for what you say here today, but if you repeat the same things outside of this forum, including on social media, those comments may not be protected by this privilege. You will be provided with a proof version of the transcript for you to check, and verified transcripts, presentations and handouts will be placed on the Committee's website as soon as possible.

The hearings may be rebroadcast in compliance with standing order 234. We ask that photographers and camerapersons follow the established media guidelines and the instructions of our secretariat.

We thank you for taking the time to be with us today. Before we invite you to make a brief presentation, I understand our Committee has explained to you that that will be followed by questions. The time for questioning is divided, relatively speaking, between the parties represented at the table—the Government, the opposition and the parliamentary crossbench—so we do actually cut you off at certain points in time, and my apologies if that comes at an awkward moment. So we will invite you to make a 5-minute presentation.

Assoc. Prof. RAIT: Thank you very much for the opportunity to appear before the Committee today, Chair. I would like to at the outset note the obvious before the Committee: that the COVID-19 pandemic is not over and that continuing vigilance by all concerned is essential. Populations that have dealt with pandemics in the past have unfortunately experienced waves of infection, and even the most accomplished public health physicians during past pandemics have been tempted and/or pressured to loosen restrictions and produced resurgent disease. Similarly, the COVID-19 pandemic may take many months or years to play out in Victoria.

There will undoubtedly in time be a comprehensive review and further inquiries conducted into the whole story, the whole picture, looking at the lasting effects of the decisions made and comparing those to efforts in other jurisdictions, but it is important to acknowledge that Victoria has taken steps so far that have successfully minimised the transmission of COVID-19, and the AMA believes the State Government should be applauded for these efforts.

The Victorian State Government should be commended for a number of strong decisions it has made in consultation with the national cabinet and robust actions that have been used to avoid the types of tragic situations that we have seen in other parts of the world, where there have been high and rather troubling rates of death and illness especially in vulnerable groups such as the elderly. Some of the decisions which have had a positive impact, we believe, were: the commitment to follow expert health advice first and foremost by the Government; the second was the formation of the national cabinet and Victoria's willing participation in it; furthermore, the cancellation of the Formula One Grand Prix and other mass gatherings; the timely staged closures of smaller group activities across the state; and also the isolation of returning overseas travellers. Equally Victoria's recent expansive expensive testing also is to be applauded.

There have been a few issues, however, that the AMA has been publicly vocal about, and these I believe are probably the subject of concerns of this Committee. We have expressed concerns about a lack of personal protective equipment for frontline health workers, and a continuing issue remains with fair distribution of these across the state. We believe this has been one of the most important issues for our members and a significant source of stress for them.

Another issue is related to general practitioners, who obviously play an important role in managing any pandemic. We believe there has been a lack of clear, two-way dialogue and a weak relationship between the State Government and general practitioners in the past, and indeed a lack of support from the State Government over

many years has contributed to difficult lines of communication with them. In a pandemic we see that this disconnect and stress plays out very clearly. GPs seem to be ignored or excluded at times from our disaster preparedness, and this was equally true during the bushfire emergency as well earlier this year.

There are also issues, we believe, with the devolved public hospital system. Public hospitals are their own masters and to a large degree with their own boards operate at arm's length from the Government rather than being line managed by the Government. While this may have had some merit in the past, I think there is a conversation now to be had around whether a devolved system serves us well in a pandemic and whether the Department of Health and Human Services—and especially Safer Care Victoria—should have a more active role to play in the management of hospitals during such a crisis. We really need more transparency from public hospitals, fairer and more equitable distribution of personal protective equipment and more consistent applications, processes and guidelines, such as PPE fitting and training.

As we lift restrictions Victoria also appears to be taking a very conservative approach compared to other jurisdictions. The AMA has no particular opinion on this, and we believe that the State Government obviously continues to be guided by its Chief Health Officer. We consider the Chief Health Officer's expertise and advice should continue to be respected by all parties. At times his decisions might appear more conservative than those in the other states, and we believe that you need to accept that we have our own local conditions and we have to take these into account over the course of the pandemic. There will continue to be circumstances where we need to make different decisions or take a slightly different course from the rest of Australia.

But moving forward there are a number of issues that also need to be dealt with. The way specific outbreaks are contained and managed will be paramount. There is a lot now riding on how well our public health teams can continue to detect cases and finesse their methods of containment. Public health teams will continue to face great pressure to act quickly and effectively—

The CHAIR: Sorry to interrupt you, Professor Rait. The time for the presentation has expired.

Assoc. Prof. RAIT: Okay.

The CHAIR: Sorry, as I said there will be some awkward moments like this, but I will pass you over to Gary Maas, MP, for the first round of questions. Thank you.

Mr MAAS: Thank you, Associate Professor, for your appearance today and thank you for that presentation. Firstly, I would like to thank you and thank your members for the outstanding work that they have done on the front line of this pandemic. It is very noble and very worthy work. We understand that you have members who work in our public hospitals as well as general practice. To that end, I was hoping that you would be able to explain for the Committee the division of responsibility between the State Government and the Commonwealth when it comes to public hospitals and primary care.

Assoc. Prof. RAIT: Sure. Well, clearly the primary care is funded by the Commonwealth through the medical benefits schedule, and also there is support as well through practice incentive payments to support general practices. So, by a large, general practice works outside the state health system. On the other hand, in combination with joint funding from the Federal Government of course our public hospital systems are separately funded, and the administration of those funds is the duty of the State. So to a large extent the public hospital system and of course the primary care general practice really exist in two separate silos.

Mr MAAS: Okay; thank you. I am the Member for Narre Warren South, and I have certainly had GPs in my electorate contact me about particular issues that they have had accessing PPE. We had the health Minister up before and she touched upon some of this as well in her explanations, but I was hoping that you would be able to explain for the Committee how PPE is provided to GPs and who bears the responsibility for that provision.

Assoc. Prof. RAIT: Yes. Quite perversely of course we have separate streams or separate responsibilities for different groups. Although there is a national stockpile, of course, that is largely for the purposes of the primary health networks that distribute to general practitioners and certain other providers, whereas of course the state sources its own supplies separately and most recently has actually developed its own task force to try and source adequate supplies of PPE for the state public hospital system. So just like of course the way in which general practice primary care is funded and the state hospital system is funded, they also have separate supply chains for personal protective equipment.

Mr MAAS: Thanks, Professor. We know many healthcare workers, including doctors, often share their accommodation with other healthcare workers, and we know there has been lots of commentary around protecting our health workers should they test positive for COVID-19 or be exposed to it in the course of their work. Do you think the Government's announcement of Hotels for Heroes, which includes doctors in hospitals but also GPs in primary care settings, adequately addresses these concerns?

Assoc. Prof. RAIT: Yes, I think they do. Up until that point I think there was a great deal of anxiety amongst many workers, particularly those in high-exposure areas like ICUs, respiratory wards, emergency departments, about the possibility of going home and contaminating their families. So I think this has actually been an opportunity to take a great burden off people so that they can actually go and accommodate themselves independently for a period of time. Now, thankfully of course the dreaded tsunami of cases has not arrived, and of course it has probably not been utilised a great deal, but for those few doctors and other healthcare workers who were obviously very anxious about their particular occupational exposure I think it was quite successful and I think it has been very welcome.

Mr MAAS: Thank you. In addition to GPs, we have noticed that a lot of public hospitals are making use of technology such as telehealth to treat patients. What are your thoughts or your members' thoughts on the use of that type of technology?

Assoc. Prof. RAIT: Well, of course telehealth has been a long time coming, and there has been a lot of advocacy by the AMA over a number of years to try and encourage telehealth and actually have that supported primarily through the MBS. There has been a constant pressure to create item numbers, and of course it is only with the advent of this pandemic that it has become available. But equally I am well aware that a number of public hospitals are embracing this too. I was only speaking yesterday to someone who is in a follow-up clinic, a rheumatology clinic, in the Royal Children's Hospital and is being converted to this sort of methodology. I think it is actually creating a lot of relief to families, particularly those with young children, who do not feel they want to venture perhaps into a hospital necessarily at the moment and also may have to travel some distance; they now can instead telecommute. So I think that the way in which hospitals have been embracing telehealth is going to be a great benefit to very many patients. Of course you cannot replace all consultations, but I think for very many specialties this is going to make life easier for patients, in particular those who live in rural and regional areas. I often wondered how we were going to get greater access for such patients, and I think telehealth may well be a solution that we can look forward to in the future.

Mr MAAS: I was actually going to ask you on your views of the use of telehealth beyond the pandemic. Would you care to share those?

Assoc. Prof. RAIT: Absolutely. We hope that telehealth is here to stay. The other issue of course is that telehealth is obviously useful in counselling for mental health issues as well, and so we are hoping that it can be continued and deployed in very many mental health environments as well.

Mr MAAS: That is great to hear. The Government has invested significantly in new beds and equipment for hospitals, including ventilators. What difference will this make for your members?

Assoc. Prof. RAIT: Well, I think obviously you can say that it was a bit overly generous to get as many ventilators and ICU beds as we have ultimately had delivered. But on the other hand I think we have to put into context the fact that I do not think that these pandemics and these zoonotic viruses are actually going to go away any time soon. If you look over the last few decades, they have occurred every decade or so, and I think we are going to actually face further examples of these. I think having adequate pandemic preparedness, including adequate ICU beds and ventilators in reserve, will be essential for us to combat these situations in the future. I am very much relieved and I know my members are very much relieved not only that they now feel they have the resources to deal with this pandemic or a second wave should it occur but they also feel that they are well prepared for any future eventuality with another respiratory virus.

Mr MAAS: Thank you, Professor. I was just also interested on your views as to the staged easing of restrictions that have been implemented or are about to be implemented. What are your views on the way that has been staged and the way that has come about?

Assoc. Prof. RAIT: Well, as I mentioned, I think that one of the issues in the past, that certainly as a student of history I have been well aware of, was the misadventure that followed in various US states and cities when

social distancing was rapidly diminished in the 1918 flu pandemic. You only have to look at the contrast between Philadelphia and St Louis to see what happened when one city in particular took the brake off rather suddenly and another had it on very firmly to see that you have got to be very slow in actually withdrawing these restrictions. So I would very much, and I am sure my members would very much, endorse the current plan to progress very slowly in Victoria, and I think that just gradually increasing the size of groups that can gather together is a very good way to proceed.

Mr MAAS: You do not think the easing of restrictions have been too slow?

Assoc. Prof. RAIT: I do not think we will know the answer to that except in retrospect. I think that one of the problems here is there is no right answer to these issues. As I mentioned, the city where I trained in the United States, St Louis, had a very thorough and very rigorous commissioner, Max Starkloff, in 1918, who was very much across social distancing. But under pressure from the mayor he let up a little bit too soon and he had a second wave. I think that there are many examples in history and other pandemics where the social distancing restrictions were eased too quickly. I think that time will tell whether of course Victoria's approach is better than anywhere else. But I do not really at this time feel I can take issue with the Chief Health Officer and his approach, because I think that being cautious in this context would be wise when you consider the history of previous pandemics.

Mr MAAS: Thanks for that answer, Associate Professor. In terms of testing, the Government set itself—well, at the time we thought—a stretch target to conduct 100 000 tests over the course of the fortnight. As it turned out, and as we have heard, there have been some 161 000 tests that indeed were conducted in that time. What are your views on the amount of testing that was conducted and why that kind of testing blitz was so important?

Assoc. Prof. RAIT: Well, of course there are two reasons why you might test. You might test for case detection purposes, to try and flesh out cases, but I think the other reason—

One of the priorities behind this massive expansion of testing was to get the epidemiological data on the number of cases that might be quasi-symptomatic or asymptomatic in the community. Getting a handle on those cases that perhaps are not readily apparent is important from the epidemiological point of view and then can inform how quickly you can relax your social distancing restrictions.

I think it has been actually very valuable from an epidemiological point of view. As I have suggested this morning in some media I have done, obviously going forward I think we just have to try and test the high-risk situations particularly, and by that I mean that you need to look at things like prisons and psychiatric facilities and possibly also schools, and I think there has been announcement today about that subsequently. But these are all very important means to try and detect at the earliest possible opportunity outbreaks and then have a robust public health response to them.

So expanded testing has been very useful from an epidemiological surveillance point of view in the past few weeks, but going forward I think it is going to be equally important in attempting to try and identify outbreaks at the earliest chance and then act accordingly.

Mr MAAS: Thank you very much for your time, Associate Professor. I actually have no further questions.

The CHAIR: I will pass to Sam Hibbins, MP, who has 3 minutes to ask his question and receive his answer.

Mr HIBBINS: I just want to just touch on preparing for future outbreaks. A number of other countries do have centres for disease control and prevention that ensure all sectors of the health system work together in responding to infectious threats. Do you think this is something that we should have here in Australia?

Assoc. Prof. RAIT: Absolutely. In fact in April last year I met with Sharon Lewin, the head of the Doherty Institute, and had some meetings also with Angie Bone of the Department of Health and Human Services and Terry Symonds as well to try and cultivate perhaps or encourage a centre for disease control to be established in Victoria. Now obviously there are politics around which state it should be located in, but I would have thought that the Doherty Institute in Melbourne would be ideal for exactly this purpose.

I think that throughout this pandemic we have seen mixed messaging and we have seen some variations in the different things that different states do, and I think that there would be much better coordination if there was a

national centre for disease control. Having said that, you would have to say that the US centre for disease control has failed miserably because it had some difficulties with its testing regime early on. So I suppose it is not a panacea necessarily, but if you look to other countries like Taiwan, Singapore, Canada, these jurisdictions have had very good centres for disease control and have not tripped up and have been very effective as well.

Mr HIBBINS: Terrific. That is all from me.

The CHAIR: Thank you. I will now pass to David Limbrick, MLC, who also has 3 minutes to ask his question and receive his answer.

Mr LIMBRICK: Associate Professor, the AMA said on 5 May, through a media release, that:

> The AMA's COVID-19 medical advice stays the same until a vaccine arrives—social distancing—

et cetera and social self-isolation—

> … must remain a part of everyday life.

Is it the view of your organisation that unless there is some sort of herd immunity through vaccine or disease progression these sorts of restrictions must remain?

Assoc. Prof. RAIT: Yes. You know, that is the advice that we have received, and that is the policy of the AMA, to say that until such time as we have one of those two outcomes—hopefully a vaccine in due course—the virus will continue to circulate and therefore we need to slow its transmission so we do not have further waves of infection.

Mr LIMBRICK: So if there is no vaccine, at the current infection rate those restrictions would be for an extremely long time. What is your view on that? Is that sustainable?

Assoc. Prof. RAIT: That is true. Well, I think you would have to reappraise your strategy if you did not have a vaccine. But notwithstanding there have been issues with prior coronavirus vaccines, I think there are a number of promising candidates at the moment, and I would suggest that it is more likely than not that we will have a vaccine within the next 12 to 18 months. Of course whether it is fully protective and fully effective is another question, but nevertheless I would expect that it would provide some degree of immunity of the herd to protect us and therefore much of the social distancing measures could be relaxed.

Mr LIMBRICK: And the other possibility of elimination, is that actually a realistic possibility in your view considering that the rest of the world may not have—

Assoc. Prof. RAIT: No, not at all. I think elimination, theoretically if you get the replication rate down under one and keep it there for a period of time, you could have the virus peter out. But I think that to maintain that position Australia would have to have a fortress mentality and really preclude any trade or industry with many other countries, and obviously the movement of people could not be locked down indefinitely. So I am not sure that economically or practically that is really viable. It would be nice to think it was. But no, I think containment is probably the preferred strategy and the most sensible one, and I think that is what national cabinet has adopted.

Mr LIMBRICK: Thank you very much, Associate Professor.

Ms VALLENCE: Thank you very much, Associate Professor, for your appearance today and your presentation. I will first up ask, Associate Professor: has the AMA at all made any representations to the Andrews Government which have so far been unaddressed?

Assoc. Prof. RAIT: Let me think of all the representations we have made. I suppose we have had a response to everything that we have queried. We have had some issues about transparency about some outbreaks, including the Cedar Meats and of course the Albert Road outbreaks. So we have had some concerns about whether medical staff were adequately briefed about those particular instances at the earliest opportunity. We have made our feelings felt to the Government about that and we have received I think adequate responses.

Ms VALLENCE: I guess on that point about your concerns around the information you have received on some outbreaks and also from your presentation about some of the concerns that you conveyed in your presentation about PPE for frontline health workers and so forth, given these concerns that you have outlined on

PPE and health workers being exposed to cases from Cedar Meats and other outbreaks, I am interested in the AMA membership. Has the membership at all expressed any concerns to you or anyone in the AMA office regarding the department's preparedness to deal with clusters and such outbreaks?

Assoc. Prof. RAIT: The two examples I have just provided. We have had feedback from members both about Albert Road—which, remember, is a private facility not necessarily run by the government, but obviously public health teams were engaged with it—and also just about the fact that with Cedar Meats many practitioners were aware of the outbreak before that was made public, largely because many workers were presenting seeking testing. We have made the point to the Government that again, allied to our issue about general practice more generally, it would be helpful to have better lines of communication with GPs to be able to give them an early warning of potential outbreaks that the health department becomes aware of and give them some intelligence so that they are aware to be more vigilant both with PPE but also to be more case suspicious and test people more vigorously.

Ms VALLENCE: You mentioned there about the PPE. In terms of what you have just said there and also in your presentation about the fair distribution of PPE and a lack of it for frontline health workers as well as concerns that you conveyed in your presentation about the fitting and training of PPE, is there any other message you are receiving from your members about the availability of PPE, the distribution and so forth? If you could explain a little bit about that.

Assoc. Prof. RAIT: Look, I think as I alluded to—and this gets back to my concerns about the devolved governance structure—it seemed to me that some hospitals in Melbourne had adequate supplies of PPE whereas others did not. Clearly that maldistribution problem really reflects the fact that we have separate health networks that have their own, if you like, agendas to try and look after their own personnel, not necessarily thinking or bearing in mind the need to think across the system. So we have had examples that I have been aware of where PPE has been running low, particularly in the respiratory wards at the Alfred hospital, for example. It has been running low in the emergency department at the Royal Melbourne Hospital on another occasion. So these messages have come through to me, and of course I have fed them back to the Government. Then they have had to bluntly try and reallocate resources around the different health networks, sometimes with some reluctance from those health services.

So it seems to me, getting back to the fact that the hospitals are not, as it were, line managed by the department given our governance structure, it creates some difficulty sometimes when you need to allocate resources more evenly or more appropriately, and so hence we have seen cases where PPE has been not adequate in some settings and it has caused some anxiety for staff.

Ms VALLENCE: You mentioned the Alfred there, and I have got two questions on the Alfred. You mentioned the clusters earlier at Albert Road, but were there any concerns raised with you about the cluster at the Alfred? And also, is it true that the Alfred sourced sanitiser from any farm supplies across the state?

Assoc. Prof. RAIT: I cannot answer the second question; I have no knowledge of that. But with respect to the first about the outbreak there, I think the chief executive is on the record having said that it is not clear how it got into the hospital and why it spread. I understand that there was some issue with delay of testing or a delay of understanding or appreciating a diagnosis in a particular patient, but bearing in mind the privacy concerns, I do not know anything specific about that patient beyond that. I know the public health team has adequately, I suppose, followed up all the potential contacts and contained that outbreak. While I think that it was disappointing that it spread as widely as it did in that particular institution, I know it was properly managed and contained ultimately.

Ms VALLENCE: As you said, ultimately it was contained, but do you think that the department could have done more with the Alfred cluster?

Assoc. Prof. RAIT: Look, I am sorry—I do not know enough about the particular situation to comment specifically. All I have heard is that it was it was possibly some delay in diagnosis and testing that led to the outbreak. Beyond that I cannot comment on how effectively it was managed.

Ms VALLENCE: Associate Professor, does the AMA receive updates—perhaps daily updates or updates at a certain frequency—on the number of health workers that test positive to the coronavirus, and if so how do you receive those updates?

Assoc. Prof. RAIT: I would not say I receive them daily, but I have received through the course of the pandemic perhaps three different briefings about that—most recently this week with an update. We were concerned, of course, that it seemed like there were a large number of healthcare workers who were developing COVID-19, and of course it has subsequently been shown to me, and indeed in other jurisdictions, that most people usually get their infections from outside their workplace, usually in their own homes or their own families. I forget the current number. I think it is 22 cases or something, or about 12 per cent of all infections amongst healthcare workers, appear to have arisen in the workplace—it was 12.7 per cent, I think. Obviously any case that occurs in the workplace is unacceptable and regrettable and clearly would imply that there must have been some breakdown in infection control and prevention. That is very disappointing, even those few cases, because you would hope—as has been the case particularly in Taiwan and Singapore—that you would have virtually no healthcare workers getting infections in the workplace because their PPE was adequate. I have to say though—and I have no real evidence—that my suspicion would be that it gets back to my point about training and the fitting of personal protective equipment and the need to have consistent processes across all of the health networks. I think that is pretty much key. As a surgeon myself, I am obviously very familiar with how to gown and glove appropriately and also how to remove my gown, gloves and masks appropriately and safely, even in an infectious situation. But for many people they actually do not do that routinely; they do not routinely have that opportunity, so they have to be trained properly to do it.

Ms VALLENCE: Thank you. Just with the very short period of time left, in relation to the lack of PPE that you mentioned and the limited testing that we had in early March to April, did members express any concerns about safety during that specific period?

Assoc. Prof. RAIT: Yes, absolutely, because I think there was a period there where we thought that perhaps testing was not sufficient. Now, obviously at the moment I am very pleased—

The CHAIR: I am sorry, Associate Professor, to cut you off there. Perhaps you could provide the rest of that answer to the Committee on notice, but the time has expired. Thank you very much for appearing before our Committee today. We appreciate you taking the time. The Committee will follow up any of those questions which have been taken on notice, and responses will be required within five working days of the Committee's request. You will also be provided with a transcript of the hearing to verify. The Committee will move on to its next witness, but thank you so much for your time today.

Assoc. Prof. RAIT: Thank you, Chair, and thanks to the Committee.

Witness withdrew.