TRANSCRIPT

PANDEMIC DECLARATION ACCOUNTABILITY AND OVERSIGHT COMMITTEE

Review of Pandemic Orders

Melbourne—Tuesday, 29 March 2022

MEMBERS

Ms Suzanna Sheed (Chair)
Mr Jeff Bourman (Deputy Chair)
Mr Josh Bull
Ms Georgie Crozier
Mr Enver Erdogan
Ms Emma Kealy
Ms Harriet Shing
Ms Vicki Ward
Mr Kim Wells

WITNESS *(via videoconference)*

Mr Ian McPhan, Chief Operations Officer, Healius Pathology.

The CHAIR: Mr McPhan, all evidence taken by this committee is protected by parliamentary privilege. Comments repeated outside this hearing, including on social media, may not be protected by this privilege.

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I welcome you to the committee and would like to give you the opportunity of making a, say, 5-minute statement on your position.

Mr McPHAN: Thank you, Madam Chair, and thank you for inviting us along to the committee. In terms of opening statements, there are two areas that we are able to provide evidence or feedback to the committee on. The first is as a pathology provider assisting with the COVID response in Victoria, and the second is as a private business operating within the COVID environment.

On the first point, as a provider assisting with the COVID response, we were extremely pleased to partner with the government and Victorians to assist in the pandemic response. The Victorian government handled it extremely well, with excellent communication and coordination between all private pathology providers and public pathology providers. It was an excellent process to be part of and experience. Overall I am very proud of the way our team worked. They worked incredibly hard during the whole pandemic, but particularly so during the omicron surge recently. The private sector as a whole worked collaboratively with each other and the Victorian health department to assist with a coordinated response. As the pandemic ramped up, we too ramped up our testing and scaled up from originally a capability of about a thousand tests a day to, at some peaks, over 20 000 tests per day.

Over the past two years we have also incorporated a number of new technologies into the end-to-end solutions to streamline and improve the response, and that too has occurred in collaboration with the Victorian health department. The breadth of services that we offered in addition to pure pathology testing, we also ran some retail locations, we ran a number of truck stops. We also operated a series of selected licence collection centres of our own. With Dorevitch Pathology being heavily involved in a number of public hospital contracts, we also greatly assisted in the public hospital test sites. The end result of all of that is that we offered services, particularly laboratory services but some other services as well, 24 hours a day, seven days a week as demand increased. So that is a summary of where we were as a private pathology provider assisting the public health response in Victoria.

As a business operating throughout the pandemic, we created systems to constantly monitor clinical reporting of pandemic orders and created mechanisms to communicate that across our organisation. We used our business continuity plans on a regular basis and adapted them to the environment as it evolved—which, as you would all be aware, evolved very quickly in some cases—and we created contingency plans for scenarios, for labour requirements, particularly should our workforce be severely impacted in any area of our business. As well as that, we adjusted our workforce and staff as they were furloughed with COVID or a close contact—so that is, we did have to enact our contingency plans in a number of cases.

So that, Madam Chair, is really the extent of the opening response. So I am happy to take any questions as either a pathology provider assisting the public health response or as a business operating throughout the pandemic.

The CHAIR: Thank you very much for that introduction. You will be asked a number of questions by the committee members. I am interested, as the Chair of the committee—one of our focuses is on issues of privacy as they relate to people's human rights, and perhaps just going straight to that now, I am wondering if you could speak to the processes or procedures that your pathology labs have in place in relation to the collection of, maintenance of and sharing of test results and any other information that comes in to you. We have heard that there are some international standards, but if you could just lay out for the layman how that works within Dorevitch.

Mr McPHAN: Sure, certainly. So we have had privacy policies consistent with national policies for many years—many, many years. Being a healthcare organisation, we have had various legal advice throughout the years as these change as well, and we adapt our policies as we continue to conduct business in the medical field. So right from the start, essentially, we collect data and only use that data for the purpose for which it was collected. People have a right to access their information, and there is a process and processes around accessing that information.

As it relates directly to the pandemic, there is no change to that, other than when we implement new technologies, such as text messaging results, then there are processes to crosscheck and verify that we are sending information to the correct numbers and those kinds of things. But the fundamental principles of collecting data and using it only for the purpose for which it is collected underpins everything that we do from that general pathology and COVID perspective.

The CHAIR: So did you, in the early stages and along the way of this pandemic, receive any guidance or assistance from the Victorian government or its agencies in how you might manage your interactions with the public, with the department and the like?

Mr McPHAN: There was guidance on a few levels. So the first one is that there was a requirement to text any results out to patients. So that is the first one—so guidance covering how that was to be done. And initially that was negative results only; I believe more recently it is positive and negative results. The second element is reporting through to the government systems. So we provided an interface in HL7 format—I believe it was HL7—back to the state government system. That was for the purposes of uploading, initially, just patient results, but as that evolved through Test Tracker, which is the online system using an iPad that was developed by the Victorian government, the data that was gathered then—some of that—was from the start of the process. So when a patient came to a drive-through, for example, they would be registered using Test Tracker, so that information was transmitted immediately. So we ended up with data being transmitted at the start of the process but also results at the end of the process. So essentially there were two systems, one of them being the Test Tracker electronic order and results receiving mechanism and the second one being the texting of results to patients. There was a third layer, which was around giving results out over the phone if people rang in. There was a protocol that was established fairly early on which involved initially patients calling the health department call centres, and then only if a period of time was exceeded, which I believe initially was 48 hours or 72 hours, they would be instructed to call the laboratory.

The CHAIR: Thank you very much for that. I have run out of time here, so I will move now to Ms Shing for her questions.

Ms WARD: She might have already gone. She has got another committee. So go to Josh.

The CHAIR: Okay, we will go to Mr Bull. Thanks, Josh.

Mr J BULL: Thanks very much, Chair. And thanks, Ian, for presenting to the committee and for all the work you have done over this incredibly tough and challenging couple of years. It would be terrific also if you could pass on our thanks to your team and to all the staff that have worked incredibly hard over this really challenging journey. I just want to ask a question in terms of PCR testing. We know of course that during the period of late December and early January we had a very high test positivity rate, and we know, or we believe—and I wanted to get your thoughts on this—that that impacted the rate or the speed of processing of those PCR results. So can you explain for the committee the way that pooling of samples generally works and how laboratories needed to adapt those processes as we dealt with omicron and perhaps in doing so step us through where you can from start to finish how those samples come through the lab and what the various stages are within that process?

Mr McPHAN: Sure. So just on the first question, around pooling, firstly we validate the various methods we use for various levels of pooling, and essentially we settled on using one in two pooling. I would need to take it on notice as to whether we used one in four at any stage, but I believe it was one in two. The issue with pooling is it becomes more difficult as the positivity rate increases, because essentially when you get a positive come up in a pooled sample you then have to take the samples back out again, the original samples, and then retest them independently—so unpooled. So there is a point where the pooling is less efficient because of that retesting. The pooling becomes less efficient than not pooling at all in the entire end-to-end process with high

volumes and high positivity rates. So that is just generally on pooling. Is there any question on that? If not, I will go on to the other steps involved in testing.

Mr J BULL: Look, I think it would be beneficial for me—and I am not sure of the other committee members as well—just to talk about that pooling process from a scientific point of view and why that is important and why that is used.

Mr McPHAN: Sure. So the pooling is used to increase the amount of testing that you can do, so your testing capacity. The figures, for example, when we are pooling we can easily cope with around 18 000 tests per day, but when we stop pooling that drops potentially to between 10 000 and 15 000 tests per day. So it has a huge impact on the total volumes that you can do. That is the primary reason of doing it. And it is extremely useful when positivity rates are fairly low but testing numbers are very high. So that is the primary reason. In terms of how it is done, within our laboratory there are two mechanisms used to pool samples. One of them is a manual mechanism; the other one is an automated system using what is essentially a pipetting device, which can put multiple patients' samples into a single well. Just to explain that a little bit: the testing itself is done in 96-well plates. Some of those wells are reserved controls and the rest are reserved for patient samples. If you are not pooling, one patient sample goes into one well in that 96-well plate. If you are pooling, then you may put up to four patient samples in the one well. As I mentioned, that is either done as a manual exercise within a fume cupboard or with the other mechanism, which is the automated mechanism done in a fully enclosed pipetting station. So that is just generally on pooling. Would you like me to go into the process end to end?

Mr J BULL: No, it is clearly a very methodical and complicated process, and I think it is important for the community to be able to get a sense of how critical all of those stages are and how much goes into the testing process.

Mr McPHAN: There are a lot of critical elements to it—sorry, Mr Bull—which are really around making sure that you have the correct patient in the correct well and you are reading the correct result when you finally test. So those mechanisms and procedures are all developed, crosschecked and ensured to be robust. They are also subject to external audit by groups such as NATA.

Mr J BULL: Thanks, Ian. We had some evidence presented earlier today around rapid antigen testing and how RATs post 6 January have effectively changed the landscape of testing within our state and across the country. I wanted to get a sense from you about how that changes the day-to-day operation for the work that you do. What does that look like in terms of the approach as we head into the winter of 2022 and beyond? How do you prepare for that now the availability of RATs is within the community and those tests are obviously used to now identify positive cases?

Mr McPHAN: The impact of that is really twofold. Firstly, there is the effect on volume. The volume of tests that we get coming through is far decreased from the peaks that we had seen previously, so that is one impact. The other one is where we offer it as a commercial option. That is probably outside the scope of this committee. It is to do with our commercial clients who are paying a commercial fee for a service, and in that we offer a model where we may support rapid antigen testing with a combination of back-end PCR testing. We do not offer rapid antigen testing. Our laboratory and national footprint of laboratories do not offer rapid antigen testing on its own without the support of PCR.

Mr J BULL: Just in terms of the technology around PCR testing, give us a sense of where that is heading in terms of its evolution. Are there opportunities for that to improve quickly as we go forward over a short period of time or do you think we are sort of at the capacity to be able to perform those PCR tests within the most effective time as possible, notwithstanding the fact that we are also using RATs as well?

Mr McPHAN: Do you mean in terms of volume uplift and capacity uplift essentially, or do you mean in terms of the evolution of the PCR itself as variants evolve?

Mr J BULL: Both, actually.

Mr McPHAN: Okay. As a new variant comes out, we confirm the targets we are currently targeting. So PCR targets certain elements of the genetic code, and the test that we use at the moment may use one, two or I think there is a test with three targets. Firstly, we confirm that those targets are still valid with any variant. There is no point testing if a variant is not detectable under the current PCR regime. And all of the methods that

we use currently are perfectly okay with the variants to date. That is one check we do. That said, if there was a variant that came out that was not detectable under the various methods that we use, then the companies that we purchase those from would be evolving their technology at the same time and in sync.

Just an important point to make on that is that very early on in the pandemic, so in early 2020, we had issues around the supply of reagents. Those issues meant that we took a decision to spread our risk, and so we developed up five different testing platforms. We can use any one of those five testing platforms. We use the one that we find the most efficient and most streamlined. In among those five testing platforms they do use various targets, and so we have got a better spread, I believe at least, of an ability to detect on going any variants that come out.

In terms of the evolving technology, it will evolve as well by demand changes. The companies that we buy this reagent from are worldwide companies. They are not small entities acting either very locally or even within Australia or a state; they are worldwide companies. But we do verify that the methods are detecting any new variant.

The other part of the question was around volume. The volume—as the variants come out, with rapid antigen tests it is possible that they may not detect the variants. I am not an expert in that area, but that is a possibility, and therefore PCR may come back in more so as the method that is more reliable for detecting.

The CHAIR: Thank you, Mr McPhan and Mr Bull. We will move on to our next committee member, Ms Crozier.

Ms CROZIER: Thank you very much, Chair. Thank you, Mr McPhan, for being before us this morning. In your opening remarks you said that you had partnered with government for the COVID response. When did you start that partnership?

Mr McPHAN: I think I got a phone call around April 2020.

Ms CROZIER: A phone call from who?

Mr McPHAN: It was one of the secretaries of health.

Ms CROZIER: Okay. The department secretary?

Mr McPHAN: Yes. And the question was whether we could rapidly increase capacity, because it was pretty evident that the state government capacity was pretty much reached at that point in time.

Ms CROZIER: Yes. It was very well known that they could not keep up with the demand. We did not have enough tests through March when there was a huge demand. We are well aware of that. Thank you. There has been information from people who have got tested who have got the wrong information from the Department of Health—their details have been incorrect, the results have been incorrect, the times and dates have been incorrect. That is well reported and documented. I am just interested in the information that you provide to the department, and we have heard from VIDRL before about their information-sharing platform. Can you just explain to the committee the information sharing that you provide to the department and how you do that in relation to the test results?

Mr McPHAN: Sure. We have essentially three sources of COVID testing. Those three sources in general are the health department initiatives around retail sites, for example, so drive-throughs. The second element are requests by general practitioners or medical practitioners, and the third element is that we provide services to a lot of public hospitals, and they did have respiratory clinics associated with them as well as their emergency departments, so that is the third. So the first are retail drive-throughs; the second, GPs; the third, hospitals. Initially there was no electronic method of capturing patient information at a drive-through, for example. I will use them first. That was resolved when Dr Finkel came in and reviewed what was happening and—

Ms CROZIER: Sorry to interrupt you. That was mid-2020, wasn't it, or late 2020?

Mr McPHAN: Mid-2020, yes, that is correct. And then the state government impressively developed a system called Test Tracker. Test Tracker enabled up-front capture of information rather than the traditional handwritten on a piece of paper pathology referral.

Ms CROZIER: Sorry to interrupt you, Mr McPhan, but these mistakes were not back in mid-2020, they have been more recent than that. So I am just trying to understand where you think the fault is with that information. Is it from the information at the testing site? Is it the information that you are providing through that pooling system that you described, or is it from the department when they are sending out the message to the person that has been impacted or been tested?

Mr McPHAN: I think without having some specific cases to review it is difficult to say. But if I go back to those three sources that I mentioned, I mentioned the Test Tracker at drive-throughs, which assists. A GP referral is still on a piece of paper. Similarly, if we get a commercial test, it is on a piece of paper. So that is a physical request form. Those physical request forms are manually entered by a data entry person. Although we have crosschecks in place for all of the data entry we do, and validation steps in place, still errors creep in—

Ms CROZIER: Yes, you mentioned the audits.

Mr McPHAN: and there is an underlying error rate that occurs in that kind of method.

Ms CROZIER: You mentioned the audits and the crosschecking from your laboratory, so what are the inaccuracies that are picked up? What is the percentage that you find through that audit process?

Mr McPHAN: I would have to take that on notice specifically around the COVID ones, if I could come back to the committee with that.

Ms CROZIER: Yes, please. Thank you. I ask that question because obviously when there were 100 000 PCR tests that were discarded—and I will come back to that question—and when people got this information from the department, it has impacted their ability to go back to work. They have been confused with what they can do. So I do think we need to understand just where the majority of the issues have occurred and what the audit process is. If I can just move to the 100 000 PCRs that were discarded in early January, how many of those were from your labs, of those 100 000 tests?

Mr McPHAN: We discarded 13 000 tests.

Ms CROZIER: Over what period of time?

Mr McPHAN: Essentially the discussion around discarding the tests was with the health department as well. I believe that there was a date decided when those tests would be discarded, and that was communicated around all private pathology laboratories and via the health department as well.

Ms CROZIER: So that was a decision by the Department of Health and that date was—

Mr McPHAN: In conjunction with, yes. It is really a clinical decision because if the sample is invalid due to excessive delays in testing, then there is no point doing the test. In particular there is no point doing the test and then billing the state government for an invalid test.

Ms CROZIER: Well, correct. How much do you bill the state government per test?

Mr McPHAN: It depends on the nature of the agreement. We have agreements with public hospitals. We have agreements with the state government as well.

Ms CROZIER: So what would that amount to through the public hospital and directly to the state government—how much?

Mr McPHAN: I think they are subject to commercial in confidence, particularly the public hospital contracts. I think the contract with the state government would be discoverable via another method, so I would prefer not to say on this. Part of the reason for that, just to explain, is that I am unsure as to whether the same rate is charged across all private pathology providers. Therefore I do not want to disclose what Dorevitch Pathology's rate was.

Ms CROZIER: How many tests have Dorevitch Pathology undertaken on behalf of the state government through those public hospitals and directly?

Mr McPHAN: The total number of tests? I think it is about 4.5 million.

Ms CROZIER: 4.5 million?

Mr McPHAN: Yes. I do have the number here if you just bear with me.

Ms CROZIER: So in total that is the public hospital and the drive-throughs and other referrals?

Mr McPHAN: It is total tests on Victorians through our laboratory, and that is from the start of the pandemic to date.

Ms CROZIER: Thank you. Could I ask just about—I want to go back—

The CHAIR: You are just about done. You are done.

Ms CROZIER: Oh, am I done?

The CHAIR: Yes.

Ms CROZIER: Okay. If I have got more time at the end, then I will come back. Thank you. I have run out of time, Mr McPhan, thank you.

The CHAIR: I think by arrangement we are going to Ms Kealy. Oh, Mr Erdogan, sorry.

Mr ERDOGAN: Thank you very much, Mr McPhan, for your attendance today and your presentation. I must admit I was very pleased to hear of a productive partnership with the Victorian government. I guess it is always pleasing to hear about good public and private partnership, especially in service delivery and especially where the matters involved are so important. There is great public interest. Some of my fellow committee members have touched on some of the challenges faced throughout this pandemic, but I guess it is important also that there is a broad approach to pandemic handling. I have seen from our jurisdiction and other jurisdictions across the country and globally a continual improvement of processes. What lessons from the previous omicron peak will you take into the likely upcoming period of high cases and high testing demand, such as in relation to your processes or staffing shortages you may have faced?

Mr McPHAN: Sure, thank you. We have a capacity guarantee with the Victorian state government which is in place up until the end of the financial year. That capacity guarantee guarantees that our laboratory will do 15 000 tests per day with a 24-hour turnaround time. What we are doing, though, is we are continually improving the equipment that we use and the automation that we use within the laboratory. So within Victoria we are currently expanding our capacity to around about 25 000 tests per day, and we are also expanding in other states. The importance of the other states is that if we reach capacity, we can send work to our sister labs in the other states where we have robust systems to send interstate for any overcapacity demand and still receive those results back in a timely manner.

We currently have the laboratory capability of around about 15 000 per day constantly, surging to 25 000 a day once we put this new instrumentation in, which is now on order. What we also do with that is that we have to surge the labour, the workforce, as well, and the workforce is start to finish. So that is from the collection points that we are responsible for through to sample receipt and initial processing before it hits the laboratory and then increasing the number of laboratory staff and then also call centre staff to take any expected surge in calls. So we have detailed plans to increase our capacity, and those plans have been executed as waves have come and gone in the last two years. We are actually quite good now, I would like to think, at that surge capability. So if we have got the underlying testing platforms in place that can cope with it, we can surge our workforce quite quickly, and we can also de-escalate that pretty quickly as well.

Mr ERDOGAN: It is fantastic to hear that increased investment but also the improvement in processes and automation. It sounds like you have got a plan going forward. I did have a couple more questions about, I guess, your engagement with the government. You said you were pleased with the partnership.

Mr McPHAN: It was excellent.

Mr ERDOGAN: It is excellent. What is the on going? Do you have regular contact with the Department of Health in relation to PCR testing, demand and capacity or any issues that arise? Is that an open channel of communication there?

Mr McPHAN: It is currently. It is probably fair to say that it is uncertain what will happen at the end of the financial year when the agreements that we have in place expire. The state government teams that we have dealt with, the teams themselves, have changed periodically, but handover from one team to another has been excellent. All of the people that we have worked with in the state government have been excellent. We have excellent operational connections, we have excellent clinical connections, we have excellent laboratory connections. And the communication by those teams within the state government has been fantastic. They really have been a high-performing team, and they have assisted, I think, all of the private laboratories to be high performing in this environment as well.

Mr ERDOGAN: Thank you for sharing that with the committee. I have got one final question I wanted to ask you about. Obviously currently the commonwealth government subsidises PCR tests through Medicare. How important do you think it is that that arrangement continues?

Mr McPHAN: I think it is vital, and it is vital to have it at the right rebate level as well. The cost of testing is high, whether that be the consumables, from PPE—personal protective equipment—right through to the reagents we use, the equipment we use, depreciation and the labour cost. All of it is very expensive. To keep a minimum amount of capacity is expensive. Obviously as the volumes increase then the cost per test decreases, but for the federal government particularly to expect a certain minimum amount of capacity within the private laboratories the rebate would have to be an appropriate level for that to be economically viable for us.

Mr ERDOGAN: Thank you very much for that, Mr McPhan, and keep up the good work.

Mr McPHAN: Thank you very much.

The CHAIR: Thank you. I will go now to Ms Kealy.

Ms KEALY: Thank you very much for your time today, Mr McPhan. I just wanted to go to the startup of pathology testing for COVID. When did you first begin discussions internally around setting up a testing platform for COVID PCR?

Mr McPHAN: I mentioned that I had a call from one of the health secretaries around April 2020. We were in discussion prior to that. At that time there was no real expectation of a major surge, but obviously COVID was well and truly present in other countries. We were looking at it at that stage, and we had plans to ramp up. Look, from memory I think we had in casual discussions said that we would increase our capacity by, I think it was, the end of April, and then I had a call from the secretary, who asked whether we could bring that forward, so we brought that forward by—

Ms KEALY: Sorry, that was Euan Wallace who called you to ask you to ramp up testing?

Mr McPHAN: No, I was just trying to think of his name.

Ms KEALY: Kym Peake, sorry.

Mr McPHAN: His name is in my phone. I would have to look it up for you, sorry. But no, it was not.

Ms KEALY: If we could get that detail, it would be helpful to know.

Mr McPHAN: Yes. Sure. I will take that on notice.

Ms KEALY: What date and when you spoke to them as well. When did you start offering large-scale diagnostic testing for COVID PCRs?

Mr McPHAN: Depending on the definition of 'large scale'. If we are talking above 10 000 per day, it took us—I think from memory it was about six weeks to ramp up from being about 1000, 1500 a day to 10 000 a day. And for that we had to fit out new space. We had to buy in equipment, train people, buy reagents in and

put all of our systems in place and validate those platforms so that they would be accredited at the time. It was about a six-week period.

Ms KEALY: So about June 2020 you would have started testing?

Mr McPHAN: No, it was before that. If I could take that on notice too, I will give you the exact dates.

Ms KEALY: Fabulous. So earlier than June, so about May, you would have got the testing up and running. Okay, that is great to know. Can we just go quickly into the number of tests that were discarded. You mentioned that it was—I have got it written down here—13 000 discarded. What discussions did you have with the department in the lead-up to the backlog of specimens at your laboratories and the likelihood that you were exceeding capacity and that it was likely that you would have to discard specimens?

Mr McPHAN: I was not involved personally on that, but members of my team were, and I have been briefed by them.

Ms KEALY: When was the department first flagged that the demand for testing was exceeding your capacity?

Mr McPHAN: I would have to take it on notice to give you the exact dates. However, the department constantly monitors the performance of our laboratory, and if it is even slightly out of step from one day to the next, we would get a phone call. During the omicron surge I believe there were multiple phone calls every day for a significant period of time. Because everything is reported through the department, including the time of collection and the time of reporting, obviously—and their statistics are fantastic, and they are right on top of it—that is part of the excellent communication that the department had with us: making sure that we had the resources we needed if they saw that those turnaround times were blowing out in any way.

Ms KEALY: In terms of the excellent support that you received from the department and working out solutions in how tests could be tested within the time frame that was required, at any stage did the department suggest to you that they could offer assistance, by perhaps VIDRL, to provide some surge capacity when you were not keeping up with the demand from the state?

Mr McPHAN: It was in fact the opposite way around; we were usually providing overflow services for some of the public laboratories—not VIDRL itself but some of the others. It tended to be that, I think, each of the private laboratories supported certain ones of the public laboratories, so they would send overflow work to us.

Ms KEALY: But then you must have had overflow work at some point in time because you threw out 13 000 tests in January.

Mr McPHAN: Yes, correct.

Ms KEALY: So did you put the request out for further support in the same way you had been asked for further support for the public system?

Mr McPHAN: I would have to take that on notice, but one of the things that we would do in the normal process is that we would send to our sister laboratories interstate to help with that capacity. However, every state was hit with omicron at the same time, so we had a national wave, where previously the waves did not coincide. The separation in time meant that we were able to use our national capacity to support the Victorian response. So it was a culmination of capacity being used in a national footprint as well as state capacity being used. When you reach a point like that, that is when you are starting to look at having to discard samples because of the amount of time that they have been sitting there.

That said, all laboratories, ours included, look at what are called late lists, and we look at what may be about to expire and is taking an unusual amount of time to process. The reason for that, as one of the members pointed out earlier, is that the impact on the patient being tested is what is critical—their having to stay away from work and various other impacts on them and their close contacts and families. For those reasons we make sure we monitor these late and outstanding lists and try to deal with the older samples and make sure that the results come back. But once capacity is so far beyond what it is designed to do, then those mechanisms—there is not a lot that can be done by the state government, by us or by anyone else.

Ms KEALY: Mr McPhan, in terms of the number of tests you have done, you have said you have done a phenomenal number of tests—4.5 million tests. This surely has resulted in a considerable windfall for private pathology testing—Healius as the owner of Dorevitch and other labs as much as any other private pathology companies. Would that be a fair summation?

Mr McPHAN: You can look up what performance has been like in annual reports. Other than that I would not comment.

Ms KEALY: Fantastic. I have had a look at your website, Mr McPhan, and noticed that—unusually, I thought—there is a public-facing policy that Healius has around political donations. I note that in 2018–19 Healius donated $1500 to Labor but in 2019–20, which would be the testing period—and there was not a federal or state election at the time—the same time you got a call from the department secretary, you donated $27 500 towards the Labor government.

Ms Ward interjected.

The CHAIR: Order. We do have a point of order. Would you like to just repeat that?

Ms WARD: Sure.

Ms CROZIER: We have missed the witness going. Where has the witness gone?

Ms WARD: I do not think we have lost the witness. There he is there, Ms Crozier. I think we can all be calm here. I think that this is not the purview of this committee, nor is it relevant to the pandemic orders nor the human rights of people that possibly have been breached by the pandemic orders. I respect, Chair, that you have been pretty flexible with the narrative and the conversation that we are having with our hearings, but I think that the cynical turn that is now being taken here is not appropriate.

Ms KEALY: On the point of order, I think that the relationship between requests to a private pathology company which has clearly made a lot of money throughout the pandemic—this is money that is paid for by taxpayer money—which coincides with a considerable increase in donations to Labor, we need to give the opportunity for Healius to respond to that.

The CHAIR: Ms Kealy, you are going into an area that is simply not relevant to the committee. It may have a political impact in other forums, but for the purposes of the evidence we are looking at taking today, which is around these orders, I think that I rule that one as not being relevant—and your time has also expired. Moving to Ms Ward.

Ms WARD: Thank you, Chair. Thank you very much for being here and thank you for taking the time to answer our questions. If you could please extend to your staff our gratitude for the insane work hours I suspect that they have undertaken in the last 2½ years—I cannot imagine how many hours are required to process 4.5 million tests in 2½ years. It is really quite astronomical. It is mind boggling, really. So thank you, and we do respect the work that they are doing and will continue to do. Thank you.

Mr McPHAN: Thank you, Ms Ward. I will make sure I pass that on to the team.

Ms WARD: Thank you. I can only imagine the juggling act that you have had to do in this kind of rolling feast of a pandemic that just comes in these waves of varying size. It was interesting to hear you talk about needing at least six weeks to actually expand, to set things in place, to deal with increased numbers of testing going from 1000 to 10 000, 12 000 tests a day and then beyond. Can you talk us through the logistics of actually having to expand your workforce and the capacity to test in a bit more detail?

Mr McPHAN: Sure. The capacity to test is a function of a number of elements. One of them is the laboratory itself, and that is anything from the amount of space that we need to process—so we fitted out a new laboratory area. We moved some existing people out of their offices and repurposed them as a dedicated laboratory space for COVID, which is still in place now. Part of the expansion in equipment—so we have got to get equipment in there to support that—initially the equipment was provided by the Minderoo Foundation, which is Mr Forrest's foundation. That equipment is still there and still in use. They also provided reagents and other consumables required for that testing. So that was the initial part of expanding the laboratory capabilities,

and within the laboratory you have some preprocessing, which has to be done in cabinets—biohazard cabinets. They were provided as part of that fit-out and part of the Minderoo Foundation equipment.

The next step is that the sample goes onto some extraction equipment—the extraction equipment as well was supplied by the Minderoo Foundation—and then it goes from there onto amplification and detection. Initially that was also supplied by the Minderoo Foundation. In concert with that you need the workforce to be able to process, and that workforce is anything from the collection points, which were controlled by the state government. The hours that they required and levels of staffing they required were determined by the health department, and we just responded to what they needed at those collection points.

The next stage of the process is as the sample is received in the laboratory. As the sample is received the area that it is received into—we rapidly expanded the number of staff that we had in there and obviously trained them up in the protocols, including protocols around prioritisation, depending on the priorities set. There is a prioritisation system as designated by the health department around COVID testing, and we adhere to that and train people in that prioritisation.

The next stage—once it has been through that initial sample receipt, it goes into the laboratory and then onto the equipment that we talked about. That equipment needs scientific operators. It needs laboratory assistants. It needs pathologists, particularly in the back end to be monitoring the clinical aspects of the testing, but also liaising with patients as per the initial requirements of the health department. So right across the board the workforce was expanded, and expanded very rapidly. Everyone was trained appropriately. Equipment was validated for the purpose that it was there to do. Then once all of that has happened you can then start taking the work in and processing it.

The other element that expanded up is the physical data entry but also the call centre component, particularly in surges. We had difficulty there where the number of calls coming into the laboratory exceeded capacity, so we had to ramp that up quickly as well. So there were quite a few lessons learned along the journey. We think we are now very well versed in enacting those ramp-up plans and ramp-down plans. Also, as I mentioned previously, we are currently ramping that capacity up to be able to cope with 25 000 per day.

Ms WARD: Yes, and that is terrific to hear as we see numbers grow—in Sydney over 20 000 a day. I imagine that having that capacity is going to be very useful over the year ahead. Who knows? If we had a crystal ball to know what our numbers would be, it would make life a lot easier. Unfortunately we do not. Regarding, then, all the roles that people play, I imagine that you would even have to increase your cleaning capacity—to have more.

Mr McPHAN: Yes, we did. That is correct, yes.

Ms WARD: Do you have an idea of the workforce that you have needed to employ—how many additional people that you have needed to employ, both in a permanent capacity but also casual?

Mr McPHAN: I would have to look it up, but if I was to hazard a guess at the moment, it would be around about 130 people.

Ms WARD: Yes. So that is a lot of training hours too.

Mr McPHAN: Yes.

Ms WARD: Thank you. I will switch tack a little bit. I understand that you have been working with embassies and airlines to facilitate travel testing. Can you talk us through how this is working, please?

Mr McPHAN: Yes. The mechanism itself, to talk that through first, is: we monitor what is required for overseas travel with various embassies, and it does vary—in particular, the timing of the PCR test. The systems we then design around meeting the requirements of whichever country it is that the person is travelling to. They jump online onto our online system. They then order a test online, and that test is dependent, particularly in timing, on what the requirement of the destination country is. The person then presents at one of our published collections points. We then collect the sample, and then it goes through with a particular prioritisation to have the result back to them.

Ms WARD: When you say you collect the sample, is that an RT-PCR test? Can you tell us what that is?

Mr McPHAN: Yes, it is.

Ms WARD: What does that look like? What is that?

Mr McPHAN: This has varied as time has gone on. Initially it was a nasopharyngeal swab, now it is a throat and nasal swab.

Ms WARD: Thank you.

The CHAIR: That is your time.

Ms WARD: No worries, thank you. Thanks very much for your time and for responding.

The CHAIR: We will move now to Mr Wells.

Mr WELLS: Thanks, Chair. Thanks, Mr McPhan. A couple of questions. I just want to explore the point you made before, that you have got a 15 000 tests per day and 24-hour turnaround capacity guarantee. Did I hear that right? I am sorry, being on Zoom, sometimes it drops out.

Mr McPHAN: Yes, that is correct.

Mr WELLS: Okay. So that is a contract with the state government?

Mr McPHAN: Correct.

Mr WELLS: And have you always met those targets?

Mr McPHAN: I think you would have to—on the whole, yes. When the omicron surge was happening and we well exceeded the capacity of the laboratory, we would still be producing 15 000 results a day with a 24-hour turnaround. So that component of the contract would be met, but the beyond-capacity tests would not be met in that time frame.

So a baseline number of tests would be met, but the above-capacity element, which got to—I think our peak was around 24 000 per day. And the problem becomes that it is a sustained peak. So if that was a peak for one day and then it dropped off, we would cope with that, but when it is five days or a week on end then you well and truly exceed the capacity of the system.

Mr WELLS: Okay. So is there an uplift in your revenue by maintaining that capacity guarantee of 15 000 per day and the turnaround of 24 hours? I mean, is there a reward or a bonus because you are able to meet that benchmark on a daily basis?

Mr McPHAN: I think that again is commercial in confidence. You may be able to request copies of the contract from the state health department. And again, the reason I say that is that I am unsure as to whether the agreements are the same across all private pathology providers, so I do not want to go into our particular agreement.

Mr WELLS: Sure. Understood. So obviously the reverse or the flip side of the question I just asked: so if you were not able to reach that 15 000 or able to turn around in 24 hours, is there a financial penalty to your company?

Mr McPHAN: Again, I would prefer not to answer that.

Mr WELLS: All right. I guess the obvious question is that if you have the 15 000 tests per day and the 24-hour turnaround, it leads me to the question about the 13 000 tests that were discarded. And I know that has been bandied around by a couple of the other committee members, and I just want to follow that up a little bit more so it is clear in my mind. So with the 13 000 of the 100 000 from your organisation being discarded—so you obviously did not charge the government for those 13 000 that were discarded.

Mr McPHAN: Yes, that is correct.

Mr WELLS: So that was a financial cost to you, to your company.

Mr McPHAN: In the collection components that is true. Obviously, if they are not tested, we are not using reagent and other consumables. So there is some cost associated with it; that is true.

Mr WELLS: Okay. Just at the start of your presentation you were glowing of the government—in your opening statements—about the way they have handled the pandemic. And you were also glowing in your comments in regard to DH. So there have been absolutely no issues between your company and DH in the way that that communication has worked?

Mr McPHAN: There have of course been issues, but the communication is such that we work through any of the issues. Various things came up at various times, but they were very good at assisting us in meeting the requirements. They also monitor the contracts very tightly, the performance very tightly. They communicate constantly about performance, which just led to some robust conversations at times and appropriate conversations by the Department of Health.

Mr WELLS: So just following up on 'robust conversations'—and sorry to loop back—those 13 000 that were discarded, that was at the time when that 'guarantee of 15 000 per day' contract was in place?

Mr McPHAN: Yes.

Mr WELLS: Right. Okay. No worries. The other issue I have is: is it part of your processes that you meet with DH and the government on a regular basis?

Mr McPHAN: Yes. We have meetings at multiple levels. Generally they are operational meetings around retail sites, but we also have meetings that are performance related and also strategic, so looking at what initiatives the health department are coming up with in terms of their public health response and how we might support that or where they need our support in that. So, for example, supporting hotel quarantine sites—as their policy changed to open up more hotel quarantine sites, we were asked to support a number of those, which we did. So, yes, there is constant communication and regular communication on multiple levels.

Mr WELLS: Okay. And those multiple levels, do they include you personally?

Mr McPHAN: Yes, it did. Not during omicron. I am now in a national role and no longer in the state role, but when I was in the state role, which was up until July last year, I was in contact with them all the time, yes.

Mr WELLS: Yes. So when you say 'in contact with them', is that the secretary of DH or people in government, DPC?

Mr McPHAN: No. It was a team that was specifically established for working with the private providers.

Mr WELLS: Okay. Just in regard to the ramping up from the 1000 tests per day to 20 000 tests per day, so increasing the testing regime in your company, you mentioned that you were able to increase the number of tests per well is what my understanding is. So it could go from one to multiple numbers. So just to be clear, was that done by technology or manually?

Mr McPHAN: It is both. So you can either have a person manually pipetting the samples in or we also have two automated platforms that can do the same thing.

Mr WELLS: Okay. And the additional staff—I think you mentioned there were an extra 130 staff—obviously there were a lot more scientists coming into your labs, so where did they come from?

Mr McPHAN: The first thing we do is utilise internally, and internally from related departments. The infectious molecular department is part of the microbiology area, so we would pull scientists from microbiology and use those. We would also, if someone has moved out of that department previously but has experience in there, call them back in as well. And we would also look externally if necessary.

The CHAIR: Thank you, Mr Wells and Mr McPhan.

Mr WELLS: Can I just ask one more? Sorry.

The CHAIR: Yes, okay.

Mr WELLS: Just to confirm, all tests by your company were done either in Victoria or another state? No tests were done overseas?

Mr McPHAN: Correct.

Mr WELLS: Thank you.

The CHAIR: Thanks, Mr Wells. In the absence of Ms Shing, I am just wondering whether Mr Bull or Ms Ward have any further questions.

Ms WARD: One of the things that has occurred to me as we have been discussing things today is: what work are you doing, if any, in Indigenous communities regarding testing and helping those communities work through any issues or challenges they may have?

Mr McPHAN: Within Victoria we are a contracted pathology provider to a number of regional hospitals as well as some metro hospitals. In terms of the clientele that come through, it has all been de-identified by the time we get it. We do not know the ethnicity necessarily of the people coming through, so we support everyone equally.

Ms WARD: Terrific. Thank you. I think Mr Bull has got another question.

The CHAIR: Mr Bull.

Mr J BULL: Thank you very much, Chair, for the opportunity to ask another question. You spoke, Ian, about the new systems, the new spaces and the new equipment needed in terms of scaling up. You spoke before about the impact or the effects on the workforce in some evidence that you provided to Ms Ward. I just wanted to get a sense of staffing levels and how your organisation managed those staffing levels, including stress and fatigue and all of the challenges that not just go with the incredibly important role that testing played before and continues to play through the pandemic, but working in an environment where of course COVID is still present within the community and within the workforce—trying to manage that tension.

Mr McPHAN: That is a really good question. Firstly, starting at a very high level it was of interest to our company board nationally. So we are an ASX-listed company, and it was of interest to our board—the level of fatigue across the organisation. We were reporting to the board on fatigue around each of the states and our response to that fatigue. Getting to a more detailed level within a state, it is the responsibility of the manager of that particular department or area to stay on top of the way their staff are either presenting or expressing their levels of fatigue and also manage that through. Suffice it to say, though, from the point of view of when I was the general manager of Dorevitch Pathology, whatever anyone needed to support their people we were providing.

Mr J BULL: Thank you so much. I think it just should be on the public record: the acknowledgement and thanks, as we mentioned before, is an incredibly important thing, and I think that the community should be thankful for the work of the organisation and what everyone has done in terms of those testing levels. So thank you so much for that.

You mentioned the involvement at a national level. What are some of the learnings from other states or territories that were discussed at that national level? And I guess to flip that question around: what is some of the advice that Victoria or that you could have provided to other states and territories, particularly as we dealt with earlier waves? You mentioned the omicron wave and how every state and territory was hit at once with that. What are some of those learnings and reflections, do you think, that you can share with the committee?

Mr McPHAN: It is something that we talk about internally quite a lot and particularly now being in a national role—of having a perspective on what is happening in each state. Mr Bull, it would be a conversation over a number of hours to fill you in on the comparisons between states. It is surprisingly variable, whether that be, now as we know, from lockdown conditions and various orders in each state through to the level of coordination between the state departments of health and the private providers. I meant what I said at the start about the level of work and collaboration that the Victorian health department had with the private hospitals. There are a lot of lessons that could have been learned in other states. We also find that some other states are just reinventing issues that have already come up in Victoria, or whichever the state is, which we find

surprising—but that is the way it is. As I say, it would be a conversation over a number of hours to fill you in on all of the different approaches that each government has had at different levels. It has been interesting.

Mr J BULL: Next time we have a couple of hours we can have that conversation. The evidence for me has been really interesting. I think hopefully a learning for all of us. Again, thanks for all your work, and thanks for your time this afternoon.

Mr McPHAN: Pleasure. Thank you.

The CHAIR: Thanks, Mr Bull. Look, we do have a couple of minutes left. Ms Crozier had one more question.

Ms CROZIER: I did. I just wanted to go back to hotel quarantine. Thank you very much, Chair. I am just wondering, Mr McPhan: were you the only provider of pathology services to hotel quarantine?

Mr McPHAN: No, we were not. The approach of the Department of Health with the private providers was pretty much to evenly split the load depending on the size of the organisation—so making sure that we were all within our capacity guarantees. The load was shared around particularly the two larger providers, us and Melbourne Pathology, but also other smaller providers as well.

Ms CROZIER: Thank you.

The CHAIR: Thank you. And in the last minute, just one more question from me. We are looking really into the quarantine, isolation and testing orders today, and I am just wondering if you could comment on the impact on your workforce in January, in that omicron wave, on being able to do the job that you were doing across all your laboratories in terms of staffing and workforce.

Mr McPHAN: Yes, it is a great question. It was very difficult during the omicron wave. We had contingency plans in place since the start of the pandemic, and the health department also required us to provide those contingency plans to ensure testing continued should various scenarios occur. So we have very detailed plans to continue to support the public health response, and we did have to enact those plans over December–January when omicron hit. Prior to that the impact was pretty minimal. I think at one point in time, after about 18 months, we had a total of five staff who had had COVID. That increased rapidly during the omicron surge, and we did have to enact those contingency plans.

The CHAIR: Thank you. That concludes our evidence this afternoon. Mr McPhan, thank you very much for appearing before the committee today. You will receive a copy of the transcript of today's hearing within the next week for your review, and you will also receive a list of any questions that were put on notice to you. Thank you again for your attendance. We will now break for lunch.

Witness withdrew.