TRANSCRIPT

PANDEMIC DECLARATION ACCOUNTABILITY AND OVERSIGHT COMMITTEE

Review of Pandemic Orders

Melbourne—Friday, 29 April 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)*

Professor Joseph Ibrahim.

The CHAIR: We will move straight onto the evidence. I will just read to you that 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 that privilege.

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Professor Ibrahim, I welcome you today. You may wish to have the opportunity of 5 minutes to make a presentation to the committee before we move to questions.

Prof. IBRAHIM: Thank you very much for the opportunity. I guess I am proud to be here as a Victorian and I am proud of our state. I just wanted to note that we have been through the phases now of fear, confusion, despair and death, and as we go forward we are looking now at relief, clarity of purpose, new hope and new life. I think what is important particularly with this group is to understand in reflecting on the pandemic that we have actually underachieved according to our true potential both as a state and as a country. We should not be judging our performance according to some misguided comparison with other nations. My attention specifically is on aged care and my comments are from the outside looking in because I am not privy to a lot of the decision-making that has occurred within the different groups.

I have summarised the overall approach, particularly in the first year, as uninformed, paternalistic and inequitable. It is uninformed in that little consideration was taken of the biopsychosocial model of older people and there was little if any consideration of the true state of affairs of the aged care system when planning was underway or a response was occurring. It was paternalistic in lacking active participation from the affected, vulnerable population. There was also with this a lack of basic understanding of what life is like when a person is older and what it is that they value in their quality of life. The third facet is that it was inequitable: the vulnerable population suffered the most and they were sacrificed the most and many of the decisions made tended to put older people at the back of the line.

Reflecting on what could be done better for the future, I think that we need to adjust our approach to the reality of what exists rather than be persuaded by the public image that our governments have wanted to project to the community about the state of affairs in aged care, that we need to understand there is complexity in the sector and not be simplistic in how we view it. Many times people have simplified it to explaining an aged care facility is like a mini hospital, which is not at all the case.

The final two points are we need greater engagement with people at the practical level who do the work so we understand how work is done, not how work is imagined by those in senior executive roles, and finally, we need transparency about how decisions are made and how the solution or how that decision was arrived at and how it was tested, to avoid perverse incentives and inadvertent consequences. These factors have all exacerbated the existing mental health issues and created new ones in aged care. I acknowledge some would be unavoidable and inherent to living and dying during a pandemic. I will stop there and am happy to take any questions you have on any matter.

The CHAIR: Thank you, Professor. I think it is fair to say that the community generally understands that aged care took the brunt of a great deal of what has happened during the pandemic. I am wondering whether you could perhaps expand on the point you just made about perhaps the lack of understanding of what was important to old people from their mental health point of view and how the orders may have impacted on them and also looking forward to a situation now where there are minimal orders and what that means going forward.

Prof. IBRAHIM: Sure. I think the first thing to explain is that older people are not a coherent group. You have well older people, who make up the majority of those over the age of 65. You then have a proportion—about 25 per cent, let us say—that are living at home with aged care packages. And you have approximately 5 per cent that are living in residential aged care. So the numbers are sort of around 4 million, 1 million and 200 000. They are very broad brushstrokes.

The important thing is as people get older what they value in life tends to change or what they are able to articulate changes. As everyone gets older, as everyone has some type of infirmity or disability, their ability to value what is at hand, what each day brings—the small things in life have a far greater value than they would for an able-bodied or younger person. The ability to have some sense of control about what you do is also far more important to that person because their choices have become so limited. So the ability to decide who does or does not come into your room has far greater importance when you are older than it does for any of us now. What the pandemic and the situation with both the lockdowns and the quarantine did is it increased the level of social isolation. The decision about what was to happen was taken out of the hands of the people that were most affected, and they were not able to voice what their preferences would be and what sacrifices or compromises they would have liked to have had. This increases the level of both anxiety and depression, which were already high, particularly in the aged care nursing home sector, running at around 50 per cent.

Approximately 50 to 70 per cent of older people in nursing homes have some cognitive impairment, and so their ability to understand the changed environment and the restrictions around them is far more complex, far more likely to lead to emotional distress. The isolation from family and friends would reduce their physical functioning as well and their engagement with their day-to-day life, and the damping down of communal activities just within the facility also reduces the person's ability to maintain their physical capability, particularly in terms of nutrition. We all know people eat more when they are in a group than if they are alone. And so if you imagine life when you are 85, you have got arthritis, you have got dementia, you are in a home by yourself, you are told you cannot come out of the room, the staff are dressed in PPE, you cannot engage with the other residents, you do not know when your family are coming and no-one is really explaining what is going on, that is not really a situation that anyone flourishes in, and I believe it would have contributed to significant mental illness and also I think to premature deaths.

The CHAIR: Thank you for that, Professor. During the course of taking evidence this committee heard from the chief executive officer of Shepparton Villages, a retirement home in a regional area. She read out the comments of a number of people in her aged care facility—comments like:

> 'I would rather be dead than be put through another lock down, my end of life was never meant to be like this!'
>
> 'Felt like I was in jail, I felt miserable'
>
> 'Cut off from my family'
>
> 'Had my choices taken away'
>
> 'I thought I was going to go crazy, it was frightening'
>
> 'Lonely, I was so isolated!'

I am just wondering from your perspective what are the key changes or initiatives that could have been looked at and that we need to look at to put in place to help ameliorate the sorts of impacts that you have just talked about that those residents felt?

Prof. IBRAHIM: I think if we go back to pre 2020, the state of aged care in the country is poor, and the royal commission reported that one in three residents is a victim of either abuse, neglect or suboptimal care, so we have got a dysfunctional system to begin with. When we add the layers of complexity with the pandemic it is no surprise that these situations are going to arise. I think we could have been far better prepared in the early stages when a lot of this would have been predictable, and incorporating the residents and their families or older people in the decision-making would have been critical. They are one of the few groups that I think were not consulted directly—so to establish a mechanism where you can incorporate the views of older people and understand that in most circumstances they will generally arrive at the decision that is of benefit to themselves and their community and that you do not need to really foist it upon them. It is the process of engagement and discussion and outlining the risks and benefits that is critically important. That process, I think, was completely overlooked, and I think part of that was the assumption that either older people cannot think or older people have dementia and therefore cannot reason, neither of which is true.

The CHAIR: So in terms of doing it better it is very much about listening—is that what you are saying?—and involving them in the process.

Prof. IBRAHIM: I think the fundamental principle would be listening. I think the number of structures that you could put in place—there is a wide variety—and I think from some of the suggestions and areas that we have looked at one approach is to have a clinical ethics committee within a residential aged care setting or

within a community of homes. You can have resident councils that contribute far more into the decision-making around what happens to themselves. Engagement of community juries where people are part of that decision-making and can represent their family members and have a say gives you much greater engagement. And these techniques are used in other sectors. Clinical ethics committees are widespread in hospitals in particular but not in aged care. Community juries have been used in other settings where you are gaining the views of the people who are going to be experiencing the outcome of your decisions. Relying on peak bodies and relying on professionals to represent the views of the resident is wrong. It is also unfair. I do not live in a residential aged care facility. I am not 85. I can advocate for them, but my view should not be the one that is pre-eminent. I think convenience drove a lot of the initial response with only consulting with people in senior offices and the peak bodies, which do not represent the residents.

The CHAIR: Thank you, Professor. Unfortunately my time is done. I will move to Ms Shing for the next group of questions. Thank you.

Ms SHING: I think we were going to move to Mr Bull in the first instance, Chair, just given that he is a new addition to the committee.

The CHAIR: Certainly. Happy to do that. And he is online. Mr Bull.

Mr J BULL: Thanks very much, Chair, and thanks to Ms Shing, I should say—and for everyone's work today. Apologies I was not able to be with you earlier. Professor Ibrahim, thank you very much for your presentation and for the comments that you have provided to the committee and the evidence that you have provided. There have of course been multiple pandemic orders to protect vulnerable Victorians over these past two and a bit years. Those include masks, vaccines and a whole range of different measures you have spoken about in your summary remarks. I just wanted to ask you how you have seen these orders in terms of protecting our most vulnerable, our most senior Victorians?

Prof. IBRAHIM: I think it is really difficult to give a simple answer to that question. My training involves training in public health, so I am drawing on the combination of what my public health training says in terms of protecting the community and reducing the risk of infection with my training in geriatric medicine, which is treating the person as a whole and giving them, really, agency with their voice. I am not professing here to know the correct answer. What I would have liked to have seen is a process that brought those two concepts together, debated them, came out with 'On balance we're favouring infection control here' or 'On balance we're taking the choice here that preserves quality of life, understanding that this increases the risk of infection and mortality' and was able to navigate that for the individual, for the community that they are living in and for the community as a whole.

So there are really quite complex decisions to be made within those three layers in those two dimensions, and having one person or one committee be sort of the judge and jury on that I think is not reasonable, particularly in the 21st century. We could have created two groups separately to debate the merits of each order to see whether they came to the same view, picking different types of participants. This sounds like it would be difficult. I was able to get 20 colleagues both in medicine and nursing and in other professions to debate an idea via the web really within a week on some of these complex issues to give us a way of thinking them through. With the power of the department and the government backing that, the potential to do substantially more in a short space of time I think was enormous, and I firmly believe that was a missed opportunity, particularly from March 2020 to about June 2020.

Mr J BULL: Thanks very much, Professor, and I take your point around it being a very complex answer. We have only got limited to hear that, but I do understand that you need to go into those levels of detail, because I am really keen to hear those answers and I guess the committee is more broadly.

I just wanted to get a sense of the evidence you have provided versus the evidence in the introductory statement, around I guess having the time and the luxury to be able to have some of these, I think you said, committees or further debate or debate within those settings themselves versus the need to protect vulnerable residents. How do those two, if we can say, opposing positions play out, do you think? And what advice can you provide to the committee around—to have your time again today, what do you think that might have looked like in terms of both of those positions, given the introductory comments versus the luxury of time, if I could put it that way?

Prof. IBRAHIM: Sure. I think that in the initial stages I was very much in favour of lockdowns and to be really quite strict with them to buy time. I think there is a question here about proportionality, about how much time do you need to buy and how much time do you need to make a decision. And I think that in the initial stages it is not unreasonable to be really quite strict about the rules you put in place, but I think you need to be time defined about how long that ought to be and what is reasonable.

The other question is that you do not need to sit around pontificating your navel or navel-gazing for weeks or months on end. What we have is a crisis with a short time line, and the question is to say, 'We have a week to arrive at a decision' or, 'We have a day to arrive at a decision'. It is about who you get together to do that and understanding the limitations of that type of decision-making. I do not think that we really drew on the intellectual experience that is available within Victoria to contribute to that whole effort. Into the future I would be wanting to see a framework to be able to draw those experts from the different universities, hospitals and aged care places to be able to formulate those ideas in a short space of time. I had three groups working on three ideas, essentially saying, 'Well, you've got three days to a week to come to a conclusion and we've got to move on from there, but we will revise if we've made a mistake in what we're doing'. It is really having some rules around operation so it is not open ended.

These questions will be debated the rest of my life. On 1 March I am fully on board with the strict lockdown. By mid-April I want to see a humane lockdown that has far more compassion and consideration about how it operates and is far more nuanced in the decision-making about areas that are high risk versus areas of low risk, homes that have a population that have a high-risk appetite and prefer quality of life to living versus the other home. None of these ideas are new; they could have been done. They just needed a bit of oomph behind them and some resource.

Mr J BULL: I just wanted to go to mandatory vaccines if I could. If you can talk about, provide evidence around, your views on mandatory vaccines within aged care settings. What are those effects on some of our vulnerable residents within the community?

Prof. IBRAHIM: In terms of mandates? I am a doctor, I have been a doctor for almost 40 years. I am fully on board with vaccination and believe that it ought to be the case. In terms of mandating, my question comes back to: have people had the opportunity, the advice and the knowledge that would encourage them to? It is always preferable to get people to act voluntarily than to force them. Is the question mandating vaccines for residents or mandating vaccines for staff?

Mr J BULL: My question relates to staff, but I am happy for you to provide your broad views of that.

Prof. IBRAHIM: I think mandating vaccines for staff as a public health measure I would back. In terms of my other hat, when I look at people's human rights, the question then is how much can the state interfere or not interfere with what you do. What mandating a vaccine to staff does is it forces yet another level on a disenfranchised group who already have little, if any, control about their work and so does not build confidence in that workforce nor does it engage them in the work that needs to be done going forward. So this is where I come back again to the construct that we are arguing. If we are arguing the human rights angle, there is a different approach to it if you are arguing infection control for all. To me, again, there is no black and white, which brings me back to my original point: we really want to have a very clear approach and process of decision-making, how those decisions are made, how those decisions are tested and for the parties that are critical to those decisions to be involved.

The CHAIR: Thank you, Professor. Mr Bull, I will cut you off there, your time being up, and we will move to Ms Kealy.

Mr J BULL: Thanks, Chair.

Ms KEALY: Thank you very much, Chair. Thank you very much, Dr Ibrahim—Professor Ibrahim, sorry—for meeting with us today. You give an insight into what it is like to be a resident of an aged care facility, and I commend you for giving a voice to these residents, who are often too timid to speak out for many reasons. They are not often given that platform very often, so thank you so much for that. We have had a broad range of people giving evidence today, and I have asked people—all the different organisations—whether they were given the opportunity to provide input to the pandemic orders so that perhaps the impact of the orders on Victorians' mental health could be minimised. Being a leading expert, as you are, in aged care, have you ever

been asked to provide input to the pandemic orders so that those harms you have gone through very articulately today could be minimised on residents in the aged care sector?

Prof. IBRAHIM: I have got a longer answer to that. The short answer is no. I provided six detailed documents to the royal commission, the federal/state health department and the regulator based on the work that I did with my colleagues around some of the hypotheticals and what I thought needed to be resolved. I was on the Safer Care Victoria older persons committee, and I stepped aside from that committee because I felt that we were not having the impact that was required and I believed that we needed to be far more outspoken in that committee. So I stepped aside, and that would have been around June of 2020. I have not been directly approached to provide advice. I have published I think 10 academic papers now around the topic, and I provided those each time to respective health departments and regulator.

Ms KEALY: Could you provide those to the committee also? It may be of assistance to us.

Prof. IBRAHIM: Yes. Which papers did you want?

Ms KEALY: Well, the 10 that you referred to that you published would be great.

Prof. IBRAHIM: Okay.

Ms KEALY: That are relevant to the pandemic orders and impact on aged care residents.

Prof. IBRAHIM: Yes. I will supply those.

Ms KEALY: That would be great. Thank you very much, Professor Ibrahim. If you were in charge of the world, would you change any of the pandemic orders that are in place today?

Prof. IBRAHIM: I think it is always dangerous to be in charge of the world, and I think what you would then tend to do is to follow your own hidden or personal biases which lean towards one or the other. In terms of my expertise in aged care, I would probably have a higher risk appetite for aged care, but that might not be beneficial to the rest of the community. Not having all the information about where the critical resources were needed and where is the most good for our state and our country, I think it is not reasonable to comment about whether the orders were not reasonable overall.

I think when you want to start splitting them based on the sector that is affected, there will be balancing measures—one group is going to be more affected than the other. My main argument has been that the adverse effects on aged care seem to have been done with little thought or consideration that they were carrying that burden. None of the work that anyone has done has been easy; I have got no issue that that has been the case. I come back to the process. And what orders would I have made? For aged care only, I would have looked for far more nuance around the clusters of homes—what they were able to do to support each other, how the hospitals were able to support the clusters and whether the rules that applied in the east of Victoria needed to apply in the west, and same with the north and south.

I think that in a sense the universality of the orders is important when I put my public hat on and say that risk communication requires simplicity to get your message across to the community and to organise millions of people in one direction. You do not want to be confusing people. The human rights aspect says you need more nuance and proportionality, because if I am in a small town which does not have a large tourist trade, does not have a whole lot of flowthrough traffic and we have not had a single case of COVID, why do I need to adhere to the same rules? But I come back here to not having good insight into the day-to-day operational complexities around that decision-making and whether they were the necessary sacrifices to be made at the time.

Ms KEALY: Joe, we have all seen what I think are heartbreaking photos of aged care residents who are reaching out to their family members through the window and that disconnection from not just their family and friends but that physical touch, you know, the ability just to have a hug with someone you love or just to feel that level of connection. How much has not having those human interactions impacted on the mental health of aged care residents, and have we seen that come through in any specific data?

Prof. IBRAHIM: I think the data is just starting to come out. I have been sent some papers from overseas to review. People are only starting to count those aspects of it now, and I think that this artificial separation between physical and mental health belies just how interconnected they are. The heartbreak falls on the

resident, their family and the staff. I think the staff have also suffered considerably, partly in having to be the enforcers of these rules, which they find heartbreaking. A lot of the workers are there and have an affectionate bond with the resident. That is what makes aged care I think generally a good sector to be working in. So staff are being asked to do things they do not fundamentally agree with at a human level but are there for infection control. Older people have both cognitive impairment and hearing and visual impairments which mean touch is far more important to understand that the person is there. The tone of the person's voice, not what they are saying, is important. You cannot get any of that through a window visit. And there is confusion, then, about what is going on—'Why is my family being locked out?'. My biggest argument here is I think we needed a separate approach to aged care in this particular pandemic, because they are the group that was most affected, and I think that we have not had enough expertise from the sector involved in the decision-making and understanding what was and what was not possible.

Ms KEALY: I will move on. I think my time is out. Thank you very much, Joe, for your time today.

The CHAIR: Thank you. We will go now to Ms Shing.

Ms SHING: Thanks very much, Professor, for providing your evidence to this committee. I note that you have in fact been pretty active in your work advocating for a reasoned, careful and proportionate response in aged care, including in the federal aged care royal commission. Just to quote you back at yourself, if I may, in referring to the national system of aged care you have referred to this response as an abject failure and hopes being raised and dashed among Australians concerned with their elderly loved ones, and that ties in very neatly with the comments you made at the outset of your contribution. You have also, in the context of staff and mandatory vaccinations, talked about an already disenfranchised group, and I note the federal aged care royal commission has talked about care, dignity and respect, but it has also talked about neglect in the context of the existing challenges facing the aged care system. I would like to get a sense from you of the existing challenges of the system, which have been widely discussed in the commission's report and in commentary since, and the way in which they in your view had an adverse impact on pandemic preparedness and pandemic response within, let us say, the private sector and then perhaps we can talk about ratios within the public sector and the difference that they could make, please.

Prof. IBRAHIM: Yes. I think it is on familiar ground, and sorry if people have heard this before, but *Neglect*, the interim report, was published in November 2019. The pandemic hit in March in Australia really, March 2020. We had three months warning from international experiences. We had clear statements that we had a workforce that was lacking in numbers, a workforce that was lacking in skill and a high level of use of restrictive practice. We also knew that clinical care and infection control were poor leading into the pandemic; this was not news. The CDNA guidelines do not refer to the state of affairs from the royal commission, and I cannot find the royal commission cited anywhere in those initial documents I think in 2020, so preparations were made on an idealised view of aged care, which was wrong.

The CDNA guidelines posit the aged care provider as the person responsible for the pandemic response in their organisation. This failed to recognise that there are 800 providers running 2700 facilities in Australia—800 providers who are divided between private large corporations, private small business owners, the not-for-profit faith-based and non-faith-based community groups, and state-owned homes, each with a different organisational philosophy, each with a different staffing profile and each with a different capacity in relationship to the aged care sector. At no point were the residents or their families told that when they enter aged care and sign their contract there is a clause in there that says the approved provider is responsible for their care in an emergency, so we had residents essentially unknowingly sign away their rights to an approved provider who is in fact a business owner, not a healthcare provider. I would liken it now to the milk bar at the corner, for those old enough, like me, to remember—asking them to run a health or public health response.

We were poorly equipped, and there was virtually no input from an aged care expert in those initial months. This is reflected in the failure to set screening guidelines that understand the biology of older people. Older people do not necessarily get a temperature. People with dementia do not come and tell you they have a cough and a sore throat. There are a whole lot of things that are tied in there that clearly demonstrate that we had not done our homework, and I do not understand how that was possible, given the royal commission was running and had reported and it was the same people involved in the royal commission and the regulation of aged care—as to why those things did not connect.

Ms SHING: Sorry, I might just cut you off there, given the time that I do not actually have available and the fact that you have been pretty prolific in your views to the royal commission but also in those articles that you are going to provide to the committee. Is it then fair to extrapolate from what you have just said that had the businesses associated with aged care—the milk bar, if you will—in terms of the work that they do been better supported through staffing levels and through a consistent national framework, we would have been better prepared for the impact of the pandemic, had the issues identified in the *Neglect* report then been translated into action or indeed prevented in the first place?

Prof. IBRAHIM: The short answer is it would have helped. The slightly longer answer is that the ability for the aged care providers to negotiate with the acute hospitals, as was the requirement with CDNA, was really non-existent. The aged care providers were not in a position to be able to negotiate how the acute hospitals that would be working with the public health units—what that response would look like, so they were really powerless to formulate a more coordinated response.

Ms SHING: So is that in relation to the obligations that they carried as the private sector and as it relates to commonwealth oversight, or is it a combination of different factors?

Prof. IBRAHIM: Well, it is a combination in that the aged care homes are obviously regulated and ruled by the commonwealth Act and that the state hospitals are a state responsibility. In formulating your pandemic plan as an aged care provider you need to know what health care resources are available to you or how they would operate, which would mean that the homes would have to negotiate with their local regional public hospital as to what was going to occur, and that, I do not think, was ever a sensible plan, and I do not think that was ever feasible.

Ms SHING: And that was around Australia, though, wasn't it? It was not just in Victoria?

Prof. IBRAHIM: That was throughout Australia. That is the nature of having the state-federal split.

Ms SHING: Yes. Now, I would just like to get a sense of this workforce that is so burnt out that in fact we have got protests that have been announced from aged care workers to take place in May. They are burnt out, they have nothing left in the tank after a really traumatic period with the pandemic response and also with care for people who are particularly vulnerable. Is it your view that where aged care workers are in a position to spend more time with residents and to provide that ongoing relationship-based approach to care in fact the health and mental health responses for residents are less severely impacted—not to say improved, but less damaged—as a consequence of restrictions and that therefore by extension ratios would make a difference were they to apply in the private sector?

Prof. IBRAHIM: Ratios are a really difficult question. I think the fundamental about more time with residents was clearly a recommendation of the royal commission—

Ms SHING: Yes.

Prof. IBRAHIM: and I do not think anyone debates that. I think there are two parts to having people. One is you need the person who is qualified for the task, so ratios in and of themselves only get you halfway there; you actually need to have people that know what they are doing in the job. I think my issue with ratios has always been you are not prescribing the nature of the work and who is needed.

Ms SHING: But if that alleviates workforce pressures, is that not surely halfway better than no way?

Prof. IBRAHIM: Well, as some people have said, I am a purist. I prefer a full solution than a solution that does not quite get is there so it would be—

Ms SHING: Not an incremental solution, a building-block approach?

Prof. IBRAHIM: Well, I think ultimately in terms of solving the issue, aged care is not a problem that can be solved in little blocks. There are so many factors that are interrelated that you have to go in and solve it at the same time. And this block-like approach means that we will be back here—well, I will not be—with similar problems in the aged care system because we will fool ourselves that we have been doing some good because we are going a bit at a time. Our approach in the pandemic has been the same: we have been doing a little bit better each time, but we could have done a hell of a lot better at the start by taking the problem on in a big way.

Ms SHING: Thanks, Professor.

The CHAIR: Thank you, Professor. We will move now to Mr Wells.

Mr WELLS: Thanks, Professor. Kim Wells. It is good to see that you are investing part of your income in Lonely Planet travel books.

Prof. IBRAHIM: Yes. It is really a question of age, isn't it? I was about to say it is a reflection of both your and my generation, but you might not want to be identified as the same age group.

Ms SHING: Hey, hey, not alone there. I think for all of us it is a nonpartisan approach.

Prof. IBRAHIM: They are also Australian—Victorian. Originally they were based in Footscray, so pretty close to where I grew up.

Mr WELLS: Yes, absolutely. Professor, in regard to the Aged Care Quality and Safety Commission 'Consumer outcomes' for aged care residents, it says:

> I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

Were the pandemic orders in conflict with that basic right?

Prof. IBRAHIM: Well, it depends on how we want to argue it. If we are arguing this as an ethics issue at uni, we might say, 'Yes, it is in direct conflict'. In terms of being realistic, now we are debating the question of what is more important, my life or my quality of life? What the pandemic brings is that additional dimension that this is not just about you; the pandemic means that there is a responsibility to the community that you live within. So the question around being able to 'live my life my way' is generally okay as long as it does not affect anyone else. The pandemic does not give you that degree of liberty. So I think here there is a needed debate around the rights of the individual versus the responsibilities of the individual in the community in which they live. Again, I come back to 'I'll have my view', but it is not one person's view that should be overriding this. This is something that calls for public debate with people that are able to hold and advocate a particular view, and I think that the absence of human rights advocates early on was to our detriment. We needed a countervailing voice about 'Where are the limits to be drawn?'. And people like simplicity, so we waver between 'shutdown for everyone and we keep you safe and alive' through to 'freedom for all and live your own life'. Neither is the right solution.

Part of the challenge with the pandemic is that as we accrued knowledge, our ability to make decisions was better nuanced as we got better techniques about reducing the risk of infection, as we got the vaccines, and with each wave we adopt and change. So the rules that were right in March 2020 may be profoundly wrong in March 2022. Trying to convey that complexity of information I think is often a challenge, and from my own experience clinically, sometimes when you are explaining every decision and every step of the way you create more disquiet and uncertainty in your patient and their family because people are not necessarily comfortable with living with uncertainty, and they simply want to know 'What should we do?'. So that is a convoluted answer to your question, I guess.

Mr WELLS: No, no. It sounds like a good thesis topic. One of the frustrations I think a lot of people had was the blame-shifting between the federal and the state governments in regard to the way aged care facilities were running. How could have that been handled so much better?

Prof. IBRAHIM: Well, the simple thing is to say, 'Well, people should talk honestly and get on with each other and make compromises'. The way of the world that we live in is that people work towards their scope of responsibility, and so each group is, I guess, avidly working to the limits of what they are able to do. The other thing is no-one wants to hold the basket when something goes wrong. The models—if you want to then change aged care to say aged care is federally funded but managed locally or managed at a state-based level, but now is not the time to be having that debate. At the start of a pandemic, or if the premiers had all agreed to take responsibility for it, maybe that was an option. I do not know. There are often layers behind that. My proposal back in March was that an expert task force was needed that was representative of the key groups and was tasked with looking after aged care—not public health, but aged care—with public health expertise. I think that would have been a strong advisory group about getting the right balance and also understanding the culture and

the tensions that exist both within aged care and in aged care's relationship to health care. I think that that sort of local knowledge and those relationships would have made things far more likely to be productive.

I think that the response early on was that people concentrated on optimising what their service was able to do, so hospitals were focused on intensive care beds; hospitals were not focused on how they were going to help aged care. I think that goes back to the very problem that we had, which was there was not enough robust advice at the federal-state level to say, 'Aged care is where a major issue sits that has got to be sorted', and people were, I think, just moving it from one area to the next.

Mr WELLS: Thanks. Thanks, Chair.

The CHAIR: Thank you. We will go to Mr Erdogan now.

Mr ERDOGAN: Thank you, Professor Ibrahim, for joining us today. You have quite extensive—and clearly you are very passionate about this area and sector. I want to just ask you about a topic that as a member of Parliament is quite frequently raised with us, about protections in the healthcare settings and the differences between the broad healthcare settings and how private operators have decided to have some of their own precautions in place. How have you seen the differences in the protections for residents play out between the public and private aged care sectors across Australia and Victoria? Have you noticed a large difference?

Prof. IBRAHIM: I think the first thing to note is that Victoria has got one of the largest public sector-owned aged care facilities in the country so that the situation in Victoria is quite different to most of the other states and territories. You cannot talk about privates without also talking about the not-for-profit groups. There are essentially three different models of operation, and the complexity comes into where these homes are located and how they operate. So a lot of the public sector homes tend to be located in regional and rural areas that are underserved by the privates and the not-for-profits. The large privates tend to be metro based. Obviously they have got a much larger footprint and financially it makes sense to be in the capital city.

The privates cannot be lumped together as one group. Some of the large providers that also operate in the health sphere have the resources, the workforce and the capability to actually develop quite comprehensive and thoughtful plans for the pandemic. They also have some resilience or redundancy if they are operating 10 or 20 facilities in terms of workforce that they can redeploy. That is very different to an owner-operator private home that only has the one home, that does not have a relationship with their local hospital, does not have any workforce to draw on and essentially is in aged care primarily in terms of an opportunity to make money. The not-for-profits have different organisational structures and different capabilities, and I think that the coroner's inquests will reveal more of those sorts of features around how some of the not-for-profits are able to operate and what they are able to draw on.

The public sector, both in terms of how we have looked at them and the reported results, clearly on face value look to have served their residents far better. It is difficult to be dogmatic about this because the public sector homes have a closer relationship with their public hospitals in rural-regional areas, which often have a lower level of intrusion from COVID. And they also have a far greater nursing workforce than the others, which was one of the benefits of being in Victoria—that the award for the public sector homes in hospitals holds for the homes—so we have got a more senior, more experienced and more professional workforce.

Mr ERDOGAN: Thank you for that. You talked earlier about how the milk bar type operations—the smaller, private aged care sector driven by profit—seem to be the worst prepared for the pandemic.

Prof. IBRAHIM: Potentially, yes. My issue is not with them, because they are pretty open about what they are in the business for. My issue comes back to the government and the regulators knowing that these groups existed, and if we were going to help the citizens of Victoria and the citizens of Australia, we needed to step in and not rely on those individuals to be running a pandemic response in their facility.

Mr ERDOGAN: You talked about the competing interests between human rights and infection control. With the current COVID settings, and entering into winter, do you think that restrictions are still needed in aged care centres—it is a high-risk setting—to keep COVID and other infectious diseases out?

Prof. IBRAHIM: My short answer would be yes, I think we will still be looking at some form of restrictions, because it is the highest risk environment in terms of the individual, their comorbidities and the risk

of death. The question I come back to is: I do not know what the older people want. This is the balance about if they are willing to take the risk and that risk does not expose the general community to a greater risk, then my view is they ought to be allowed to take that on. If the risk they pose is also substantial to the rest of the community, then there is a shared responsibility that we have. Again I come back to there being no black-and-white answer here—we should embrace the grey. If there is anything I can say, it is that we have to embrace the uncertainty, say we are uncertain and explain this is how we are dealing with that uncertainty and that if we are wrong we will change what we do. So do not be fearful that as we embark on this course there is no coming back from it. It is 'We will review, be it in a week, be it in a month, and these are the parameters we use, and we will change the direction'. I think most of the people I have dealt with are perfectly reasonable when you do not give them an ultimatum.

Mr ERDOGAN: I think the ongoing review piece is important. And obviously adoption of rapid antigen tests, I notice, as someone who has a grandfather in a not-for-profit in metropolitan Melbourne, has been a bit of a game changer. It seems the aged care sector is more open to people visiting after taking a rapid test on the spot. Do you think rapid tests have made a big difference across the state?

Prof. IBRAHIM: I think the rapid testing has given people a lot more confidence as to what is happening, and again it provides a sort of objective tool where you do not get into an argument with someone. If you are RAT-negative, then it is okay; if you are RAT-positive, then I do not have to argue with you about whether you do or do not have symptoms or whether I have taken your temperature correctly or not correctly. I think that gives that level of certainty that takes the emotion out of the argument, which I think helps facilitate the discussion between the aged care staff and families.

Mr ERDOGAN: I know Mr Bull touched earlier on vaccinations. Obviously older Australians were prioritised—people in aged care in particular, being in a high-risk setting—and now many people in aged care settings are going around for their fourth shot. How important do you believe that is—that older Australians are given priority with vaccinations?

Prof. IBRAHIM: Again, from an aged care point of view I would say that is critical. I think that if we wanted to debate around, 'How do you allocate vaccines?' and, 'Do you allocate them to the groups that are most likely to reduce the load in the community versus the load in aged care?', it brings us back to that debate about trying to blend aged care with public health when aged care is but one aspect of public health and public health is just one aspect of our overall lives. For me, I cannot disentangle those. Sometimes I wish I was not dual qualified, because the world would be much simpler for me; I could just look at it as a geriatrician or could just look at it as in public health. This is an incredibly hard area, and overall people have done really well to cope with that. Where I think we have let ourselves down is that we did not use all of the people that we had available and we did not try to solve problems before they arose, which we could have foreseen.

Mr ERDOGAN: Thank you, Professor Ibrahim, for your full and frank answers.

The CHAIR: We will go to Ms Ward.

Ms WARD: Thank you. Thank you for the time that you are spending with us and for passing on to us what you have learned and your experience. It is really appreciated. Thank you for all your work.

I was interested—you were talking about the public and private sector aged care facilities. Now, I know that in the public sector aged care facilities there have been around 900 air-filtration devices put into these places. Is that much of a game changer that you are seeing, and have you got much to tell us around how that is working in the private sector? I have had related to me back in my community that where there has not been an outbreak those filtration devices have been removed within the private sector, which I found a bit odd. I do not know whether you have got any experience of that.

Prof. IBRAHIM: No. Here I have got to say I do not know and I would be just speculating, and even I know not to speculate on something I know nothing about.

Ms WARD: Well done. Okay. I appreciate that. So bearing in mind that, have you got some views on what an aged care facility could or should look like as we head into winter in terms of the pandemic? But I guess there is also for me another question around how we manage any infection. We know that in the past with aged care we have always had issues around influenza but also issues around gastro. So are there lessons that come

out of this in terms of how we manage our own interactions with aged care facilities as visitors? But that is I suppose a side question too. The overall question is: how do you think COVID would be best managed this winter in aged care?

Prof. IBRAHIM: Well, I think the debate has been that influenza is likely to be more of an issue than COVID. I do not have I guess the public health or infectious disease epidemiology projections around what to do, but you have pointed out that there are three issues that we can see now. What are we doing to prepare for all three types of potential outbreaks? What are we doing that helps give us consistency? The biggest challenge in aged care is not what they are doing on their site; it is that the one down the road is doing something different and the families want to know 'Why aren't you doing what they're doing?' or 'Why can't you be more liberal?'. So the question about what standard of practice we expect and what scope and range of freedom that they have around decision-making I think would be really important. I think what we have seen with the pandemic is in a sense what people call 'perverse incentives', in that life is a lot quieter if I do not have to manage any families visiting me, so I might make the decision, if I am an aged care provider—and I do not have any objective evidence of this—to say, 'Look, we prefer a no-visitor policy because I do not have to staff and worry about people coming in and out and asking difficult questions'. So I am now using the guise of the pandemic as a way to do something that is convenient for my operations but not my residents.

Ms WARD: But have you heard anecdotally that this is occurring, or is this speculation?

Prof. IBRAHIM: I am going to call that a speculation.

Ms WARD: Okay.

Prof. IBRAHIM: And then from what you know of human behaviour you will make your own decision. But I think that having a set of operating be they rules or guidance or where you go for guidance—because the problems that the aged care sector faces are fairly generic to each home because they are about older people who are approaching the end of their life and their relationships with family and relationships with staff. I do not understand why we have to have every home work through the solution to the same problem. Where are we providing the 80 per cent of the work and allowing the 20 per cent to contextualise? That is what I would be looking for.

Ms WARD: Is that part of the challenge, though, where you have got public, you have not for profit and you have got private?

Prof. IBRAHIM: I think that the challenge exists partly because there are differing philosophies, but also they are not accountable to the state, so what you put up as guidance material—who is going to pick it up, and what will they do with it? And if your operations and your profit—if your financial livelihood depends on being accredited by the regulator, then you follow the money and you will do whatever the regulator is asking you to do. So if that clashes with what state public health arm is saying, then I know who is going to win in that battle. I think this is one of the challenges with the pandemic response. We cannot fix aged care through the pandemic response. In some ways maybe I have been too harsh—hard to believe!—in that I was expecting far more of the pandemic response to address the aged care gap.

Ms WARD: Well, that comes to my next question then, which is: what have we learned in the last two years? I am hoping that you have observed some innovations that have happened in some facilities that you wish were replicated elsewhere. What have you seen around how to manage visitations and so on that has been done really well in some facilities that could be replicated, that means that visitor restrictions can be eased or there can be a different perspective put onto how to manage that?

Prof. IBRAHIM: There is a voluntary industry code, which is a great thing to happen where people are able to come together to do that. My question, because I will always look at the opposite, is: why did it need to be an industry-driven voluntary code when the expertise sat with the government? You have a voluntary code, which means that you have variable enforcement and understanding throughout the country, which generates angst and concern. But that is a good example where the sector has done something together. Individual operators have surveyed their residents and staff about what they want to do, how they operate. So you have, again, I guess examples of excellence, but there is no centralised or standardised mechanism to share that information. And the sector is still plagued by, in a sense—it is predominantly market driven, so it is a competitive place, so

'Why would I give you a competitive advantage by revealing what I have or haven't done that engages our residents and families?'.

Ms WARD: So nothing has come on your radar, though, that you could share now where you think someone—you do not necessarily have to name them, but where you think that there have been adaptations made that others could learn from?

Prof. IBRAHIM: I think there has been a lot of very small-scale adaptations in the use of iPads, the window visits and engagement with either schools or the adopt-a-grandmother program—ways of increasing social engagement and reducing isolation. I confess I have not looked at that probably for a good six to nine months now. I guess my question would be: could I go somewhere and find that information today? And what would drive me to do that? And is that a state responsibility, is that the regulator's responsibility, is that a federal department responsibility? Who is responsible for that? And everyone will say, 'Well, I'm doing my job as described by the legislation'.

Ms WARD: Thank you. Thanks, Suzanna.

The CHAIR: Thank you. Professor, that is all the questions for today. Thank you so much for your attendance here. It has been good to talk to you and get a better understanding of the mental health impacts on particularly those, I suppose, in residential aged care, where there is no doubt the impact was felt the greatest. You will receive a copy of the transcript of this hearing for review within the next week and any questions that may have been given to you on notice, and eventually the transcript will be placed on the website. Thank you again for your attendance today.

Witness withdrew.