TRANSCRIPT

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into the Victorian Government's COVID-19 contact tracing system and testing regime

Melbourne—Wednesday, 18 November 2020

(via videoconference)

MEMBERS

Ms Fiona Patten—Chair

Dr Tien Kieu—Deputy Chair

Ms Jane Garrett

Ms Wendy Lovell

Ms Tania Maxwell

Mr Craig Ondarchie

Ms Kaushaliya Vaghela

PARTICIPATING MEMBERS

Dr Matthew Bach

Ms Melina Bath

Mr Rodney Barton

Ms Georgie Crozier

Dr Catherine Cumming

Mr Enver Erdogan

Mr Stuart Grimley

Mr David Limbrick

Mr Edward O'Donohue

Mr Tim Quilty

Dr Samantha Ratnam

Ms Harriet Shing

Mr Lee Tarlamis

Ms Sheena Watt

WITNESS

Dr Mukesh Haikerwal, General Practitioner.

The CHAIR: Hello, everyone. Welcome back. Today we are very pleased to be joined as part of the Inquiry into the Victorian Government's COVID-19 Contact Tracing System and Testing Regime by Dr Mukesh Haikerwal, a GP in the west. Thank you so much for joining us today. Today with me I have Deputy Chair Tien Kieu, Ms Georgie Crozier, Dr Matthew Bach, Dr Catherine Cumming, Ms Kaushaliya Vaghela, Ms Wendy Lovell, Mr Enver Erdogan and Ms Melina Bath.

Just so you know today, Doctor, all evidence taken at this hearing is protected by law, and that is under our constitution as well as the Legislative Council's standing orders. This means that it has parliamentary privilege. However, if you were to repeat those comments outside you may not have the same protection. Any deliberately false evidence or misleading of the committee could be considered a contempt of Parliament. Today we are recording and we have Hansard, who will provide you with a proof transcript. I would encourage you to have a look at that to make sure we have not misrepresented you in any way. Ultimately that transcript will be available on our website. We would really welcome you to make some opening remarks, and then we will have a broader committee discussion after that.

Dr HAIKERWAL: Thank you very much. I would like to thank you all for inviting me to attend the inquiry and to present and also for putting this inquiry onto the agenda. My name is Mukesh Haikerwal and I am a GP in Altona North. The end of the year is the end of my 30th year working as a GP in this area. I have taken the liberty of providing you with a written document with my details on the back of it, and I do not intend to read all of the pages before you. I would like to make some opening comments based on that, but really I would welcome any questions you might have of me.

I would like to start by saying that we are in a much better position now in Victoria than we have been. The height of our misery was in the middle of July, when we reached the 725 cases in a day, and we have reached 3500 health workforce participants who have been infected in this process as well. In my role as a general practitioner I have moved through various phases of this contagion, starting off with when we were not particularly aware of how significant it was going to become through to the first lockdown and then the second lockdown, and each of those parts of the journey have impacted directly in our practice, which is a large multidiscipline practice in the area, together with our respiratory clinic, which has been federally funded to provide the community with a testing service. It is not just a testing service but a service for people who have respiratory illnesses that otherwise could not be seen in the general practice to be seen and consulted with by a GP with full protective gear on so that they can then be looked after and treated without necessarily having to go to the emergency department. We also do testing and of course that is also a big part of this process.

One of the things we fundamentally brought here when we set up our clinic was the rigour of gathering the patient information and data to the extent that we deployed something called the national health identifier, which has to be very specific for the patient so we know we have got the right patient, right place, right time. That has been instrumental in being able to see who is actually coming and where they are coming from, especially when they turn out to be positive, and that information has led us to the next stage: what happens when somebody turns up positive? We started testing on site on 3 April and we had zero cases until 2 July. On 2 July we had our first case and up until now we are at about 110 cases. There have been luckily no cases since the middle of October, I am really pleased to say. We have therefore interfaced with patients face to face prior to testing, during testing and after testing. We have written to every single one of their GPs electronically informing them of their results and about any outcomes of the consultations they will have had with us. We have had our services evaluated by the University of Melbourne—both the drive-through service, which is unique for Australia, and our respiratory clinic, which is one of over 140 across the country. We have made sure that we have given good service to the individuals by following them up, especially after they test positive, and that is how I know and feel the pain that they have gone through at each of the intervals that they have had.

We have had many constant problems throughout the process. I think we have worked through them with the department, and I think the most important thing for this committee that I can bring is what we had in what I would call our two local spikes in September to October. At that time we had on our site 22 cases that were reported within five days. I called the chief health officer after the first nine on day one and said, 'Do you want

me to do something about this?', and so we embarked on a process which I think is really useful, which is working with the local council, working with the local GPs and other providers in the area, and working with a very good branch of the health and human services department in the community testing and support scheme, which made us have a very direct impact on the local spikes. We tried to replicate these in other areas. I know that Wyndham is trying very hard in this area and I know I have reached out to other areas like Chadstone and Coolaroo when they had their outbreaks and indeed to my colleagues in Shepparton, and I think there is a lot to be learned from what has happened over here.

I am speaking to you as a frontline general practitioner. I have had a representative role for many years, and I continue to have, but really I am not speaking here with a political hat on but as a GP on the front line working with other GPs and other providers around here, all of whom are looking to improve the system and provide our support to the system to make sure the system works for us and for our patients so they get a decent set of support mechanisms when they are in this position of having contagion. We want to make sure they get their results when they need them, when they have had them, and make sure that there is a proper scheme so that in the future we learn from this and actually use all the people who are able to provide services, provide care, provide knowledge—local knowledge; intelligence, you might say—and make sure we have a system that we can be proud of.

I concluded on my little piece of paper—I am sorry, if there are any typos; I apologise. I have been putting in 16 hours a day since April around the clinics and so I have thrown this together, so if there are any mistakes, I beg your forgiveness right here, right now. We have a great system in evolution. We used to be the stand-out jurisdiction in the country doing health, and I want to make sure that we get back there. Thank you.

The CHAIR: Thank you, Mukesh. I think that is a goal that we all would like to achieve, and hopefully this inquiry assists us in making those recommendations to continue that improvement. I would also like to say I think, thanks to you, the systems are better now than they were. I think this is due to some of the things that you have highlighted this afternoon.

We had Professor Rait here on Monday, and his real concern was that lack of communication with general practitioners and with the patient's own doctor. You were saying that when you do the testing at your clinic you ask the patient who their doctor is and you electronically send the results to them. Do you believe that that has been fixed? I mean, my understanding now is anyone who goes for a test is asked who their GP is and those results are sent through, but I am wondering if that is what you are hearing practically and on the ground.

Dr HAIKERWAL: No, I do not think it is fixed. I know there is a will to fix it. I know there is a direction to fix it. It does not mean it has been fixed. The pathology labs are very good at sending on copies to GPs if it is noted, but the systems that have underpinned some of the testing have not made that a matter of fact. I get reports from my local hospital, for instance, very well, but for patients who have been to other facilities to be tested, I do not tend to get their results in my general medical practice. I then have to go through that whole process of, 'Where did you go? So who was testing it there? Which lab did they use at that site, not this site? Which lab do I ring to try and get your results?', and then I will try and get it electronically into my system. So no, I do not think it is there yet, but it certainly needs to get there.

The CHAIR: Yes. I certainly was at a testing site on the weekend, and they were asking those questions and putting it in—but not yet. That still seems to be one of our problems—well, a significant issue that could be improved. Where else do you think has been overlooked? I think certainly with Salesforce the government has been working but chasing its tail, it would appear, in this. Where else do you think that we really need to change—something that fundamentally improves our health system overall?

Dr HAIKERWAL: It is a fundamental problem with the relations between the federation. For some reason GPs are deemed to be the responsibility of the commonwealth and nothing to do with the healthcare system in Victoria or any other state. That is fundamentally wrong and flawed, because we are Victorians, we work with Victorians, we look after Victorians, we have 2 million people seeing a GP every day across the country, and we employ Victorians and we keep them healthy. So that is a fundamental problem.

I am afraid to state my age. I first started in 1991, where you are sitting now nearly, for something called the Brand report, which looked into healthcare—a report for Victoria. I was probably the only GP to turn up because nobody was bothered to go because they never report about general practice. I said to the Chair, 'Why

haven't you talked about general practice?'. They said, 'It's not part of our terms and it's a commonwealth responsibility'. So it is fundamental. We have gone through many changes along the way where even the department has done some really good work about working with general practice, understanding the value that can be brought to the system with a joined-up system, making sure that people get the care where they need it and not necessarily having to be in hospital all the time. I think that this is something that is often spoken of but not operationalised, and in many of my years of advocacy this has been a key part of it, working with many good health ministers actually in the state and many good secretaries of health. I have literally walked and talked with them for years, and I do not think it gets beyond that level. That is the problem. It is in the fabric of the organisation, not necessarily in the higher echelons.

The CHAIR: Thank you. I think that is the first time I have heard that clarified, just that commonwealth responsibility, even though I have always known it. Deputy Chair, Tien Kieu.

Dr KIEU: Thank you, Chair. Dr Haikerwal, thank you very much for your contribution today and also for your role you play in public health issues in general. I would just like to find out a little more, particularly on the pandemic so far. Some people for one reason or another do not go to the GP as frequently as they would have done before. For some reason they may be afraid of contamination or infection at the public health places. That definitely is a wrong impression, but the perception is important for those people, hence that may present some challenges for GPs about their regular patients in terms of testing and in terms of case management after being identified as positive. I heard a story which I also brought up on Monday of particular people, obviously students and visa holders, who for one reason or another do not have health insurance or theirs ran out, and I have heard cases where some GPs somehow charged them $60 or thereabouts to have tests and test results. So how would you address those challenges in order to help the public system and public health?

Dr HAIKERWAL: Thank you very much for the question. There are probably two parts to your question, and I might try to answer the two parts. One is a general issue of people being scared to go out (a) to see their GP and (b) to get tested, and the second part is the access to services, which I will address separately. What we have seen since the pandemic started is a general concern about going out to get care and just wanting to lock up and stay at home, and one of the things I think we will see is a tidal wave of chronic disease come through because people have not kept up with their normal care. What has happened is many practices have not allowed people into the building unless they are COVID negative with a COVID test. So again you are withdrawing some services, but they are now coming back online. Practices are well set up. We have a taskforce looking at healthcare workforce contagion, and in general practice it is extremely low. General practice has done a very good job of keeping the system well cared for, for people coming in. So they are properly checked before they come in, and when they come in, the facilities are kept clean, people are hand-sanitised and everybody is wearing a mask—the best thing we have done is putting masks on everybody—and making sure of social distancing is a really important part of what is going on.

So what has happened, then, is people are now starting to come in and get care, but there is the perception that the test is unpleasant. Look, no test is pleasant, but it is not as bad as it is made out to be. Some communities have a concern that they are going to get brain tumours or brain infections from having the swabs done—and this is all about the community comments that go out there—and some people are scared about getting tested because of losing income, about the very real bad press, I guess, they get around it. The whole stigma is a major issue, and the experience that others have had they do not want to repeat. So there is a problem about getting tested from that side, and there is a problem about people coming in and seeing their GP. That is all getting addressed as people open up their practices and people are now feeling safer to come in. As far as our respiratory clinic is concerned, the University of Melbourne infectious diseases people, the two reviews of our system say it is probably one of the safest places in Australia to be. It is the last place you will get COVID, because that cleanliness has been kept there. It is hard to convince people about that.

Dr KIEU: The wrong perception.

Dr HAIKERWAL: Yes. In terms of services to get tested, services like our federally funded clinic are obviously fully funded even for international guests to the country. If they get a test, the commonwealth will pay for it if they have not had anything there. Obviously all the state facilities are similarly funded by the state and so on. If a private practice is doing a private consult, then generally with an international student they are in the country with insurance. Obviously that would have lapsed for some people now. Some of the community health services like Cohealth have been exemplary in how they have done that work with students and so on.

So I think they have a lot to be proud of with what they have done there. Unfortunately as a business, people have to continue their business if they are seeing people. What we are finding—and I literally had this conversation before coming on just now—is that we are all peddling faster, seeing more people, to stay still, because actually trying to make an income is really difficult at this time.

Dr KIEU: Thank you.

The CHAIR: Thank you. Ms Georgie Crozier.

Ms CROZIER: Thank you very much, Chair. Dr Haikerwal, lovely to see you, and thank you very much for your opening remarks and all the work that you have done. I had the privilege actually—I think it was in lockdown 1 earlier in the year—to have a virtual tour of your respiratory clinic that you set up, and I was really impressed at the time. It was absolutely fabulous, and I have spoken to the committee about that.

I am interested in your comments in your opening remarks in relation to that work that you have done in the local community off the back of what Dr Alan Finkel in his report spoke about in terms of the local public health expertise being essential, knowing your community and having that involvement, which I think you have largely done. You said in your opening remarks that you have reached out to other communities that have been affected by COVID clusters or outbreaks. I am just wondering if you could provide to the committee any dialogue that you have had with the department about those initiatives and ideas and what the feedback has been, because I think it is of great value, the work that you have been doing over the last eight or nine months, and should be, in my view, a great platform to continue to work on.

Dr HAIKERWAL: Thank you very much. What we did locally was enlist local government. Hobsons Bay City Council have been amazing. At every step of the way they have really walked with us, and we have walked with them and enlisted our other, in this case, GP colleagues from the area, and a branch of the department has actually worked very well and closely to support this effort. The area in Melbourne with the largest number of cases is Wyndham. One of the issues we had in Wyndham was at Al-Taqwa College. Many of the people that go there live in our area. One of my local colleagues was quoted in the *Age* as actually giving information that was not right, because he was not told that there was an outbreak in that college.

Ms CROZIER: Could you explain that a little bit more to the committee, what happened and why he was not told?

Dr HAIKERWAL: Well, nobody has ever been told about anything, ever. In my area I did not know the school had a problem. I did not know that not even a kilometre away from me the three abattoirs had a problem. In fact our site is the old site of SBA-Don smallgoods. I am sitting where there was probably an abattoir first. We are not even a kilometre away, and we only found out when people came to be tested, saying, ‘We’ve got a DHHS letter. We need to be tested’.

Ms CROZIER: So that lack of communication from DHHS to healthcare providers—

Dr HAIKERWAL: Zero communication—zero.

Ms CROZIER: Zero. And in your opinion, or your observation is, that needs to be improved. Has it improved? Because we know that there have been delays in the contact and the follow-up in the contact tracing. Do you think that communication to providers like you has led to significant challenges with the contact-tracing aspects?

Dr HAIKERWAL: It is a major challenge on two grounds. One is that we are not supposed to test people if they are negative, if they have no symptoms. I said in public on the radio, ‘Actually, I’m going to test anybody who comes here who is the direct contact of a positive. They won’t have symptoms. I’m going to test them. I want to keep my community safe, and I want to do it today, tomorrow, not next week or the week after, when DHHS is going to see them. Put me in jail, but that’s what I’m going to do. It’s really important that people get tested now and stop that magnifying of effects if you do not get in early and lock people down and get them to isolate early’. So that has been a major issue. The actual words—we are not allowed to use the words ‘asymptomatic testing’, federally and state, number one. Number two is: if you do not know what is going on and you are going on hearsay, it is not good practice. You could actually be proactively getting people to come and get tested at the right time so that we reduce the spread of disease, because you get in early and have people

isolate early. I have actually had cases—I am looking at my list here as I am talking to you of my cases, and I can see the names of someone who was isolating. A family member who was isolating went to work and came back to be told that another person in the household was now positive. Now, what happens to the people they are working with?

Ms CROZIER: Has your follow-up been better than the department's, then, in terms of what you have done?

Dr HAIKERWAL: I can see everybody here, I can see the postcodes, I can see where they are, and that is how I spotted the spikes in my area. That is the local knowledge: I can see the streets, I can see, walking out my gate, where it starts. I can see families, because I know them by name. Dr El-Khoury, my colleague in Complete Family Care in Newport, when I said to him, 'We've been asked, thank goodness, by the testing people, "Can you please help us with these mystery cases?"', I asked him and he said, 'This isn't two families; this is one family. This is husband and wife. It's the same family. Oh, and by the way they have got this many kids'. All of a sudden we unravelled another web that we could then address together as a community across a community.

Ms CROZIER: You sound like you have prevented more clusters from forming by the work you have done. Thank you very much.

The CHAIR: Yes, indeed. Ms Kaushaliya Vaghela.

Ms VAGHELA: Thanks, Chair, and thanks, Dr Haikerwal, for your time, for your submission and for the great work that you did in Melbourne's west during the pandemic. Now, health services and healthcare workers have been at the front lines for many months protecting the Victorian community and saving lives, like they do every day, regardless of whether there is a local pandemic. Health services know all too well the impact that the pandemic has had on communities and how Victoria's systems are continuously improving to ensure we can prevent the spread of the virus in our community. So can you share a little bit with us some of the changes and improvements you have seen over the course of the pandemic and how the contact-tracing systems have evolved?

Dr HAIKERWAL: Yes. Thank you and thanks for the very important question. The first thing is that it starts off with the testing itself, and we have had access to more testing, which has been really good. The issue, of course, with some of the blitzes was that the number of tests therefore increased dramatically and the labs could not cope with the numbers, and so time lines for reporting blew up from two or three days to seven or eight days, which of course is understandable from a lab point of view, but if you are waiting for your result, you quite rightly are in need of your result. So we are now quoting two or three days maximum at the moment, so that has been a big improvement as labs have become more tooled up to do this. Many labs are sending the results electronically, which is also important, and I think having the good information is an important part of it. Reporting of positive cases changed from waiting for 45 minutes to an hour to reported on the phone to going online. There are some modifications that will happen to that, but that is really important. It means you can do that. When you do report it, you still do not get ongoing engagement about what has happened to the case you have reported when people are actually signed off and so on. That is something that will evolve.

I think what has been really important in my area and in the work we have done is the physical outreach from the department actually working with us, a small group. We have mooted local public health units. I am convinced that they are important. I am yet to see the benefits that they are going to bring. But do not expect it to be two weeks or four weeks or six weeks. In six months we will be somewhere good, but what we have had to do is to do stuff now, and so I think that has all been an important part of it.

The other part that has changed in the system is the recognition through our DHHS COVID advisory group with primary care of the role of general practice. That needs to get carried within the higher echelons of DHHS so that they actually then carry out the suggestions that come from that group, not just pay it lip-service. But at least there is a group there that can do it. And I am very hopeful that with local public health units working as they have done in other jurisdictions we may get some local responses, nimble responses, rapid responses but, most importantly, collaborative responses with the other service providers and supporters within the local communities, who are vital. Our local community has reached out to Wyndham, and we worked with some of the collateral that we have all established with different languages. Also, the community liaison with local

communities within our municipality, we are leveraging that across. We were helped by the information provided by DHSS, which is quite good as well.

So, look, it was very fast when this happened. It was a very large number. I do not think that any jurisdiction in the country would have managed it full stop, and we were probably on a poorer footing because the public health clout had been cut to a very basic level. We have now grown it, and I think we will not hopefully lose it again, because hopefully we will have learned the lesson. It is not just the lesson of Victoria, it is the lesson of the UK. They killed off their public health and now they are crying for it, and I think that we will all learn together that the health of the public is the number one focus of the department of health, and we cannot lose that capacity to do that in a systematic way.

The CHAIR: Thanks. It is sad that such an obvious statement needs to be made. Thank you. Wendy Lovell.

Ms LOVELL: Thank you. Thanks, Dr Haikerwal. It is not often that someone who is presenting to a committee can actually touch two very special places for me, and you mentioned both Hobsons Bay and the City of Greater Shepparton in your presentation. I grew up in Hobsons Bay and I now reside in Shepparton—

Dr HAIKERWAL: Lovely.

Ms LOVELL: so I understand very much the similarities between both of those areas because they are both areas that have very much welcomed new settlers to our country and where families often live in very densely populated homes, with multigenerational families living in those homes. I think your response of those localised responses is the right way to go in both of those communities. I just wondered: did you have any pushback from the department when you first wanted to set up those localised responses and did they fully understand just the uniqueness of those communities that you represent?

Dr HAIKERWAL: Thank you. In the first place I did not ask, I just did it, because I knew what the response would be, and then what I was very surprised about, very grateful for, was the very good support I did get from the team there—Mia Bromley, her sister Naomi, Hazel Fetherston. Brilliant work. Literally working for only half an hour every other day, banging through what the issues were and nailing the problems. They were escalating within DHHS to understand whether there was a disconnect between the CCOM teams and saying, 'Okay, you've got your lovely five teams', and yet people are still falling between. We are still given the wrong information. We need to establish wraparound services so that people feel safe to isolate, they feel safe to go and get tested and they feel safe to quarantine as a family. People do not want to be put into hotel quarantine; they want to be with their families. How can we help them do it safely? Who is going to take the dog for a walk? Who is going to get the shopping? Who is going to get the grants from the state government or the federal government? This is what was done, and real-life needs were addressed so people felt comfortable to then go and be isolated. People had very bad responses from people around them when they said, 'Look, I've tested positive', and that is a lesson that we had not learned from AIDS. We hoped that we would have learned that from AIDS; we have not. This is something that is an illness—it should be treated as an illness and people should be supported, not pilloried for it.

The response in Shepparton was amazing. People just queued up for 4½ hours, many people, including you—you know this. That sort of response is because the community got it. People did not get the message here, because I do not think it was quite so easily understood, as you say, because of some of the problems about communication, which may necessarily not just be language but communication. Some people were being followed up by text message. They could not read. And they are not CALD, they just could not read. So they are the sorts of things that people can help with. So we used to go to that guy who could not read. My wife would go out—she is a GP—with a pulse oximeter and leave it with him and follow up his care. I would ring him and say, 'How are you?'. He would say, 'I can't breathe'. 'What's your reading? It should be 97 or 98'. He said, 'It is 88'. I said, 'Go outside and take some deep breathes and stop smoking'. That is the sort of thing you do. You get people into a place where they can then look after their own health. But it is really interesting that you say that. The response was similar but so much more pronounced in Shepparton because people got the message quickly.

Ms LOVELL: I think a little bit later on in the pandemic too. But you said you got—

The CHAIR: Sorry, Wendy. Your time is well and truly expired. Enver Erdogan.

Mr ERDOGAN: Thank you. Thank you, Dr Haikerwal. It is great to hear about your utilisation of local community networks to meet the challenges of this global pandemic. I did have a couple of questions on issues about moving forward. Obviously this inquiry is looking at how we can make improvements. Do you believe going forward that there needs to be some sort of automatic notification process where—I would say it does not necessarily have to be a cluster but multiple cases, say, within a 2 or 5-kilometre radius—all the local GP clinics are notified to watch out for something? Do you think having an automated process such as that should be implemented and DHHS should work to do that?

Dr HAIKERWAL: Yes. Look, I think that is a really important point you raise, that early notification, early warning systems are the first part of defence in any good defence to a war, and that is what we have, we have a war against this virus. I think that the fact that we did not realise that the three abattoirs down the road from us were having problems—or we are a big distribution centre for logistics; maybe those had problems. You know, we had an issue of a supermarket chain reported as having an outbreak. There are actually two along the same road. We had to say, 'Well, which one?'. All that sort of local knowledge is really important to keep [inaudible]. Yes, absolutely, early warning systems.

Mr ERDOGAN: Yes, because I thought that with the advancements and communications being easier than ever, an automated system where there are multiple cases, once you have set the parameters, all the local GP clinics are notified because they will be seeing different patients, different families coming in. Another point that has actually come out of your evidence, which I found very interesting, is do you believe maybe for anyone that gets tested, regardless of positive or negative, not just in the fight against COVID, which you are focused on, but also other comorbidities that your clients might have, because if they do not have COVID they may have respiratory issues, they may have other issues, there could be a requirement where in all testing, the person getting tested must nominate a GP clinic to be notified? And so then if it is not COVID, it rules out one potential illness, but I guess there are other potential illnesses that are investigated thoroughly or correctly?

Dr HAIKERWAL: Look, I think you are right. Eighty per cent of people in Australia identify a general practitioner that they see regularly. That leaves 20 per cent, and many of those will be students and other groups that are itinerant, do not have a regular abode and so on. Generally there is some benefit in having that GP notified. For my sins, one of my pieces of work was working with what was the National E-Health Transition Authority. What is now called My Health Record was one of the things I was trying to work on. I had to leave because it did not quite go the way I wanted it to. There is lots of history around that and you will have seen that. But there is a collateral, to use that, so I actually use My Health Record to put people's COVID status up, with their permission, and I also send reports to their GP. So, yes, having that train is important. If you have got some visibility, you know to look for other things, absolutely. And I think that as we look at the new local public health units in the future the biggest danger to us as a community is chronic disease, and if we have a way of identifying and supporting people with those more effectively we will be a much healthier society for it.

Mr ERDOGAN: Thank you, Doctor.

The CHAIR: Thank you. We will go to Catherine, then Melina, then Matthew.

Dr CUMMING: Thank you, Doctor, for your response. Your work with Hobsons Bay council and understanding the urgency and seeing the gaps should be commended. I could not thank you enough on behalf of my community in the west, but thank you. Do you believe that the councils should continue to be involved with testing and tracing and isolating with the local GPs, and what could DHHS do? And do you feel that we are ready for the next wave? And would you agree that the severe lockdown has done a lot of damage? And what could we do to prevent that going forward, as in we have got this summer period, you would hope that we could get all our ducks in a line, get all the problems solved, so that when the weather turns in May, June, July we feel confident that we do not need to go into another lockdown?

Dr HAIKERWAL: Thank you very much. I will try and go through your points, not necessarily in the right order. An interesting point: as I trained in Britain, I have many friends who are medical in Britain, and they were telling me all over Britain in the summer, all great. Guess what? Where are we in Britain? Not good. The lockdown—very severe. I have never been in a situation in curfew since I was a child in war-torn Africa in Nigeria. It is horrible to even think about curfew. Guess what? It did what it had to do, and there was no other way of doing it, I am afraid, because of the lack of pick-up, I believe, up until now. So in the future will we be better prepared? My oath I hope we will be because of a committee like this. This is why I said at the outset I

am grateful for you to put up a committee like this, and I thank you for participating and quizzing us on this because this is the only way forward. Be honest about it. You do not have to be Napoleonic and say, 'This is what we going to do'. You have just got to be big about things. If you do not know, say, 'Look, we don't know. We will fix it. Yes, we made a mistake. We'll fix it'. And I think that has started to happen. We have got reorganisation of testing people. We have got new software coming. We have actually had the original proposed software dumped because it could not deliver. There is other software that has been promised by other companies which can make that happen. So I think that there is a lot that can happen and will happen because of this sort of activity actually probing and finding out the answers and allowing people the dignity to say, 'Look, sorry, I got it wrong, but I learned from that'.

One of the things I do is something called medtech. In a medtech you fail quickly and fail fast so you can recover, and in many ways you do not want to do that in health, you never want to fail. Well, unfortunately there are going to be mistakes, and we are going to learn from them. In health we call it open disclosure—you disclose there has been a problem and then you go and fix it, and I think that is what is starting to happen. So one of the problems has been that people were not informed in time. They did not get contacts in time. People were being addressed from the ground floor to their balcony to ask them about how their symptoms were. All these things have got to stop. You have got to have properly trained people who are aware of the privacy, the confidentiality, the personal nature of health when they do that sort of work. But we are learning all that, and I think what we are going to see is that we will be ready for the next phase if there is one, but it is going to take an awful lot more work still, and you, ladies and gentlemen, will be the people who will be driving that with your results from this conversation.

Dr CUMMING: Prevention is better than cure.

The CHAIR: Indeed. Thank you. Ms Melina Bath.

Ms BATH: Thank you very much, Doctor. I think we are very privileged. I would just like to thank you for your leadership and wise counsel in all of this whole pandemic. I think you have been an outstanding leader. I have read your submission and I think it is fabulous, and I would really love to see it, if you do not mind, be part of our submissions to go on the website if that is permissible for you. At 24 in your multiple-point part you speak about problems with multiple disjointed, disconnected messages from different people within DHHS not understanding the outcomes of their decisions, and I think somewhere in your context of discussion today you talked about incorrect information being given from the department, so that might be a way of helping us understand more fulsomely that point.

Dr HAIKERWAL: Look, I think that we were running really fast and many people in their own departments in the department were doing what they had to do. So the example I gave, for instance, was about surgery. Now, it makes absolute sense that if you are going to do surgery you should have a test before that because of the dangers to the individual and everybody in that environment where they are being treated. And you want to be sure that the people that you are treating therefore do not have the contagion or, if they do, you have the right precautions. Now, one thing is, as was said earlier by Dr Cumming, prevention is better than cure. What we have done in AIDS is universal coverage—everybody is treated as though they have got it and therefore you just get on with the rest of your life as you do that. However, there was a need to get testing, and most centres are not allowed to do asymptomatic testing. So one part is saying, 'Go and get tested', the other part is saying, 'We cannot test you'. So, fair go, give us a proper way of doing this and we can then do this with you. Other things that happened along the way were when you had a blitz, and we were given permission to do that, you then could see people. We could not say, we still cannot say, 'asymptomatic testing'. We use the words, 'If you need a test, you get a test'. 'If you need a test because you come from an area of high contagion, you get that'—we did not use those words, but nonetheless we made sure people got tested. I think that sort of joined-up message is important.

The other message was of course: when you do get a positive test, what are you going to do? How do you isolate? We had four phone calls, one after the other, from different people saying different things, and the next family member has the same thing as well. I think that is the sort of thing that makes no sense. If you involve a general practitioner, the GP, and say, 'I've got a family of five', I will soon talk to the family of five and say, 'This is what you need to do, and by the way, do you understand this? This is what you can do, understanding you have to go and get your food somewhere' or whatever. So I think these are all the things—local intelligence, local knowledge, local involvement. We do not want to take it over; we still need DHHS to sign

off we have met the right parameters. And if we do sign off, make it in a way that we can do it and have the right guidance to do it properly. So I think there are many things that we can improve there, but we are learning.

Ms BATH: Fiona, have I run out of time?

The CHAIR: I am afraid you have, Melina. In fact if you do not mind, Mukesh, we will just give Dr Matthew Bach a question. Thank you very much for your time.

Dr HAIKERWAL: Thank you. Not at all.

Dr BACH: Thanks, Chair, and thanks again, Dr Haikerwal, for being with us. I was interested in your earlier comments, and you referred back to a similar point just now in response to Ms Bath, about your desire to continue carrying out asymptomatic testing despite the fact that you were directed not to do so by the Department of Health and Human Services. If I heard you correctly, when you first brought up this point you referred to the fact that if you are not going to do that, if GPs are not doing that, those individuals, who may well be indeed in some cases, as you said, confirmed close contacts of COVID patients, may not be followed up for some time by the department. Would you mind speaking to us a little bit more about those lag times? Because I am concerned if that is still a problem.

Dr HAIKERWAL: I do not believe it is a problem now because our case load has gone down dramatically. As we were building up to the 725, it was a problem, very much in July. As I said, we started actually getting positives on 2 July, and the more we started going down that road towards mid-July, it became a problem. What would happen is that you would make a report and you would check in on the people to say, 'Are you okay? We've written a letter to your GP. What's happened?'. And we got the messages about multiple calls and so on. But some people were saying, 'Well, I didn't get a call' two or three days later—'I didn't get a call'. Many of my patients, you will see reports of them in the media, on the *7.30* report and places, actually stating, 'Well, we haven't been contacted'. So because of that we had to say, 'We understand people aren't being contacted. We will go ahead of the curve and say, "You've just been tested positive. Can we talk to your family members? Are there any other people that we need to tell to come and get tested now? We need to test you"'. I was kind of being a little bit provocative when I was saying, 'You're allowed to use clinical judgement when you do a test' but the actual guidance says you should not test if people are asymptomatic. We use the logic of the circumstance—and I quite happily will put this to anybody, and I have—that it is illogical if you are trying to remove contagion. So we would therefore say, 'We're going to test you, understanding that you are asymptomatic'. But that way you are stopping the spread.

Dr CUMMING: Has DHHS provided GPs with toolkits for people who have symptoms, as in what to do when they are isolating at home? Have they got any of those resources available?

Dr HAIKERWAL: There are resources on the web, and obviously this has changed over time. It is interesting—the words that we used we took from the US CDC about isolating for five days around the time the symptoms have faded. They have increased that to 10 days now, but we would not get away with giving people 10 more days of isolation—they just would not do it. So we have to be cautious about advising people. The results come back negative, but there is still time for it to convert, so that is why you need a few days extra.

Dr CUMMING: But more of that needed—

The CHAIR: I am sorry, Catherine, to butt in, but we are over time and we have got other witnesses waiting for us. Thank you very much, Doctor. This has been really terrific, and we have learned so much today. Your willingness to be so candid has been greatly appreciated by us all. You will receive a transcript, a draft transcript, of today's session. Please, I do encourage you to have a look. It will ultimately make it onto our website. We will send you a formal email just to be certain that you are happy for the information you have provided in written form to be included as a submission.

Dr HAIKERWAL: Thank you very much, and thank you for all your work as well. I do appreciate it.

The CHAIR: Thank you, Doctor.

Witness withdrew.