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Ms Lizzie Blandthorn MP
Chair
Public Accounts and Estimates Committee
Parliament of Victoria
Spring Street
East Melbourne 3002

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

Thank you for the opportunity to provide a submission to the Inquiry into the Victorian Government’s Response to the COVID-19 Pandemic.

Victoria is facing a once-in a century health crisis. With hundreds of daily COVID-19 infections (now at over 10,000 cases in total), admissions to hospital are rising along with transfers to intensive care units, and increased rates of death. The health system is under unprecedented stress.

In the short term, the trajectory of infections remains uncertain. In the longer term, the continuing health impacts of COVID-19 are not yet fully understood nor appreciated, with the secondary health consequences of the pandemic likely to be devastating. As a result of widespread avoidance of care and underutilization of healthcare, a high number of non-COVID-19 related illnesses will result in time and we need to prepare the system for this.

We are also very concerned about other secondary effects of the pandemic – the rise in alcohol consumption, mental health issues and domestic violence that have already been seen and the long term impacts of economic and social effects.

This submission will begin by providing some background. We will then outline the current situation in Victoria along with some of the missteps the state government has made in response to the pandemic during the past few months. We will then outline some of the issues in the Victorian health system that have possibly caused and at the very least, magnified those missteps.

Background

When AMA Victoria made its appearance before the Public Accounts and Estimates Committee in May, we stated that the “COVID-19 pandemic is not over and continuing vigilance is essential”.

We were of the view at that time that Victoria had taken steps to successfully minimise the transmission of COVID-19. In this context, we noted:

- the commitment to follow expert health advice first and foremost;
- the formation of the National Cabinet and Victoria’s willing participation in it;
- the cancellation of the Formula One Grand Prix and other mass gatherings;
• timely staged closures of smaller group activities across the state;
• strict isolation and quarantine of returning overseas travellers;
• Victoria’s expansion of testing (following months of tracking behind the national mean).

AMA Victoria made known our concerns at that time about a lack of personal protective equipment (PPE) for frontline health workers and a continuing issue with fair distribution across the state. This has been one of the most important issues for our members and a significant source of stress for them.

AMA Victoria also made the point that specific outbreaks would need to be contained and well managed, as restrictions were lifted. Of paramount importance was how well our public health teams could continue to detect cases and finesse their methods of containment.

Public health teams face pressure to act quickly and effectively and a culture of blame and finger-pointing is unhelpful in achieving this. That is not to say, however, that systems, resourcing, governance, decisions and actions should not be questioned or that constructive criticism should not be provided. State government can assist in this as well - by being more transparent in their governance structures and decision-making, areas for improvement and in sharing their data and modelling. One example of this are statements that the majority of infections in healthcare workers are community acquired, yet contradicted by other statements that 80 per cent of infections are workplace acquired.

**Current Context**

Since that time, the situation in Victoria has deteriorated dramatically. One senior AMA Victoria figure recently stated that it has been like witnessing a “slow car crash.”

The Government’s missteps in responding to the pandemic during the past few months have included:

• The public perception of tolerance of large demonstrations;
• The mismanagement of the hotel quarantine system;
• Poor (or non-existent) micro-communication of health messages to non-English speaking and CALD communities;
• Delays in notifying people of positive cases and issues with contact tracing (which appears overrun);
• Inconsistent messaging and guidelines (for example, when people should isolate);
• Lack of investment in planning and responses with general practice and primary health networks;
• Lack of support to general practice, including delays in the ability to notify of positive results and clinical advice;
• A lack of a two-way communication with external stakeholders;
• Lack of responsive distribution pathways for resources; (e.g. PPE)
• Lack of transparency and accountability;
Siloed decision-making within the Victorian Government that put individuals at risk such as the decision to furlough all St Basils staff without ensuring a plan for care for residents, leaving their basic needs unmet.

It is clear however that by far the largest problem in the past few months has been Victoria’s mismanagement of its hotel quarantine system. It appears that flaws in Victoria’s hotel quarantine system may be the main driver of the high number of cases of community transmission currently occurring in Victoria. This mismanagement is one of the most disappointing aspects of the state government’s response to the pandemic.

Furthermore, it remains unclear which Minister and which department was fundamentally responsible for operating hotel quarantine. No explanation has been given why the scheme was not supervised by DHHS or why the offer of assistance from the Federal Government to deploy the Australian Defence Force to enforce quarantine was rejected.

Managing Victoria’s response to the pandemic

Many AMA Victoria members have questioned whether good governance has underpinned the Victorian Government’s response to the pandemic and whether the right structure is in place moving forward.

In March 2020, the State Control Centre was activated to oversee and coordinate Victoria’s response to the pandemic, but we rarely hear from the Emergency Management Commissioner, nor are daily press conferences held in the State Control Centre. It appears that the Premier Daniel Andrews and his cabinet, make the decisions, supported by advice from the DHHS.

AMA Victoria members consider it important to reflect on whether the current structure is the most effective way to manage a pandemic. We believe a trigger is required to initiate a different structure that is a cross-department and cross-healthcare response, led by clear governance and accountability frameworks. This should be led by experts in emergency management with high level advice from health practitioners.

Managing Victoria’s public health system

Victoria’s devolved public hospital system means hospitals have autonomy and independence rather than being line-managed by government. They are their own masters, to a large degree, with their own boards operating at arm’s length from the state government. This system has its strengths but in responding to a pandemic, AMA Victoria questions how well this structure serves the community.

During a pandemic, ideally the best system is one which supports leadership, co-operation, information sharing, collaboration, coordination, oversight and centralised decision making. These are not the strengths of a devolved governance system which, in contrast, drives competition between public health services and is prone to inconsistency of standards across networks, silos and protectionism.
AMA members have questioned whether, in a pandemic, the DHHS (and especially Safer Care Victoria) should have a more active role to play so that, for example, there might be more transparency from public hospitals or a fairer and more equitable distribution of PPE between various public hospitals and a more consistent application of processes and guidelines – such as PPE use and training, inter-hospital transfer, and the need to plan and execute responses with their regions’ GPs.

Whilst the health systems in states such as New South Wales and Queensland are not perfect, they operate differently, relying on a central department which coordinates and integrates the different arms of public health, primary care and public hospitals. They both integrate and factor general practice much more within their planning and responses than here in Victoria.

In Victoria, there is no central oversight or planning for these different, important and inter-connecting parts of our healthcare system; and additionally, there is no strong interface with the aged care sector. (A situation that is exacerbated further by the divide in responsibilities between the state and federal government.)

There is no meaningful engagement and integration of general practitioners into the Victorian public health system and there remain constant communication issues between government departments, public hospital management, general practice, primary care and aged care.

It should be noted that, whilst the Chief Health Officer may be one of the main spokespeople for this public health crisis, the role itself, is not positioned within the Victorian DHHS structure as influentially as in other states; nor does this role oversee and co-ordinate the entire system. The mixed messaging from public hospitals to staff over masks is one example of this issue.

AMA Victoria supports reforms to drive the structural changes necessary to support the delivery of a more cohesive and efficiently coordinated public health system in Victoria; one that is less siloed and more accountable and effective. The pandemic has cast a spotlight on these issues and whilst we appreciate not all these issues cannot be resolved at the moment, we believe that some can be addressed and we will be advocating on these issues into the future.

*The lack of planning, collaboration and two-way communication between the DHHS and stakeholders*

The structural changes as outlined above might also help drive improvements in the way in which DHHS engages with its stakeholders.

Since the beginning of the pandemic, AMA Victoria has consistently received feedback from members that there is a lack of meaningful planning, collaboration and two-way communication between the DHHS and its external stakeholders. We have seen this particularly in the relationship DHHS has with general practitioners and front line staff in public hospitals.
AMA Victoria has been repeatedly disappointed by the efforts of DHHS to engage meaningfully with stakeholders, seek feedback, test assumptions, plans and ideas and to understand the experience on the ground; to learn and to rectify issues quickly.

When it came to the hotel quarantine system, people with concerns had nowhere to take them. There was no point of contact with whom stakeholders could communicate issues. It was unclear who had oversight over all the moving parts, with the capacity to engage and work with stakeholders such as general practitioners and then have the authority to act on those concerns. There were too many silos and no one person responsible for taking feedback. Depending on which individual responded to an inquiry, concerns that were raised could be thwarted and communication might be ineffective, inadvertently blocked or even lost or forgotten.

General practitioners need a much stronger two-way dialogue with the state government so that model development, enactment, collaboration and feedback can be improved. Ongoing relationships of trust must be created between DHHS, hospital medical staff and general practitioner stakeholder groups so that planning can be more effective, and that issues can be addressed as they arise.

Indeed, there has been a lack of a two-way dialogue and strong relationship between the state government and general practitioners – and a lack of support from the state government over many years.

Whilst DHHS has taken some steps to improve the lines of communication in the past few months, AMA Victoria believes there needs to be a genuine, long-term culture shift in DHHS’s to improve its engagement with stakeholders. In a pandemic, we see that disconnect and stress play out very clearly, whereby GPs are ignored or excluded from our disaster preparedness.

**Transparency**

It is well-established that open and transparent systems are more effective. Problems can be acknowledged, solutions identified and experiences learned. Such systems have a built-in agility and are better positioned to respond to problems as they arise, which is critical to responding effectively to a pandemic.

The data and modelling informing the state government’s decision making is drip-fed to the public in daily press conferences. AMA Victoria would like to see more transparency from the state government so that information is more widely shared and better understood.

AMA Victoria also calls on the state government to demonstrate more transparency when it comes to health worker infections. We support calls for a national real-time database of healthcare worker infections overseen by an independent review panel. There is currently no transparency around the numbers of cases of COVID-19 being acquired by health workers in the workplace, despite constant reassurances from the state government that this information will be forthcoming.
Conclusion

The COVID-19 pandemic will have a significant impact on the medical workforce and the structure of the Victorian health system; whether it be from acquired infection in the workplace or from the long-term stress and fatigue of working at the coal-face through a pandemic or from the broader health consequences of the virus. It is AMA Victoria’s recommendation that a Royal Commission be called into the Victoria’s Response to the COVID-19 pandemic. This type of inquiry will be necessary in order to learn and apply lessons learned from this pandemic and build a sustainable and resilient workforce and health system for the future.

Thank you again for the opportunity to provide this submission.

Yours sincerely,

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