

TRANSCRIPT

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

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

Melbourne—Tuesday, 11 August 2020

(via videoconference)

MEMBERS

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Mr Richard Riordan—Deputy Chair

Mr Sam Hibbins

Mr David Limbrick

Mr Gary Maas

Mr Danny O'Brien

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WITNESS

Associate Professor Julian Rait, President, Australian Medical Association Victoria.

The CHAIR: Good morning, and welcome to the AMA. This is the second series of public hearings for the Public Accounts and Estimates Committee Inquiry into the Victorian Government's Response to the COVID-19 Pandemic.

The committee will be reviewing and reporting to the Parliament on the responses taken by the Victorian government, including as part of the national cabinet, to manage the COVID-19 pandemic and any other matter related to the COVID-19 pandemic. Members that are attending these hearings are attending remotely from home or from their electorate offices, so we note that members are not required to wear a face covering if they are working by themselves in an office under the stay-at-home directions of 6 August, part 2, section (7)(i).

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

We invite you to make a brief opening statement of no more than 5 minutes. We ask that you state your name, position and the organisation you represent, for broadcasting purposes, and this will be followed by questions from members of the committee. Thank you.

Assoc. Prof. RAIT: Thank you, Chair. I am Associate Professor Julian Rait. I am the President of AMA Victoria. Since appearing before this committee in May the situation in Victoria has obviously deteriorated. By far one of the most disappointing aspects of the government's response in the past few months has been the mismanagement of Victoria's hotel quarantine system. AMA Victoria questions whether the Victorian government's response to the pandemic has been underpinned by good governance and whether the right structure was established quickly enough to manage these risks. It has always appeared to us that the Premier, Daniel Andrews, and his cabinet have been in a leadership role and made decisions supported by the advice from DHHS. AMA Victoria considers it is important now to reflect on whether this structure has been the most effective way to manage a pandemic. We believe a trigger was required earlier to initiate perhaps a different structure, an across-department and across-health care response, led by clear governance and accountability frameworks and by experts in emergency management and with high-level advice from health practitioners.

Additionally, AMA Victoria questions how well Victoria's devolved public hospital system serves the community during a pandemic. Ideally the best system during a pandemic is one which supports leadership, cooperation, information sharing, oversight and, to a certain degree, centralised decision-making. These are not the strengths of our devolved governance system. AMA Victoria questions whether, in a pandemic, the DHHS should have a more active role to play. For example, there might be a more transparent distribution of personal protective equipment to public hospitals and a more consistent application of processes and guidelines about their use. Healthcare safety, for both patients and caregivers, is under great scrutiny at the moment. Safety for patients, staff and their families should be our number one priority. However, the foundation of trust should begin with our health workforce.

A number of health services distinguish themselves via daily communication about the availability of PPE and about maintaining high-quality PPE and being prepared to do whatever it takes to ensure that the workplace be made as safe as possible. Unfortunately this experience is not a universal one for our members across the health system. Furthermore, in Victoria there is no central oversight or planning which coordinates and integrates the different arms of public health, primary care and public hospitals—important and interconnecting parts of our health system. Additionally, there is no strong interface with the beleaguered aged-care sector—a situation of course that is exacerbated further by the arbitrary division of responsibilities that has occurred between state and federal governments. There is no medical engagement either with general practitioners with the Victorian public health system, and there remain constant communication issues between government departments, public hospital management, general practice, primary care and aged care.

AMA supports reforms that drive the structural changes necessary to support the delivery of a more cohesive and effectively coordinated public health system in Victoria. Since the beginning of the pandemic there has been a lack of meaningful leadership and two-way communication between the department and external stakeholders. We have seen this particularly in the relationship that DHHS has had with general practitioners and frontline staff in public hospitals. General practitioners need a much stronger two-way dialogue with the state government so that collaboration and feedback can be improved during the pandemic. Ongoing relationships of trust can be created between the department, hospital medical staff and general practitioner stakeholder groups so that planning can be more effective and issues can be addressed as they arise.

Also, the data and modelling informing the state government's decision-making is drip-fed to the public in daily press conferences, and we would like to see more transparency from the state government, so that information is better understood, along with more transparency when it comes to circumstances surrounding healthcare worker infections.

Finally, Chair, the COVID-19 pandemic has had a significant impact on the medical workforce and the structure of the Victorian health system, whether it be through acquired infection in the workplace or from the long-term stress and fatigue of working at the coalface through a pandemic and the broader health consequences that this can pose to healthcare workers.

It is AMA Victoria's recommendation that, in time, a royal commission should be called into Victoria's response to the COVID-19 pandemic. This type of inquiry would be necessary in order to learn and apply lessons from this pandemic and build a more sustainable and resilient workforce and healthcare system for the future.

The CHAIR: Thank you, Professor Rait, for your introduction. I will hand the call to Mr Gary Maas, MP.

Mr MAAS: Thank you, Chair. Thank you, Associate Professor, for your presentation, and thank you for your appearance before the committee. I would just like to take you to the topic of hospital preparedness. As you would be aware, the government has invested significantly in new beds and equipment for hospitals, including ventilators, and to increase the ICU capacity. Would you be able to inform the committee of the types of differences that this would make for your members in the fight against COVID-19?

Assoc. Prof. RAIT: Thank you, Mr Maas. Look, I think that the preparedness that has been deployed to our hospitals has been quite good. I think there has been a considerable amount of investment in new equipment, and this has allowed obviously for there to be considerable capacity, particularly in our intensive care facilities. I think that there has been an understanding as well that there needed to be additional beds created, and I know there has been some planning particularly around St Vincent's on the Park and other types of facilities that can be used, particularly to house people that might of course come from aged care. So I think that there has been sufficient planning in regard to the number of beds.

The only reservation I suppose I have is just regarding the surge workforce that has been stood up. I am not sure how much that would be able to deliver if there were further stresses on the healthcare system. As you have probably already heard, there are about 1000 healthcare workers who are actively infected at the moment, and I can think in the case of one particular hospital near the front line that that involves 150 of their workers. And of course if the numbers were to escalate, I think we could have some considerable difficulties providing sufficient staffing. So my concern is not about resourcing infrastructure; I think I could certainly give the government eight out of 10 for that. But I am more concerned about, of course, the issues that flow from just staff becoming infected and their immediate contacts having to be isolated as well. I think that is more likely than not to be the rate-limiting situation for our hospital system, not necessarily the number of beds or the amount of ventilators that we can pull out if we need them.

Mr MAAS: Thank you. Would you say there have been any differences between what we could call the first wave and this second wave in terms of the equipment that has been provided?

Assoc. Prof. RAIT: Oh yes. I think there was some difficulty sourcing some equipment during the first wave because of course that was when many other countries were also looking for such equipment. And of course we had supply chain issues with the delivery of some ventilators and other types of equipment, which then led to some very thoughtful investigation of some Australian-based manufacturing. But I think there has been an opportunity in that lull between the first and the second waves to actually reinforce some of the

equipment and some of the beds. I am not sure—I have been equally reassured, though, about the supply chains for PPE, but that is a separate issue.

Mr MAAS: I think the last time we caught up telehealth had just been introduced as a measure to treat a patient. Would you be able to give us any further updates on what your members' views might be of that?

Assoc. Prof. RAIT: Of course that has been a subject of advocacy by both the AMA and the RACGP to the federal government. We were able, of course, to get many items available for people to be able to utilise telehealth in the community, and that has obviously been a very important part of maintaining the health of the community, particularly the primary care interface.

The only thing that I think I would have to say is that notwithstanding that GPs are under some financial stress, and I think there is a case to be made for some targeted support for them, and also possibly for pharmacies who also have seen their businesses affected. So I think there is a case to be made to consider beyond just the benefits that telehealth has provided, not just to the community but also to the businesses of primary healthcare providers, and maybe during this second wave we need to consider some more targeted support to them as well, because I think compared to the first wave there have been some further impacts on those particular practices.

Mr MAAS: Would you say that it is important to retain the financial support for telehealth through Medicare?

Assoc. Prof. RAIT: Absolutely. That is an established part of AMA policy. I think what we would like to see, of course, is for that to be able to continue. It has also been very interesting, because I think it has actually made a lot of mental health consultations more accessible to people, so people have been able to access consultations with mental health care providers as well as their GPs, which has actually been a great advantage. In fact, I wonder why we did not do this much sooner, because it has really been very beneficial to many people who have been obviously in some mental distress. Perhaps in retrospect we should have done this earlier.

Mr MAAS: I think it is fair to say that the pandemic has brought forward a lot faster many ways we go about doing things in our society. Associate Professor, would you say that telehealth has played a role in helping to reduce community transmission at all?

Assoc. Prof. RAIT: Of course it has meant that people who are vulnerable have not necessarily had to attend their practitioners. So, yes, I would have to agree with that, because for many elderly people and those who have chronic health conditions of course circulating in the community can pose a considerable risk. Even in my 91-year-old mother's case we have been able to use telehealth effectively, and it has been very helpful for her.

Mr MAAS: Just finally on telehealth, what do you think the future should be for it?

Assoc. Prof. RAIT: Well, I think that we need to sort of embed it, but I think the key thing is to make sure that it is not misused. The concern we have seen is lot of these pop-up clinics that have been developed are people who have wanted to just exclusively approach the public and get remunerated for just doing online consultations alone. I think that the federal government's decision to actually make that much more aligned to a real practice of bricks and mortar who can provide physical examination support as well is important, because I think otherwise we would see much of the allocation of funds to that being whittled away through others who are perhaps trying to exploit the system.

Mr MAAS: Thank you. There has been much said about the effect on our mental health as a result of the pandemic. Would you be able to take the committee through the sorts of impacts that the pandemic has had on the mental health of your members?

Assoc. Prof. RAIT: Yes, sure. Look, I think that one of the biggest issues is just really the duration for which people have had to work with a high level of stress. We are all aware that many of us can still work for short periods of time under stress and provided we can decompress and relax and go back to normality, we can recover. But unfortunately, given the fact we have had these two waves of infection through Melbourne, many of our members have had to endure very many months of constant stress, and obviously that has led to anxiety and again to cases of depression.

We have been very active of course through various different supports, and I believe we should acknowledge we have received some additional support from the government just to further our doctors health program and make sure that we can provide particular support, including many telehealth consultations to doctors in their workplaces or easily after hours. I think this has been very important to provide that sort of counselling connection. Sadly, of course, because of the pandemic, we have a situation where we are discouraging people and doctors to interact, and I think that that has actually been a contributor to the fact that people have had further mental health issues as a result of this pandemic too.

Mr MAAS: Thank you for mentioning the Victorian Doctors Health Program. We know that that is one such initiative that has been able to provide support. Can I ask you what initiatives are most effective, in your view, in supporting the mental health of healthcare workers who are dealing with the challenges that COVID-19 presents on daily basis?

Assoc. Prof. RAIT: Well, to be quite frank, I think it is the type of leadership they have in their workplace. I mentioned in my presentation that there are some of our health leaders, some of our CEOs in our health services, who are actually behaving in a very exemplary way. They are actually communicating openly and transparently and frequently with the staff, and I think that that builds a sense of trust and that sense of trust reduces anxiety. Sadly, that is not true of every health service, but I wish it was, because I think that sort of leadership that we see in some health services is really what is actually doing a very great deal to alleviate people's stress and therefore improve their mental health. So good leadership, I think, has been a very important part of maintaining the mental health of the workplace and our workforce, and I can only obviously encourage through this group that further and more of our leaders in the healthcare sector embrace that sort of approach.

Mr MAAS: Thank you. I will take you to hospital visitor direction. As you are aware, the Victorian government has imposed restrictions on the number of visitors to public hospitals. What impact would you say that has had in helping to reduce the spread of COVID in Victoria's hospitals?

Assoc. Prof. RAIT: Well, my sister has been unwell. Not with COVID, but I have had to see her in hospital during the pandemic and have been very much aware of these restrictions. Look, I think that it is still a very important issue, and painful though it may be to families and obviously to the patients themselves, it is clear that restricting the interaction between patients and families, especially when they are vulnerable in hospitals, is very important. And obviously those measures have been very important to and I think very much well-received by our membership.

Mr MAAS: There has been some criticism about the imposition, particularly in the maternity setting. Do you believe that the restrictions that have been imposed represent an appropriate response?

Assoc. Prof. RAIT: Look, it is a very difficult one. My wife is a midwife, and I have spoken to her about this. I have also spoken to a number of the cohort—elder children, who obviously are in that sort of era of having children, and their friends and family—who were very much concerned by that particular change. But I was happy to see that there was some recalibration of that to allow more time for the partners to be in with the new mothers. I think that that change probably was appropriate and I think was well received in the end. So I think dialling that back to where it was was quite appropriate. I think our members were supportive of it.

Mr MAAS: And just finally from me in terms of hospital visitor directions: are there any circumstances that you can see that the restrictions would be eased at any point?

Assoc. Prof. RAIT: Well, I think that is a call for the Chief Health Officer. I think that we need to see the numbers of infections fall considerably, probably down to 10 or 20 a day or something like that, to really allow that, because so long as there is continuing community transmission there is the ever-present risk that that is actually going to spread into our healthcare facilities, as unfortunately we have seen in various aged-care settings. So I think until the level of community transmission is considerably reduced I would not be relenting on any of those measures at this point.

Mr MAAS: Thank you. No further questions from me. Thank you, Chair.

The CHAIR: Thank you, Mr Maas. I will hand the call to Mr O'Brien, MP.

Mr D O'BRIEN: Thank you, Chair, and good afternoon, Professor Rait. Just following on from the question Mr Maas was just asking about visitation restrictions in hospitals, has that put any additional pressure on doctors? I am sure it has on hospital staff generally, but what sort of feedback have you had? Because obviously I am sure all members of Parliament have had the complaints from distressed relatives. How has that affected doctors?

Assoc. Prof. RAIT: Well, obviously on an individual basis there have been examples where our members have had to deal with families who are very distressed about that, and of course that has added to their anxiety and concern. But equally I think that they have also reconciled that with the fact that it is an important public health measure. So on the one hand I think they obviously feel great empathy for the families concerned, and on the other they understand entirely the public health rationale for what has been done. It is never easy to get this balance right, but I think there has been confidence by and large that the measures are appropriate to protect the community more generally and to reduce the propensity for community transmission to spread into healthcare settings.

Mr D O'BRIEN: Following on from that and again the commentary earlier about mental health impacts on doctors—just the stress of having to deal with this situation onwards—are you aware of whether we have actually lost any doctors to service as a result of having to take stress or mental health leave?

Assoc. Prof. RAIT: Yes, quite a number. I could probably think of three or four of my immediate colleagues in that category, and also I am aware particularly of those who are actually providing mental health care who have actually also been very stressed by this. Because, you know, they have had to deal with a lot of distress and mental anguish amongst the profession, and they have been, I think, also affected by that and have suffered some fallout from it as well. So I particularly worry about those of our members who are actually having to deal more and more with the mental health problems, because I think they in turn run risks themselves of having to take time out.

Mr D O'BRIEN: And its snowballs too, of course. If you take more out, it puts more pressure on the rest, which leads me to my next question. You mentioned there are about 1000 healthcare workers affected—I think it might actually be more than that—including 150 at one hospital. Do you have any idea of the numbers statewide of doctors that have been taken out of service because they have tested positive or are otherwise under isolation?

Assoc. Prof. RAIT: I think it is probably—the majority of the healthcare workers who are affected I believe are nurses and particularly those involved in aged care, but I would suggest probably about 20 per cent of the total number are medical practitioners. That would be my estimate.

Mr D O'BRIEN: And following on from that, you talked about surge capacity and the availability of doctors as well as nurses and aged-care support and the like. How thin is the line? How close do we get to a point where the optimum number of doctors is no longer available to us?

Assoc. Prof. RAIT: Well, I think I am on the public record about two or three weeks ago where I was very concerned about a number of hospitals that had to go on bypass over one weekend. And that was because they had quite a number of people who were infected or isolated because they were close contacts, but I believe there actually were very quickly some measures taken to provide more staff and to work with the hospitals to improve the rostering. So although it did provide some initial stress and anxiety to my members, I think that very quickly it was corrected.

Mr D O'BRIEN: Are you aware whether—I know we are bringing in nursing staff from interstate. Have we had to bring in doctors from interstate and are we at the point anytime soon that that will need to occur, if not?

Assoc. Prof. RAIT: Well, look, there are some doctors who have been deployed by AUSMAT, which is the national disaster teams which are involved in aged care. So there have been, as I understand, some of those doctors deployed to assist with the aged-care crisis, and also we have stood up a few of what are called the FEMOs, the field emergency medical officers, who are mainly state based and who have also provided assistance. Of course they have also been involved in screening passengers returning sometimes on overseas flights from hot areas of the world, and also they have been involved sometimes in providing assistance to the primary carers who have been involved in some of the quarantine hotels. So there are some I suppose ancillary staff who are involved, some of whom have come from interstate.

Mr D O'BRIEN: There has been some concern, of course, about the consistency of messaging coming from government on some of the restrictions. Do you have any concerns about that, particularly in relation to things like the Black Lives Matter protest and the impact that had on community behaviour?

Assoc. Prof. RAIT: Yes. Look, again, I mean it is hard to know exactly how many cases arose from the Black Lives Matter situation. I was on the public record earlier for being very firmly against the Formula One Grand Prix because I could see that that was a large public gathering that could put Victoria and Melbourne in particular at risk, and I believe that the Black Lives Matter protest, notwithstanding it was a just and admirable cause, would have potentially accelerated the pandemic. We know that there were a number of cases that perhaps were seeded from that particular protest into the towers in Flemington and Kensington and North Melbourne. So it certainly contributed to some degree, but I think the greater problem at that point, as I remarked at the time, was that it actually gave a very I suppose inappropriate signal to the rest of the community about almost like permission to sort of go out and gather in large numbers, and I think that that was more than likely the more significant impact of it—that it actually gave or provided the wrong signal. So notwithstanding I endorse people's rights to protest normally and I would certainly have sympathy with the views of the protesters on this issue, I just thought it was a very irresponsible thing to do. In fact our Australian Indigenous Doctors' Association spoke out against it, as they did with the protests in Sydney recently. So the medical advice was very clearly not to go and not to participate, because of the risks.

Mr D O'BRIEN: And that of course applies to any protests, including the planned one that turned out to be a complete fizzer on the weekend, where police actually arrested the organisers beforehand, I understand. But have you been concerned about the general level of consistency and how that has applied to health in terms of the communications from the government, whether it is restrictions or mask wearing and the like?

Assoc. Prof. RAIT: Well, look, I think the mask wearing is a tricky one because I think the guidance changed. So therefore for many months no-one was particularly sure about the role of masks in the community and therefore it was discouraged. I suppose in the context of there being minimal community transmission, that was quite reasonable. When the guidance did change, which was in July based on some new evidence that I think arose in the *Lancet* early in June and changed guidance by the WHO, then of course it was a different situation. It was well timed given that we obviously had emerging community transmission. So in some ways, yes, the messages were mixed, but in others it is to some degree unavoidable because of the changing understanding about the virus and also the changing knowledge base that we have as the pandemic progresses. Things that we knew six months ago sometimes are no longer the case. Equally, things that we did not know six months ago are now readily apparent. So that can create some difficulties trying to get consistent messages over time. But I certainly think that particularly around the protest it was very much a mixed message the public had about whether it was right to go out and mingle.

Mr D O'BRIEN: Thank you. I think my time is nearly up, but very quickly, you mentioned concerns about the transparency of distribution of PPE. Has that got any better or is there still work to do?

The CHAIR: Sorry to interrupt you there, Associate Professor Rait, but the member's time has expired. I will pass the call to Mr Sam Hibbins, MP.

Mr HIBBINS: Thank you, Chair, and thank you for appearing today. I want to pick up on the issue of protections for healthcare workers, particularly in our public hospitals. In your view, are the PPE and the infection control procedures that are currently provided and currently in place in public hospitals adequate, and if not, what improvements would you like to see?

Assoc. Prof. RAIT: Well, I would like to acknowledge, as I mentioned earlier, that some are doing a very good job. Some hospital networks are doing a great job. This is the problem about our devolved governance structure. But others are, shall we say, well behind. I just have an example here if I could share it, Chair. This is a headline that was in *Australian Doctor* a short time ago from an ENT surgeon, a member of ours, saying that he cannot get N95s in one particular hospital where he works. He admits he can get them in another, but in one hospital he cannot get them at all, which is, I think, very seriously concerning because ENT surgeons in particular are at very high risk of being infected by aerosolised procedures. In fact there have been whole operating theatres where ENT procedures have been performed where people have been infected because of the aerosols generated by those types of operations. So it distresses me considerably to hear that we still have inconsistency; that there is, shall we say, an A class of hospital CEOs and managers who are doing a fantastic

job basically reassuring their staff that they are doing whatever it takes to support them and there are others who are not perhaps as interested in building trust. Unfortunately we have a situation sometimes in some hospitals where they are not as responsive and not as cognisant of their obligations in an occupational health and safety sense to provide all that is required.

Mr HIBBINS: Earlier today I put to the minister the suggestion that all clinical staff in public hospitals who are dealing face-to-face with patients should have access to an N95 mask. The minister indicated that at the moment the recommendations are for those in high-risk areas to have N95 masks. Where do you think the line should be drawn? Should all staff have access to them?

Assoc. Prof. RAIT: I think they should. I have another article here, and it basically quotes some research from Switzerland that shows that it is very hard to predict who the superspreaders are, but we do know that the superspreaders are really the ones that are driving a lot of the outbreaks. Now, the superspreaders are those that produce aerosols, basically in their speech or their singing or their shouting or just their exhalation from exercising. It is extraordinarily hard to predict who these bugs are. So we have to kind of look back, I think, in time to what we had in the HIV/AIDS era when we had universal precautions, because I think it is coming to that. I suppose the guidance has been updated in Victoria, and I am very grateful—as many of our members are—that on 30 or 31 July an N95 and a face shield became the standard for people that were dealing with suspected or confirmed COVID cases.

Maybe it could have happened about a month earlier based on the evidence, but at least it arrived at that point. But I think we are going to actually understand that super spreading and the production of aerosols by some people is significant, and it may be that you are absolutely right, Sam, that we need to make sure that all healthcare workers are adequately protected, and that probably means an N95 and a face shield.

Mr HIBBINS: I want to go now to the release of information in regard to healthcare worker infections. What information would you like to be seeing the government share, and why?

Assoc. Prof. RAIT: I think that we do not see sufficient information about the actual circumstances of healthcare worker infections. We have been asking for some time, and it has been promised, that we would be provided with a breakdown of the infections, particularly where they were thought to have been acquired. Sometimes this requires genomics. As I understand it some of the outbreaks, such as those down at the Alfred around their oncology ward, have been investigated in that regard, but that information has not been shared with us—exactly what the nature and source of the infections were and whether they all emanated from one infected patient or not.

It is true that of course it spreads between healthcare workers, sometimes in tearooms and other places where perhaps people are less conscious of the need to maintain distancing and masking. But nevertheless, we are also aware of many cases, including some junior staff who have been involved in screening clinics and so on, where it is absolutely clear that they caught the infection unfortunately through their work and have become very sick as a result. Clearly we would like to have more information about that because it would then inform us how we could take greater precautions, including, it might mean, as you suggest, N95s for all.

Mr HIBBINS: Thank you. I want to ask you to expand on your point about the devolved nature of Victoria's healthcare system. Obviously with federal taking aged care, we have got primary care, we have got the state's responsibility for hospitals—

The CHAIR: I am sorry to cut the member off there, but his time has expired. The time for questions has expired on this occasion. If this discussion here today has raised any issues for anyone the number for Lifeline is 13 11 14 and the number for Beyond Blue is 1300 224 636.

Associate Professor Rait, we thank you very much for appearing before the committee again today. The committee will follow up on any questions that you took on notice in writing, and responses will be required within five working days of the committee's request. The committee will now take a very short break before the resumption of the consideration of the next witness.

Assoc. Prof. RAIT: Thank you, Chair.

Witness withdrew.