



Interim Report: Inquiry into the Queensland Government's health response to COVID-19

Report No. 43, 56th Parliament
Health, Communities, Disability Services and
Domestic and Family Violence Prevention Committee
September 2020

Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee

Chair	Mr Aaron Harper MP, Member for Thuringowa
Deputy Chair	Mr Mark McArdle MP, Member for Caloundra
Members	Mr Michael Berkman MP, Member for Maiwar
	Mr Martin Hunt MP, Member for Nicklin
	Mr Barry O'Rourke MP, Member for Rockhampton
	Ms Joan Pease MP, Member for Lytton

Committee Secretariat

Telephone	+61 7 3553 6626
Fax	+61 7 3553 6699
Email	health@parliament.qld.gov.au
Committee Web Page	www.parliament.qld.gov.au/Health

Acknowledgements

The committee acknowledges the inquiry assistance provided by departments and agencies of the Queensland Government and by the Queensland Parliamentary Library and Research Service, together with the contributions of the various organisations and other stakeholders who submitted or provided evidence to the committee's inquiry.

Contents

Abbreviations	iii
Chair's foreword	vi
Recommendations	viii
1 Introduction	1
1.1 Role of the committee	1
1.2 Inquiry referral	1
1.3 Inquiry process	2
1.4 Interim report	2
2 Novel coronavirus with pandemic potential	3
2.1 Identification and emergence of COVID-19	3
2.1.1 Symptoms and spread of COVID-19	4
2.1.2 Initial modelling of COVID-19	6
2.2 Preparedness planning: Protecting public health in an infectious disease pandemic	7
2.2.1 Transparency, public engagement and communication	7
2.2.2 Social distancing measures	7
2.2.3 International travel and border control	8
2.2.4 Isolation and quarantine measures	8
2.2.5 Balancing rights and interests	9
2.3 Impacts of COVID-19	9
2.3.1 Mental health: Depression and anxiety	9
2.3.2 Social isolation and domestic and family violence	11
3 Legislative and governance frameworks for managing COVID-19	13
3.1 Division of responsibilities: strategic governance	13
3.1.1 National partnership on COVID-19 emergency health response	13
3.2 Commonwealth legislation	14
3.2.1 <i>Biosecurity Act 2015</i> (Cth)	14
3.2.2 Human biosecurity emergency powers	15
3.3 Queensland legislation	15
3.3.1 <i>Public Health Act 2005</i> (Qld)	16
3.3.2 Public health emergency powers	17
3.4 Australian Government decisions and the Queensland Government's health response	18
3.4.1 <i>Public Health and Other Legislation (Public Health Emergency) Amendment Act 2020</i> (Qld)	18
4 The Queensland Government's health response to COVID-19	20
4.1 Leadership and coordination across the Queensland Government	20
4.1.1 Role of the Queensland Ambulance Service	21
4.1.2 Role of the Queensland Police Service	22
4.1.3 Role of the Department of Communities, Disability Services and Seniors	22
4.2 Pandemic planning	23

4.3	Governance and coordination	24
4.4	Engagement with stakeholders	24
4.4.1	Stakeholder views on governance and coordination	25
4.4.2	Stakeholder views on engagement in pandemic planning	27
4.5	Hospital and health services’: Preparedness and response	29
4.6	Intensive care unit capacity and ventilators	30
4.6.1	Stakeholder views on HHSs preparedness and response	31
4.7	COVID-19 testing and tracing	34
4.7.1	Stakeholder views on COVID-19 testing and contact tracing	35
5	Public Health Directions	39
5.1	Public messaging and interpretation of Public Health Directions	39
5.2	Operation of Public Health Directions	43
5.3	Public Health Directions and human rights	44
5.3.1	Impacts on people with disability	44
5.3.2	Impacts on people living in closed environments	45
5.3.3	Impacts on Aboriginal and Torres Strait Islander people	46
5.3.4	Impacts on older Queenslanders	47
5.3.5	Impacts on people in mandatory quarantine	47
6	Ensuring continuity of care across the health sector	50
6.1	Personal Protective Equipment (PPE)	50
6.1.1	Stakeholder views on levels and access to Personal Protective Equipment	51
6.2	Telehealth	55
6.2.1	Stakeholder views on telehealth and continuity of medical care	56
6.3	Emergency dispensing and digital prescriptions	58
7	Continuing to protect Queenslanders	61
7.1	Looking forward	61
7.1.1	Vaccine development and distribution in Queensland	62
7.1.2	Further easing of restrictions	65
7.2	Remaining vigilant	68
	Appendix A – Submitters	69
	Appendix B – Officials at public departmental briefings	71
	Appendix C – Witnesses at public hearings	72
	Appendix D – Division of government responsibilities for public health emergency	74
	Appendix E - Diagram submitted by Queensland Health outlining its pandemic health response leadership team	79
	Statements of Reservation	80

Abbreviations

AASW	Australian Association of Social Workers
ACSA	Aged and Community Services Australia
ADF	Australian Defence Force
AHMAC	Australian Health Ministers' Advisory Council
AHMPPPI	Australian Health Management Plan for Pandemic Influenza
AHPPC	Australian Health Protection Principal Committee
AMAQ	Australian Medical Association Queensland
ATSICCHOs	Aboriginal and Torres Strait Islander Community Controlled Health Organisations
Biosecurity Act	<i>Biosecurity Act 2015 (Cth)</i>
CALD	culturally and linguistically diverse
CDNA	Communicable Diseases Network Australia
CEO	Chief Executive Officer
CHO	Chief Health Officer
COAG	Council of Australian Governments
COTA	Council on the Ageing
COVID-19 Response Plan	the Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)
CRC	Cairns Regional Council
DAF	Department of Agriculture and Fisheries
DCDSS	Department of Communities, Disability Services and Seniors
DFV	domestic and family violence
DPC	Department of the Premier and Cabinet
DSA	<i>Disability Services Act 2006 (Qld)</i>
ESSA	Exercise and Sports Science Australia
HHSs	hospital and health services

HRA	<i>Human Rights Act 2019 (Qld)</i>
ICU	intensive care unit
IHR	International Health Regulations (2005)
LHD	listed human disease
LSA	<i>Legislative Standards Act 1992 (Qld)</i>
LFA	Lung Foundation Australia
MERS	Middle East Respiratory Syndrome
National CD Plan	<i>Emergency Response Plan for Communicable Disease Incidents of National Significance: National Arrangements</i>
NDIS	National Disability Insurance Scheme
NSW	New South Wales
NMS	National Medical Stockpile
PCQ	Palliative Care Queensland
PGAQ	Pharmacy Guild of Australia Queensland Branch
PHDs	Public Health Directions
PHNs	Primary Health Networks
PoCT	Point of Care Testing
PPE	personal protective equipment
Public Health Act	<i>Public Health Act 2005 (Qld)</i>
PSA	Pharmaceutical Society of Australia
QAIHC	Queensland Aboriginal and Islander Health Council
QAMH	Queensland Alliance for Mental Health
QAS	Queensland Ambulance Service
QCCL	Queensland Council for Civil Liberties
QDMCC	Queensland Disaster Management Cabinet Committee
QDN	Queenslanders with Disability Network
QH	Queensland Health

QHRC	Queensland Human Rights Commission
QIMR BMRI	QIMR Berghofer Medical Research Institute
QLS	Queensland Law Society
QMHC	Queensland Mental Health Commission
QNMU	Queensland Nurses and Midwives' Union
QPHNs	Queensland Primary Health Networks
QPS	Queensland Police Service
RACFs	residential aged care facilities
RACGP	Royal Australian College of General Practitioners
RANZCP	Royal Australian and New Zealand College of Psychiatrists
SARS	Severe Acute Respiratory Syndrome
SDCC	State Disaster Coordination Centre
SICCN	Statewide Intensive Care Clinical Network
SHECC	State Health Emergency Coordination Centre
SPOC	State Police Operations Centre
SUQ	Shooters Union Queensland
TGA	Therapeutic Goods Administration
UQ	University of Queensland
VIC	Victoria
WHO	World Health Organization
WHQ	Women's Health Queensland

In this report the terms 'Australian Government' and 'Commonwealth Government' have been used interchangeably.

Chair's foreword

This report presents the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's interim findings and recommendations from its inquiry into the Queensland Government's health response to COVID-19.

A number of issues were raised in the submissions and other evidence presented to our inquiry, and these warrant careful consideration once the public health emergency has passed. The emergency period is not likely to cease until well after the end of the 56th Parliament.

Not since the Spanish Flu pandemic in 1919 has Queensland and the rest of Australia faced the kinds of health, social and economic challenges that COVID-19 presents.

COVID-19 is an insidious virus that can be fatal. It spreads extremely easily and rapidly, sometimes with no symptoms. It continues to threaten the health and wellbeing of every Queenslanders. Responding to this public health emergency has required swift and decisive actions by the Queensland Government to implement public health measures that limit people's movement to prevent the spread of the disease.

As happened over a hundred years ago with the Spanish Flu, the COVID-19 pandemic has necessitated tough border entry restrictions, quarantine measures and mandatory isolation for those suspected of carrying the virus. On the expert health advice of Queensland's Chief Health Officer, Dr Jeannette Young PSM, restrictions on businesses and changes to how we socialise were also implemented. I commend Dr Jeannette Young, for her central role in the management of COVID-19 in Queensland.

There can be no doubt that the decisions by the Queensland Government to act early and decisively to declare a public health emergency and to close our borders have put Queensland in an enviable position compared to other states and territories.

Managing a public health emergency must be done properly and thoroughly with a suite of measures, as highlighted by the World Health Organization in its guidelines for pandemic management.

I personally commend the Queensland Government for ignoring the 64 calls from the Opposition this year for the state's borders to be opened. After chairing this inquiry and hearing from expert witnesses who agreed with the early steps taken by the government, I cannot begin to imagine the disastrous situation Queensland would be in today had borders not been closed.

I acknowledge the many sacrifices made by Queenslanders in the effort to protect public health. Importantly, I thank every frontline worker across the government's health response who has risked their own health and safety to serve and protect others. This includes the nurses and support workers at COVID-19 fever clinics and the doctors, nurses and other care workers providing medical care for COVID-19 positive patients.

Every one of us in our great state has a personal responsibility to do the right thing, with social distancing, keeping up with good hand hygiene practices and, if sick, staying home and getting tested for COVID-19. Queensland's strong position now is a result of the continued and collective effort of all Queenslanders.

I note that the LNP members of the committee have raised concerns in their Statement of Reservation about the role of the Chief Health Officer in issuing Public Health Directions to protect Queenslanders during the COVID-19 pandemic. Interestingly, the LNP Opposition voted with Government members in the Legislative Assembly on 18 March 2020 to pass the Public Health and Other Legislation (Public Health Emergency) Amendment Bill 2020. That Bill had a direct bearing on the capacity of the Chief Health Officer to issue Public Health Directions.

As stated in the explanatory notes, the Bill amended the *Public Health Act 2005* to:

... strengthen powers of the chief health officer and emergency officers appointed under the Act for the COVID-19 emergency to implement social distancing measures, including regulating mass gatherings, isolating or quarantining people suspected or known to have been exposed to COVID-19 and protecting vulnerable populations such as the elderly.

Only the Chief Health Officer can issue Public Health Directions. It is not a function that the Premier or any other Minister of the Government can fulfil under the legislation supported by the Opposition. The LNP members of the committee should be well aware of this.

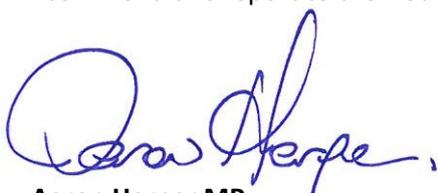
I also note that the Member for Maiwar has used his Statement of Reservations to make quite serious allegations about written advice provided to the committee by the Queensland Police Service. This advice was provided in response to a question the member asked at the committee's public hearing on 19 August 2020. Such allegations have the potential to reflect adversely on the Member and the Queensland Police Service, and deserve to be properly and thoroughly investigated. There is a very clear process in the Parliament's Standing Orders for committees to deal with such matters affecting their proceedings when they arise. Unfortunately, as the Member acknowledges in his statement, he has not as yet raised these allegations with the committee as is required under the Standing Orders.

This global pandemic has seen over 29 million people infected around the world, and over 926,000 COVID-19 deaths. We cannot become complacent, but we ought to be entirely optimistic with the excellent scientific and clinical research being undertaken in Queensland by leading universities and other clinical research bodies to develop a vaccine for COVID-19.

I would like to acknowledge the hard work of committee members on this inquiry. The committee's work reflected in this interim report will assist further scrutiny of the Queensland Government's COVID-19 health response next parliament.

Finally, on behalf of the committee, I thank those individuals and organisations who made written submissions and gave evidence at our briefings and hearings for the inquiry. I also thank our Parliamentary Service staff and staff of the Department of the Premier and Cabinet, Queensland Health and the Queensland Police Service for their assistance.

I commend this report to the House.



Aaron Harper MP

Chair

Recommendations

Recommendation 1 **38**

That the Queensland Government formally acknowledges frontline workers in Queensland Health and other agencies across the government for their contributions to the government's health response to COVID-19.

Minister responsible: Premier and Minister for Trade

Recommendation 2 **38**

That Queensland Health continues to engage with stakeholders to provide information about future Public Health Directions and other changes to government policy related to the COVID-19 health response.

Minister responsible: Deputy Premier and Minister for Health and Minister for Ambulance Services

Recommendation 3 **49**

That Queensland Health ensures its public health messaging platforms are diversified and developed to ensure cohorts of Queenslanders with complex health issues, or increased vulnerability to COVID-19, receive tailored advice to suit their information needs and addresses how they can stay safe during the pandemic.

Minister responsible: Deputy Premier and Minister for Health and Minister for Ambulance Services

Recommendation 4 **55**

That the Australian Government better supports and empowers its Primary Health Networks to access personal protective equipment supplies from the National Medical Stockpile to distribute emergency stock to general practitioners, residential aged care facilities and allied health workers as required in the event of an outbreak.

Minister responsible: The Australian Minister for Health

Recommendation 5 **58**

That the Premier seeks support through the National Cabinet for the Australian Government to provide ongoing funding through the provision of permanent Medicare item numbers to support the extension and availability of telehealth services in Australia beyond 30 September 2020.

Minister responsible: Premier and Minister for Trade

Recommendation 6 **60**

That the Premier seeks support through the National Cabinet for the Australian Government to make permanent the temporary changes to prescribing contained in the Australian Government's National Health (COVID-19 Supply of Pharmaceutical Benefits) Special Arrangement 2020 to allow emergency dispensing arrangements and dispensing based on digital images of prescriptions.

Minister responsible: Premier and Minister for Trade

1 Introduction

1.1 Role of the committee

The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (committee) is a portfolio committee of the Legislative Assembly which commenced on 15 February 2018 under the *Parliament of Queensland Act 2001* and the Standing Rules and Orders of the Legislative Assembly.¹

The committee's primary areas of responsibility include:

- Health and Ambulance Services
- Communities, Women, Youth and Child Safety
- Domestic and Family Violence Prevention
- Disability Services and Seniors.

The functions of a portfolio committee include dealing with an issue referred to it by the Assembly or under another Act, whether or not the issue is within its portfolio area.²

1.2 Inquiry referral

On 22 April 2020, the Legislative Assembly agreed to a motion referring to the committee an inquiry with the following terms of reference:

1. *That the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee inquire into and report to the Legislative Assembly on the Queensland Government's Response to COVID-19 in relation to the health response only;*
2. *That in undertaking the inquiry, the Committee should take into account the Australian Government's health response to COVID-19 and its impacts on the Queensland Government's response;*
3. *That in conducting the inquiry the Committee is to be conscious of any requests for witnesses or materials and ensure that any requests do not unreasonably divert resources from the immediate COVID-19 response; and*
4. *That the Committee report to the Legislative Assembly by no later than 3 months after the conclusion of the Public Health Emergency declared under the Public Health Act 2005 regarding COVID-19.*³

At the time the committee finalised this interim report, the declared public health emergency for COVID-19 in Queensland was due to expire at 11.59pm on 2 October 2020.⁴ If the public health emergency is not further extended, the committee's deadline for reporting to the Legislative Assembly on its inquiry is 2 January 2021, after the dissolution of the 56th Parliament of Queensland.

¹ *Parliament of Queensland Act 2001*, section 88 and Standing Order 194.

² *Parliament of Queensland Act 2001*, section 92.

³ Queensland Parliament, Record of Proceedings, 22 April 2020, pp 738-740.

⁴ As per the Public Health (Further Extension of Declared Public Health Emergency - COVID-19) Regulation (No. 4) 2020, notified on 14 August 2020, which extended the concluding date of the declared public health emergency from 17 August 2020 to 2 October 2020.

1.3 Inquiry process

The committee called for written submissions on 18 May 2020, notifying stakeholders of the closing date of 3 July 2020.

The call for submissions was publicised via: the Parliament's social media accounts (Facebook, Instagram, LinkedIn and Twitter); emails to 1,042 stakeholders identified by the secretariat; and over 4,000 groups and individuals who subscribe to the committee's email update service. Forty-nine written submissions were accepted by the committee. A list of submissions is provided at **Appendix A**.

Given that the COVID-19 pandemic was still unfolding in Queensland and across Australia at the time the committee called for submissions, the issues raised may not reflect all of the issues related to the Queensland Government's health response to the pandemic.

On 16 June 2020 the Department of the Premier and Cabinet (DPC) provided the committee with a written brief focusing on the impact of the Australian Government's health response to COVID-19 on Queensland's health response to COVID-19. Queensland Health (QH), provided a written brief as the lead agency for Queensland's health response on 17 June 2020. The committee published both written briefs on the inquiry webpage.

The committee received a series of public oral briefings by Queensland Government agencies for the inquiry. These briefings were broadcast live on Parliament TV. On 23 June 2020, the committee received a public briefing from QH. A second public briefing took place with QH on 3 July 2020 with officials from the DPC and the Queensland Mental Health Commission (QMHC) also appearing before the committee. A list of officials who attended briefings is provided at **Appendix B**.

The committee conducted public hearings in Brisbane on 13 July and 19 August 2020. The 19 August 2020 hearing included officials from QH, the Office of the Health Ombudsman, Queensland Police Service (QPS) and the Queensland Human Rights Commission (QHRC). A list of witnesses who appeared at these hearings is provided at **Appendix C**.

Correspondence for the inquiry, transcripts of briefings and hearings, written briefs, tabled documents, written clarifications and responses to questions taken on notice provided by briefing officers and witnesses are available on the committee's webpage.

1.4 Interim report

This report to the 56th Legislative Assembly provides the committee's interim findings and recommendations for the inquiry focusing on the key issues raised by submitters and stakeholders appearing before the committee.

2 Novel coronavirus with pandemic potential

This section provides an overview of the events leading to the declaration of a public health emergency both nationally and in Queensland in response to the threat posed by a novel coronavirus – COVID-19. Further, this section outlines: current understanding of the symptom and transmission of COVID-19; initial modelling and best practice pandemic management of a contagious disease outbreak; and, the impacts of COVID-19 on mental health and physical and social wellbeing.

Coronaviruses are, 'a large family of viruses that cause respiratory infections. These can range from the common cold to more serious diseases'.⁵ Human coronaviruses were first identified in the mid-1960s.⁶ As coronaviruses have been present for many years, humans have built up a general immunity to them.⁷ However, more recently novel coronaviruses have emerged from animal reservoirs, 'causing serious and widespread illness and death'.⁸ In these cases, the disease can be more severe because the human body has no immunity to it.⁹

Diseases that spread from animals to humans are called zoonotic diseases.¹⁰ Both Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS) are examples of zoonotic diseases to emerge in recent years.¹¹ The cause of the SARS outbreak in 2002 was closely related to other coronaviruses isolated from bats, while MERS was identified in 2012, and transmission via dromedary camels, continues to cause sporadic outbreaks.¹²

2.1 Identification and emergence of COVID-19

In late December 2019, the World Health Organization (WHO) reported a cluster of cases of pneumonia in Wuhan, Hubei Province, China. This eventually led to the identification of a novel coronavirus believed to have a zoonotic source.¹³ The full genetic sequence of SARS-CoV-2 (COVID-19)¹⁴ from the early human cases and the sequences of many other virus isolated from human cases from China and internationally since then, show that COVID-19 has an ecological origin in bat populations.¹⁵

⁵ Australian Government, Department of Health, 'What you need to know about coronavirus (COVID-19)', <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/what-you-need-to-know-about-coronavirus-covid-19>.

⁶ Centers for Disease Control and Prevention (CDCP), 'Human Coronavirus Types', <https://www.cdc.gov/coronavirus/types.html>.

⁷ Healthdirect, 'About coronaviruses', <https://www.healthdirect.gov.au/about-coronaviruses>.

⁸ National Institute of Allergy and Infectious Disease, 'Coronaviruses', <https://www.niaid.nih.gov/diseases-conditions/coronaviruses>.

⁹ Healthdirect, 'About coronaviruses', <https://www.healthdirect.gov.au/about-coronaviruses>.

¹⁰ CDCP, 'Zoonotic Disease', <https://www.cdc.gov/onehealth/basics/zoonotic-diseases.html>.

¹¹ Healthdirect, 'About coronaviruses'; CDCP, 'Human Coronavirus Types'; Australian Government, Department of Health, 'What you need to know about coronavirus (COVID-19)'.

¹² WHO, *Coronavirus disease 2019 (COVID-19) Situation Report – 94*, p 2, <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200423-sitrep-94-covid-19.pdf>; NIAID, 'Coronaviruses'.

¹³ World Health Organization (WHO), 'Archived: WHO Timeline – COVID-19', <https://www.who.int/news-room/detail/27-04-2020-who-timeline---covid-19>.

¹⁴ The WHO's International Committee on Taxonomy of Viruses originally named the virus 'SARS-CoV-2' due to the genetic similarity of the virus with the coronavirus responsible for the SARS outbreak of 2003. To avoid confusion, the WHO announced on 11 February 2020 the name for the new disease would be 'COVID-19'.

¹⁵ WHO, *Coronavirus disease 2019 (COVID-19) Situation Report – 94*, p 2.

While some of the earliest known cases had a link to a wholesale seafood market in Wuhan, some did not. Many of the initial patients were either stall owners, market employees, or regular visitors to this market. Environmental samples taken from this market in December 2019 tested positive for COVID-19, further suggesting that the market in Wuhan City was the source of this outbreak, or played a role in the initial amplification of the outbreak. The market was closed on 1 January 2020.¹⁶

By 10 January 2020 the WHO had published technical guidance on its website providing advice to all countries on how to detect, test and manage potential cases based on available evidence. On 13 January 2020, WHO officials confirmed a case of COVID-19 in Thailand – the first recorded case outside of China.¹⁷

On 21 January 2020, the Australian Government added 'human coronavirus with pandemic potential' to the Biosecurity (Listed Human Diseases) Determination 2016 as a listed human disease.

On 29 January 2020, under section 319 of the *Public Health Act 2005* (Qld) (Public Health Act), Hon Dr Steven Miles MP, Deputy Premier and Minister for Health and Minister for Ambulance Services, declared a public health emergency in Queensland due to the outbreak of COVID-19 in China, its pandemic potential due to cases spreading to other countries, and the public health implications in Queensland resulting from recently arrived travellers from the epicentre of the outbreak.¹⁸

The COVID-19 emergency was declared for all of Queensland. A copy of the public health emergency order was published in the Queensland Government Gazette on 31 January 2020. The COVID-19 emergency has been extended by regulation on three occasions, most recently the end date was extended from 17 August 2020 to 2 October 2020, and may be further extended.¹⁹

2.1.1 Symptoms and spread of COVID-19

In Australia, current evidence suggests that symptoms of COVID-19 range from mild illness to pneumonia. According to the Australian Department of Health, people with coronavirus may experience symptoms such as:

- *fever*
- *respiratory symptoms*
- *coughing*
- *sore throat*
- *shortness of breath.*²⁰

Other symptoms identified include a runny nose, headache, muscle or joint pains, nausea, diarrhoea, vomiting, loss of sense of smell, altered sense of taste, loss of appetite and fatigue.²¹ Under QH's *Public*

¹⁶ WHO, *Coronavirus disease 2019 (COVID-19) Situation Report – 94*, p 2.

¹⁷ WHO, 'Archived: WHO Timeline – COVID-19'.

¹⁸ COVID-19 Emergency Response Bill 2020, explanatory notes, p 1.

¹⁹ Public Health and Other Legislation (PHOL) (Public Health Emergency) Amendment Bill 2020, explanatory notes, p 1; Queensland Government, Queensland Health, 'Chief Health Officer public health directions', <https://www.health.qld.gov.au/system-governance/legislation/cho-public-health-directions-under-expanded-public-health-act-powers>.

²⁰ Australian Department of Health, 'What you need to know about coronavirus (COVID-19)', <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/what-you-need-to-know-about-coronavirus-covid-19#what-is-covid19>.

²¹ Australian Department of Health, 'What you need to know about coronavirus (COVID-19)', <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/what-you-need-to-know-about-coronavirus-covid-19#what-is-covid19>.

Health Alert No. 17 (4 August 2020), anyone with these symptoms, no matter how mild, should be tested.²² Some people infected with the virus may remain asymptomatic.

Important to the management of an infectious disease is how it transmits. Current understanding of COVID-19 suggests that it can spread from person to person in the following ways:

- *close contact with an infectious person (including in the 48 hours before they had symptoms)*
- *contact with droplets from an infected person's cough or sneeze*
- *touching objects or surfaces (like doorknobs or tables) that have droplets from an infected person, and then touching your mouth or face.*²³

COVID-19 is a new disease to which there is no existing immunity in the community. This allows the virus to spread widely and quickly. Some cohorts in the community are at greater risk of getting the virus, or at a greater risk of becoming seriously ill if they contract it. The Australian Department of Health has identified the following people as most at risk of getting the virus:

- *travellers who have recently been overseas*
- *those who have been in close contact with someone who has been diagnosed with COVID-19*
- *people in correctional and detention facilities*
- *people in group residential settings.*²⁴

The following people are likely to be at higher risk of serious illness if they contract COVID-19:

- *Aboriginal and Torres Strait Islander people 50 years and older with one or more chronic medical conditions*
- *people 65 years and older with chronic medical conditions*
- *people 70 years and older*
- *people with chronic conditions or compromised immune systems*
- *people in aged care facilities*
- *people with a disability.*²⁵

²² Queensland Health, 'COVID-19 Public Health Alert (No. 17), 4 August 2020', https://www.health.qld.gov.au/_data/assets/pdf_file/0039/997293/covid-19-health-alert-17.pdf.

²³ Australian Department of Health, "What you need to know about coronavirus (COVID-19)", <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/what-you-need-to-know-about-coronavirus-covid-19#what-is-covid19>.

²⁴ Australian Department of Health, "What you need to know about coronavirus (COVID-19)", <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/what-you-need-to-know-about-coronavirus-covid-19#what-is-covid19>.

²⁵ Australian Department of Health, "What you need to know about coronavirus (COVID-19)", <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/what-you-need-to-know-about-coronavirus-covid-19#what-is-covid19>.

2.1.2 Initial modelling of COVID-19

At the committee's first public briefing, Dr Jeanette Young, Deputy Director-General of QH and Queensland's Chief Health Officer (CHO), explained the context of early modelling based on evidence coming out of China. That modelling has since been released by the Doherty Institute.²⁶ Dr Young stated:

We started our planning based on around 20 per cent of our population, or one million Queenslanders, contracting the virus in the first wave, which we thought would last around six months. We estimated, again based on the information out of China, that 80 per cent would get mild disease, not requiring hospital treatment; 20 per cent would need to be hospitalised, so 200,000 people across the six months; and five per cent, or 50,000 people, would need intensive care and probably ventilation. Estimates of deaths were very unsure at that time. They varied from around one per cent, or 10,000 Queenslanders, up to three per cent, or 30,000 Queenslanders.²⁷

Dr Young further advised this modelling suggested that '12,500 Queenslanders would die in the first wave of the pandemic'²⁸ and, based on this data, QH formed the view that:

... the first wave would really start to escalate in late April, peak around two to three months later and gradually reduce. The Queensland government allocated an additional \$1.2 billion over the 2019-20 and 2020-21 financial years to support the health system to cope with that expected wave. Without that support we would have been overwhelmed and we would have seen the outcomes that we are still seeing today across the world in countries that were not able to prepare.²⁹

QH explained to the committee that to further estimate the scale of the health response which could be required:

Using Commonwealth modelling and partnering with the Commonwealth Scientific and Industrial Research Organisation (CSIRO) Collaborative, Queensland Health has developed its own modelling which is made available to approved stakeholders, in particular Hospital and Health Services, on the internal System Performance Reporting (SPR) platform and via daily reports. This modelling has been independently assured and validated by the University of Western Australia and includes forecasting of:

- *the effective transmission rate (R0)*
- *hospital bed and Intensive Care Unit (ICU) capacity requirements (including ventilators) with a linkage to Queensland Health's COVID Response Framework*
- *medication needs for COVID-19 patients and maintaining business as usual services*
- *COVID-19 cases by Hospital and Health Service and what this means for Queensland's public health system.³⁰*

²⁶ Doherty Institute, 'COVID-19 modelling papers and press conference', <https://www.doherty.edu.au/news-events/news/covid-19-modelling-papers>. See Moss et al. 2020. "Modelling the impact of COVID-19 in Australia to inform transmission reducing measures and health system preparedness".

²⁷ Public briefing transcript, Brisbane, 23 June 2020, p 4.

²⁸ Public briefing transcript, Brisbane, 23 June 2020, p 3.

²⁹ Public briefing transcript, Brisbane, 23 June 2020, p 4.

³⁰ Queensland Health, correspondence dated 17 June 2020, p 10.

2.2 Preparedness planning: Protecting public health in an infectious disease pandemic

Research has identified a range of evidence-based and best practice strategies to protect public health in response to infectious disease outbreaks. In the absence of a viable vaccine for COVID-19, public health strategies which range from less invasive measures such as good hygiene practice to more restrictive measures such as travel and border restrictions can aid in reducing and slowing the spread of communicable diseases.³¹

2.2.1 Transparency, public engagement and communication

During a communicable disease outbreak, capturing public health data surveillance is necessary to understand the nature of the threat and, 'inform the public, provide early warning, describe transmission characteristics and incidence and prevalence, and assist a targeted response'. Surveillance strategies include rapid diagnosis, screening, reporting, case management reporting, contact investigations, and the monitoring of trends.³²

In addition to public health data, meaningful engagement and effective communication are essential in preparedness planning for public education. The WHO report *Ethical considerations in developing public health response to pandemic influenza* identified the following principles as essential for managing a communicable disease outbreak: trust, transparency, communicating to the public early, dialogue with the public, and planning.³³ Advanced planning allows for the development of communication strategies that can reach the entire population and which are linguistically and culturally appropriate.³⁴

The WHO states the following types of information should be communicated during all periods of a pandemic:

- *the initiatives being undertaken to allow citizens or communities to participate in the development of pandemic response policies;*
- *the nature and scope of the threat and related risks, and the spread of the pandemic;*
- *the steps that are being taken to respond to the pandemic, including new policy developments and their justifications;*
- *scientifically sound, feasible and understandable measures people can take to protect themselves and/or others from infection.*³⁵

According to the WHO, public engagement and involvement of relevant stakeholders should be part of all aspects of planning. Policy decisions and their justifications should be publicised and open to public scrutiny. The timely and transparent sharing of information can not only improve the evidence-base of policy, but facilitate public engagement in decision-making processes.³⁶

2.2.2 Social distancing measures

Social distancing measures are, 'community-based measures to reduce contact between people (e.g. closing schools or prohibiting large gatherings)'. Community-based measures may also be complemented by individual behaviours that reduce close contact with people during routine

³¹ Institute of Medicine, *Forum on Microbial Threats. Ethical and Legal Considerations in Mitigating Pandemic Disease: Workshop Summary*, Washington DC: National Academies Press, 2007, pp 81-89.

³² Institute of Medicine, *Forum on Microbial Threats. Ethical and Legal Considerations in Mitigating Pandemic Disease: Workshop Summary*, Washington DC: National Academies Press, 2007, pp 81-89.

³³ WHO, *Ethical considerations in developing public health response to pandemic influenza*, p 2.

³⁴ WHO, *Ethical considerations in developing public health response to pandemic influenza*, p 4.

³⁵ WHO, *Ethical considerations in developing public health response to pandemic influenza*, p 4.

³⁶ WHO, *Ethical considerations in developing public health response to pandemic influenza*, p 2.

activities at work or in other locations (e.g. substituting phone calls for face-to-face meetings, avoiding hand-shaking).³⁷

The WHO advises planning for social distancing measures should:

- mitigate any adverse cultural, economic, social, emotional and health effects for individuals and communities
- include input from employers, unions and other relevant stakeholders, particularly concerning work closure procedures, alternative work schedules, and protections for people who comply with social distancing against their employers wishes, and
- be provided in advance to key actors charged with implementing these measures to allow them to adapt them to the local culture and context and prepare for implementation.³⁸

2.2.3 International travel and border control

Public health measures such as international travel bans and internal border control are designed to limit and/or control the spread of a communicable disease outbreak across entry points to a country (by road, air or sea). Examples provided by the WHO include, 'travel advisories or restrictions, entry or exit screening, reporting, health alert notices, collection and dissemination of passenger information'.³⁹

In accordance with the WHO report, ethical planning of travel restrictions and border controls should, 'respect, to the extent possible, the individual right to freedom of movement', and ensure the informed consent of affected travellers for examinations and treatment in line with the International Health Regulations (2005) (IHR). The IHR is an international public health treaty that commits signatory countries to take action to prevent, protect against, control and provide a public health response to the international spread of disease. As a signatory, Australia has a range of obligations, including reporting and maintaining certain core capacities at designated points of entry and informing the WHO if any measures implemented interfere with international trade or travel.⁴⁰

2.2.4 Isolation and quarantine measures

The WHO considers isolation to be, 'the separation, for the period of communicability, of infected persons (confirmed or suspected) in such places and under such conditions' to prevent or limit the transmission of a virus. Quarantine is considered to be the restriction of the movement of healthy persons who have, or may have, been exposed to a suspected or confirmed case of infection with a highly communicable disease during the likely infectious period. Quarantine is therefore a precautionary measure.

Planning for isolation and quarantine should ensure these measures:

- are voluntary, to the greatest extent possible
- provide for infection control measures appropriate to different containment contexts (hospitals, homes, temporary shelters)
- ensure safe, habitable and humane conditions of confinement, including the provision of basic necessities (food, water, clothing, medical care) and, if feasible, psychosocial support for people who are confined

³⁷ WHO, *Ethical considerations in developing public health response to pandemic influenza*, p vi.

³⁸ WHO, *Ethical considerations in developing public health response to pandemic influenza*, p 10.

³⁹ WHO, *Ethical considerations in developing public health response to pandemic influenza*, pp v-vi.

⁴⁰ Australian Government, Department of Health, *Australian health sector emergency response plan for novel coronavirus (COVID-19)*, p 8.

- consider strategies to address potential financial and employment consequences of confinement, and
- protect the interests of household members of individuals who are isolated and treated at the household level, including recommending or providing alternative housing if living with the isolated patient puts them at significant risk of illness (e.g. an immunocompromised family member).⁴¹

2.2.5 Balancing rights and interests

Human rights are universal legal guarantees protecting individuals and groups against actions that interfere with fundamental freedoms and human dignity. Some of the most important characteristics of human rights are, 'that they are: guaranteed by international standards; legally protected; focus on the dignity of the human being; [and] oblige states and state actors'.⁴²

The WHO states that effective disease containment requires the need to balance the interests of the community and the rights of individuals in the implementation of public health measures, in particular more restrictive measures such as quarantine. Additionally, key to implementing such strategies is: the consideration of human rights; review of existing public health laws to ensure there is the necessary authority to implement them; and, the importance of grounding public health actions in scientific evidence.

When considering whether to adopt particular public health strategies, countries should rely on the best available scientific evidence. According to the WHO, restrictions on individual liberties, 'should not be adopted unless there is a reasonable expectation that they will have a significant impact on containing the spread or mitigating the impact of the disease, and they should be terminated when they no longer appear to offer significant benefits'.⁴³

2.3 Impacts of COVID-19

Since COVID-19 was first detected in Australia in January 2020, the day to day lives of Queenslanders have changed significantly. Since the implementation of social distancing, border controls, quarantine and other Public Health Directions limiting the operation of businesses and activities, there have been reports of widespread impacts on mental health and physical and social wellbeing.

2.3.1 Mental health: Depression and anxiety

Preliminary research from by Monash University School of Public Health and Preventive Medicine, using an anonymous online survey from 3 April to 2 May 2020, reported a whole of population increase in psychological symptoms. The study found a, 'very high prevalence rate of people experiencing clinically significant symptoms of depression'. Thoughts of suicide and self-harm had also increased, and irritability was reportedly widespread.⁴⁴

Importantly, while there appears to be a whole of population increase in psychological symptoms, some groups are especially vulnerable, listed as follows:

First, people living in the least resourced communities, including in rural areas, occupying the lowest socioeconomic positions, or who might have been unemployed prior the pandemic. Second, people who have lost a job, or opportunities to study, many of whom are young adults. Third people living alone who lack the opportunity for day to day interactions and proximity to family members. Fourth, sexual and other minority groups who are already marginalised.

⁴¹ WHO, *Ethical considerations in developing public health response to pandemic influenza*, p 10.

⁴² WHO, *Ethical considerations in developing public health response to pandemic influenza*, p v.

⁴³ WHO, *Ethical considerations in developing public health response to pandemic influenza*, p 10.

⁴⁴ Fisher et al., *Medical Journal of Australia, Mental health of people in Australia in the first month of COVID-19 restrictions: a national survey*, 2020, pp 8-10.

*Finally, people whose occupation is to provide unwaged care to children or other dependent family members, most of whom are women.*⁴⁵

The study emphasises the importance of considering the consequences of these problems for occupational and social functioning given they are highly relevant to national recovery. People experiencing poorer mental health difficulties are less motivated, energetic, socially engaged, confident or able to concentrate, plan, organise, trust or initiate.⁴⁶

Mr Ivan Frkovic, Commissioner of the QMHC, advised the committee that COVID-19 impacts the whole of society. Mr Frkovic suggested, 'we are all on the vulnerability spectrum or continuum', and that:

*If you think about it, prior to COVID-19 approximately 60 per cent of the Australian population was psychologically strong and well. Those people are now, like all of us, becoming more vulnerable. We also had people who were vulnerable prior to the COVID-19 virus. Those were people such as the homeless and unemployed ... We also had people who had been directly impacted by COVID-19, particularly people who were impacted by the virus itself but who also lost their job ... Then we had people with severe and complex enduring mental illness who lived prior, during and hopefully soon post COVID-19 and their families and carers. In that continuum everybody will swing up and down from that vulnerability. We are all more vulnerable in this new environment.*⁴⁷

Mr Frkovic also told the committee of the importance of thinking long term about mental health and the impacts of COVID-19:

Mental health has to be thought about as the immediate response, short term and long-term, and we need to keep an eye on that.

*COVID-19 has also further emphasised the nexus between personal, social and economic circumstances and mental health. Social and economic circumstances will certainly impact on mental health. I would suggest that the mental health and wellbeing impacts of COVID-19 are not yet fully realised, and I thank the committee for looking at mental health issues. Things will change over time from our immediate response to medium- to long-term responses depending on a range of factors, for example, JobKeeper and JobFinder. All of those things are critical aspects.*⁴⁸

Professor Brett Emmerson, Queensland Chair, Royal Australian and New Zealand College of Psychiatrists (RANZCP), affirmed this view:

*One thing I can say is that there is heightened anxiety throughout the community as soon as there is uncertainty. There are a very large number of people who are facing uncertainty about accommodation, whether they have a job, social security, JobKeeper changes are coming up, and there is a great unknown. People respond to that in a normal way, which is to get anxious. Unfortunately, there has certainly been an increased use of alcohol.*⁴⁹

Professor Emmerson also told the committee of an increase in suicide rates:

Certainly our impression in Metro North is that suicides are up. About two weeks ago I was at a professional function with Professor David Crompton, the Director of the Australian Institute of

⁴⁵ Fisher et al., Medical Journal of Australia, *Mental health of people in Australia in the first month of COVID-19 restrictions: a national survey*, 2020, pp 8-10.

⁴⁶ Fisher et al., Medical Journal of Australia, *Mental health of people in Australia in the first month of COVID-19 restrictions: a national survey*, 2020, pp 8-10.

⁴⁷ Public briefing transcript, Brisbane, 3 July 2020, p 13.

⁴⁸ Public briefing transcript, Brisbane, 3 July 2020, p 13.

⁴⁹ Public hearing transcript, Brisbane, 19 August 2020, p 11.

*Suicide Research and Prevention at Griffith University, and his assessment is that the suicide rate is up by about five per cent so far. That is their assessment. There is a government target to try and halve the suicide rate by 2025, I think. I am not sure that we will see that with this COVID epidemic and then the economic impact that this will have on so many people.*⁵⁰

2.3.2 Social isolation and domestic and family violence

The impact of social isolation as a result of COVID-19 has been linked to poorer mental health and wellbeing in the general population. However, it is particularly problematic for some groups such as those already marginalised in society, older Queenslanders and people at risk of domestic and family violence (DFV).⁵¹ Given the need for families to spend more time at home during COVID-19 there is increased risk to the safety of individuals and families already experiencing, or at risk of, DFV.

Women's Health Queensland (WHQ) submitted the importance of acknowledging a gendered effect of COVID-19 given that women perform more unpaid work than men which has increased significantly as they spend more time at home. Associated with this, WHQ submitted women will have less financial independence resulting in less ability for divorce or to remove themselves from DFV situations.⁵² Similarly, Mr Mike Bosel, Chief Executive Officer, Brisbane South, Primary Health Networks, expressed concern about the potential for increased DFV as a result of COVID-19, 'particularly across the backdrop of children having to remain confined in home for a period of time'.⁵³

To address the impacts of COVID-19 on mental health and physical and social wellbeing, Commissioner Frkovic, QMHC, advised the committee of federal and state initiatives and funding targeting these issues:

*They include: no-gap Medicare relief for GPs and psychologists to provide support to individuals, both face to face and via digital platforms; funding for universal phone and digital support services through Beyond Blue, Lifeline, Kids Helpline et cetera; and funding for the immediate enhancement of psychological psychosocial support through the community mental health and AOD sectors. ... These immediate mental health and AOD responses have been complemented by funding through broader social programs which have also had an impact on mental health; for example, the Queensland government response around housing and homelessness, domestic and family violence, Aboriginal and Torres Strait Islander services, and services for people from culturally and linguistically diverse backgrounds. All of those have also impacted on mental health even though they are not mental health specific.*⁵⁴

Committee comment

The novel coronavirus COVID-19 has extraordinary potential to cause serious and widespread illness and death as a consequence of its zoonotic origins. It is highly contagious and spreads readily and quickly from person to person via close contact (even when no apparent symptoms are present), contact with airborne respiratory droplets and exposure to droplets from an infected person left on surfaces.

⁵⁰ Public hearing transcript, Brisbane, 19 August 2020, p 10.

⁵¹ Fisher et al., Medical Journal of Australia, *Mental health of people in Australia in the first month of COVID-19 restrictions: a national survey*, 2020; Beyond Blue, 'Staying well, staying positive: a guide to coping with coronavirus for older Australians', <https://coronavirus.beyondblue.org.au/managing-my-daily-life/coping-with-isolation-and-being-at-home/staying-well-staying-positive-coping-with-coronavirus-for-older-australians.html>.

⁵² Submission 18, pp 8-9.

⁵³ Public briefing transcript, Brisbane, 3 July 2020, p 35.

⁵⁴ Public briefing transcript, Brisbane, 3 July 2020, p 14.

As a new disease in humans, there is no existing immunity in the community. Groups at greater risk of contracting the virus include travellers returning from disease hotspots, people who have been in close contact with people who are infected, people in correctional and detention facilities, and people living in group residential settings.

Groups at greater risk of serious illness from contracting the virus include people with disability, people aged 65 years and older with chronic medical conditions, Aboriginal and Torres Strait Islander people aged 50 years and older with chronic medical conditions, and people in aged care facilities.

The committee notes the issue of mental health is one that flows from the pandemic and as time goes by, may loom large and impact on Queenslanders for a lengthy period of time. Thus, it is important that appropriate support is available to the Queensland community.

Based on initial modelling of the virus, Queensland Health began planning the Queensland Government's health response to the virus based on credible modelling, using infection rates in China. That modelling suggested that one million Queenslanders could contract the virus in the first wave, peaking in April 2020 and lasting for six months. Of those one million cases: 200,000 people would need to be hospitalised; 50,000 would need intensive care and probably ventilation; and 12,500 Queenslanders would die.

Based on these projections, the Queensland Government allocated an additional \$1.2 billion over the 2019-20 and 2020-21 financial years to support the health system to cope.

The WHO's best practice guidelines for managing a communicable disease outbreak advocate a multi-pronged approach which includes early public warnings about transmission risks and prevalence, surveillance strategies such as rapid diagnosis, screening, reporting of cases and contact investigations (tracing). The WHO also stress the need to balance the interests of the community with the rights of individuals, the consideration of human rights, and the importance of grounding public health actions in scientific evidence. These guidelines provide a useful framework for assessing the government's health response to COVID-19.

In stark contrast to the very large numbers of COVID-19 cases Queensland authorities had anticipated and prepared for, the very low rate of infections, hospitalisations and deaths linked to the virus to date in Queensland represent an extraordinary achievement.

3 Legislative and governance frameworks for managing COVID-19

To respond to the COVID-19 health emergency, the Australian Government and state and territory governments have been guided by a suite of legislative and regulatory governance frameworks. Relevant to the terms of reference for the committee's inquiry, the Australian and state and territory governments have joint responsibility to act to protect the public health of Australians in light of the COVID-19 pandemic.⁵⁵

This section of the report outlines the division of responsibilities between the Australian and Queensland Governments in seeking to ensure the health system is effective in managing the pandemic as it unfolds in Queensland. In particular, this section outlines how the Queensland Government has given effect to bans and restrictions under Australian Government public health directives through local legislation and orders.⁵⁶

3.1 Division of responsibilities: strategic governance

At the time COVID-19 emerged in late 2019, the *Emergency Response Plan for Communicable Disease Incidents of National Significance: National Arrangements* (National CD Plan), published in May 2018, detailed the current division of responsibilities for health responses by Australian, state and territory governments. **Appendix D** provides the comprehensive, whole-of-government framework for responding to a communicable disease and breaks down the responsibilities for Australian governments as applicable at the time of its publication.

In February 2020, the Australian Department of Health released the *Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)* (COVID-19 Response Plan), which provides for a health sector focused response specific to COVID-19. The COVID-19 Response Plan states that it is to be supported by the National CD Plan.⁵⁷ The COVID-19 Response Plan also provides an operational plan for implementation by the Australian and state and territory governments. The operational plan has been adapted from the Australian Department of Health's *Australian Health Management Plan for Pandemic Influenza* (AHMPPI). Published in August 2019, the AHMPPI is regularly used to inform Australia's broader communicable disease planning and is particularly relevant to respiratory disease outbreak.

As outlined in the COVID-19 Response Plan, the AHMPPI:

*... benefits from studies and mathematical modelling conducted on influenza and Sudden Acute Respiratory Syndrome (SARS), another coronavirus. Although the novel coronavirus [COVID-19] is behaving differently in some ways to both influenza and SARS, the principles behind the response measures used to manage the response to the SARS outbreak and pandemic influenza are useful to inform this response.*⁵⁸

3.1.1 National partnership on COVID-19 emergency health response

The *Biosecurity Act 2015* (Cth) (Biosecurity Act) (refer section 3.1.2 below), provides the legislative framework for the Australian Government's health response to COVID-19. To facilitate a flexible, national partnership to the COVID-19 emergency, the Biosecurity Act recognises the federal nature of

⁵⁵ Council of Australian Governments (COAG), *National Partnership on COVID-19 Response*, p 3.

⁵⁶ Hon Steven Miles MP, Deputy Premier and Minister for Health and Minister for Ambulance Services, Queensland Parliament, Record of Proceedings, p 680-681.

⁵⁷ Australian Government, Department of Health, *Australian health sector emergency response plan for novel coronavirus (COVID-19)*, p 11.

⁵⁸ Australian Government, Department of Health, *Australian health sector emergency response plan for novel coronavirus (COVID-19)*, p 41.

government in Australia. Subsection 478(5) places limits on interference with state and territory bodies and officials:

*A direction must not be given under subsection (1) to an officer or employee of a State, Territory or State or Territory body unless the direction is in accordance with an agreement between the Commonwealth and the State, Territory or body.*⁵⁹

An intergovernmental agreement – *National Partnership on COVID-19 Response* – has been signed by Australian, state and territory governments. The agreement provides that all jurisdictions have public health responsibilities under the Constitution and the COVID-19 Response Plan, and that all jurisdictions are committed to fulfilling their expectations under the COVID-19 Response Plan.⁶⁰ To ensure a flexible approach, the COVID-19 Response Plan states that choices on the implementation of public health measures may vary across states and territories to reflect the jurisdictional context, particularly in relation to timing of implementation and stand down, however negotiation within the Australian Health Protection Principal Committee (AHPPC) will ensure a coordinated and consistent approach.⁶¹

The AHPPC is the key decision-making committee for health emergencies. Its membership is comprised of all state and territory CHOs, and it is chaired by the Australian Chief Medical Officer. AHPPC is also tasked with the role of mitigating emerging health threats related to infectious diseases, the environment as well as natural and human made disasters. The AHPPC has an ongoing role to advise the Australian Health Ministers' Advisory Council (AHMAC) on health protection matters and national priorities.⁶²

3.2 Commonwealth legislation

The first case of COVID-19 was confirmed by the Australian Minister for Health, the Hon Greg Hunt MP, on 25 January 2020. The individual who contracted COVID-19 was a man from Wuhan who had flown to Melbourne from Guangdong, China on 19 January 2020.⁶³

In response to the COVID-19 outbreak that followed in Australia, on 18 March 2020 the Governor-General declared that a human biosecurity emergency exists under section 475 of the Biosecurity Act.⁶⁴ The Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) Declaration 2020 provides the Australian Minister for Health expansive powers to determine emergency requirements or issue directions and set requirements in order to combat the outbreak.⁶⁵

3.2.1 Biosecurity Act 2015 (Cth)

The Biosecurity Act authorises activities used to prevent the introduction and spread of target diseases into Australia. People reasonably suspected to have a listed human disease (LHD) specified under the Act are required to comply with a range of biosecurity measures and requests for information as directed by the Director of Human Biosecurity, Australia's Chief Medical Officer, Australia's Minister for Health, or a biosecurity official or human biosecurity officer as stipulated in the Act. The Governor-

⁵⁹ Biosecurity Act, section 478(5).

⁶⁰ COAG, *National Partnership on COVID-19 Response*, p 12.

⁶¹ Australian Government, Department of Health, *Australian health sector emergency response plan for novel coronavirus (COVID-19)*, p 3.

⁶² Australian Government, Department of Health, 'Australian Health Protection Principal Committee', <https://www.health.gov.au/committees-and-groups/australian-health-protection-principal-committee-ahppc>.

⁶³ The Hon Greg Hunt MP, Minister for Health, 'First confirmed case of novel coronavirus in Australia', media release, 25 January 2020.

⁶⁴ Parliament of Australia, 'COVID-19 Human Biosecurity Emergency Declaration Explainer'.

⁶⁵ Parliament of Australia, 'COVID-19 Human Biosecurity Emergency Declaration Explainer'.

General also has the power to declare a human biosecurity emergency, which authorises the Australian Health Minister to implement a broad range of actions in response.

The Australian Government's declaration of 'Human coronavirus with pandemic potential' as a LHD on 18 March 2020 was the first time these powers under the Biosecurity Act have been used.⁶⁶ The Governor-General has since extended the human biosecurity emergency period for COVID-19 to 17 September 2020, unless further extended.⁶⁷

3.2.2 Human biosecurity emergency powers

During the human biosecurity emergency period, the Australian Health Minister has the power to issue any direction to any person and determine any requirement that he or she is satisfied is necessary to:

- prevent or control the entry to, emergence, establishment, or spread of COVID-19 in Australia
- prevent or control the spread of COVID-19 to another country, or
- implement a WHO Recommendation under International Health Regulations.⁶⁸

The emergency powers available to the Minister under sections 478 and 479 of the Biosecurity Act are expansive and may be used to:

- set requirements to regulate or restrict the movement of persons, goods, or conveyances
- require that places be evacuated, and
- make directions to close premises.⁶⁹

The Minister must also be satisfied that the direction/requirement is:

- likely to be effective in, or contribute to, achieving the purpose for which it is to be given
- appropriate and adapted to achieve the purpose for which it is to be given
- no more restrictive or intrusive than is required in the circumstances
- if a requirement, that the manner in which the requirement is to be applied is no more restrictive or intrusive than required in the circumstances, and
- if the direction/requirement is to apply during a period—that period is only as long as is necessary.⁷⁰

3.3 Queensland legislation

States and territories have legislative powers that enable them to implement biosecurity arrangements within their borders and which complement Australian Government biosecurity

⁶⁶ Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) (Essential Goods) Determination 2020, explanatory statement, p 1.

⁶⁷ Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) Variation (Extension) Instrument 2020, explanatory statement, p 1.

⁶⁸ *Biosecurity Act 2015* (Biosecurity Act), sections 477 and 478.

⁶⁹ Biosecurity Act, sections 478 and 479; Parliament of Australia, 'COVID-19 Human Biosecurity Emergency Declaration Explainer'.

⁷⁰ Parliament of Australia, 'COVID-19 Human Biosecurity Emergency Declaration Explainer'.

arrangements. They also have a broad range of public health and emergency response powers available under public and emergency legislation for responding to public health emergencies.⁷¹

Following the first confirmed case of COVID-19 in Australia on 25 January 2020, the Queensland Minister for Health and Minister for Ambulance Services, now Deputy Premier, Hon Dr Steven Miles MP, made a public health emergency declaration on 29 January 2020. This enabled emergency powers under the *Public Health Act 2005* (Public Health Act) to be exercised to contain the spread of COVID-19 in Queensland.⁷²

Similar to arrangements within the Australian Government, these emergency powers under the Public Health Act are exercised in conjunction with strategic governance plans, in particular the *Queensland Health Pandemic Influenza Plan*⁷³ released in May 2018 and the *Queensland Whole-of-Government Pandemic Plan*⁷⁴ released in March 2020.

3.3.1 Public Health Act 2005 (Qld)

In Queensland, the Public Health Act provides the basic safeguards necessary to protect public health through cooperation between the state government, local governments, health care providers and the community. This is achieved by:

- preventing, controlling and reducing risks to public health
- providing for the identification of, and response to, notifiable conditions
- defining obligations on persons and particular health care facilities involved in the provision of declared health services to minimise infection risk
- providing for the notification by doctors and registered nurses of child abuse and neglect, and protecting children who have been harmed or are at risk of harm when they present at health service facilities
- collecting and managing particular health information, and establishing mechanisms for health information held by the department to be accessed for appropriate research
- inquiring into serious public health matters
- responding to public health emergencies, and
- providing for compliance with this Act to be monitored and enforced.⁷⁵

Chapter eight of the Public Health Act sets out the key provisions relating to public health emergencies. Most relevant to the COVID-19 pandemic are:

- Part 2: Declaring a public health emergency (s 319 – s 326)
- Part 3: Emergency notifiable conditions (s 327 – s 331)

⁷¹ Australian Government, Department of Health, *Australian health sector emergency response plan for novel coronavirus (COVID-19)*, p 8.

⁷² Queensland Government, Queensland Health, 'Chief Health Officer public directions', <https://www.health.qld.gov.au/system-governance/legislation/cho-public-health-directions-under-expanded-public-health-act-powers>.

⁷³ Published by the State of Queensland (Queensland Health), April 2018, https://www.health.qld.gov.au/data/assets/pdf_file/0030/444684/influenza-pandemic-plan.pdf.

⁷⁴ Published by the State of Queensland (Queensland Health and Queensland Fire and Emergency Services), March 2020, https://www.qld.gov.au/data/assets/pdf_file/0025/124585/FINAL-QLD-WoG-Pandemic-Plan.pdf.

⁷⁵ Queensland Government, Queensland Health, 'Public Health Act 2005', <https://www.health.qld.gov.au/system-governance/legislation/specific/public-health-act>.

- Part 4: Role of chief executive (s 332)
- Part 5: Appointment of emergency officers (s 333 – s 342)
- Part 6: Powers of emergency officers (s 343 – s 348), Entry of Places and Emergency Powers
- Part 7: Extra Powers of emergency officers (medical) (s 349 – s 362), Detention Powers, Extension of detention order, Other provisions about detention
- Part 8: General enforcement matters (s 363 – 365).

3.3.2 Public health emergency powers

On the declaration of a public health emergency, the Chief Executive of QH is responsible for the overall management and control of the response to the emergency. During pandemic management, the CHO provides high-level medical advice to the Chief Executive of QH and the Minister on health issues, including policy and legislative matters associated with the health and safety of the Queensland public.⁷⁶

A public health emergency declaration gives the CHO wide-ranging powers to assist in containing or responding to the spread of COVID-19 in the community by:

- restricting people's movement
- preventing people from entering certain premises
- requiring people to stay at certain premises
- requiring certain premises to open, close or limit access
- restricting contact between people, and
- providing any other directions the Queensland CHO thinks are necessary to protect public health.⁷⁷

During a public health emergency, emergency officers have broad powers.⁷⁸ These powers include the power to:

- direct a person to stay at a stated place for 14 days (and comply with conditions)
- direct the owner or operator of a facility to open, close or limit access to that facility
- enter places (without a warrant)
- make a person leave a place
- require a person to answer questions
- require a person to give the emergency officer reasonable help to exercise their powers, and
- give any other direction reasonably necessary to assist in containing, or responding to, the spread of COVID-19 within the community.⁷⁹

⁷⁶ Queensland Government, *Queensland Whole-of-Government Pandemic Plan*, p 10.

⁷⁷ *Public Health Act 2005* (Public Health Act), s 362B.

⁷⁸ Public Health Act, Chapter 8, Part 7, Division 6; Part 7A.

⁷⁹ Public Health Act, Chapter 8, Part 6, see particularly s 345(1).

Emergency officers who are medical doctors have additional powers, including the power to detain people who pose a public health risk and establish an isolation area in which people who pose a public health risk can be detained.⁸⁰

3.4 Australian Government decisions and the Queensland Government's health response

On March 13 2020, to ensure the implementation of a public health response which does not rely solely on containment-based strategies such as screening and contact tracing, the Australian Government endorsed social distancing measures, as set out by the AHPPC and advocated for by the WHO internationally.⁸¹ The Australian Government also announced that:

- effective as at 11.59pm on 15 March 2020, all persons entering Australia, regardless of their country of origin, will be required to self-isolate for 14 days on arrival
- effective as at 11.59pm on Sunday 15 March 2020, a 30-day ban on docking of international cruise ships will be implemented, and
- non-essential public gatherings of more than 500 people should not occur from 16 March 2020.⁸²

On 15 March 2020, the National Cabinet, comprising the Prime Minister, state Premiers and territory Chief Ministers, asked all states and territories to ensure they had appropriate legislative provisions in place to implement and monitor social distancing measures. On 18 March 2020, the Prime Minister advised of further restrictions, including advice to not travel overseas, restrictions on non-essential indoor gatherings of more than 100 people, and restrictions on entry into aged care facilities.⁸³

3.4.1 Public Health and Other Legislation (Public Health Emergency) Amendment Act 2020 (Qld)

On 18 March 2020, Queensland Parliament passed the *Public Health and Other Legislation (Public Health Emergency) Amendment Act 2020* to strengthen powers of the CHO and emergency officers appointed under the Public Health Act to implement social distancing measures – including regulating mass gatherings, isolating or quarantining people suspected or known to have been exposed to COVID-19; and protecting vulnerable populations such as the elderly and remote communities with a high Aboriginal and Torres Strait Islander population. In particular, the Act empowers the CHO to make Public Health Directions that are reasonably necessary to assist in containing, or responding to, the spread of, COVID-19 within the community.⁸⁴

In effect, to respond to the risk posed by COVID-19 the Queensland Government has implemented legislation providing authority to enforce restrictions concerning:

- confining people to their homes (except for permitted purposes)
- regulating social gatherings and movement
- restricting certain businesses and activities
- limiting who can cross the Queensland border

⁸⁰ Public Health Act, Chapter 8, Part 7.

⁸¹ Public Health (COVID-19) and Other Legislation Amendment Regulation 2020, PHOL (Public Health Emergency) Amendment Bill 2020, explanatory notes, p 1.

⁸² Public Health and Other Legislation (PHOL) (Public Health Emergency) Amendment Bill 2020, explanatory notes, pp 1-2.

⁸³ PHOL (Public Health Emergency) Amendment Bill 2020, explanatory notes, p 2.

⁸⁴ *Public Health and Other Legislation (Public Health Emergency) Amendment Act 2020*; Queensland Health, correspondence dated 17 June 2020, p 8.

- detaining individuals who have arrived in Queensland from overseas and interstate in a hotel for 14 days, and
- limiting access to aged care facilities to protect the elderly and protecting communities with high Aboriginal and Torres Strait Islander populations.

Committee comment

Governments are guided by agreements and plans that establish their respective responsibilities to take action. The Australian and Queensland governments' responses to COVID-19, including the imposition of significant restrictions on citizens' movements, and the activities of whole industries to protect public health, have been underpinned by legislation, governance frameworks and national plans.

In Queensland *Public Health Act 2005* (Qld) provides a range of powers to the Chief Health Officer to issue Public Health Directions during a declared public health emergency. These directions and their enforcement have been central to the Queensland Government's COVID-19 health response.

4 The Queensland Government's health response to COVID-19

This section outlines the preparedness of Queensland Government agencies, particularly QH as the lead agency, in responding to the health emergency arising from the spread of COVID-19 in Queensland. The section also highlights stakeholder views about the Queensland Government's health response to COVID-19. As the terms of reference require the committee take into account the Australian Government's health response to COVID-19 and its impacts on the Queensland Government's health response, this section also briefly considers the role of the DPC in the Queensland Government's response and its interface with the Australian Government.

The submissions to the inquiry articulated widespread support for the Queensland Government's health response to COVID-19, often commending the Queensland Government and QH for its coordination, timeliness, and management of the COVID-19 pandemic in Queensland.⁸⁵ Stakeholders also raised concerns about aspects of the response including: stakeholder engagement in pandemic planning, the availability of PPE, the effectiveness of public health messaging about Public Health Directions (PHDs) and infringements of PHDs on human rights.

The Minister for Health and Ambulance Services has the overall responsibility for Queensland's health system. The Queensland Government's health response to COVID-19 has been led by QH and informed by the advice of the Queensland CHO, Dr Jeannette Young PSM. Queensland's public health services are delivered through the Department of Health (Queensland Health (QH)) which includes the Queensland Ambulance Service, and Queensland's 16 hospital and health boards which govern hospital and health services (HHSs) across the state.⁸⁶

4.1 Leadership and coordination across the Queensland Government

While QH led the Queensland Government's health response to COVID-19, DPC led the coordination of actions across the Queensland Government. DPC also supported the Queensland Government's linkages with the Australian Governments through the National Cabinet.

Director-General of the DPC, Mr Dave Stewart, told the committee QH has been supported by a whole-of-government approach which has drawn on Queensland's existing disaster management arrangements:

These existing arrangements have provided a solid, practised and scalable framework for guiding the Queensland government's response to COVID-19. The early declaration of a public health emergency in Queensland on 29 January this year and the rapid activation of Queensland's disaster management arrangements have been instrumental in ensuring a coordinated whole-of-government approach to supporting the health response to COVID-19.⁸⁷

Mr Stewart told the committee the Queensland Government's ability to use the Queensland Disaster Management network had been one of its strengths, with the body established early in the pandemic and meeting from 30 January 2020.⁸⁸ That network meeting evolved into the Queensland Disaster Management Cabinet Committee (QDMCC), a Cabinet sub-committee.⁸⁹

⁸⁵ See for example submissions 1, 2, 5, 9, 11, 14, 19, 20, 32, 33, 39, 41, 44 and 45.

⁸⁶ Queensland Health, 'Queensland Health Organisational Structure', <https://www.health.qld.gov.au/system-governance/health-system/managing/org-structure>; Queensland Health, *Handbook for Queensland Hospital and Health Boards*, p 2.

⁸⁷ Public briefing transcript, Brisbane, 3 July 2020, pp 1-2.

⁸⁸ Public briefing transcript, Brisbane, 3 July 2020, p 10.

⁸⁹ Public briefing transcript, Brisbane, 3 July 2020, p 10.

Mr Stewart explained the QDMCC was created to strengthen existing disaster and management arrangements in recognition of the significance of the pandemic and the potential for widespread impacts:

*This cabinet committee involves ministers and their directors-general, ensuring a whole-of-government consideration. This approach has also ensured leveraging of the expertise in and networks of each agencies to provide a comprehensive response to the pandemic.*⁹⁰

As a further element of the government's frontline COVID-19 crisis management, the DPC stood up the COVID-19 Response and Recovery Task Force to build on the state's disaster response and recovery capability in this new and unprecedented environment. The department's lead officer on this taskforce, Mr Paul Martyn, told the committee:

The task force supports the state by enhancing coordination of efforts across the government on a range of issues, including economic recovery strategies, easing of restrictions, supply of personal protective equipment and improving public communication. The task force has worked closely with Queensland Health to deliver Queensland's initial road map to the easing of restrictions on 8 May and subsequent road maps. The task force has also worked to support the government's work on easing of restrictions most recently at noon today.

*In addition to the health response to COVID-19, the task force has also supported the Queensland government's economic recovery response, including establishing the industry recovery alliance that I talked about earlier. The task force developed and released stage 1 of the Unite and Recover Jobs Strategy on 15 May and stage 2 on 16 June. The task force is an operational unit within the Department of Premier and Cabinet. It is staffed by officers seconded from 10 different agencies across government and it works closely with other parts of the department and with Queensland Health and it reports to the director-general.*⁹¹

In other evidence, Mr Martyn told the committee the task force comprised 23 staff with officers seconded from up to ten agencies of the government including the Department of State Development, Manufacturing, Infrastructure and Planning, Queensland Treasury, Trade and Investment Queensland, the Department of Housing and Public Works, Queensland Treasury Corporation, the Department of Transport and Main Roads, the Department of Environment and Science, and the Department of Natural Resources, Mines and Energy.⁹²

The DPC also led the Queensland Government's interaction with the Australian Government to guide the response to COVID-19. In his evidence at the 3 July briefing, Mr Stewart further highlighted his department's role in facilitating this interaction:

*Several examples illustrate the work of the Department of Premier and Cabinet in facilitating this federal-state collaboration. These include—advocating for the implementation of restrictions on foreign nationals entering Australia; the process of easing restrictions; the development of COVID-safe plans for workplaces; and the coordination of protections for remote communities. Each of these initiatives has enhanced and complemented the Queensland government's health response to COVID-19.*⁹³

4.1.1 Role of the Queensland Ambulance Service

QH identified the Queensland Ambulance Service (QAS) as supporting the Queensland Government's health response to COVID-19 in provision of emergency medical services throughout Queensland. The QAS delivers, 'ambulance services through 15 Local Ambulance Service Networks' which are aligned

⁹⁰ Public briefing transcript, Brisbane, 3 July 2020, p 2.

⁹¹ Public briefing transcript, Brisbane, 3 July 2020, p 8.

⁹² Public briefing transcript, Brisbane, 3 July 2020, p 9.

⁹³ Public briefing transcript, Brisbane, 3 July 2020, p 2.

to the HHSs.⁹⁴ In response to the CHO's early advice concerning the likelihood of a potential COVID-19 pandemic, the QAS, 'immediately commenced a rapid strategic planning process', noting COVID-19 posed a threat to QAS service delivery and its ability, 'to achieve its mission to provide timely, quality, and appropriate patient-focussed ambulance services'.⁹⁵

QH advised the committee:

*A pandemic event in Queensland would likely cause a significant surge in demand for ambulance services and potentially impact the availability of QAS's frontline workers, namely paramedics, patient transport officers, and emergency medical dispatchers responding to this increasing demand.*⁹⁶

To manage a potential demand surge, QH advised that a cross-disciplinary Demand Surge and COVID-19 Planning Team was established to:

- *Deliver an agile and scalable approach ensuring that ambulance service delivery capacity is maintained on a statewide basis; and*
- *Support the Whole-of-Government COVID-19 response through the continued delivery of the QAS Mission.*⁹⁷

4.1.2 Role of the Queensland Police Service

The QPS was also identified by QH as a partner in supporting the whole-of-government response to the emerging COVID-19 pandemic in Queensland, particularly as a key coordinating body and for its role in ensuring compliance with Public Health Directions. Commissioner Katarina Carroll, QPS, advised the committee that the Service, in its support of QH's response to COVID-19, established Task Force Sierra Linnet within the State Police Operations Centre (SPOC) to prepare, plan and coordinate the QPS's response.

Commissioner Carroll added that the operation of the SPOC required the allocation of significant policing resources to undertake a multitude of functions including:

*... planning, strategy, command, legal, information, investigations, administration, logistics and intelligence. The QPS redeploys up to 1,200 to 1,300 staff a day ... from policing functions and corporate functions to duties associated with the COVID-19 response across the state, sometimes at very short notice, to implement various public health measures associated with the emergency. The QPS has also agreed to appoint all approximately 12,000 police officers as emergency officers general under the Public Health Act 2005 and assume responsibility for the delivery of emergency officer general roles, such as the service of quarantine notices at Queensland borders, including state and international.*⁹⁸

4.1.3 Role of the Department of Communities, Disability Services and Seniors

The Department of Communities, Disability Services and Seniors (DCDSS) advised the committee that it has 'functional lead agency responsibility' for the human and social aspects of recovery following disaster events, including pandemics. In this role, DCDSS 'delivers essential services and promotes the interests of vulnerable Queenslanders who may be at increased risk as a result of COVID-19, including people with disability and seniors'.⁹⁹

⁹⁴ Queensland Health, correspondence dated 17 June 2020, pp 32-33.

⁹⁵ Queensland Health, correspondence dated 17 June 2020, p 33.

⁹⁶ Queensland Health, correspondence dated 17 June 2020, p 33.

⁹⁷ Queensland Health, correspondence dated 17 June 2020, p 34.

⁹⁸ Public hearing transcript, Brisbane, 19 August 2020, p 19.

⁹⁹ Department of Communities, Disability Services and Seniors, correspondence dated 16 June 2020, p 1.

DCDSS established the Care Army to support the Queensland community during the pandemic, particularly Queenslanders over 65 and Aboriginal and Torres Strait Islanders over the age of 50 who may be at greater risk. The Care Army consists of volunteers whose primary focus is to provide social connection and essential services, for example delivering groceries and medicines, to Queensland's seniors.¹⁰⁰

On 19 March 2020, the Queensland Government activated the Community Recovery Hotline which served as an initial contact point for people wishing to volunteer for the Care Army, and those seeking the Care Army's assistance. By 3 June 2020, the hotline had received 13,400 calls including more than 2,000 requests for essential food and 1,200 for essential medication.¹⁰¹ The DCDSS also advised that as of 29 May 2020, 'more than 28,200 Queenslanders had registered their interest in helping others through the Care Army. Forty-eight organisations have engaged the Care Army, and more than 5900 volunteering opportunities have been offered to registered Care Army volunteers'.¹⁰²

DCDSS told the committee that COVID-19 presented a significant and unprecedented challenge for many people with disability, the people who support them, and the sector as a whole. While the Australian Government has lead responsibility for the National Disability Insurance Scheme (NDIS), DCDSS advised that the Minister for Disability Services and Seniors has a key 'shareholding' role to ensure Queenslanders with disability are supported.

To ensure people with disability and disability providers are supported during the pandemic, the *Queensland Disability Strategy – in response to the COVID-19 pandemic* was developed. Key areas of focus for the department to sustain Queensland's disability service system and workforce, and keep people with disability safe and well cared for, include:

- engagement and communication
- uninterrupted departmental service delivery
- supporting the disability sector to respond to emerging needs and maintain service delivery, and
- ongoing monitoring of disability service supply, demand and effectiveness.¹⁰³

4.2 Pandemic planning

Pandemic planning in Queensland for coronaviruses was well developed and provided a sound basis for planning for the management and response to COVID-19. Dr Young explained for the committee the background to the development of Queensland's pandemic planning over her 15 year tenure as CHO:

I was part of the Australian Health Protection Principal Committee where we developed the very first pandemic plan for Australia. Then we went through the swine flu pandemic which, in hindsight, thank goodness, was a very mild disease. We have had continuing waves since then. ... We looked at what we did and we evaluated our plans again. Since then we have had multiple other events that did not reach the threshold for being declared a pandemic but certainly tested our systems and made us look at them time and time again. ... We had MERS, Ebola and all of

¹⁰⁰ Queensland Government, 'Care Army', <https://www.covid19.qld.gov.au/carearmy>; Department of Communities, Disability Services and Seniors, 'The Queensland Care Army: how your organisation can get involved', <https://www.csyw.qld.gov.au/resources/dcsyw/news/qld-care-army-ngo-fact-sheet.pdf>.

¹⁰¹ Department of Communities, Disability Services and Seniors, correspondence dated 16 June 2020, p 4.

¹⁰² Department of Communities, Disability Services and Seniors, correspondence dated 16 June 2020, p 6.

¹⁰³ Department of Communities, Disability Services and Seniors, correspondence dated 16 June 2020, pp 9-10.

these other events that meant we could test them and manage them. Then last year—very fortunate timing—here in Queensland we reviewed our pandemic plan again.

By doing that continual reviewing, continuing to have those networks of people to talk to and practising, when it happens you have something that you can grasp hold of. The difficulty, of course, with this pandemic was that it was not the pandemic that we were expecting it to be. Although we had looked at other potential pandemics and how we would modify our plans, such as Ebola, most of our pandemic planning to date had been about flu. This was a coronavirus—very, very different. Although we could use a lot of those strategies, we had to rapidly amend the plan. We did that as a national committee [the AHPPC].¹⁰⁴

4.3 Governance and coordination

Dr Young advised the committee that Queensland's State Health Emergency Coordination Centre (SHECC) was stood up to respond to the COVID-19 pandemic on 25 January 2020, the same day the first case was confirmed in Victoria.¹⁰⁵ QH explained that the SHECC was activated as an:

... emergency coordination centre focused on ensuring an effective, coordinated response by Queensland Health, which comprises the Department of Health and the 16 Hospital and Health Services (HHSs) ... SHECC functions include coordination of information, reporting, planning and logistic support to operations.¹⁰⁶

The standing up of SHECC also engages liaison officers from several government agencies, including QAS, QPS, Queensland Fire and Emergency Services, Department of Education, Department of Communities, Disability Services and Seniors, Department of Agriculture and Fisheries (DAF), local government representatives and the Australian Defence Force (ADF).¹⁰⁷

In a written briefing to the committee, QH advised that the State Disaster Coordination Centre (SDCC) was also activated to coordinate the whole-of-government support for QH as the lead agency for the response functions of public health, mental health and medical services under the Queensland State Disaster Management Plan. The SDCC is led by the State Disaster Coordinator under the direction of the Queensland Disaster Management Cabinet Committee.¹⁰⁸

In addition to what QH termed 'business as usual' governance arrangements, QH advised of the establishment of two internal governance mechanisms; the Pandemic Health Leadership Response Team and the Pandemic Health Response Implementation Advisory Group, intended to develop and guide the implementation of QH's 'tactical response to the COVID-19 pandemic'.¹⁰⁹ The network of governance frameworks involved in QH's response to COVID-19 are illustrated by **Appendix E** to this report which is a diagram submitted by QH outlining its pandemic health response leadership team.¹¹⁰

4.4 Engagement with stakeholders

A written briefing provided by QH on 17 June 2020 discussed stakeholder engagement in planning preparation for QAS service delivery in consultation with the Primary Health Networks (PHNs) and the provision of primary health care.¹¹¹ Additionally, QH have referred to stakeholder engagement

¹⁰⁴ Public briefing transcript, Brisbane, 23 June 2020, p 7.

¹⁰⁵ Public briefing transcript, Brisbane, 23 June 2020, p 14.

¹⁰⁶ Queensland Health, correspondence dated 17 June 2020, 4.

¹⁰⁷ Queensland Health, correspondence dated 17 June 2020, p 4.

¹⁰⁸ Queensland Health, correspondence dated 17 June 2020, p 4.

¹⁰⁹ Queensland Health, correspondence dated 17 June 2020, p 6.

¹¹⁰ Queensland Health, correspondence dated 17 June 2020, p 7.

¹¹¹ Queensland Health, correspondence dated 17 June 2020, pp 15, 37-38.

in its pandemic planning response to older Queenslanders, Queenslanders with disability, culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander Queenslanders.¹¹²

4.4.1 Stakeholder views on governance and coordination

Stakeholders in their submissions and other evidence during the inquiry generally commended the Queensland Government for its governance and timely response to the emergence of COVID-19 in Queensland. Stakeholders commended QH, particularly the CHO, Dr Jeannette Young and her team, and acknowledged the effectiveness of coordination across all levels of government to respond to the pandemic.

The Public Advocate submitted:

*... Australia has seen a level of co-operation between levels of Government that has been unprecedented outside of war time, which has allowed key decisions to be made and implemented swiftly, efficiently and consistently. This response has been important to ensure that vulnerable members of the community, particularly older people and people with disability, receive appropriate care and supports along with necessary health protections.*¹¹³

Echoing a similar sentiment, the Queensland Aboriginal and Islander Health Council (QAIHC) stated:

*Australia and Queensland acted quickly and decisively, closing international borders, enforcing quarantine, locking down the nation at the point of highest risk, and meticulously contact tracing. Federal and state governments demonstrated ability to work collaboratively, seeking advice from experts and putting health first, whilst maintaining autonomy for the benefit of their people. The situation we see in Australia is exceptionally promising, and the government's actions and leadership in the response should be commended.*¹¹⁴

Representing frontline health workers, the Queensland Nurses and Midwives' Union (QNMU) submitted that it:

*... applauds the QLD Government for their timely and effective decision-making and coordination with all levels of government, particularly with the National Cabinet, and the community about minimising the risks of COVID-19 transmission. The QNMU also commends the Queensland community for their response to such adversity.*¹¹⁵

Commenting on Queensland's disaster management arrangements, QAIHC stated that the, 'Queensland Government acted early and activated the State Health Emergency Coordination Centre ... to respond to the COVID-19 pandemic. QH, as lead agency, has decisively implemented a number of responses to prevent community transmission and protect the population'.¹¹⁶

With respect to the work of Dr Young, Member for Noosa, Ms Sandy Bolton MP submitted that the Queensland Government's health response to COVID-19 was, 'exceptional overall', and that the CHO:

*... made some very tough decisions which has kept, and continues to keep, our residents safe. Our active case results are a testament to swift and decisive action and should be commended.*¹¹⁷

¹¹² Queensland Health, correspondence dated 17 June 2020, pp 27-28.

¹¹³ Submission 11, p 1.

¹¹⁴ Submission 32, p 4.

¹¹⁵ Submission 23, p 3.

¹¹⁶ Submission 32, p 7.

¹¹⁷ Submission 19, p 4.

The Pharmaceutical Society of Australia (PSA) also acknowledged the leadership demonstrated by Queensland officials:

*The PSA acknowledges the Queensland Government's overall health response that helped Queensland to contain the pandemic. In general, the health response was exemplary and, in many areas, world leading. The PSA would like to acknowledge the Premier Annastacia Palaszczuk, Deputy Premier Steven Miles and Chief Health Officer Jeanette Young, in particular, for their leadership, communication, grit and speed to action.*¹¹⁸

The timeliness of the Queensland Government's response was often associated with the performance of the state in reducing the spread of COVID-19 and managing its impacts. For example, the Pharmacy Guild of Australia Queensland Branch (PGAQ) suggested, 'The positive position we find ourselves in today, is in no doubt due to the governments' approach of listening to the medical experts and taking a proactive and rapid response to implementing measures to protect all Queenslanders'.¹¹⁹

Similarly, the Queensland Alliance for Mental Health (QAMH) commented:

*The response implemented by Queensland Health and the Queensland Government more broadly to ensure the safety and health of Queenslanders as the virus spread throughout the community was effective and adequately done despite the challenging and difficult situation unfolding for Australia and worldwide. The quick decisions led by the Queensland Government and the public health emergency declared under the Public Health Act 2005 contributed to an effective management plan to control the spread of COVID-19.*¹²⁰

At the public hearing held 19 August 2020, the committee heard from Commissioner Katarina Carroll, QPS who, in response to questions regarding the effectiveness of the governance and coordination underpinning Queensland's health response, stated:

*The arrangements are extraordinarily robust and well proven. What would normally happen is that it is generated from the bottom up. You have a disaster at the local level, the local committee is chaired by the mayor and once they do not have capacity to deal with it anymore it then goes to a district level which is chaired by a superintendent of police. Once they do not have the capacity it then goes to the state and is led by the State Disaster Coordinator who reports to the QDMC. It is an extraordinary framework in terms of everyone within the framework knows what their role is and is well practised at it because we have used in it the past. What we have done this time round is pushed the requirements from the top down.*¹²¹

Lastly, Queensland's Health Ombudsman, Mr Andrew Brown, submitted that the number of health system complaints received by the Office of the Health Ombudsman (up to when submissions closed on 3 July 2020) appeared 'muted'. Mr Brown added that, 'during a period of significant pressure and uncertainty, during which thousands of complaints were received by the Office, the numbers of complaints which related to COVID-19 do not indicate a high level of public concern about administration by public authorities'.¹²²

Stakeholders also raised issues about the operation and impacts of restrictions which they believe could have been better. These issues are outlined below.

¹¹⁸ Submission 37, p 5.

¹¹⁹ Submission 14, p 1.

¹²⁰ Submission 47, p 3.

¹²¹ Public hearing transcript, Brisbane, 19 August 2020, p 21.

¹²² Submission 29, p 4.

4.4.2 Stakeholder views on engagement in pandemic planning

Feedback concerning the level of engagement with stakeholders was varied. Some stakeholders reported a positive level of engagement with the Queensland Government during the early stages of the pandemic. However, a number of stakeholders outlined their concern at a lack of consultation which generated confusion and also meant stakeholders were unsure how to respond to the unfolding pandemic.

In its submission, the RANZCP reported the following positive experience in terms of the level of its engagement with the Queensland Government:

*The RANZCP Queensland Branch also wishes to congratulate the Government on the quality of communication from Queensland Health. This includes the weekly teleconferences organised by the Mental Health Commission to bring together NGOs, health services, PHNs and clinical directors on the COVID-19 mental health impact.*¹²³

Aged and Community Services Australia (ACSA) submitted that the aged care sector had been engaged in effective consultation with the Queensland Government. ACSA commended the Queensland Government for the government's, 'willingness to work collective with Commonwealth government agencies and the aged care sector to ensure the uptake and advancement of strategic policy matters associated with the management of COVID-19 outbreaks in aged care'.¹²⁴

Queenslanders with Disability Network (QDN) echoed a similar positive sentiment in its submission:

*The Queensland Government have demonstrated a commitment to the safety and wellbeing of people with disability during this time, and also worked collaboratively across government to ensure the voice of people with disability and their experiences have informed the planning, design, implementation and evaluation of responses and actions.*¹²⁵

Commenting specifically on the Queensland Government's stakeholder engagement, the Queensland Law Society (QLS) commented 'We have also been pleased to see that the health response has reflected thoughtful community engagement in many instances, responding to the needs of most Queenslanders'.¹²⁶

The Public Advocate acknowledged that the Queensland Government's health response to COVID-19 to date has been an 'unquestionable success'. In relation to engagement with stakeholders and the community health sector, the Public Advocate's submission included the following comments in support of the Queensland Government's response to COVID-19:

In addition to its frontline health response, the government's approach included targeted responses for key cohorts, including people living with disability and mental illness, as well as older Queenslanders, particularly those living in residential aged care facilities.

*To inform and facilitate its COVID-19 response for these different groups, QH convened a number of inter-agency working groups with membership from key stakeholders representing government agencies, service providers, community service and advocacy organisations.*¹²⁷

The Public Advocate explained further:

The regular meetings of the working groups supported information sharing and an issue identification process that was used to develop and adjust the health responses to the pandemic for these cohort groups. They also kept key stakeholders abreast of key developments with

¹²³ Submission 8, p 1.

¹²⁴ Submission 45, p 4.

¹²⁵ Submission 35, p 1.

¹²⁶ Submission 41, p 1.

¹²⁷ Submission 11, p 1.

*sector wide ramifications in a timely way. This also contributed to improved communication and acceptance and support of the new measures or procedures to support those changes. The working groups were also instrumental in identifying gaps in information and guidance to the community and service providers about the virus and the health directives, as well as actioning some issues that were long-standing challenges for the health system in the pre-COVID-19 environment.*¹²⁸

The Public Advocate also commented on the positive level of engagement by the government with key stakeholders:

*In addition to its frontline health response, the government's approach included targeted responses for key cohorts, including people living with disability and mental illness, as well as older Queenslanders, particularly those living in residential aged care facilities. To inform and facilitate its COVID-19 response for these different groups, QH convened a number of inter-agency working groups with membership from key stakeholders representing government agencies, service providers, community service and advocacy organisations.*¹²⁹

While stakeholders acknowledged these successes of the Queensland Government's health response to COVID-19, some also raised concerns about planning, coordination and leadership and stakeholder engagement. For example, concerns about coordination at various levels of leadership and the need for stakeholder engagement in the early stages of the pandemic were raised by Health Consumers Queensland who stated:

We do acknowledge this was the first time the health system was faced by such a challenge as COVID-19 and how well the system has worked to protect the health and wellbeing of Queenslanders. However, what it also showed up was:

- *the gaps in planning and preparedness for such situations, including a consumer, clinician and stakeholder engagement plan*
- *system leadership support for consumer involvement was not consistent across the system*
- *the need for consistent, targeted and honest communication with Queenslanders.*¹³⁰

QAIHC submitted there was early consultation between the Queensland Government and the Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs) sector. QAIHC told the committee that, due to the slowly increasing number of cases in Italy and Iran, a meeting was convened on 5 March 2020 involving Dr Young, Ms Haylene Grogan (Aboriginal and Torres Strait Islander CHO) and QAIHC CEOs and clinical leaders. The committee also heard that QAIHC was invited to participate in Queensland Health's primary care COVID-19 group which meant QAIHC was able to communicate crucial clinical information regularly back to the sector and provide real-time situation reports directly from SHECC.¹³¹

The Cairns Regional Council (CRC) acknowledged QH's, 'extensive and integrated public-health response' had worked to limit infections in Queensland' though there were:

... significant challenges to implement the PHDs [Public Health Directions] ... In particular, this included the lack of a lead agency to coordinate PHD implementation, including pre-briefings to key support agencies responsible for enforcement and implementation. Rather, QH advised

¹²⁸ Submission 11, p 2.

¹²⁹ Submission 11, p 1.

¹³⁰ Submission 39, p 7.

¹³¹ Submission 32, p 9.

*agencies of PHDs at the same time as the public, resulting in confusion and uncertainty and despite requests, did not provide further interpretation or clarification.*¹³²

The lack of stakeholder engagement in initial pandemic planning was also raised by QAIHC which stated:

*QAIHC was not immediately engaged by Queensland Health in issues and actions needed to safeguard Aboriginal and Torres Strait Islander peoples. A process for rapid communication with QAIHC as the primary point of contact on health matters pertaining to the Aboriginal and Torres Strait Islander community would have facilitated better communication with the ATSI CCHO.*¹³³

Supported Accommodation Providers' Association (SAPA) raised similar concerns about the lack of consultation with industry in its submission which stated:

There was no initial communication from QLD Health with our sector in the weeks that followed the outbreak. Our members needed to know in a timely manner:

- 1. Where and how additional supports would come in the event of a confirmed case*
- 2. What assistance would be made available to help relocate offsite*
 - a. confirmed / suspected cases; and*
 - b. close contacts of confirmed cases who needed to be placed into isolation.*

*There was no communication and our members were left in the dark on how to respond in the event of a suspected or confirmed case within their facilities.*¹³⁴

4.5 Hospital and health services': Preparedness and response

Queensland Health (QH) held a critical hospital planning and pandemic preparedness planning forum on 10 March 2020. The forum was attended by the Minister for Health and Minister for Ambulance Services, QH Leadership Board, HHSs Chief Executives and key Executive Directors and Clinical Leads, consumer representatives and union delegates. The purpose of the forum was to conduct critical hospital planning and pandemic preparedness and more specifically to:

- Inform participants of the likely timeline, stages of the COVID-19 response in Queensland and potential impact on the health system workforce and the broader community.*
- Explore systems considerations for COVID-19 such as hospital thresholds and triggers, funding and workforce, and*
- Ascertain the status of hospital preparedness plans to double intensive care capacity and triple ED capacity.*¹³⁵

QH advised the focus of the forum was wide-ranging but with emphasis on, 'hospital capacity (particularly ED [emergency department] and ICU [intensive care unit]), health system funding and the health workforce'. The department also advised that the coverage of these topics was not to the exclusion of other service areas including aged care, primary care and First Nations health, but rather that these areas require specific input from lead areas within the department. Planning in these areas was therefore conducted separately to the broader health system.¹³⁶

¹³² Submission 9, p 5.

¹³³ Submission 32, p 11.

¹³⁴ Submission 34, pp 3-4.

¹³⁵ Queensland Health, correspondence dated 17 June 2020, pp 13-14.

¹³⁶ Queensland Health, correspondence dated 17 June 2020, p 14.

Based on the initial modelling conducted on early evidence outlined above, QH considered there would be 'a major peak in COVID-19 cases toward the end of April 2020'. In response to the anticipated cases, QH advised the Queensland Government provided funding of \$1.2 billion to expand the health system to:

- *double intensive care capacity*
- *triple ED capacity*
- *employ more paramedics, ambulance services*
- *deliver more acute care services*
- *expand fever clinics*
- *deploy new infrastructure and better utilise our existing hospitals*
- *expand community screening and contact tracing services*
- *expand Health Contact Centre services including establishing self-quarantine health and compliance checks and doubling the capacity of the 13 HEALTH nurse triage and general information*
- *resource backfilling of health staff who are unwell*
- *continue non-urgent elective surgery in the private sector*
- *deliver more support for regional health services*
- *provide more aeromedical services for regional and remote communities*
- *expand suppliers to source and secure PPE*
- *deploy new infrastructure and better utilise our existing hospitals*
- *upscale information and communications technology capacity and support levels to increase health services delivery flexibility across the state (including telehealth) and supporting alternative working arrangements for up to 40,000 staff*
- *prepare to rapidly deploy information technology to support intensive care, ED, fever clinics and other hot spots as they occurred*
- *prepare for an increase in cyber security attacks targeted at healthcare organisations experiencing major disruptions due to COVID-19.*¹³⁷

4.6 Intensive care unit capacity and ventilators

In relation to intensive care unit (ICU) capacity and the availability of ventilators, QH advised the Statewide Intensive Care Clinical Network (SICCN) worked to guide the local expansion of ICUs in Queensland. QH noted a 'significant procurement exercise' was undertaken to ensure appropriate ventilator availability and associated medical equipment to manage a 'substantial increase in demand for ICU beds'.¹³⁸

In a written brief to the committee, QH explained the SICCN:

... undertook an initial scoping of current ICU capacity and stock take of ICU equipment. Appropriate areas within hospitals were identified as possible ICU expansion areas. Re-skilling of clinical staff was also undertaken to support the current ICU workforce. A daily survey of ICU demand and capacity was commenced to enable early identification of areas of need that may

¹³⁷ Queensland Health, correspondence dated 17 June 2020, pp 14-15.

¹³⁸ Queensland Health, correspondence dated 17 June 2020, p 16.

*require redeployment of equipment or clinical staff. The SICCN met twice a week to update on resourcing and share learnings regarding the clinical course of COVID-19 patients within ICUs.*¹³⁹

To respond to demand surges as a result of COVID-19 outbreaks, QH advised that surge planning modelling was undertaken for ICU beds and the required equipment for invasive and non-invasive ventilation. In its brief to the committee, QH stated this was supported by HHSs, 'to determine the technology requirements and rapidly deploy information technology to support intensive care, emergency departments, fever clinics and respond to hot spots as they arose'.¹⁴⁰

Noting the interface between Commonwealth decisions and state health responses, importantly on 26 March 2020 National Cabinet announced the decision to temporarily suspend all 'semi-urgent' elective surgery.¹⁴¹ QH advised that, in line with the advice of National Cabinet, it suspended non-urgent category 2 and 3 elective surgery, while category 1 and urgent category 2 surgeries continued to be delivered. QH supported affirmed the decision of the National Cabinet noting, 'Temporary service suspension protected the health and safety of clients and staff and allowed for the release of HHS staff and facilities to respond to COVID-19 healthcare demand'.¹⁴²

Concerning the continuity of health care services, QH stated in a written brief to the committee that the Director-General of QH wrote to the Chief Executives of HHSs concerning a temporary statewide suspension of the BreastScreen Queensland program on 30 March 2020. The committee was advised by QH that this was, 'informed by expert clinician opinion, falling rates of client attendance at screening appointments, and continued escalation of the COVID-19 pandemic'.¹⁴³

4.6.1 Stakeholder views on HHSs preparedness and response

Similar to feedback concerning the Queensland Government's governance and coordination of its response to COVID-19, in their submission stakeholders were largely positive in their submissions and evidence before the committee regarding the health response provided by HHSs and to ICU capacity and related medical equipment availability.

The QNMU provided the following assessment of HHSs preparedness:

*The QLD Government has engaged a measured approach to planning by modelling scenarios for mild, moderate and high-volume cases of COVID-19 since the public health emergency was declared in January. In our view, the QLD Government has supported hospitals in preparing for the earlier predicted clinical care demands, through improving Emergency Departments (EDs) and critical care capacity, increasing the number of hospital beds, planning for the use of external medical facilities, providing assessment and treatment centred care for those who tested positive for COVID-19 and increasing workforce capacity.*¹⁴⁴

In its submission, PHAA was particularly supportive of the efforts of HHSs in responding to the unfolding pandemic, stating:

... the Queensland government, especially Queensland Health and the hospitals, did an excellent job in preparing for a massive influx of patients. Significant resources were mobilised to support

¹³⁹ Queensland Health, correspondence dated 17 June 2020, p 16.

¹⁴⁰ Queensland Health, correspondence dated 17 June 2020, p 16.

¹⁴¹ The Hon Scott Morrison MP, Prime Minister of Australia, 'National Cabinet Update', media release, 26 March 2020.

¹⁴² Queensland Health, correspondence dated 17 June 2020, p 24.

¹⁴³ Queensland Health, correspondence dated 17 June 2020, p 24.

¹⁴⁴ Submission 23, p 5.

*ongoing care of patients and preparedness for the pandemic, communications were prepared and new emergency protocols for potential COVID-19 patients were quickly installed ...*¹⁴⁵

Concerning the potential impacts of COVID-19 on the operation of Queensland's health system, the Royal Australian College of General Practitioners (RACGP) submitted:

*The early policies agreed by the Australian Health Protection Principal Committee (AHPPC) and implemented by the Australia's federal, state and territory governments have reduced initial pressure on our healthcare system, ensuring it is ready to cope with potential future waves of infection as society gradually reopens.*¹⁴⁶

In its submission, yourtown praised the continuity of healthcare delivered by HHSs:

*The combined public health response of Queensland and the Australian Governments have clearly played an important part in this result. The low numbers of patients with coronavirus and additional state investment have meant that hospitals have not only been able to care for them but also to continue to provide for patients with other acute needs.*¹⁴⁷

With respect to ICU capacity and management in Queensland during the pandemic, the QNMU reflected that, 'Health services have prepared for the potential increases in demand for intensive care unit (ICU) services, implementing rapid ICU upskilling and training for nurses to be deployed to ICU locations as needed.'¹⁴⁸

In relation to decisions by the National Cabinet concerning the suspension of non-urgent category 2 and 3 surgeries, ACSA submitted:

*The decision made by the National Cabinet to stop all urgent elective surgery and outpatient appointments enabled Queensland Health to double the number of intensive care beds or ventilated bed capacity across public and private hospitals in Queensland to 800 beds. This action was accompanied by the acquisition of more ventilators. The difficulty with stopping elective surgery for several months is that there is now a back log elective surgery cases which will affect the health and wellbeing of the older Australians.*¹⁴⁹

Also raising concerns about a backlog to surgery waiting lists, the RACGP stated that while it fully understands the need to pause elective surgery and category 3 referrals:

*... some GPs have reported the removal of patients from the waiting list entirely. Some HHSs rather than simply pausing category-3 patients removed them completely from the waiting list. Many GPs felt that they were not consulted in this process. Patients also remain concerned that if they are referred again that they will now go to the bottom of the waiting list. Some of these patients have already been waiting for one or two years for non-urgent but important procedures.*¹⁵⁰

On this matter, the RACGP requested additional resources from the Queensland Government, 'to ensure existing category-3 referrals are fast tracked and that new category-3 referral that have been withheld until after 1 August 2020 are seen as soon as it is possible'.¹⁵¹

QH advised in relation to these concerns that at the time of the National Cabinet decision, extensive negotiation was undertaken with private providers 'to develop agreements to ensure capacity was

¹⁴⁵ Submission 27, p 4.

¹⁴⁶ Submission 36, p 3.

¹⁴⁷ Submission 22, p 2.

¹⁴⁸ Submission 23, p 10.

¹⁴⁹ Submission 45, p 6.

¹⁵⁰ Submission 36, p 5.

¹⁵¹ Submission 36, p 5.

available across the whole health system to respond to COVID-19, as well as pass on the Australian Government's viability payment to support the ongoing operation of private hospitals.¹⁵² Further, to address the backlog as a result of pandemic decision making, the Queensland Government announced on 14 June 2020 an investment of \$250 million to support an increased capacity in elective surgery.¹⁵³

The CHO, Dr Young, also told the committee:

*Suspending certain non-elective surgery was very difficult and suspending the BreastScreen service was particularly difficult, but none of this was done without careful consideration of the impacts and the necessity for why it needed to be done.*¹⁵⁴

Palliative Care Queensland (PCQ) raised important considerations about ICU planning it felt were not adequately addressed, advising in their submission that in some countries and jurisdictions, ICU planning had been executed in accordance with plans for corresponding surges in palliative care.

PCQ stated:

We did not see this done in Queensland. Palliative Care is needed during a pandemic for Queenslanders who are dying without the virus, ensuring that care can still be provided to them and their family. Palliative care is also needed during a pandemic for Queenslanders who are dying with the virus. Bereavement care needs to be included in the palliative care for both cohorts as well.

...

*It appears that less planning and resourcing has been directed to ensuring the infrastructure needed to care for those who will die, from COVID-19 or otherwise, during the pandemic.*¹⁵⁵

QH advised it has undertaken a number of strategies to increase its capacity to deliver palliative care as part of its COVID-19 aged care response, including the funding of a project to bring together the temporary statewide expansion (excluding the Gold Coast) of specialist palliative care telephone service 'Pallconsult', negotiated agreements with pharmacists to stock and deliver palliative care medicines and 'the national caring@home project'.¹⁵⁶

The department also advised of actions by its Clinical Excellence Division to support the provision of palliative care in residential aged care facilities (RACFs):

*... Clinical Excellence Queensland has worked with Primary Health Networks and RACFs to determine the distribution and availability of imprest across Queensland RACFs. Queensland Health is also working with the Commonwealth in relation to the Commonwealth's proposed Comprehensive Palliative Care in Aged Care Measure.*¹⁵⁷

¹⁵² Queensland Health, correspondence dated 18 August 2020, p 11.

¹⁵³ Queensland Health, correspondence dated 18 August 2020, p 12.

¹⁵⁴ Public briefing transcript, Brisbane, 23 June 2020, p

¹⁵⁵ Submission 38, p 1; p 3.

¹⁵⁶ Queensland Health, correspondence dated 18 August 2020, p 41.

¹⁵⁷ Queensland Health, correspondence dated 18 August 2020, p 41. Note 'imprest' here refers to an authorised stock of medicines held by licensed health services (in this case, residential aged care facilities) for predetermined use, and supplied by a pharmacy or authorised seller of poisons. It does not refer to PPE or broader clinical stock.

4.7 COVID-19 testing and tracing

In an initial brief to the committee, QH stated the testing regime for SARS-CoV-2 (COVID-19) was conducted based on advice from the Communicable Diseases Network Australia¹⁵⁸ (CDNA), which is continually reviewed and updated.¹⁵⁹ In regards to early testing, QH initially focused on returning travellers with fever and/or respiratory symptoms, and the close contacts of those travellers. This was expanded on 25 January 2020 to include any person presenting with fever, or a history of fever, or acute respiratory symptoms. This was again expanded on 4 June 2020 to include any person who met clinical or epidemiological criteria as well as anyone who presented to a fever clinic, including those with atypical symptom presentations for COVID-19.¹⁶⁰

Concerning testing capacity, QH advised of its capacity to conduct up to 10,000 tests per day, across 29 public hospitals. QH also explained that due to the expansion of routine testing, results for 'most Queenslanders are available on average within 24 hours' however, for remote communities these may take up to three days due to the distance to the nearest laboratory.¹⁶¹ Importantly, QH also told the committee that through work with the Commonwealth Department of Health and the Kirby Institute, Point of Care Testing (PoCT) has continued to be rolled out in remote and isolated communities, providing testing capability to Aboriginal and Torres Strait Islander communities.¹⁶²

The committee was also informed by QH of the role of fever clinics and contact tracing to identify people who have contracted COVID-19. Fever clinic, which have operated out of the HHSs for people who may have contracted COVID-19. QH explained fever clinics are typically in emergency departments or separate areas to keep potentially infected people away from other areas of the hospital for the safety of patients and staff. The Commonwealth Government has also set up fever clinics across the country, including in Queensland.¹⁶³ Concerning contract tracing, QH stated it can commence contact tracing and outbreak response within four hours of a first case being notified to a relevant jurisdictional authority. According to QH, Public Health Physicians are available 24 hours a day to assist in tracing and additional staff have been trained to ensure capacity in the event of an outbreak.¹⁶⁴

Lastly, there has also been discussion of the role of pharmacies in the ongoing testing of COVID-19. In terms of expanding community testing capacity, the CHO, Dr Young, advised the committee that QH is planning a pilot trial to determine whether community pharmacies can test for COVID-19. Dr Young explained:

*We know there are still people with very mild symptoms who do not consider they might have COVID, but they often go to their local community pharmacy where they know the pharmacist and they have a relationship. That is why we think it would be useful to add that in as an extra benefit to the testing process in Queensland. At this stage it is a pilot. We will see how that works and see if there are any issues with it.*¹⁶⁵

¹⁵⁸ CDNA was established in 1989 as a joint initiative of the National Health and Medical Research Council of Australia and Australian Health Ministers' Advisory Council to provide national public health coordination and best practice prevention and control of communicable disease.

¹⁵⁹ Queensland Health, correspondence dated 18 August 2020, p 21.

¹⁶⁰ Queensland Health, correspondence dated 18 August 2020, p 21.

¹⁶¹ Queensland Health, correspondence dated 18 August 2020, p 22.

¹⁶² Queensland Health, correspondence dated 18 August 2020, p 22.

¹⁶³ Queensland Health, correspondence dated 18 August 2020, p 22.

¹⁶⁴ Queensland Health, correspondence dated 18 August 2020, p 30.

¹⁶⁵ Public hearing transcript, Brisbane, 19 August 2020, p 20.

4.7.1 Stakeholder views on COVID-19 testing and contact tracing

A number of submitters and witnesses before the committee expressed positive views about QH's COVID-19 testing regime and use of fever clinics and contact tracing to prevent the spread of COVID-19 in Queensland. Outlined below, stakeholders also raised considerations about: the 'transparency' of testing data for Aboriginal and Torres Strait Islanders, early testing criteria, public messaging about COVID-19 testing and the equity of access for vulnerable groups such as people living with disability and older Queenslanders.

Reflecting positively on the efforts of QH's response efforts early in the pandemic, the QNMU submitted:

Testing and contact tracing capacity has grown significantly as we understand more about the nature of the COVID-19 virus ... The QNMU acknowledges the exceptional efforts of the QLD Government to increasing testing and tracing capacity for COVID-19 transmission. The rapid increase in surveillance collection methods have informed QLD's public health response and contributed to the rapid decline in new cases.

*QLD has performed a record number of COVID-19 tests and has now reached capacity to perform 10,000 tests per day. Improving testing capacity has enabled QLD to also broaden groups and populations who are eligible for testing, such as conducting community testing within groups showing mild symptoms ...*¹⁶⁶

CRC proffered a similar view concerning its local HHSs' testing and tracing strategy:

*The significant efforts by Queensland Health and Pathology stakeholders to expedite a proactive and sustained Polymerase Chain Reaction swab testing regime, coupled with vigorous contact tracing, has undoubtedly resulted in successful treatment and recovery of confirmed COVID-19 patients without creating additional stress to Cairns Base Hospital surge capacities.*¹⁶⁷

QAIHC also expressed support for QH's testing response, noting that fever clinics were effectively established in all HHSs across Queensland. QAIHC added:

*The volume and geographical distribution of the clinics across the state was appropriate to need. In addition, Queensland Health has also supported the establishment of Australian Government funded fever clinic across Queensland. These were particularly successful in major regions and cities and removed early pressure on primary health care for testing which was a very positive outcome.*¹⁶⁸

The QAIHC also raised PoCT in its submission which noted:

*While the debate around the health risk of Point of Care Testing (PoCT) machines was underway, Queensland Health developed a hub and spoke model for testing which included identifying and building urgent testing capacity of five remote sites through use of helicopters to transport specimens. While the PoCT machines were yet to be approved for use within ATSI CCHOs, the hub and spoke model of testing provided intermediate relief for Aboriginal and Torres Strait Islander communities in a situation of great risk.*¹⁶⁹

While QAIHC acknowledge these efforts, they also raised concerns about the transparency of Aboriginal and Torres Strait Islander testing and screening data. To overcome the 'limited visibility' of

¹⁶⁶ Submission 23, p 7.

¹⁶⁷ Submission 9, p 5.

¹⁶⁸ Submission 32, p 9.

¹⁶⁹ Submission 32, p 10.

such data, QAIHC recommended QH 'build into policy a requirement that Aboriginal and Torres Strait Islander person status is collected on all pathology, fever clinic and notification forms'.¹⁷⁰

In response to the availability of Aboriginal and Torres Strait Islander COVID-19 data, QH advised the committee that this data is published in the COVID-19 statistics available on the relevant QH website. Further, 'The Aboriginal and Torres Strait Islander Health Division is in the process of developing routine reporting tools to allow for ongoing monitoring of First Nations COVID-19 cases in Queensland. This includes cases, recovered, deaths, hospitalisations and testing volumes by HHS'.¹⁷¹

QIMR Berghofer Medical Research Institute (QIMR BMRI) noted QH's response to the pandemic was 'by necessity, urgent and based on available, but incomplete, information'. Concerning testing criteria specifically, QIMR BMRI added:

*Also early in the pandemic, the criteria for testing were very tight. Again, this was understandable given the uncertainty about the disease incubation period and the possibility of asymptomatic transmission, and concerns over the availability of testing kits and the capacity of the public health system to handle testing. Now that the initial phase of the pandemic has been negotiated, it will be important to review if the testing criteria were too tight, or targeted at the wrong people.*¹⁷²

QH advised that the early testing criteria, however, in the first instance:

*Testing guidelines are determined by public health and laboratory experts based on available epidemiological evidence taking into consideration the availability of resources including testing kits. At the beginning of the pandemic testing was targeted at returning international travellers [sic], particularly from China, as the group most likely to be infected on arrival to Queensland. Since this time testing criteria have been expanded.*¹⁷³

The Australian Medical Association Queensland (AMAQ) in its submission raised concerns about communication around QH's testing strategy, noting Queenslanders were receiving 'conflicting and inaccurate information about when they need to be tested, and how they should approach testing'. The AMAQ added that although this messaging has been improving it caused, 'undue community distress and system inefficiency'. To resolve such issues the AMAQ stated, 'Involvement of the medical profession at all levels in planning and disseminating the public health message is essential'.¹⁷⁴

Concerns about a lack of clarity in public messaging about testing was also voiced by the PHAA which referenced the following quote from its submission to the Australian Senate Inquiry on COVID-19:

*... the development and roll-out of community COVID-19 testing services was not clearly articulated, and whilst it was pleasing to have the 'pneumonia/chest' clinics developed, the mechanism for access to these remains unclear.*¹⁷⁵

Noting the importance of testing, the AMAQ also submitted:

Testing is critical, and it must be an urgent priority to ensure that every Aboriginal and Torres Strait Islander health service is provided with testing kits, the associated consumables, and the necessary training. Specialised Indigenous health services and programs that respond to the needs of the majority of Aboriginal and Torres Strait Islander people who live in cities and towns

¹⁷⁰ Submission 32, p 19.

¹⁷¹ Queensland Health, correspondence dated 18 August 2020, p 26.

¹⁷² Submission 4, p 2.

¹⁷³ Queensland Health, correspondence dated 18 August 2020, p 15.

¹⁷⁴ Submission 26, p 1.

¹⁷⁵ Submission 27, p 6.

*must be made a priority and properly funded to provide greater protections coming out of this pandemic.*¹⁷⁶

Equitable access to testing was also recommended by the PHAA in its submission to the Australian Senate Inquiry. That submission was provided by the PHAA as an attachment to its submission to the committee. In particular, the PHAA recommended, 'Government should ensure that everyone in Australia, including asylum seekers, refugees, those on bridging visas, and temporary visa holders including migrant workers and international students, has access to testing and related treatment through the provision of access to Medicare'.¹⁷⁷

QDN raised the need for 'priority testing for people with disability and the disability workforce' in its submission.¹⁷⁸ The need to ensure testing is accessible to people living with a disability was also raised by the QHRC which has recommended that the Queensland Government consider, 'infection control training for all disability service and accommodation providers and guidelines for the screening and testing of people with disability and their carers'.¹⁷⁹

Concerning priority testing for healthcare workers, QH advised that workers who, 'come into contact with confirmed, probable, and suspect cases must be protected through the appropriate use of personal protective equipment in accordance with the recommended infection control guidelines. Healthcare workers with influenza-like illness must not work while they are symptomatic. They should be tested for SARS-CoV-2 and undergo isolation pending results'.¹⁸⁰

In relation to QH's provision of fever clinics for COVID-19 testing, ACSA recommended that, 'mobile fever clinics be operational within aged care facilities and aged care community care centres during the pandemic, particularly where there are suspected or confirmed cases of COVID-19, ensuring residents do not have to leave a facility for testing'.¹⁸¹ QH responded to this recommendation advising that, 'COVID-19 testing occurs at residential aged care facilities in line with the acute respiratory illness (suspected COVID-19) in RACF resident clinical pathway produced by Queensland Health. This pathway details isolation and treatment steps to be taken in managing suspected COVID-19 cases in residential aged care facilities'.¹⁸²

In terms of expanding community testing capacity, the CHO, Dr Young, advised the committee that QH is planning a pilot trial to determine whether community pharmacies can test for COVID-19. Dr Young explained:

*We know there are still people with very mild symptoms who do not consider they might have COVID, but they often go to their local community pharmacy where they know the pharmacist and they have a relationship. That is why we think it would be useful to add that in as an extra benefit to the testing process in Queensland. At this stage it is a pilot. We will see how that works and see if there are any issues with it.*¹⁸³

The pilot trial is discussed further in Part 7 of this report in relation to the delivery of a vaccine.

¹⁷⁶ Submission 26, 4.

¹⁷⁷ Submission 27, p 18.

¹⁷⁸ Submission 35, p 3.

¹⁷⁹ Submission 44, p 28.

¹⁸⁰ Queensland Health, correspondence dated 18 August 2020, p 16.

¹⁸¹ Submission 45, p 6.

¹⁸² Queensland Health, correspondence dated 19 August 2020, p 14.

¹⁸³ Public hearing transcript, Brisbane, 19 August 2020, p 20.

Committee comment

The committee acknowledges the overwhelmingly positive support expressed by submitters and other stakeholders during the inquiry for the Queensland Government's health response to COVID-19.

The committee also acknowledges the contributions and sacrifices made by frontline health workers in dealing with COVID-19. Those workers include:

- the public officials within Queensland Health and across the government working on the whole-of-government response to the pandemic
- the doctors, nurses and other staff at fever clinics
- emergency response workers and staff within the public health system working on contact tracing
- laboratory technicians and other private testing staff working on COVID testing, and
- Queensland Police Service and other agency staff involved in enforcing the Public Health Directions.

The actions taken by the government and key public officials such as the Chief Health Officer, Dr Jeannette Young PSM, were guided by well-advanced pandemic planning, and helped to minimise infection and transmission risks in the state at critical early stages of the pandemic.

The reliance of the government's actions on expert medical advice provided by the Chief Health Officer and other experts within Queensland Health have ensured very high levels of respect and compliance within the community with Public Health Directions and other advice to reduce infection and transmission risks.

On this note, the committee also acknowledges the contribution of individual Queenslanders who acted on expert advice and restricted their movements and exposure risks to COVID-19.

The committee notes the important contribution that community pharmacies currently make in protecting the health of Queenslanders. With respect to the QH pilot trial of COVID-19 testing in community pharmacies and the authority provided by the Commonwealth to enable pharmacists to administer a viable COVID-19 vaccine if or when it becomes available, the committee also acknowledges the important role pharmacies will continue to play in supporting Queensland's frontline health system to COVID-19, and looks forward to considering the results of the trial.

Recommendation 1

That the Queensland Government formally acknowledges frontline workers in Queensland Health and other agencies across the government for their contributions to the government's health response to COVID-19.

Minister responsible: Premier and Minister for Trade

Recommendation 2

That Queensland Health continues to engage with stakeholders to provide information about future Public Health Directions and other changes to government policy related to the COVID-19 health response.

Minister responsible: Deputy Premier and Minister for Health and Minister for Ambulance Services

5 Public Health Directions

During a declared public health emergency, the CHO has powers granted under the Public Health Act to issue Public Health Directions (PHDs) 'to assist in containing, or respond to, the spread of COVID-19' in Queensland.¹⁸⁴ PHDs have played, and continue to play, a central role in the Queensland Government's health response to COVID-19.

In Queensland there are currently PHDs in effect that restrict: movement across the Queensland Border, including access into Queensland via the international border; going out, travel, recreating and gathering; and the operation of businesses, activities and undertakings.¹⁸⁵

Reflecting on the complexity of PHDs, the CHO told the committee that, given the constantly changing nature of the COVID-19 pandemic, decisions about changes to restrictions in Queensland are managed on a day by day basis.¹⁸⁶ Similarly, Commissioner Katarina Carroll, QPS, told the committee that COVID-19 had created a dynamic environment in which changes to PHDs could occur on a daily and even hourly basis.¹⁸⁷

5.1 Public messaging and interpretation of Public Health Directions

A range of strengths and limitations concerning the public messaging about the CHO's PHDs were identified by stakeholders. A common theme to arise from the committee's inquiry relates to the effectiveness of public health messaging to educate and inform Queenslanders on restrictions; and, to inform industries of changes to business operations as a result of restrictions.

The QNMU advised the committee that through the effective dissemination of information to the general public, Queenslanders were, 'well informed and engaged in the state's response'.¹⁸⁸ Supportive of this, PHAA associated Queensland's, 'very low numbers of coronavirus cases, intensive care unit patients and deaths', as a result of, 'Queensland Government policies and public education initiatives within the collective National response'.¹⁸⁹

The RANZCP expressed strong support for QH's public health messaging in its submission which stated, 'the Queensland Government's commitment to providing updates to the public through consistent and clear messaging based on medical advice has also played a key role in helping the community deal with the concerns and uncertainties of the pandemic especially during quarantine'.¹⁹⁰ This sentiment was supported by the submission from Shooters Union Queensland (SUQ) which outlined that most of the health response, especially the community education about social distancing and awareness of the signs/symptoms of COVID-19 was, in its view, conducted 'very well'.¹⁹¹

In terms of ensuring public messaging was readily interpretable by all Queenslanders, the QHRC submitted that QH's, 'Policy and Action Plan for CALD Communities has focused on ensuring there is translated material about COVID-19 made available to culturally and linguistically diverse communities'.¹⁹²

¹⁸⁴ Queensland Health, 'Chief Health Officer public health directions', <https://www.health.qld.gov.au/system-governance/legislation/cho-public-health-directions-under-expanded-public-health-act-powers>.

¹⁸⁵ Queensland Health, 'Chief Health Officer public health directions', <https://www.health.qld.gov.au/system-governance/legislation/cho-public-health-directions-under-expanded-public-health-act-powers>.

¹⁸⁶ Public hearing transcript, Brisbane, 19 August 2020, p 29.

¹⁸⁷ Public hearing transcript, Brisbane, 19 August 2020, p 24.

¹⁸⁸ Submission 23, p 5.

¹⁸⁹ Submission 27, p 4.

¹⁹⁰ Submission 8, p 1.

¹⁹¹ Submission 15, p 2.

¹⁹² Submission 44, p 16.

Highlighting the importance of translating PHDs, QHRC also submitted:

*This was an important step, because it went some way to ensuring that people with English as a second language became aware of their obligations. Without access to information on the Public Health Directions, there is a risk that CALD communities might disproportionately and unfairly receive infringement notices.*¹⁹³

However, not all stakeholders found the Queensland Government's public health messaging user-friendly or accessible. For example, QDN advised the committee:

*For people with disability, access to information about COVID-19 in user-friendly and accessible as part of the public health promotion information was critical. People with disability reported as the emergency unfolded, a range of experiences and barriers to getting factual information about the coronavirus, what it meant for them and what they needed to do. QDN was able to rapidly produce user-friendly information about COVID-19 both in written and video formats, which were publicly shared on 24 March 2020 so that Queenslanders with disability had access to user-friendly information in the early phases of the declared worldwide pandemic and state of emergency.*¹⁹⁴

In response to these matters, QH advised that it has provided funding to QDN and Health Consumers Queensland to develop a 'know your rights' health advocacy tool for COVID-19, which is in the final stages of development. The committee was also advised that QH has since, 'worked with the Department of Communities, Disability Services and Seniors and QDN to provide clarification of Public Health Directions and other advice to people with disability'.¹⁹⁵

The committee heard that blanket public health messaging was problematic for particular cohorts, for example the Lung Foundation Australia (LFA) advised the committee that people living with very complex lung diseases require 'more much tailored information than hand washing'.¹⁹⁶ The need for more tailored messaging was highlighted by the wait times for advice on the LFA's 1800 health line. Mr Mark Brooke, Chief Executive Officer, LFA, told the committee there has been an almost '600 per cent increase in the number of Australians with lung disease seeking tailored information about COVID and their disease' and that the LFA's usual call times had risen from 20 minutes per patient, to 55 minutes per patient and a four-week waiting list for call backs.¹⁹⁷

Difficulties with the use of blanket messaging were also raised by Ms Melissa Fox, Chief Executive Officer of Health Consumers Queensland, who stated:

*Another thing that is important is recognising that blanket messaging does not work. That was something that we heard early on, particularly from the members of our network when they or their loved ones live with multiple complexities in their lives and pre-existing health conditions. They really needed that nuanced messaging—and they still need that nuanced messaging—about how to remain socially engaged and active and have a full life whilst also protecting themselves. It is challenging when we see that restrictions are lifted and certain things are possible within the confines of social distancing, but that is challenging in some environments.*¹⁹⁸

The relevance of public health messaging was also a concern for some Queensland communities. For example, the QAIHC told the committee that in the early stages of the pandemic, 'QH did not have the capacity to develop culturally safe communications about COVID-19, with Minister Miles confirming

¹⁹³ Submission 44, p 16.

¹⁹⁴ Submission 35, pp 4-5.

¹⁹⁵ Queensland Health, correspondence received 18 August 2020, p 21.

¹⁹⁶ Public hearing transcript, Brisbane, 19 August 2020, p 15.

¹⁹⁷ Public hearing transcript, Brisbane, 19 August 2020, p 12.

¹⁹⁸ Public hearing transcript, Brisbane, 13 July 2020, p 16.

that a few weeks into the pandemic no suitable resources existed for Aboriginal and Torres Strait Islander populations'.¹⁹⁹ The QAIHC also advised the committee:

At the Direction of the now Deputy Premier, IUIH [Institute for Urban Indigenous Health] and QAIHC were engaged to coordinate and distribute a series public health communications. Given the expediency of the issue and the delay in sourcing Queensland Health funding, both organisations initially provided this assistance to Queensland Health at our own expense. This type of service delivery is not sustainable for community organisations.

*The public health directions released by Queensland Health were not always translated into directions suitable for lower socio-economic, more remote settings or relevant to the social determinants of health context that is reality for many Aboriginal and Torres Strait Islander peoples in Queensland. For example, the guidance to "use the spare bedroom with the ensuite to self-isolate" is not an option in most remote community households or where overcrowding is present.*²⁰⁰

From the perspective of older Queenslanders, COTA informed the committee that the Queensland Government needed to, 'more effectively balance the messaging' during the public health emergency. This related COTA's view public health messaging focused too much on older Queenslanders. COTA submitted that, 'Yes, some older Queenslanders were at greater risk of contracting COVID-19, but not all older Queenslanders were at equally high risk. Many Queenslanders under 65 were also in the high-risk category due to existing illnesses, however, the focus remained on older Queenslanders'.²⁰¹

The Queensland Alliance for Mental Health (QAMH) submitted that 'rapid and regular changes in messaging to the community and workforce', did not resolve 'heightened confusion and anxiety'.²⁰² Also identifying issues regarding the clarity of messaging to the general public, the Health Ombudsman, Mr Andrew Brown, advised the committee that the multiple channels of information available to the public was a source of confusion for Queenslanders. Mr Brown explained:

*Despite the creation of a National Coronavirus Helpline and the existence of the Queensland Health enquiries line (13 HEALTH), there were multiple potential sources of information and this appeared to cause confusion to members of the public (as well as challenges for the OHO to correctly redirect callers to the appropriate information source). Further, there was some indication of confusion at the agency level, with callers reporting referral between multiple agencies. There appeared to be no clear, single point of contact for all enquiries that could provide all relevant information.*²⁰³

The Queensland Health Ombudsman, Mr Andrew Brown, also commented that there appeared to be, 'some confusion evident among health service providers as to what the current restrictions or guidelines were'. As a result of this confusion, Mr Brown noted that, 'a significant proportion' of the complaints received by the OHO concerned how health services were to be provided during the pandemic'. Mr Brown further highlighted the following themes in complaints:

- *refusals to provide health services to people*
- *a lack of precautions or unnecessary precautions being taken in providing treatment*
- *unnecessary or unsuccessful referrals for testing or failures to refer for testing.*²⁰⁴

¹⁹⁹ Submission 32, p 13.

²⁰⁰ Submission 32, p 13.

²⁰¹ Submission 6, p 9.

²⁰² Submission 47, p 5.

²⁰³ Submission 29, p 2.

²⁰⁴ Submission 29, p 2.

Concerning the interpretation of PHDs, the issue of what was deemed an 'essential service' under the CHO's PHDs, the confusion this caused and the consequences of this for the community was raised by a number of stakeholders.²⁰⁵ The Australian Association of Social Workers advised the committee that despite being:

*... a key allied health service, social work is often missing in services for older people outside of hospitals and particularly in residential aged care. During the lockdown this has meant that attention to the emotional needs of individuals has been limited and while we recognise that many aged care services have worked hard to support residents with psychosocial distress and anxiety, the lack of qualified and experienced personnel to do this means gaps to service delivery.*²⁰⁶

Exercise and Sports Science Australia (ESSA) also raised issues about the definition of 'essential service' in relation to the continuity of allied health services during the pandemic. ESSA's submission stated:

*Whilst the issuing of public health directions in Queensland has worked relatively well, there is a lack of understanding that some businesses operate both non-essential and essential services in the same facilities. The decision to close gyms and fitness studios as non-essential services on 22 March, 2020 had unintended consequences, restricting access for patients to clinical healthcare delivered by Accredited Exercise Physiologists (AEPs) using gym spaces for rehabilitation and exercise therapy.*²⁰⁷

The 'essential' versus 'non-essential' distinction for business restrictions under the CHO's PHDs also created issues for Queensland's rural sector. Submissions from SUQ and Firearm Dealers Association Queensland expressed concern that the decision to close gun shops, firearms dealers and armourers under *Non-essential Business, Activity and Undertaking Closure Direction (No. 4)* (Direction No. 4) had negatively impacted the rural sector.²⁰⁸ In its submission, the SUQ told the committee:

*Most gunshops are mixed businesses (that is, they sell not only firearms and ammunition but also a range of other goods) and this was a particular problem in rural areas, where many of our members are primary producers or occupational users of firearms. The breadth of Direction meant that primary producers or occupational users of firearms could not even make purchases online or send their firearms for repair during the period of restriction imposed by the Direction.*²⁰⁹

In response to these issues, QH advised that following the first signs of the flattening of the curve, QH in consultation with DPC, Treasury, QPS, DAF and industry supported changes to Direction No. 4, 'to ensure licensed gun shops, gun dealers, and armourers and those who rely on their services were not unnecessarily negatively impacted by restrictions'. On 9 April 2020, *Non-essential Business, Activity and Undertaking Closure Direction (No. 5)*, eased restrictions on weapons dealers and licensed armourers to allow the supply of weapons and ammunition, 'to prescribed persons who required a weapon for occupational purposes relating to primary production, animal welfare, nature conservation or pest management, and veterinary surgeons'.²¹⁰

²⁰⁵ See for example submission 9, 15, 19, 24 and 28.

²⁰⁶ Submission 33, p 11.

²⁰⁷ Submission 28, p 6.

²⁰⁸ Submissions 15 and 24.

²⁰⁹ Submission 15, p 5.

²¹⁰ Queensland Health, correspondence dated 18 August 2020, pp 7-8.

5.2 Operation of Public Health Directions

Some stakeholders commented on the operation of PHDs and their impacts for Queenslanders. Specific aspects raised include border restrictions, mandatory quarantine protocols and the observance of social distancing by the general public.

While previous section 5.1 notes the support for public health measures, such as border restrictions to prevent the spread of COVID-19, one submission recommended Queensland borders open in alignment with a date nominated by the Prime Minister to, 'allow for industry to reopen'.²¹¹ This view is in contrast to other submissions which recommend domestic borders remain closed until COVID-19 cases are brought under control in other states.²¹²

The LFA advised that border restrictions had negatively impacted access to tertiary care centres for people with lung cancer living in the border communities of Victoria-New South Wales. Mr Mark Brooke, Chief Executive Officer, LFA, stated there had not been any Queensland specific commentary yet but, 'being able to easily access care cross-border is incredibly important to particularly patients with severe lung disease and/or lung cancer'.²¹³

The committee notes that effective 20 August 2020, *Border Restrictions Direction (No. 12)* permitted entry to Queensland from a hotspot for essential medical care without an exemption when the medical care cannot be provided in the hotspot.²¹⁴ Additionally, QH advised the committee that border controls have been a 'key component in Queensland's strategy and success to date keeping Queenslanders safe'.²¹⁵ Importantly, since submissions closed to the inquiry, the status of COVID-19 infections rates in New South Wales and Victoria have increased, posing significant risk to Queensland.²¹⁶ As a result of this, QH advised:

Queensland has had to strengthen border protections again to guard against the risks posed by the recent epidemiological situation in other jurisdictions. The Chief Health Officer decision to revise border directions has been based on public health considerations for Queensland, in response to the evolving situation in Victoria and NSW and increased numbers of attempted and actual breaches of border restrictions. As of Saturday 8 August 2020, the Chief Health Officer has declared all of NSW and the ACT, COVID-19 hotspots in addition to all of Victoria.

...

*Collaboration across government facilitates a whole of Government response, to enable the striking of a balance between keeping Queenslanders safe and with the economic considerations, Queensland Health has played a role in channeling [sic] information between government and the Chief Health Officer. Ultimately, the Chief Health Officer makes decisions regarding border closures based on what is necessary to assist in containing, or to respond to, the spread of COVID-19.*²¹⁷

²¹¹ Submission 7, p 1.

²¹² See submission 2.

²¹³ Public hearing transcript, Brisbane, 19 August 2020, p 14.

²¹⁴ Queensland Health, 'Chief Health Officer Public Health Directions Update', <https://www.qld.gov.au/health/conditions/health-alerts/coronavirus-covid-19/current-status/public-health-directions/border-restrictions>.

²¹⁵ Queensland Health, correspondence dated 18 August, p 33.

²¹⁶ Queensland Health, 'COVID-19 hotspots', <https://www.qld.gov.au/health/conditions/health-alerts/coronavirus-covid-19/current-status/hotspots-covid-19>.

²¹⁷ Queensland Health, correspondence dated 18 August, p 33.

5.3 Public Health Directions and human rights

Submissions to the inquiry raised a number of issues concerning the impact of PHDs on vulnerable Queenslanders and, in some cases, the limitations of human rights under the *Human Rights Act 2019*. Key areas of concern for stakeholders included the rights of people with disabilities, the rights of people living in 'closed environments', such as correctional or detention facilities, Aboriginal and Torres Strait Islanders and older Queenslanders. Mandatory quarantine conditions were also raised as a human rights concern.

5.3.1 Impacts on people with disability

Specifically, the Public Advocate drew the committee's attention to amendments made to the *Disability Services Act 2006* (Qld) (DSA) and the *Forensic Disability Act 2011* (Qld), during the public health emergency, which 'restrict the freedom of movement of people with disability and their access to services and the community'. For example, amendments to the DSA:

*... provide for the locking of gates, doors and windows by disability service providers to ensure a person with disability complies with a public health direction. It provides immunity from criminal and civil liability for disability service providers if they act (i) honestly and without negligence; (ii) in compliance with the policy made by the department; and (iii) takes reasonable steps to minimise the impact on a person living at the premises who is not a relevant adult with an intellectual or cognitive disability.*²¹⁸

The Public Advocate advised the committee that there appeared no rationale or justification for these amendments:

*A key concern is the absence of any identified or demonstrated need for these amendments. Other than general statements about protecting the health, safety and wellbeing of people with disabilities and the broader community, there is no clear explanation in the explanatory notes or the statement of Consistency with Fundamental Legislative Principles of the purpose of the amendments and why they are needed.*²¹⁹

QDN raised concerns about people with disability residing in congregate house settings such as group homes or supported accommodation facilities. In particular, QDN received 'numerous reports' of congregate housing settings:

... restricting the rights of people with disability beyond what was required under public health directives. This included not allowing outside support staff who deliver essential disability services to enter and restricting visits by family members. Of concern to QDN was that many of these conditions were being more strictly enforced even as COVID-19 restrictions for the general public were being eased.

...

*QDN members reported significant inconsistencies in how public health directives were being implemented in congregate settings and more broadly what was considered an 'essential service'. People with disability received different advice on what support workers were 'essential' depending on which service providers they spoke to. In extreme cases, this left some people with disability without any formal disability supports during the peak of the pandemic.*²²⁰

In response to these concerns, QH advised:

To date, the Chief Health Officer has not directed the locked down of disability accommodation or other supported accommodation settings, with the exception of Aged Care. This is in

²¹⁸ Submission 11, p 4.

²¹⁹ Submission 11, p 4.

²²⁰ Submission 35, pp 8-9.

*recognition of QHRC's recommendations that restrictions must be reasonable, necessary and proportionate to the health risk. On behalf of the Chief Health Officer, Queensland Health has undertaken initial consultation on how a Public Health Direction could be applied to disability accommodation services.*²²¹

The QHRC highlighted the disproportionate impact of PHDs on people with disability and the importance of considering alternative strategies before reducing services:

*... there appears to have been limited recognition of the fact that general restrictions might be inappropriate, or might disproportionately impact people with disability. The distress suffered by people with some disabilities if confined at home, the greater importance of social contact, activities and outings, and confusion as to the definition of 'essential services' under public health directions are just some examples. Reductions in services should only occur after considering the impact on the health and safety of the individual, and the substitution of alternative in-home services. Careful consideration of these issues, supported by clear and early messaging to people with disability and their supports, and effective avenues for complaint, would have eased anxiety and avoided potentially harmful reductions in services to this cohort.*²²²

QDN noted similar concerns about the disproportionate impact of PHDs on Queenslanders with disability:

*Access to ongoing care to have regular health care needs met is critical, and for some QDN members, as 'non-essential' health care was ceased, this had significant impact on their day to day functioning and pain management. ... These 'non-essential' health care services play a key role in meeting people's day to day needs and will need to be more thoroughly considered to reduce the impact on people with disability's physical and mental health.*²²³

To support Queenslanders with disability during the pandemic, QH advised the committee that on 23 March 2020 it commenced daily meetings to discuss the NDIS (COVID-19) Plan of Action. The focus of these meetings was to coordinate assistance for participants of the NDIS and other people with disability. On 1 April 2020, QH advised it stood up a COVID-19 Working Group on Disability Support with representatives from key advocacy organisations and relevant Queensland Government agencies. The Working Group produced the *QH COVID-19 Disability Policy and Action Plan* with actions that commenced immediately. Through these groups, QH has encouraged the National Disability Insurance Agency and service providers to ensure people with disability continue to receive essential services.²²⁴

5.3.2 Impacts on people living in closed environments

The human rights of people living in closed environments such as prisons and youth detention centres was another area of concern arising from the Queensland Government's health response to COVID-19. The QHRC told the committee people living in closed environments are at a greater risk of infection than the general population due to, 'shared facilities, difficulties in implementing social distancing and

²²¹ Queensland Health, correspondence dated 18 August 2020, p 22. Between 29-31 July 2020, Queensland Health consulted with the Queensland Human Rights Commission, Queenslanders with Disability Network, Department of Communities, Disability Services and Seniors, Disability Connect Queensland, Office of the Public Advocate, Office of the Public Guardian, Department of Housing and Public Works, Supported Accommodation Providers' Association, National Disability Services and the National Disability Insurance Scheme Quality and Safeguards Commission.

²²² Submission 44, p 14.

²²³ Submission 35, pp 7-8.

²²⁴ Queensland Health, correspondence dated 18 August 2020, p 21.

isolation, the potential for workers to bring infection in from the community, and the often compromised health conditions of residents'.²²⁵

The QHRC commended the Queensland Government for the 'immense success achieved by protecting and preserving the lives of people in closed environments', however to ensure compatibility with human rights, the QHRC advised that closed environments will need to be continuously monitored. The QHRC submission stated, 'As community infection rates decline, lockdown measures must continue to be reasonable, necessary, and proportionate to the health risk'.²²⁶

The QHRC advised that actions taken during the pandemic, such as lockdowns, have engaged the right to humane treatment while deprived of liberty and the ongoing compatibility with human rights needs to be considered. For example:

*Many closed environments have been subject to lockdowns of varying degrees during the pandemic, resulting in bans or limits on visits from family, friends, advocates and others. Denying people in closed environments access to family visits can result in significant mental health concerns for them. Visitors also provide informal oversight, and a way to complain and seek review, which is particularly important in the absence of formal oversight mechanisms, such as the Community Visitor Program or an independent prison inspector.*²²⁷

In response to these matters, the QHRC advocated for the need for transparency in relation to PHDs, in particular for the Queensland Government to provide a rationale for its management of COVID-19 in closed environments where the same objective could be achieved with less restrictions on rights.²²⁸

In response to issues raised by stakeholders concerning closed environments and congregate housing, QH advised the committee that epidemiological evidence has highlighted these settings pose a greater risk of COVID-19 exposure given the, 'higher concentration of people in close contact over an extended period'. Further, 'industry-specific workforce arrangements', such as the casual workforce relied upon in aged care facilities, can in combination with the difficulty in maintaining social distance in such settings, be more conducive to outbreaks.²²⁹

5.3.3 Impacts on Aboriginal and Torres Strait Islander people

Concerning the rights of Aboriginal and Torres Strait Islander Queenslanders, the QHRC noted the inconsistency of the application of public health restrictions imposed by the Australian Government on designated Indigenous communities, and those imposed by the Queensland Government for the rest of the state which, 'caused significant frustration in some communities, including Palm Island and Yarrabah', and significantly impacted on freedom of movement in and out of these communities.²³⁰

Highlighting this inconsistency, the QHRC submitted:

... the Queensland Chief Health Officer lifted restrictions imposed on Aboriginal and Torres Strait Islander communities in other parts of the state on 16 May 2020. Throughout May, the Queensland Government also relaxed restrictions across Queensland, and allowed residents to travel greater distances. In contrast, restrictions under the Commonwealth Biosecurity Act remained static until 12 June 2020, thereby preventing residents of designated Indigenous

²²⁵ Submission 44, p 6.

²²⁶ Submission 44, p 6.

²²⁷ Submission 44, p 7.

²²⁸ Submission 44, p 8.

²²⁹ Queensland Health, correspondence dated 18 August 2020, p 21.

²³⁰ Submission 44, p 18.

*communities from travelling as far as other people in Queensland and requiring many to quarantine for 14 days.*²³¹

In consideration of these issues, QH advised that human rights were considered by the CHO in her decision-making to restrict access to remote communities; and, that this was done in consultation with the mayors of the remote communities and were, 'considered necessary for a temporary period to protect the health and safety of the remote communities'. Further, on 10 July 2020, the Commonwealth Direction on remote Indigenous communities was revoked, effectively removing all travel restrictions affecting remote communities.²³²

5.3.4 Impacts on older Queenslanders

COTA advised the committee of its concerns that COVID-19 disproportionately impacts Queenslanders aged 65 years and older. In particular, COTA told the committee that QH's *Queensland ethical framework to guide clinical decision making in the COVID-19 pandemic*, potentially limits older Queenslanders right to life under the *Human Rights Act 2019*. According to COTA the document, 'provides an ethics based framework to assist in making clinical decisions about whether to withdraw or withhold life-sustaining measures from a patient at a time when those medical resources must be rationed due an overwhelming demand for intensive clinical support generated by a pandemic'.

COTA explained its view that this document potentially limits the right to life by rationing access to urgently required healthcare to seriously ill people on the basis of their age. Mr John Stalker, Policy Coordinator, COTA added:

*The need to have this framework to manage health service provision is understandable. However, what was not acceptable was the fact that the framework could single out and deny those seriously ill with the virus over 65 years of age from accessing life-sustaining treatment. These concerns deepened when it was realised that the safeguards contained within the Human Rights Act could be overridden by parliament in exceptional circumstances such as a threat to public safety, health or order. COTA Queensland accepts that situations may arise that necessitate the limitation of rights. However, at no time should such a limitation have an adverse health or safety impact on any individual or be based on the age of an individual.*²³³

In response to concerns raised about the *Queensland ethical framework to guide clinical decision making in the COVID-19 pandemic*, QH advised the committee that this document is currently under review.²³⁴

5.3.5 Impacts on people in mandatory quarantine

The QHRC advised the committee of its concerns surrounding the provision of access to fresh air and exercise for individuals required to undergo mandatory quarantine. The committee heard that many people reported being confined to rooms, 'with no opening windows or balconies' and, that time outside was at the discretion of QPS. The Queensland Council of Civil Liberties (QCCL) also reported having received a number of complaints from people who had completed hotel quarantine and were not allowed outside to access fresh air. QCCL highlighted that, 'Hotel rooms are not meant to be lived in 24 hours a day for 14 days. They are generally only used for sleeping and changing clothes'.²³⁵

The QHRC submitted these quarantine protocols are, 'unacceptable given that international human rights standards entitle prisoners to a minimum of one-hour fresh air and exercise per day', and that 'appropriate accommodation should be provided that allows safe access to fresh air and exercise,

²³¹ Submission 44, p 18.

²³² Queensland Health, correspondence dated 18 August 2020, p 24.

²³³ Public hearing transcript, Brisbane, 19 August 2020, p 39.

²³⁴ Queensland health, correspondence dated 25 August 2020, p 1.

²³⁵ Submission 40, p 5.

taking the particular needs of each person under quarantine into account'.²³⁶ Noting the ongoing need to quarantine as the COVID-19 pandemic continues to unfold, the QHRC added:

*Mandatory hotel quarantining of people arriving from overseas since 28 March 2020 may have significantly contributed to the success of 'flattening the curve' in Queensland. However, in view of the fact that mandatory quarantining is likely to continue for some time, and people quarantined will be required to pay from 1 July 2020, the conditions under which quarantine occurs needs to be reconsidered in order to ensure that human rights are respected.*²³⁷

In relation to Queensland's quarantine process, the QCCL raised concerns that the power to detain a person for 14 days provided under Part 7A of the Public Health Act has no right of review. QCCL submitted, 'it is fundamental that a person who is detained has a right of review before a Court'. QCCL noted in its submission that the removal of the right of review has been justified on the basis that the significant number of people likely to be detained during the public health emergency would burden the court and divert resources of public health officials.²³⁸

QH noted these concerns about quarantine conditions and advised, 'areas and individuals within QH have liaised with the QHRC and other agencies' on the matter. QH also stated the State Disaster Coordination Centre has and continues to, 'work closely with industry to identify appropriate hotel accommodation for those individuals in self-quarantine. The increase in the number of people in self-quarantine with the introduction of mandatory hotel quarantine for persons travelling to Queensland from COVID-19 hotspots has placed additional pressure on accommodation resources'.²³⁹

Additionally, QH told the committee that moving people in quarantine, before the completion of the 14 days, represents a transmission risk, therefore:

*The appropriateness of wellness breaks must be considered in this context facilitating such breaks has the potential to place additional people at risk, including hotel staff and Queensland Government staff managing quarantine. Persons arriving from overseas continue to be the single most common source of COVID-19 infection in Queensland.*²⁴⁰

Another submitter, Mr Brett Tobin, advised the committee of his family's negative experience of the quarantine process which while, 'well meaning, actually isolates, ostracizes and vilifies those people'. In his submission, Mr Tobin detailed receipt of multiple quarantine notices with conflicting advice received from QH which caused him and his family great distress.²⁴¹ In response to Mr Tobin's experience, QH advised the committee it is following up with him directly on these matters.²⁴²

In response to the concerns about testing during hotel quarantine, QH told the committee, 'Work to develop guidelines for screening and testing for COVID-19 in hotel quarantine, focusing on testing at the end of the quarantine period, was completed on 6 July 2020. All HHSs with quarantine hotels have implemented end of quarantine testing based on the guidelines'.²⁴³

²³⁶ Submission 44, p 12.

²³⁷ Submission 44, p 11.

²³⁸ Submission 40, p 4.

²³⁹ Queensland Health, correspondence dated 18 August 2020, p 19.

²⁴⁰ Queensland Health, correspondence dated 18 August 2020, p 19.

²⁴¹ Submission 31, p 1.

²⁴² Queensland Health, correspondence dated 18 August, p 20.

²⁴³ Queensland Health, correspondence dated 18 August, p 20.

In response to the human rights issues raised by stakeholders and the need for further publically available rationales of PHDs, QH advised there are a range of factors considered by the CHO when making a COVID-19 PHD, including:

... the epidemiological situation globally, nationally and in Queensland; public health system capacity to respond to outbreaks (i.e. contact tracing, testing), health system capacity to deal with a sudden surge in demand for care (i.e. PPE, ventilators and medication availability); and community adherence and acceptance of control measures (i.e. social distancing, quarantine requirements). All these factors are considered according to the need for protecting Queenslanders from the risks associated with COVID-19 while seeking to minimize social and economic disruption to the community. Queensland Health is considering the feasibility of publishing these consideration [sic].²⁴⁴

Committee comment

The committee notes the enormity of the task that has been undertaken by the Queensland Government, specifically Queensland Health, in ensuring that Queenslanders receive timely public health messaging concerning Public Health Directions, and COVID-19 health advice generally.

The committee commends the Queensland Government on its work to date, and notes the importance of providing information via a range mediums and the advantages associated with blanket messaging.

To ensure public health messaging on COVID-19 reaches all Queenslanders and can address their particular health circumstances, the committee recommends that public health messaging platforms are diversified to ensure cohorts of Queenslanders with complex health issues, or increased vulnerability to COVID-19, receive tailored advice to suit their information needs and addresses how they can stay safe during the pandemic.

The committee notes that Public Health Directions have been based on expert medical advice. The committee notes that Queensland Health is actively addressing the issues raised, including the feasibility of publishing further information supporting the department's decisions to issue Public Health Directions.

Recommendation 3

That Queensland Health ensures its public health messaging platforms are diversified and developed to ensure cohorts of Queenslanders with complex health issues, or increased vulnerability to COVID-19, receive tailored advice to suit their information needs and addresses how they can stay safe during the pandemic.

Minister responsible: Deputy Premier and Minister for Health and Minister for Ambulance Services

²⁴⁴ Queensland Health, correspondence dated 18 August 2020, pp 5-6.

6 Ensuring continuity of care across the health sector

This section discusses the following issues concerning the continuity of care in the wider health sector during the COVID-19 pandemic:

- the availability of PPE for frontline health workers
- telehealth services, and
- emergency dispensing and digital prescriptions.

6.1 Personal Protective Equipment (PPE)

The provision of PPE in Queensland is a split responsibility with QH providing PPE to the public health workforce, distributed to its HHSs across the state. Private practitioners however, are required to source their own PPE, although during a national public health emergency such as COVID-19, the Commonwealth Government, through its federally funded Primary Health Networks²⁴⁵ (PHNs), is required to distribute PPE from the National Medical Stockpile²⁴⁶ (NMS) where possible.²⁴⁷

QH has advised the committee that, in the early stages of the pandemic, sourcing sufficient PPE stocks was a high priority, 'to ensure the wellbeing and safety of staff and to ensure COVID-19 patients could be appropriately cared for'.²⁴⁸

Dr Young told the committee:

*I am not sure that anyone in the world expected to have an outbreak of a disease in a city where the vast, vast majority of the world's masks were made. They were not sending those masks out of Wuhan because they needed them there. That is where the vast majority of the world's surgical masks came from.*²⁴⁹

In a written brief to the committee, QH outlined a range of measures taken to ensure Queensland frontline health staff would have access to the required levels of PPE. This includes a COVID-19 PPE demand planning and modelling tool. However, QH noted, as the pandemic unfolded in early 2020 reaching pandemic status:

... local and international supply chains progressively became volatile as panic ordering and demand far outstripped supply. In Queensland, the impact of global infection rates started to be realised for supply and procurement from mid to late-January and progressed to include restriction of supply and notification of forced allocation from key suppliers. These market conditions worsened over time, making it increasingly difficult to source PPE and other critical

²⁴⁵ Australian Department of Health, 'Primary Health Networks', <https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN-Background>. Primary Health Networks were established to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care. Through practice support, they work closely with general practitioners and other health professionals to build health workforce capacity and the delivery of high quality care.

²⁴⁶ Australian Department of Health, 'National Medical Stockpile', <https://www.health.gov.au/initiatives-and-programs/national-medical-stockpile>. The National Medical Stockpile is a strategic reserve of drugs, vaccines, antidotes and personal protective equipment for use in national health emergencies. We purchase and stockpile these items so Australia is more self-sufficient during an emergency and able to meet high levels of demand.

²⁴⁷ Submission 13, p 4.

²⁴⁸ Queensland Health, correspondence dated 17 June 2020, p 22.

²⁴⁹ Public hearing transcript, Brisbane, 19 August 2020, p 30.

*items, leading to a fundamental change in the way sourcing, procurement and supply teams operate in order to ensure surety of supply.*²⁵⁰

To highlight the procurement conditions CHO, Dr Jeannette Young, told the committee:

*To illustrate the impact of the market and the international supply challenge to source all of that PPE, a simple surgical facemask, which used to cost 60 cents, is selling for \$6.*²⁵¹

The committee heard that these conditions led to Queensland Government ministers convening an 'Executive Governance Oversight Committee for PPE procurement in March 2020, led by Directors-General from: QH; the Department of State Development, Manufacturing, Infrastructure and Planning; and the Department of Housing and Public Works, supported by the DPC. According to QH, the oversight committee's focus was:

*... to solely focus on demand and supply of critical PPE items and emerging critical items. This included diverse purchasing arrangements to optimise the opportunity for current supplier and manufacturers to meet existing and future demand, the provision of specifications for critical PPE items for manufacturers, and support for fit testing and clinical appropriateness aligned with Therapeutic Goods Administration (TGA) approval.*²⁵²

In a written brief, DPC advised the committee:

*Manufacturers or businesses having difficulties accessing supplies to operate, employ staff and meet their customer needs could access this Queensland Government service, which enabled them to retool to provide essential PPE for health workers, such as gowns, N95 masks, face shields and hand sanitiser.*²⁵³

On 19 May 2020, the Premier announced \$50 million to develop and expand manufacturing and production capacity of health consumables, devices and PPE. This is in addition to the \$1.2 million committed on 5 April 2020 to support Logan's Evolve Group to commence making N95 medical masks to help meet the need for PPE.²⁵⁴

QH stated that its demand modelling tool could be used to forecast PPE usage in the event of an outbreak; and that to identify shortages early, daily reporting mechanisms on pandemic and non-pandemic stock levels were established. QH explained that daily reporting included, 'tracking of available stock, forecast days of coverage of existing stock and the status of orders (i.e. total quantity of orders, percentage of those fulfilled and quantity of items still to be delivered)'.²⁵⁵

6.1.1 Stakeholder views on levels and access to Personal Protective Equipment

The availability of PPE for frontline medical and community health staff has been a key concern to submitters and witnesses before the committee. While some stakeholders commended QH's efforts to procure PPE, concerns were raised during the inquiry regarding conflicting advice as to where emergency supplies of PPE could be obtained; and whether QH or the Commonwealth-funded PHNs are responsible for its distribution.

²⁵⁰ Queensland Health, correspondence dated 18 August 2020, pp 22-23.

²⁵¹ Public briefing transcript, Brisbane, 23 June 2020, p 4.

²⁵² Queensland Health, correspondence dated 18 August 2020, p 23.

²⁵³ Department of the Premier and Cabinet, correspondence 16 June 2020, p 13.

²⁵⁴ Department of the Premier and Cabinet, correspondence 16 June 2020, p 13.

²⁵⁵ Queensland Health, correspondence dated 18 August 2020, p 23.

For example, while the QNMU commended the Queensland Government's 'efforts to resource local PPE supply chains and work towards providing adequate supplies of PPE to health services around Queensland', it also submitted:

*... it is important to recognise that in the early stages of the pandemic, QLD's stockpile and supply chains were inadequate to cope with the potential demand. QLD health services were forced to be diligent about appropriate use and monitoring of PPE, leaving health professionals vulnerable to the potential risks of contracting COVID-19.*²⁵⁶

Queensland PHNs (QPHNs) submitted to the committee that PHNs had a range of roles to play in responding to COVID-19 including, 'surgical masks and other PPE distribution' and that in each of these tasks:

... the QPHNs drew extensively on the knowledge, data, connections, and relationships they have built across the Hospital and Health Services (HHSs) and the primary health and community sectors. They were able to move rapidly, problem-solve locally and use their existing primary health models and resources to adapt and to scale up to deliver the necessary COVID-19 response.

*Responses were also initiated by the PHNs themselves, again leveraging their relationships with GPs and wider primary care clinical provider networks and communities in their regional and local areas to assist preparedness and facilitate the COVID-19 health response.*²⁵⁷

However, the RACGP in its submission noted difficulties experienced by its members in seeking to obtain PPE from PHNs:

Unfortunately the logistical challenges faced in ensuring PPE was made available where it was needed most appeared to overwhelm some PHNs, resulting in restricted access for practices. When stock was available there were long waits and only limited supplies and generally only surgical masks were provide, not the other important items such P2/N95 masks, gloves, gowns and protective eyewear.

...

*The lack of supply of PPE and the confusion and a lack of transparency regarding supply and distribution created unnecessary stress, concerns and a decline in morale for many Queensland GPs. While the government advice to patients who felt unwell was to see their GP, some GPs reported feeling unsafe to work due to a lack of PPE.*²⁵⁸

The Queensland Alliance for Mental Health told the committee of a range concerns within the community health sector about access to, and the wearing of, PPE:

*Whilst we were informed that it was not necessary for home visiting, I think it was complicated by the different views in the media and different reports around the world about whether masks and PPE should be used in public spaces and those sorts of things. Probably what it did was lead to anxiety from both consumers and staff about whether they should have access to PPE. It just was not available to the community mental health sector. It was being prioritised for GPs—which I totally understand. What it probably led to in our sector was real anxiety in the workforce and high absence rates of staff who were delivering direct services.*²⁵⁹

The CRC also raised concerns about the availability of PPE to community based human and social services, in particular of the disruption to frontline services. According to CRC, this was due to an

²⁵⁶ Submission 23, p 5.

²⁵⁷ Submission 13, p 4.

²⁵⁸ Submission 36, pp 5-6.

²⁵⁹ Public hearing transcript, Brisbane, 19 August 2020, p 7.

acute shortage of PPE, 'resulting in increased risk and anxiety. This included vital personalised in-home care for people with a disability, those living with a life-threatening illness or age-related mobility issues for example'.²⁶⁰

ACSA were also critical of the ability to obtain PPE during the pandemic, including the Commonwealth Government's messaging on distribution:

At the onset of the pandemic the Queensland Government ordered in advance large quantities of PPE, centralised the procurement supply chain and utilised local manufacturers to produce PPE. ACSA members had difficulty in obtaining PPE from local manufacturers and suppliers of PPE and the Primary Health Networks who distributed PPE.

...

*ACSA members raised concerns about messaging by the Department of Health on how and when to access PPE from the National Stockpile and how efficiently the supplies of PPE could be distributed by Queensland Health to aged care facilities especially remote regional facilities.*²⁶¹

In response to these concerns, CHO, Dr Jeannette Young advised the committee that the aged-care sector has since received online and face-to-face training about the use of PPE within the sector. Dr Young also explained, in the event of a positive case in a RACF, QH now has an agreement with the Commonwealth whereby, 'We [QH] provide the first three days of PPE that an aged-care facility needs', which would then be replaced by the Commonwealth.²⁶²

The PSA expressed to the committee the need for pharmacists, as frontline healthcare workers, to be protected against COVID-19 to protect staff and patients. The PSA reported, 'The overall experience of the pharmacy profession during this pandemic has been that equitable and timely distribution of personal protective equipment (PPE) for pharmacists in primary care and in hospitals did not occur'.²⁶³

The PSA, whilst it acknowledged the Australian Government is responsible for management of the National Medical Stockpile, sought assurances from the Queensland Government that, in future public health emergencies, adequate PPE supplies will be planned for, negotiated and procured to ensure pharmacists and other essential health workers in this state can be properly protected.²⁶⁴

In response to the concerns raised with the committee by private practitioner member groups such as the RACGP and PSA, QH advised that supply of PPE to private providers is managed by the Commonwealth Department of Health, through the NMS and that QH's role, 'is limited to acting as a logistics partner to support the delivery of PPE to private aged care providers and other private providers'.²⁶⁵

Concerning PPE stock levels and distribution to Queensland's public health workforce, QH advised:

The pandemic has shown that clinical stock supply reserves can be strengthened to build resilience against future significant events. Consequently, on 25 June 2020 the Deputy Premier and Minister for Health and Ambulance Services announced that the Queensland Government is establishing a critical supply reserve to protect against future supply chain disruption and ensure all essential frontline workers have access to critical clinical supplies and equipment (Queensland Clinical Stockpile).

²⁶⁰ Submission 9, p 4.

²⁶¹ Submission 45, p 7.

²⁶² Public hearing transcript, Brisbane, 19 August 2020, p 21.

²⁶³ Submission 37, p 10.

²⁶⁴ Submission 37, p 10.

²⁶⁵ Queensland Health, correspondence dated 18 August 2020, p 17.

*This strategic reserve of supplies will put Queensland in a strong position, enhancing the resilience of the supply chain and storage networks for the critical supplies vital to maintaining essential services and supporting frontline workers.*²⁶⁶

At the public hearing on 19 August 2020, CHO, Dr Young, explained that Queensland's PPE stocks at the beginning of the pandemic were the largest in the country other than the Commonwealth stockpile. In response to concerns about access to PPE for frontline workers such as general practitioners, Dr Young explained:

*There was always the intent that the Commonwealth stockpile would be utilised for the primary healthcare sector, and indeed it was. GPs and pharmacists could access the Commonwealth's stockpile through the primary healthcare networks, and they did. A lot of GPs made a decision at that time—which I think was very sensible—that they would not be testing patients because that is when you actually needed the PPE. Instead, they would assess patients using telehealth, and the Commonwealth government put out Medicare item numbers very, very quickly to enable GPs to do that. So they would organise telehealth appointments, assess their patients and refer patients to the nearest testing centre. Then I provided, out of the state stockpile, PPE to those testing centres so they could safely test patients.*²⁶⁷

In addition, the DPC advised the committee that in the early stages of the pandemic QH had received numerous, unsolicited offers to supply PPE. An online portal was established by QH and the former Department of State Development, Manufacturing, Infrastructure and Planning to identify, match and manage supply chain shortages. DPC also advised:

Manufacturers or businesses having difficulties accessing supplies to operate, employ staff and meet their customer needs could access this Queensland Government service, which enabled them to retool to provide essential PPE for health workers, such as gowns, N95 masks, face shields and hand sanitiser.

*On 19 May 2020, the Premier announced \$50 million to develop and expand manufacturing and production capacity of health consumables, devices and PPE. This is in addition to the \$1.2 million committed on 5 April 2020 to support Logan's Evolve Group to commence making N95 medical masks to help meet the need for PPE.*²⁶⁸

A critical demand planning and forecasting process was implemented, including a risk adjustment procurement approach to enable Queensland Health to plan supply needs and support the needs of Hospital and Health Services.²⁶⁹

At the public hearing on 19 August 2020, Dr Young assured the committee that any concerns about PPE availability and stockpiles for Queensland had been resolved by the Queensland Government. Dr Young stated:

*There will be no situation in Queensland, no matter how many cases we had—and I desperately hope we do not have the cases—where we would not have the PPE that is needed. We do not just have that one storage facility that was seen yesterday, we have multiple because, of course, you do not want to put all of your equipment into one place and risk losing that whole facility so we have multiple. We have plenty of PPE going forward. Indeed, PPE is now being produced here in Brisbane, which is even better. There is no risk of people working in Queensland in the primary healthcare sector or in the NDIS sector or in the aged-care sector running out of PPE.*²⁷⁰

²⁶⁶ Queensland Health, correspondence dated 18 August 2020, p 16.

²⁶⁷ Public hearing transcript, Brisbane, 19 August 2020, p 30.

²⁶⁸ Department of the Premier and Cabinet, correspondence dated 16 June 2020, p 13.

²⁶⁹ Department of the Premier and Cabinet, correspondence dated 16 June 2020, p 13.

²⁷⁰ Public hearing transcript, Brisbane, 19 August 2020, p 21.

Committee comment

The committee notes the importance that frontline health workers across all sectors place on having access to reliable stocks of PPE during public health emergencies such as the COVID-19 pandemic. For these frontline workers, PPE is a critically important barrier to help minimise infection and transmission risks to protect their own health and safety, as well as the welfare of family members and other they live and interact with. Having and wearing PPE is also critically important for frontline health workers to protect the health and safety of their patients, particularly those patients who are weak and frail or have compromised immune systems.

The committee notes the actions by the Queensland Government, including substantial investments in local manufacturing capacity, to ensure the security of supply of PPE in the state. In the event of a global public health emergency which impacts on commercial supplies of PPE, it is imperative that emergency PPE reserves are available for use by frontline health workers across all health sectors so they can continue to provide essential health services.

In addition to the Queensland Government funding dedicated to PPE announced in April and May 2020, the committee acknowledges that on 18 August 2020 the Premier and the Minister for Health announced a major expansion of Queensland's PPE supplies to protect against COVID-19 and any other health threat. This future proofing of Queensland's PPE boosted the Queensland stockpile by tens of millions of pieces, housed in the newly expanded storage site located in Inala.

Concerning the distribution of PPE, the committee notes the logistical difficulties experienced by Queensland's PHNs in managing access to the emergency PPE reserves during the COVID-19 pandemic. The committee believes the Australian Government needs to better support and empower its PHNs to be able to access and logistically supply PPE through the national stockpile to distribute emergency supplies to support GPs, residential aged care facilities and allied health providers.

The committee also acknowledges the vital role played by Queensland Health in providing emergency stocks of PPE to general practitioners under an agreement brokered with the Commonwealth Government.

Recommendation 4

That the Australian Government better supports and empowers its Primary Health Networks to access personal protective equipment supplies from the National Medical Stockpile to distribute emergency stock to general practitioners, residential aged care facilities and allied health workers as required in the event of an outbreak.

Minister responsible: The Australian Minister for Health

6.2 Telehealth

'Telehealth' and related virtual health services have emerged during the COVID-19 pandemic as a key platform for continuity of primary health care in Queensland, and across Australia. On 30 March 2020, the Hon Greg Hunt MP, Minister for Health, in a joint media release with Professor Michael Kidd AM (now Deputy Chief Medical Officer) announced the expansion of Medicare-subsidised telehealth services for all Australians, providing extra incentives for their use by general practitioners and other health practitioners.²⁷¹ Minister Hunt stated:

We are making telehealth a key weapon in the fight against the COVID-19 pandemic. Expanding the consultation services available by telehealth is the next critical stage in the Government's response to COVID-19.

²⁷¹ The Hon Greg Hunt MP, Minister for Health, 'COVID-19: Whole of population telehealth for patients, general practice, primary care and other medical services', media release, 29 March 2020.

Services will include GP services and some consultation services provided by other medical specialists, nurse practitioners, mental health treatment, chronic disease management, Aboriginal and Torres Strait Islander health assessments, services to people with eating disorders, pregnancy support counselling, services to patients in aged care facilities, children with autism, and after-hours consultations.

...

The new arrangements will commence on Monday 30 March and will be in place until 30 September 2020, when they will be reviewed in light of the need to continue our battle against COVID-19.²⁷²

QH advised the committee that utilising telehealth to increase health services delivery flexibility across the state as a part of the expansion of the health system to respond to COVID-19, which the Queensland Government committed \$1.2 billion to on 24 March 2020.²⁷³ At the time of writing, the Commonwealth Government had not confirmed whether telehealth funding would be extended beyond 30 September 2020. However, Minister Hunt commented on 10 July 2020 that he intended that telehealth would be a positive legacy of the COVID-19 crisis and was already engaged with the medical community in planning telehealth's long-term future.²⁷⁴

6.2.1 Stakeholder views on telehealth and continuity of medical care

Submitters and witnesses before the committee had mixed views on the use of telehealth during the COVID-19 pandemic and as an ongoing option for health care in Queensland. While most stakeholders acknowledged the benefits of telehealth in terms of continuity of medical care, particularly during the public health emergency, a number of stakeholders noted that telehealth may not be an appropriate method of delivering care to all cohorts.

PHAA outlined some of the broader benefits of telehealth services for Queensland as a highly decentralised state:

The state of Queensland has a large and dispersed regional population which represents challenges for health care access at the best of times. ... Looking forward, efforts should be made to maintain telehealth resources ... to enable dispersed populations to maintain and initiate engagement with routine health and wellbeing checks including cancer screening and non-communicable disease support.²⁷⁵

Similarly, ACSA noted telehealth is 'extremely relevant' for Queensland given, 'the geographical vastness of the state and the remoteness of some rural residential aged care facilities'; and that telehealth had enabled residents to continue to 'meet' with their GP during the pandemic.²⁷⁶

QDN's submission reflected a similar view, noting the benefits of telehealth for people living with a disability. The submission stated:

For many people with disability, calls for more responsive, accessible, virtual models of care, and 'closer to home' care models have been ongoing over many decades. Whilst it is not a one size

²⁷² The Hon Greg Hunt MP, Minister for Health, 'COVID-19: Whole of population telehealth for patients, general practice, primary care and other medical services', media release, 29 March 2020.

²⁷³ Queensland Health, correspondence dated 17 June 2020, p 14.

²⁷⁴ The Hon Greg Hunt MP, Minister for Health, 'Continuous care with telehealth stage seven', media release, 10 July 2020.

²⁷⁵ Submission 27, p 6.

²⁷⁶ Submission 45, p 10.

*fits all, many QDN members have reported positive benefits and outcomes from these changes to the way health services have been delivered over the past four months.*²⁷⁷

However, QDN also highlighted that it is well known that people with disability are rated one of the groups with the, 'lowest rating on the national digital inclusion index' associated with, 'poorer access to technology and lower skills and digital literacy'. To ensure equity of access to telehealth services, QDN submitted:

*QDN, therefore, sees an urgent need for training and support to enable people with low digital literacy skills to access online and virtual tele-health and allied health therapies. This is a critical and ongoing need that will need to be addressed. In the post COVID-19 environment, as health and a range of other essential services move to more virtual models of care that rely on digital devices, equity of access to service will be at risk for people with disability.*²⁷⁸

A number of barriers to telehealth have been identified by RACGP, for example, 'concerns have been raised about how to conduct a high-quality and effective health assessment that is valued by the patient via telehealth'. The RACGP noted that for Aboriginal and Torres Strait Islander Queenslanders telehealth 'needs to be culturally safe, well-resourced and supported'.²⁷⁹

The RACGP also identified a number of barriers for patients of culturally and linguistically diverse (CALD) backgrounds, and those from refugee and asylum seeker backgrounds, including:

- limited English language skills
- reduced access to technology including phones and internet connectivity
- a lack of video consultation platforms currently available that enable the use of interpreters
- the unavailability of the Translating and Interpreting Service (TIS National) for video consultations (video consultations offer a layer of 'visual examination' and non-verbal information, superior to telephone consultations, which is particularly useful where language barriers exist), and
- an increase in mental health symptoms, compounded by past experiences of trauma.²⁸⁰

Queensland University of Technology, Faculty of Health (QUT) noted the need for further research on telehealth, 'to optimise client outcomes', including:

- *the effectiveness of telehealth services, such as in the area of therapeutic alliance between psychologists and their clients;*
- *ethical and legal issues, including safe environments for telehealth, ensuring confidentiality and privacy; and*
- *practical issues involving internet access and technology.*²⁸¹

The importance of face-to-face consultations was raised by a number of stakeholders. For example, QDN advised its members reiterated that virtual healthcare 'does not meet everyone's needs' and that there remains a need for 'ongoing choice' in healthcare delivery.²⁸² Similarly, other witnesses before the committee acknowledged the need for 'one-to-one' physical consultation and examination. Dr Bruce Willett, Queensland Chair, RACGP, told the committee, 'not all medical practice

²⁷⁷ Submission 35, p 5.

²⁷⁸ Submission 35, p 7.

²⁷⁹ Submission 36, p 8.

²⁸⁰ Submission 36, p 8.

²⁸¹ Submission 25, pp 2-3.

²⁸² Submission 35, p 7.

can be conducted by telehealth. The figure I would give is about 30 per cent of general practice is appropriate for telehealth. You do have to examine patients at times'.²⁸³

In agreement, Professor Brett Emmerson, Chair of the Queensland Branch of the RANZCP advised the committee that while telehealth is a 'great option to have', telehealth does not remove the need for face-to-face and one-to-one interactions in psychiatry.²⁸⁴

Mr Mark Brooke, CEO of LFA, highlighted the importance of telehealth as one option along a continuum of care: Telehealth was rolled out remarkably quickly. I think is a world-leading example of how Australia was very agile in meeting the needs of patients, but for people with lung disease it is part of an answer. There has to be a blended approach. It is very difficult to do spirometry via a television screen. Older Australians will warm to it, but it needs to be considered as part of a continuum of care and not just substituted as a low-cost base for delivering services.²⁸⁵

Committee comment

The committee acknowledges the important role played by telehealth services in ensuring continued access to essential primary health services during the COVID-19 pandemic. The committee notes that, regrettably, the Australian Government's temporary telehealth funding is due to cease on 30 September 2020.

The committee recommends that the Premier seek support from other government leaders at the National Cabinet for the Australian Government to provide ongoing funding to support the availability of telehealth through the provision of permanent Medicare item numbers for telehealth services in Australia so these vital services are available beyond 30 September 2020.

Recommendation 5

That the Premier seeks support through the National Cabinet for the Australian Government to provide ongoing funding through the provision of permanent Medicare item numbers to support the extension and availability of telehealth services in Australia beyond 30 September 2020.

Minister responsible: Premier and Minister for Trade

6.3 Emergency dispensing and digital prescriptions

During the public health emergency, continuity of medical care and the need to consider COVID-safe practices that limit the spread of the virus generated discussion amongst stakeholders concerning permanent changes to the way in which medicine can be dispensed and prescribed in Queensland. QH noted access to medicines during the acute stage of the pandemic and as it continues to unfold has been a key issue reported by pharmacy stakeholders.²⁸⁶

Concerning emergency dispensing arrangements, the National Health (Continued Dispensing - Emergency Measures) Determination 2020 (the Determination) expanded the list of medicines that may be supplied by community pharmacies as a Pharmaceutical Benefit or Repatriation Pharmaceutical Benefit under continued dispensing arrangements. The Determination allows an approved pharmacist to supply a Pharmaceutical Benefit/Repatriation Pharmaceutical Benefit medicine to a patient without a current prescription, on the basis of a previous prescription from a

²⁸³ Public hearing transcript, Brisbane, 19 August 2020, p 5.

²⁸⁴ Public hearing transcript, Brisbane, 19 August 2020, p 9.

²⁸⁵ Public hearing transcript, Brisbane, 19 August 2020, p 13.

²⁸⁶ Queensland Health, correspondence dated 19 August 2020, p 44.

Pharmaceutical Benefit prescriber.²⁸⁷ The PSA recommended that these emergency dispensing arrangements should be permanently adopted in legislation.²⁸⁸

Further, Professor Trent Twomey, President and Senior National Vice-President, PGAQ, also supports the extension of emergency dispensing arrangements, and added:

The No. 1 medication misadventure, or medication safety issue, and the PSA referred to this also, is people actually running out of their medicine because of unnecessary red tape. This is not pharmacists prescribing ... this is about pharmacists just keeping Queenslanders on the medication that the prescriber has intended. Whether it be in a first wave, a second wave, whether it be indeed not in a pandemic situation, Queenslanders, Australians in that respect, run out of their medication every week.

*In fact, the continued dispensing arrangements which have been expanded by the Commonwealth and enabled by the Queensland government, saved 75,000 ED presentations and GP presentations between the months of April and May this year alone. That is a nationwide figure. It had zero cost to the taxpayer. It did not have just direct savings to the taxpayer, both at a state and a federal level because of those prevented admissions and presentations, but also it had increased productivity benefits and increased health benefits because Queenslanders and Australians were able to stay on their medication.*²⁸⁹

In relation to medicine supply shortages, the PGAQ also recommended that further consideration be given to pharmacist therapeutic substitution, whereby a medicine prescribed to an individual but which is unavailable is substituted for another medicine, may be dispensed by pharmacists without the need to consult the prescriber. This is currently permitted in the United States and Canada.²⁹⁰

In response, QH advised that to improve access to medicines during the pandemic it amended the Communicable Diseases Program Drug Therapy Protocol to enable pharmacists to supply a Schedule 4 (prescription only) medicine without a prescription and also to supply an alternative Schedule 4 medicine (with or without a prescription) as per a protocol developed and published by the Therapeutic Goods Administration (TGA)²⁹¹. QH added:

*Pharmacist substitution as per a TGA protocol (known as Serious Shortage Medicine Substitution Notices) was the preferred model supported by the TGA and jurisdictions to provide a nationally consistent approach. Once the TGA publishes a Serious Shortage Medicine Substitution Notice, pharmacists in Queensland are immediately able to perform a medicine substitution in accordance with the Notice and Communicable Diseases Program DTP [Drug Therapy Protocol] while the current declared public health emergency relating to COVID-19 remains in place.*²⁹²

In relation to image based prescriptions, the Commonwealth Government's National Health (COVID-19 Supply of Pharmaceutical Benefits) Special Arrangement 2020 (the PBS Special Arrangement) made, 'temporary changes to medicines regulation to make the supply of medicines during the COVID-19 pandemic more convenient and effective. One of the measures in the PBS Special Arrangement

²⁸⁷ Queensland Health, *Fact sheet: Continued Dispensing – Emergency Measures*, https://www.health.qld.gov.au/data/assets/pdf_file/0026/954026/fs-continued-dispensing.pdf.

²⁸⁸ Submission 37, p 4.

²⁸⁹ Public hearing transcript, Brisbane, 13 July 2020, p 3.

²⁹⁰ Submission 14, pp 3-4.

²⁹¹ The Therapeutic Goods Administration is responsible for monitoring medicine shortages and facilitating alternative supply arrangements. Intelligence on medicine shortages impacting on community pharmacies should be shared with the Therapeutic Goods Administration.

²⁹² Queensland Health, correspondence dated 18 August 2020, p 45.

amends the usual rules for prescribing under the Pharmaceutical Benefits Scheme to allow supply of a medicine on a digital image of a prescription and provide an alternative to posting prescriptions'.²⁹³

To support this measure, an amendment was made to Queensland's legislation, the *Health (Drugs and Poisons) Regulation 1996* (Qld) that:

- enables a prescriber to send a digital image of a prescription to a dispenser; and
- gives a temporary exemption from the requirement to send paper copies of prescriptions to dispensers, other than prescriptions for controlled (Schedule 8) drugs, restricted drugs of dependency²⁹⁴ and anabolic steroids.²⁹⁵

The AMAQ supported the initiative and told the committee:

*Fast tracking e-Prescribing and the Special Arrangement have been important steps to reduce the risk of COVID-19 transmission. Electronic methods of prescribing reduce the need for patients to come into a medical practice unnecessarily, and, in conjunction with telehealth and pharmacy home delivery services, reduce the need for vulnerable patients to leave their home to receive medication.*²⁹⁶

Committee comment

The Australian Government's temporary arrangements allowing emergency dispensing and dispensing of medicines using image based prescription have been a convenient and effective strategy for managing the supply of medicine during the COVID-19 pandemic. These special arrangements have been complementary to telehealth services and should continue, like telehealth, on a permanent basis after the COVID-19 pandemic.

The committee also notes the important contribution that community pharmacies make to the state's health system in helping to protect the health of Queenslanders.

Recommendation 6

That the Premier seeks support through the National Cabinet for the Australian Government to make permanent the temporary changes to prescribing contained in the Australian Government's National Health (COVID-19 Supply of Pharmaceutical Benefits) Special Arrangement 2020 to allow emergency dispensing arrangements and dispensing based on digital images of prescriptions.

Minister responsible: Premier and Minister for Trade

²⁹³ Queensland Health, *Image based prescriptions: Information for prescribers*, https://www.health.qld.gov.au/_data/assets/pdf_file/0025/966202/fs-prescribers-imagebased-prescriptions.pdf.

²⁹⁴ Restricted drugs of dependency are listed in Appendix 8 of the Health (Drugs and Poisons) Regulation 1996 and include benzodiazepines, codeine and phentermine.

²⁹⁵ Queensland Health, 2020, *Image based prescriptions: Information for pharmacists*, <https://www.health.qld.gov.au/_data/assets/pdf_file/0024/966201/fs-pharmacist-imagebased-prescriptions.pdf - accessed 26 August 2020>.

²⁹⁶ Submission 26, p 4.

7 Continuing to protect Queenslanders

This section concludes the interim report by considering the learnings of the Queensland Government's health response to the COVID-19 pandemic to date and their importance in protecting the health of Queenslanders looking forward. A number of vaccine development projects currently underway in Queensland are outlined, including consideration of how Queensland might distribute and administer a viable vaccine. Finally, brief examination of Queensland's current COVID-19 status, alongside a high-level comparison with New South Wales and Victoria, highlights the need to remain vigilant as the pandemic continues to unfold.

7.1 Looking forward

Queensland's strong position in relation to COVID-19 is not only attributable to the Queensland Government's timely and effective health response, but to the Queensland community which has contributed to the collective response in preventing the spread of COVID-19. Both government officials and stakeholders have acknowledged the efforts made by Queenslanders and their resilience in the face of the new way we must live due to COVID-19.

Commissioner Katarina Carroll, QPS, told the committee that overwhelmingly, Queenslanders have been 'extraordinary' in the COVID-19 response.²⁹⁷ Similarly, the CHO, Dr Jeannette Young PSM, acknowledged the commitment of Queenslanders and the impact of COVID-19 on Queensland lives:

I do want to take this opportunity to acknowledge and thank every single Queenslanders who has made a sacrifice to support our response to COVID-19 in this state. As a result of all those efforts and everyone's contribution to the response I know we have saved Queenslanders' lives.

*We understand that the response has completely changed the way we work, socialise and carry out our day-to-day activities. We acknowledge that we did not have a significant amount of time to prepare or ease into those restrictions, as of course we would have preferred to have done, because we knew that every single delay could cost lives and have catastrophic consequences. We needed to act very quickly so we could stop the spread of the virus before it became unmanageable.*²⁹⁸

Reflecting on the challenges Queensland has faced since the initial stages of the pandemic, Dr Young added:

*Our response has been challenging, and we have had to make some very difficult decisions to ensure that Queenslanders' lives were protected. While protecting the health of Queenslanders has, of course, been the primary goal of our response, we have also had to consider the impacts to the economy, to individual businesses and the enormous social impacts that the response has had on Queenslanders. Those are matters that none of us have taken lightly. I, of course, never took lightly the restrictions that I had to impose on people in relation to some very significant events, particularly funerals, and also the requirement for people to postpone other major life events such as weddings, significant birthdays and other celebrations.*²⁹⁹

COTA referenced the collective Queensland response in its submission which stated the, 'actions undertaken by the Queensland Government, health care workers and the broader community have ensured that to date the numbers infected have not been as high as originally forecast'.³⁰⁰

²⁹⁷ Public hearing transcript, Brisbane, 19 August 2020, p 28.

²⁹⁸ Public briefing transcript, Brisbane, 23 June 2020, p 3.

²⁹⁹ Public briefing transcript, Brisbane, 23 June 2020, p 2.

³⁰⁰ Submission 6, p 1.

Similarly, the QNMU commented on the solidarity of Queenslanders in responding to the challenges of COVID-19:

*The QNMU also commends the Queensland community for their response to such adversity. The manner in which the vast majority of Queenslanders have reacted to the pandemic has demonstrated outstanding social solidarity and a commitment to be united to address such a significant and unprecedented threat.*³⁰¹

With no currently available vaccine or treatment for COVID-19, the committee received an update from the CHO concerning Queensland's way forward. Dr Young, shared with the committee, 'what we might expect to see going forward':

I believe—and experts believe—that there are four conceivable ways out of this pandemic: natural herd immunity, the virus mutating to become less contagious or less severe, effective treatments, or a vaccine. All Australian jurisdictions have rejected the natural herd immunity approach from day one of this pandemic as we knew the cost would be devastating in terms of lives lost. There is now considerable evidence that the virus that causes COVID-19, SARS-CoV-2, is not mutating to become less infectious. It is mutating—viruses do—but its characteristics are remaining the same.

*There are several treatments for COVID-19 that are currently being explored by researchers across the world and clinicians are looking at currently available treatments and therapeutics, and some of them have shown some great promise. This includes medication already being used to treat other diseases such as dexamethasone and remdesivir; convalescent plasma therapy, which involves giving people with severe symptoms, severe disease, convalescent plasma from recovered patients to boost their ability to fight the virus; and then there are some new antiviral medications in the pipeline. That is all encouraging.*³⁰²

7.1.1 Vaccine development and distribution in Queensland

The importance of a vaccine to protect the health of Queenslanders is widely acknowledged.³⁰³ A number of institutions in Queensland are currently conducting research in Queensland to understand COVID-19, develop a vaccine, improve testing and diagnostics, and examine impacts on the health system and workforce and the community.³⁰⁴

QIMR BMRI are currently conducting a suite of COVID-19 research projects, including research aimed at, 'laboratory screening of existing and potential new drugs, developing a test to detect who has immunity to the virus, and understanding why some patients become severely sick while others develop only mild symptoms'. Senior Scientist and Acting Director, Professor David Whiteman commented on the importance of detecting whether someone has previously carried the virus:

*At the moment, no test can tell us if someone has previously been infected and has recovered, only if someone is currently infected. It looks likely that those who have recovered will have immunity against reinfection. This is important to know, since immune people can re-join the workforce and help support the economy. Our researchers will work towards developing a test that shows who has been infected and recovered so that those people, in particular doctors and nurses, can be at the front line of the response.*³⁰⁵

³⁰¹ Submission 23, p 3.

³⁰² Public hearing transcript, Brisbane, 19 August 2020, p 18.

³⁰³ See for example submissions 12, 14, 26, 27, 32,

³⁰⁴ Research Australia, *COVID-19 Series: Report 1 – COVID-19 How Australia's health and medical research sector is responding*, pp 35-41.

³⁰⁵ QIMR Berghofer Medical Research Institute, 'QIMR Berghofer fast tracks vital coronavirus research', <https://www.qimrberghofer.edu.au/2020/03/qimr-berghofer-fast-tracks-vital-coronavirus-research/>.

During the public hearing on 19 August 2020, the committee received an update on vaccine development from the CHO and discussed how a vaccine might be distributed in Queensland. Dr Young explained:

*There are currently over 160 candidates in development worldwide and some have entered human trials, including here at the University of Queensland. Having said that, we do of course need to be realistic that if—and hopefully when—a vaccine candidate is proven to be suitable, effective and appropriate, it is a massive task to scale that vaccine production to population-wide levels. A lot of work has already started in that space. I think we should be hopeful that a vaccine will be developed, but realistically we also need to expect to be fighting COVID-19 without one for potentially the next 12 months and possibly longer. Until we have a vaccine, our best defence will still be to slow the spread of the virus through all of the strategies we have done to date, in particular physical distancing, good hygiene and testing people as soon as they might have it.*³⁰⁶

Due to the University of Queensland's (UQ) existing vaccine technology, UQ was tasked by the Coalition for Epidemic Preparedness to develop a coronavirus vaccine, in collaboration with the Doherty Institute. On 26 August 2020, UQ reported pre-clinical testing of its COVID-19 vaccine had, 'produced positive indications about its potential effectiveness and manufacturability'. Associate Professor Keith Chappell, UQ project co-leader, explained that in, 'hamster models, the vaccine combined with the Seqirus MF59® adjuvant, provided protection against virus replication, and reduced lung inflammation following exposure to the virus'.

Minister for State Development, Tourism and Innovation, Hon Kate Jones MP, made a statement acknowledging a, 'vaccine is vital in putting an end to this pandemic. That's why the government has thrown its support behind UQ with \$10 million in funding to fast-track this research'.³⁰⁷ On 27 August 2020, Deputy Premier and Minister for Health and Minister for Ambulance Services, Hon Dr Steven Miles MP, announced the call for volunteers to take part in the next stage of clinical trials on Queensland's coronavirus vaccine. The announcement stated that following positive results from the first stage of testing, UQ now has approval to extend phase one clinical trials to people aged 56 and over.³⁰⁸

In relation to the administration of a viable vaccine for COVID-19, submissions from PGAQ and the PSA raised issues about the vaccines pharmacists are authorised to administer and the locations where it is permitted. PGAQ commended the Queensland Government for granting special authority to healthcare workers, including pharmacists, under the *Drug Therapy Protocol – Communicable Diseases Program*³⁰⁹ which authorises pharmacists to supply Antiviral medications and importantly, to administer a coronavirus vaccine if/when one becomes available. However, 'to Queenslanders in better access to medicines and primary healthcare through the Queensland community pharmacy network', the PGAQ has recommended these measures be permanently extended.³¹⁰

³⁰⁶ Public hearing transcript, Brisbane, 19 August 2020, p 18.

³⁰⁷ University of Queensland, 'UQ vaccine scientists report positive results from pre-clinical testing', <https://www.uq.edu.au/news/article/2020/08/uq-vaccine-scientists-report-positive-results-pre-clinical-testing>.

³⁰⁸ Hon Dr Steven Miles MP, Deputy Premier and Minister for Health and Minister for Ambulance Services, 'Volunteers needed for next phase of trials on Qld COVID-19 vaccine', media release, 27 August 2020.

³⁰⁹ Queensland Health, 'Drug Therapy Protocol – Communicable Diseases Program', https://www.health.qld.gov.au/_data/assets/pdf_file/0028/953614/dtp-cdp-factsheet.pdf.

³¹⁰ Submission 14, p 3.

The PGAQ also submitted:

The COVID-19 pandemic highlighted the urgent need to increase the breadth of vaccination services that Queenslanders of all ages can access through the established vaccination network of community pharmacies, while general practices closed their doors, community pharmacy stayed open to continue providing vaccinations. There are significant economic benefits and health system savings to be gained by ensuring all Queenslanders eligible for NIP [National Immunisation Program] vaccines can conveniently access them through their local pharmacy.³¹¹

Concerning the locations in which pharmacists are authorised to administer vaccines, the PSA:

... strongly contends that the current restriction on location of where pharmacist immunisers can administer vaccines (i.e. within a community and hospital pharmacy building) is also limiting the opportunity for Queenslanders and the Queensland community to be better protected. There was a range of missed opportunities during the COVID-19 pandemic, for example, pharmacist immunisers could have been deployed to administer vaccines to help ease the health burden in aged care settings or to cover the needs of people who were unable to make vaccination appointments due to closures of schools, general practices and work places.³¹²

In terms of how a viable vaccine will be distributed and administered in Queensland, the CHO, Dr Young, explained to the committee that:

We have already had discussions with the Pharmacy Guild about rolling out the vaccine through community pharmacies throughout the state. We have had quite a few years now of a very successful flu vaccination program being delivered by community pharmacies. We need to wait and make sure that we know what the vaccine is and any issues with its delivery or its storage—anything like that—but I would hope that all of our community pharmacies would be able to deliver it.

Not all community pharmacies have participated in the flu vaccine delivery process. I have spoken to the guild to ask, if it were possible, if they could get all community pharmacies to do the necessary training and preparation to be able to do it. There are requirements for pharmacies that they have to have—physical and environmental requirements as well as storage requirements and training requirements. It is not a simple thing for a community pharmacy to vaccinate, but I would like to, wherever possible, have that occur. We know that there are community pharmacies in nearly every single community in Queensland, so it is a very quick way of being able to get out to as many people as possible.

During the last pandemic we stood up school clinics, but that was harder because you then have to go and organise all of those additional staff. We probably will have pop-up clinics to vaccinate, but I think our main strategy will be to use those places that currently vaccinate—community clinics, which some local governments run for instance, health services of course run them and GPs run them. We will take all of our current processes, use them and enhance them, rather than creating a brand-new process. That is the plan at this stage.³¹³

Committee comment

The committee notes the importance of research to better understand the COVID-19 virus and to develop a viable vaccine to ensure the health and wellbeing of Queenslanders, and to support the easing of restrictions without the risk of community outbreaks. The committee acknowledges the leading research work being undertaken by institutions in Queensland such as QIMR BMRI and UQ.

³¹¹ Submission 14, p 6.

³¹² Submission 37, p 9.

³¹³ Public hearing transcript, Brisbane, 19 August 2020, p 20.

To ensure a viable vaccine can be distributed and administered safely and efficiently, the committee also acknowledges the actions taken by the Queensland Government to grant special authority to pharmacists and other healthcare workers to administer a COVID-19 vaccine if and when one becomes available.

The committee supports the Queensland Government's leveraging of the existing vaccine network and encourages the continued development of its distribution plans as COVID-19 vaccine research continues.

7.1.2 Further easing of restrictions

The committee notes advice from QH about the balancing act in continuing PHDs and the relevant restrictions on business and other activities to protect public health, while seeking to open the economy up and return social life to normal. However, while a vaccine is in development, the easing of restrictions is a complex task where the status of COVID-19 cases changes daily. This has recently been evidenced by outbreaks in Queensland, New South Wales and Victoria, and has highlighted the need for ongoing border management and good hygiene practices to contain the spread of the virus.

Dr Young explained:

*Reflecting on where we are now and the achievement of how we have effectively suppressed COVID-19 in Queensland and how it has not only saved many lives, initially the modelling suggested that 12,500 Queenslanders would die in the first wave of the pandemic if we did not mitigate it. I also think that we have strengthened our community's confidence and that they will be able to go out and resume their normal lives. While the easing of restrictions has been difficult because people have not understood the time frames and why some industries have been able to get up before others, it is important that we do it in a considered way and that we continue to evaluate what we have done.*³¹⁴

7.1.2.1 Brisbane Youth Detention Centre outbreak

At 31 August 2020, Queensland had recorded a total of 1,122 confirmed cases of COVID-19, with 27 active cases, 18 hospitalisations and tragically six lives lost to COVID-19.³¹⁵ On 20 August 2020, QH advised a 'massive contact tracing, testing and quarantining operation' commenced after an Ipswich woman tested positive for COVID-19. QH reported this appeared to be a case of community transmission, given the woman, 'indicated she had not travelled interstate or overseas and authorities have not yet identified any contact with a known or likely source'.³¹⁶

The woman who tested positive works at the Brisbane Youth Detention Centre in Wacol where on 22 August 2020, a further six people tested positive to COVID-19. As a result of this outbreak, the CHO, Dr Young, 'has ordered upgraded restrictions on aged and other care facilities and hospitals across Greater Brisbane, and Ipswich and surrounds'. On 22 August 2020, QH advised:

The measures put in place overnight across the West Moreton, Metro North and Metro South Hospital and Health Services:

- *Residential aged care and disability accommodation services were placed into effective lockdown with visitors being restricted,*
- *Public and private emergency departments were instructed to use PPE to treat all patients,*

³¹⁴ Public briefing transcript, Brisbane, 23 June 2020, p 3.

³¹⁵ Queensland Health, 'Queensland COVID-19 statistics', <https://www.qld.gov.au/health/conditions/health-alerts/coronavirus-covid-19/current-status/statistics>.

³¹⁶ Queensland Health, 'COVID-19 case identified in Ipswich', <https://www.health.qld.gov.au/news-events/doh-media-releases/releases/covid-19-case-identified-in-ipswich>.

- *Public and private hospitals were also asked to restrict visitors as soon as possible.*

*From today, gatherings in homes and in public have been restricted to 10 people in the following local government areas: City of Brisbane, City of Ipswich, Logan City, Scenic Rim Region, Somerset Region, Lockyer Valley Region, Moreton Bay Region, Redlands City. Gatherings across the rest of Queensland outside those areas have been limited to 30 people.*³¹⁷

In response to this outbreak, QH advised it has increased testing capacity in the surrounding areas and strongly urged people to get tested, particularly if they attended any of the locations identified through contact tracing, and to stay at home until they received the results. At the time of writing, the Brisbane Youth Detention Centre outbreak continued to unfold with the number of cases associated with the cluster at 11 on the 26 August 2020.³¹⁸

7.1.2.2 Outbreaks in Victoria and New South Wales

The emergence of a 'second wave' of COVID-19 in Victoria (VIC) and New South Wales (NSW) has demonstrated the significant impact of community transmission. With active cases of COVID-19 identified as a result of community transmission increasing from late July 2020 into August 2020, both VIC and NSW have had to impose new restrictions to slow the spread of COVID-19 and locate the sources of infection.

As at 30 August 2020, VIC reported 4,226 cases that 'may indicate community transmission', and 2,830 active cases of COVID-19. Additionally, 472 people were hospitalised as a result of COVID-19, including 25 in intensive care. In total, VIC has reported 15,580 people have recovered from the virus. Tragically, 524 Victorians have lost their lives to COVID-19.³¹⁹

As a result of community transmission, some clusters of which have unknown sources, the VIC Government has implemented strict stage four restrictions from 6.00pm on 2 August 2020 in Metropolitan Melbourne. According to the VIC Department of Health and Human Services, stage four restrictions involves, a curfew between 8.00pm until 5.00am. This means, 'you must be at your home during these hours. The only reasons to leave home between 8pm and 5am will be work, medical care and caregiving'.³²⁰ In regional VIC, stage three restrictions have been in place from 11.59pm on 5 August 2020 which require regional Victorians remain at home unless:

- *to shop for food and necessary goods or services*
- *to provide care, for compassionate reasons or to seek medical treatment*
- *to exercise or for outdoor recreation*
- *for work or education, if you can't do it from home.*³²¹

As at 29 August 2020, NSW reported 3,844 confirmed cases and tragically 54 people have lost their lives to COVID-19. The NSW Department of Health reported that it, 'is treating 67 COVID-19 cases,

³¹⁷ Queensland Health, 'Urgent new COVID-19 measures after youth detention centre cluster detected', <https://www.health.qld.gov.au/news-events/doh-media-releases/releases/urgent-new-covid-19-measures-after-youth-detention-centre-cluster-detected>.

³¹⁸ Queensland Health, 'Contact tracing – coronavirus (COVID-19)', <https://www.qld.gov.au/health/conditions/health-alerts/coronavirus-covid-19/current-status/contact-tracing>.

³¹⁹ Victorian Department of Health and Human Services, 'Coronavirus update for Victoria – 30 August 2020', <https://www.dhhs.vic.gov.au/coronavirus-update-victoria-30-august-2020>.

³²⁰ Victorian Department of Health and Human Services, 'Stage 4 restrictions', <https://www.dhhs.vic.gov.au/stage-4-restrictions-covid-19>.

³²¹ Victorian Department of Health and Human Services, 'Stay at home: Regional Victoria stage 3', <https://www.dhhs.vic.gov.au/stay-home-regional-victoria-covid-19>.

including six in intensive care and four who are ventilated. 85 per cent of cases being treated by NSW Health are in non-acute, out-of-hospital care'.³²²

Due to the widening spread of COVID-19 in Sydney's CBD cluster across multiple locations in the Sydney and Central Coast, NSW Health is:

*... strongly advising people who live or work in these areas to not visit aged care facilities at this time. This is a precaution while the cluster is investigated, cases are identified and isolated and contact tracing is done. NSW Health will continue to closely monitor the number and location of cases in Sydney and the Central Coast and will adjust the advice regarding visitor restrictions on aged care facilities according to the level of local risk.*³²³

The significance of these outbreaks and the issue of community transmission in VIC and NSW are central considerations to decisions made by the CHO, and the Queensland Government, in relation to easing restrictions. At the public hearing on 19 August 2020, the CHO, Dr Young, told the committee:

The situation in Victoria has had a significant health impact on their own population but also across Australia. We have had to work with them and support them, and of course we will always do that. It has also meant that we have had to look at what we need to do in Queensland as a result. We have then seen multiple clusters emerge in New South Wales over the past few weeks, with 82 reported cases over the past week of which the vast majority were locally acquired.

Given the devastating impact COVID-19 has had on the health and livelihoods of Victorians, culminating in that terrible loss of life, particularly across residential aged-care facilities, it is absolutely vital that we continue to do all the work we have done in Queensland to stop a resurgence of the virus happening here in Queensland and the restrictions that would inevitably have to be put in place.

*The decisions to reimpose border restrictions on Victoria and then subsequently New South Wales and the Australian Capital Territory were not taken lightly—of course not—but limiting people's ability to enter Queensland from a place where the virus is more prevalent remains probably our most effective protection as we go forward. We have endeavoured to strike a balance between protecting Queenslanders and minimising the impact on people, whether that be social impacts or economic impacts. We are in a continual process of finetuning our restrictions to ensure they are responsive to the situation at hand and are able to be adapted to rapidly changing conditions.*³²⁴

With recent outbreaks unfolding in Queensland, neighbouring NSW and in VIC, decisions concerning the easing of restrictions, in particular border restrictions, is a daily process, according to Dr Young:

*At the moment there is actually a day-by-day examination of what is happening. I meet with my colleagues around the country every day. ... to find out what is happening in those states and territories where their cases are and what impact that may have on Queensland. After those meetings we make a decision about whether we need to change our response in Queensland as a result. That is a daily decision-making process.*³²⁵

³²² New South Wales Department of Health, 'COVID-19 (Coronavirus) statistics', https://www.health.nsw.gov.au/news/Pages/20200829_00.aspx.

³²³ New South Wales Department of Health, 'COVID-19 (Coronavirus) statistics', https://www.health.nsw.gov.au/news/Pages/20200829_00.aspx.

³²⁴ Public hearing transcript, Brisbane, 19 August 2020, pp 17-18.

³²⁵ Public hearing transcript, Brisbane, 19 August 2020, p 29.

7.2 Remaining vigilant

Importantly, this interim report captures a point in time of the Queensland experience of COVID-19. The committee has examined the Queensland Government's health response during the initial stages of the pandemic, and received submissions reflecting stakeholder views as at 3 July 2020. The committee's final report, due three months after the end of public health emergency³²⁶, provides an opportunity to consider the Queensland response to COVID-19 in the latter part of 2020, moving into 2021.

Despite the successes of the Queensland Government health response to COVID-19, and efforts of the Queensland community, the committee acknowledges that, at the time of writing, tragically six Queenslanders have lost their lives to COVID-19.³²⁷ To protect the health of all Queenslanders, it is vital the lessons learned from the Queensland Government's health response to date are incorporated into strategies moving forward, this includes: engaging with stakeholders and the community on the health response; ensuring public messaging reaches all Queenslanders in a way that is both meaningful and clear in its explanation of health advice; and, making sure that vulnerable Queenslanders are appropriately supported during the COVID-19 pandemic.

The CHO, Dr Young, has acknowledged there is still work to be done:

*We have seen how the virus has devastated and continues to devastate populations overseas when health systems just become overwhelmed with cases. I am proud to say that we avoided that scenario here in Queensland, but I do not underestimate the enormous sacrifices that many, many Queenslanders and Queensland businesses have had to make. We have a tough road ahead, but I think if we respond to those economic challenges and we continue to respond to the health challenges we will manage those challenges as well.*³²⁸

Finally, Dr Young has stated:

*... we cannot be complacent. The job is not yet done. Until we have an effective treatment or a vaccine we have to be very, very cautious. We must continue to be vigilant, to ensure that the hard work done by all of Queensland—all 5.1 million Queenslanders—and their sacrifice to date is not undermined. We must continue to all work together to protect the health of all in Queensland.*³²⁹

Committee comment

The committee notes that, to limit the spread of COVID-19, decisions concerning the easing of border restrictions and other movement restrictions must be made with consideration of outbreaks in other states. The community transmission outbreaks observed in NSW and VIC highlight the need to remain vigilant and to minimise the risk of interstate travellers exposing Queenslanders to COVID-19. The committee supports the Queensland Government's current border restrictions taken on the advice of the Chief Health Officer.

The committee acknowledges that to ensure community transmission is limited within Queensland, there may be a need to restrict entry to the state for people arriving from jurisdictions where community transmission continues to be a problem.

³²⁶ If the public health emergency is not extended beyond its current end date of 2 October 2020, the committee will be required to report to the Legislative Assembly by 2 January 2021.

³²⁷ Queensland Health, 'Queensland COVID-19 statistics', <https://www.qld.gov.au/health/conditions/health-alerts/coronavirus-covid-19/current-status/statistics>.

³²⁸ Public briefing transcript, Brisbane, 23 June 2020, p 6.

³²⁹ Public briefing transcript, Brisbane, 23 June 2020, p 2.

Appendix A – Submitters

Sub #	Submitter
001	Daniel Lavery
002	John and Pam Williams
003	Desiree Lyall
004	QIMR Berghofer Medical Research Institute
005	Amy Reed
006	COTA Queensland
007	Lois McLaughlin
008	Royal Australian and New Zealand College of Psychiatrists Queensland Branch
009	Cairns Regional Council
010	Terrie Ferman
011	Public Advocate
012	Lung Foundation Australia
013	Queensland Primary Health Networks
014	Pharmacy Guild of Australia Queensland Branch
015	Shooters Union Queensland
016	MIGA
017	Leigh Kelly
018	Women's Health Queensland
019	Sandy Bolton MP, Member for Noosa
020	Stroke Foundation
021	United Workers Union
022	Yourtown
023	Queensland Nurses and Midwives' Association
024	Firearm Dealers Association Queensland
025	Queensland University of Technology (Executive Dean of Faculty of Health)

- 026 Australian Medical Association
- 027 Public Health Association of Australia
- 028 Exercise & Sports Science Australia
- 029 Andrew Brown, Health Ombudsman
- 030 Phil Clarke, Queensland Ombudsman
- 031 Brett Tobin
- 032 Queensland Aboriginal and Islander Health Council
- 033 Australian Association of Social Workers
- 034 Supported Accommodation Providers' Association
- 035 Queenslanders with Disability Network
- 036 Royal Australian College of General Practitioners
- 037 Pharmaceutical Society of Australia
- 038 Palliative Care Queensland
- 039 Health Consumers Queensland
- 040 Queensland Council for Civil Liberties
- 041 Queensland Law Society
- 042 Tenants Queensland Inc
- 043 Asthma Australia
- 044 Queensland Human Rights Commission
- 045 Aged & Community Services Australia
- 046 Sharon William
- 047 Queensland Alliance for Mental Health
- 048 The Society of Hospital Pharmacists of Australia
- 049 Confidential

Appendix B – Officials at public departmental briefings

Queensland Health

- Dr John Wakefield, Director-General
- Dr Jeannette Young PSM, Chief Health Officer and Deputy Director-General, Prevention Division
- Barbara Phillips, Deputy Director-General, Corporate Services Division
- Nick Steele Deputy Director-General, Healthcare Purchasing and System Performance Division

Queensland Ambulance

- Russell Bowles ASM, Commissioner, Queensland Ambulance Services

Cairns and Hinterland Hospital and Health Service

- Tina Chinery, Acting Chief Executive

Sunshine Coast Hospital and Health Service

- Adjunct Professor Naomi Dwyer, Chief Executive

Metro North Hospital and Health Service

- Shaun Drummond, Chief Executive

Department of the Premier and Cabinet

- Dave Stewart, Director-General

Queensland Mental Health Commission

- Ivan Frkovic, Commissioner

Queensland Police Service

- Commissioner Katarina Carrol
- Deputy Commissioner Stephan Gollschewski, State Disaster Coordinator
- Assistant Commissioner Shane Chelepy, Operations Commander COVID-19

Office of the Health Ombudsman

- Jess Wellard, Executive Director, Assessment and Resolution

Queensland Human Rights Commission

- Scott McDougall, Queensland Human Rights Commissioner
- Sean Costello, Principal Lawyer
- Rebekah Leong, Principal Lawyer
- Heather Corkhill, Senior Policy Officer

Public Advocate

- Mary Burgess, the Public Advocate

Appendix C – Witnesses at public hearings

Pharmacy Guild of Australia

- Professor Trent Twomey, Queensland Branch President and Senior National Vice President
- Gerard Benedet, Queensland Branch Director

Pharmaceutical Society of Australia

- Shane MacDonald, Queensland President
- Chris Campbell, General Manager Policy and Queensland State Manager

Australian Medical Association of Australia

- Dr Chris Perry, President

Public Health Association of Australia

- Terry Slevin, Chief Executive Officer, National
- Letitia Del Fabbro, Branch President, Queensland Branch
- Associate Professor Louisa Gordon, Member, Queensland Branch

Health Consumers Queensland

- Melissa Fox, Chief Executive Officer

Queensland Aboriginal and Islander Health Council

- Angela Young, General Manager, Police and Research

Royal Australian College of General Practitioners (RACGP)

- Dr Bruce Willett, Chair RACGP Queensland
- James Flynn, State Manager RACGP Queensland

Queensland Alliance for Mental Health

- Jennifer Black, Chief Executive Officer
- Lourdes Gomez, Senior Advisor, Policy and Sector Development

Royal Australian and New Zealand College of Psychiatrists

- Professor Brett Emerson, Queensland Branch Chair
- Amelia Rhodes, Policy Manager

Lung Foundation Australia

- Mark Brooke, Chief Executive Officer
- Patricia Schluter, Advocacy and Policy Manager

Asthma Australia

- Michele Goldman, Chief Executive Officer
- Angela Cartwright, Policy and Advocacy Manager

COTA Queensland

- John Stalker, Policy Coordinator

QIMR Berghofer Medical Research Institute

- Dr Fabienne Mackay, Director and Chief Executive Officer

Queensland University of Technology

- Distinguished Professor Patsy Yates AM, Executive Dean, Faculty of Health

Appendix D – Division of government responsibilities for public health emergency

	State or territory government	Australian Government
All	<ul style="list-style-type: none"> • Work with local government to ensure good communication, integration and support; • work with other jurisdictions and the Australian Government to support an integrated health response; • work with the Australian Government to maintain essential services and continued functioning of civil society; • as far as possible, maintain government services. 	<ul style="list-style-type: none"> • Work with jurisdictions to support an integrated health response; • work with state and territory governments to maintain essential services and continued functioning of civil society; • as far as possible, maintain government services; • coordinate with international partners and multilateral institutions where required.
Health – public health (see Glossary for definition)	<ul style="list-style-type: none"> • Undertake primary responsibility for the response to a communicable disease emergency; • establish and maintain public health services, including primary operational management of: <ul style="list-style-type: none"> ○ contact tracing; ○ laboratory testing; ○ distribution of antivirals/ vaccines if required; ○ identification/implementation of appropriate social distancing measures; • undertake surveillance activities and feed these into national processes; • manage state and territory government health resources to support the response, including (where applicable) a state/territory Medical Stockpile; • declare changes in stage of the relevant jurisdictional health sector plan appropriate to the specific region or area (these may vary across the jurisdiction and country); • work with local government, business and the community to support preparedness, implementation of response measures and recovery. 	<ul style="list-style-type: none"> • Support preparedness by establishing and exercising national plans and arrangements; • lead the national response to the CDINS; • work with State and Territory Governments to coordinate the operational health sector response; • gather and disseminate surveillance information at a national level; • manage Australian Government health resources to support the response, including the National Medical Stockpile; • declare changes in stage of the relevant national health sector plan; • work in partnership with owners and operators of critical health infrastructure by providing advice and secretariat support to the Health Sector Group; • provide information of the location and number of care recipients in aged care facilities and likely vacancies in the event of an evacuation or relocation.

	State or territory government	Australian Government
Health – Healthcare systems	<ul style="list-style-type: none"> Undertake primary operational management of clinical care services; <ul style="list-style-type: none"> establish and maintain public health services, hospitals and laboratories; manage cases; coordinate allocation within the jurisdiction of available clinical care resources; support clinical care through guidance for the health sector appropriate to the context of the specific jurisdiction. 	<ul style="list-style-type: none"> Provide high level guidance for the health sector; establish infection control guidelines and advise on any adaptation required for the current situation.
Health – borders and international links	<ul style="list-style-type: none"> Work with the Australian Government to implement human biosecurity and border control activities, as described in Human Biosecurity Officer agreements (funding agreements between the Commonwealth and State and Territory Governments). 	<ul style="list-style-type: none"> Coordinate Australia's international border health activities; ensure international health reporting obligations are met.
Health – communication	<ul style="list-style-type: none"> Coordinate sharing of information to support the jurisdictional health sector response, and to maintain essential and government services; provide situation specific advice to ministers and jurisdictional decision making bodies, such as the State Emergency Management Committee (SEMC); communicate about the management of individual cases of the disease; coordinate the jurisdictional public information strategy on health aspects of a communicable disease outbreak response. 	<ul style="list-style-type: none"> Coordinate sharing of information to support the health sector response and to maintain essential and government services; provide situation specific advice to ministers and national decision making bodies, such as the Australian Government Crisis Committee (AGCC) and National Crisis Committee (NCC); develop and disseminate key messages and information about the overall direction of the response; provide nationally consistent guidance for health professionals; coordinate the national public information strategy on health aspects, and on national aspects of a communicable disease response.
Emergency management agencies	<ul style="list-style-type: none"> Develop, maintain and exercise emergency management arrangements; support the response to a communicable disease emergency, as appropriate; support cross-government sharing of information and situational 	<p>Department of Home Affairs (Emergency Management Australia)</p> <ul style="list-style-type: none"> Develop, maintain and exercise national emergency management sector arrangements; facilitate provision of Australian Government support; contribute to the coordination of

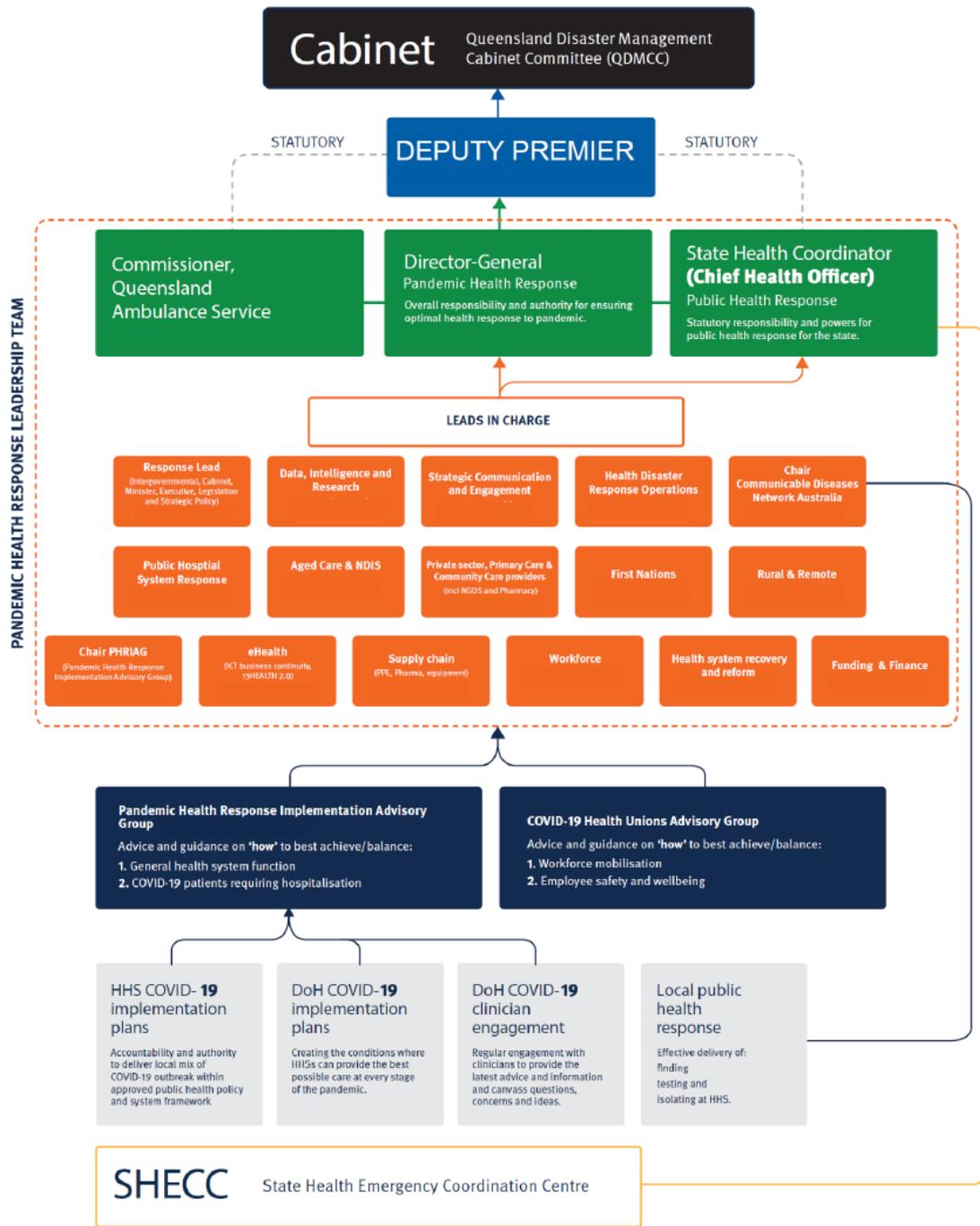
	State or territory government	Australian Government
	<p>awareness;</p> <ul style="list-style-type: none"> • coordinate the jurisdictional public information strategy on national aspects of a communicable disease outbreak response; • represent state/territory at NCC meetings. 	<p>information and situational awareness through the Australian Government Crisis Coordination Centre;</p> <ul style="list-style-type: none"> • manage the operation of senior officials-level committees, such as AGCC and NCC.
Department of Home Affairs (Australian Border Force)		<ul style="list-style-type: none"> • Regulate visas for temporary entrants / visitors who have special requirements during a CDINS; • conduct agreed regulatory functions on behalf of commonwealth agencies at the border; • undertake border protection, on and off shore; • Implement international border communication activities if recommended; • operate a 24/7 intelligence area to provide information on travellers.
Departments of Agriculture (and Water resources)/ Primary Industries	<ul style="list-style-type: none"> • Undertake primary operational management of animal health monitoring, surveillance, response and recovery; • for zoonotic and emerging diseases, contribute to the jurisdictional public information strategy; • work with port/airport authorities and the Australian Government, concerning implementation of measures to manage communicable disease emergency activities at international borders; • support the continuity and security of the food chain. Work with the Australian Government in this area. 	<ul style="list-style-type: none"> • Coordinate nationally the animal health aspects of emerging and zoonotic disease management; • for zoonotic and emerging diseases, contribute to a national public information strategy; • manage animal biosecurity and border control activities; • implement human biosecurity and border control activities; • liaise with airlines, shipping lines, airports, seaports and industry concerning communicable disease emergency activities; • Work with state and territory governments and Food and Grocery Sector Group to support continuity and security of the food chain.
Departments of Human/social services	<ul style="list-style-type: none"> • Support community recovery; • deliver support services, such as mental health and social work; • work with the Australian Government to maintain essential services; • maintain services to the disabled and residential and community aged care sector; • keep the social services workforce informed of the CDINS situation to 	<p><i>Department of Human Services</i></p> <ul style="list-style-type: none"> • Support community recovery; • deliver government payments and services, e.g. recovery payments; • deliver other support services, such as mental health and social work; • work with state and territory governments to maintain essential services;

	State or territory government	Australian Government
	<p>minimise workforce and resource shortages.</p>	<ul style="list-style-type: none"> operate the <i>national call centre</i> – an important vehicle for distributing communicable disease emergency information to the public.
Departments of Human/social services (cont.)		<p><i>Department of Social Services (DSS)</i></p> <ul style="list-style-type: none"> Provide advice on DSS programmes and services that may be available to support affected communities; advise on any issues that impact on the delivery of DSS programmes and work with DHS to resolve any issues that arise in relation to social security payments or services; keep the DSS workforce informed of the CDINS situation to minimise workforce and resource shortages.
Prime/First Minister/ Premier's departments	<ul style="list-style-type: none"> Provide <i>advice</i> to the Premier/First Minister and to the Cabinet; support the operation of senior officials-level <i>committees</i>; represent state/territory at <i>NCC</i> meetings. 	<p><i>Department of Prime Minister and Cabinet</i></p> <ul style="list-style-type: none"> Provide <i>advice</i> to the Prime Minister and to the Cabinet; develop and maintain the <i>Australian Government Crisis Management Framework</i>.
International and trade matters	<p><i>Relevant S/T Government departments</i></p> <ul style="list-style-type: none"> Provide <i>skilled resources</i> (e.g. medical or logistics personnel) to support requests for assistance, where possible. 	<p><i>Department of Foreign Affairs and Trade</i></p> <ul style="list-style-type: none"> Monitor and disseminate relevant <i>communications from overseas posts</i>; provide assistance to <i>Australians overseas</i>; (working with Health) provide <i>advice to travellers</i> (Smartraveller); keep the <i>diplomatic community informed</i>; coordinate with international partners; manage requests for/ offers of <i>assistance</i>.
Defence		<ul style="list-style-type: none"> Assist the national response to a communicable disease emergency by filling capability shortfalls within other government departments within Defence's capacity. <p>This support will be predicated on Defence's other operational commitments at the time of the</p>

	State or territory government	Australian Government
		request and be assessed on a case by case basis (<i>expertise</i> is available particularly in communications and logistics). Defence should only be considered after all commercial options have been exhausted.
Police	<ul style="list-style-type: none"> Support the response to a CDINS as required (particularly through the police role in emergency management arrangements). 	<i>Australian Federal Police</i> <ul style="list-style-type: none"> Support the response to a CDINS as required, particularly through police presence in airports.
Transport	<ul style="list-style-type: none"> Maintain essential services; communicate with relevant industry stakeholders concerning communicable disease emergencies. 	<i>Department of Infrastructure and Regional Development</i> <ul style="list-style-type: none"> Provide advice on transport security matters; assess airport curfew dispensation requests; process aviation cabotage requests; assist in facilitating additional commercial airline resources or access to airports.
Energy	<ul style="list-style-type: none"> Maintain essential services; engage and consult with business and industry stakeholders concerning communicable disease emergencies. 	<i>Department of Environment and Energy</i> <ul style="list-style-type: none"> Provide emergency management related information to the energy industry and business sectors through business.gov.au; support maintenance of essential services.

Source: Australian Government, Department of Health, *Emergency Response Plan for Communicable Disease Incidents of National Significance: National Arrangements*.

Appendix E - Diagram submitted by Queensland Health outlining its pandemic health response leadership team



Statements of Reservation **INTERIM REPORT;**

INQUIRY INTO QUEENSLAND GOVERNMENTS HEALTH

RESPONSE TO COVID 19

STATEMENT OF RESERVATIONS

The LNP Members of the Committee whilst generally accepting the terms of the interim report wish to raise a number of matters of concern.

RECOMMENDATIONS

The report of the Committee Contains 6 Recommendations.

In relation to Recommendations 5 and 6;

- A. Recommendation five seeks “*...the extension and availability of telehealth services in Australia beyond 30 September 2020*”. Whilst an extension of service appears warranted, whether or not that occurs should be based on evidence particularly as to the breadth of any extension.
- B. In relation to recommendation six the same point is raised. It is acknowledged that the impacts of COVID19 are unique and all steps should be taken to ensure the prompt delivery of pharmaceuticals. Again any extension of this should occur on the basis of evidence.
In both cases an extension should not be automatic rather they should be based on evidence.

Additionally, we believe there should be two additional recommendations;

Recommendation seven

The Queensland Government acknowledges all Queenslanders who have complied with restrictions, since the Declaration by the Minister for Health,

thus giving our health services and front-line workers the opportunity to prepare for what could have been a catastrophic outcome.

Recommendation eight

The Queensland Government move at an appropriate time, at a national level, to establish a nation wide *Health Pandemic Response Plan* where there is uniformity of action in dealing with future pandemics and avoiding cross jurisdictional issues.

QUARANTINE

During the Inquiry the Chief Health Officer Dr Jeanette Young gave evidence on two occasions.

She provided evidence to the Committee on the 19th of August 2020 and was asked a question regarding exemptions to health directives. Dr Young made the following statements;

“There are two parts to an exemption. The first part is to exempt people to come physically into Queensland. The second part is – if the have asked, and some people do - to exempt people from Hotel quarantine. They are the two parts and they are two separate decisions.

If someone asks to be exempt from Hotel Quarantine I will go through that. There have been very very few occasions where I have exempted people and I have become tighter as we have gone through.”

In the same answer Dr Young stated;

“The ability to exempt people has become less and less possible because of the risks of people having the infection. There are few now that are able to be exempt from hotel quarantine. Even those exempted from hotel quarantine will usually go into home quarantine or some other quarantine.”

Later in her evidence in answer to the same question Dr Young made this comment;

“I am sure some people think I am too lenient here, but I am the Chief Health Officer and my background is Health so I do exempt people who need health care services that can only be delivered in Queensland”

The role of the Chief Health Officer is acknowledged as important and the functions she performs in relation to the COVID 19 emergency cannot be overestimated. However there are a series of inconsistencies particularly in relation to quarantining that have left Queenslanders shocked and dismayed ;

- a) The entry into Queensland of AFL Players, officials and their families
- b) Jayne Brown – A Queensland resident who underwent brain surgery by Professor Charles Teo on 10/8/20 at the Prince of Wales Private Hospital, Randwick. Professor Teo wrote to Dr Young, as Ms Browns treating neurosurgeon on 13/8/20 stating;
*It is my belief that Jaynes condition is classified under “**exceptional circumstances**” and that home isolation is imperative for her healing during this time.*

The request was denied

- c) Luella Gillard born 9/10/2017 a Queensland resident who underwent her second open heart surgery on 13/8/20 at The Children's Hospital at Westmead in NSW. Luella's mother obtained three reference from Luella's; Paediatric Cardiothoracic Surgeon; Paediatric Cardiologist and her Clinical Psychologist seeking that Luella isolate at her acreage home in Palmview Queensland.

This was rejected.

- d) Elena Turner tragically lost her son. She was only given permission to enter Queensland, view his body but then must return to New South Wales without attending his funeral.

- e) Family Members wishing to visit dying relatives
- f) A large number of celebrities entering Queensland

DR YOUNG'S INTERVIEW OF 10 SEPTEMBER

On the 10th of September Dr Young addressed the media on exemptions and said;

“I’ve given past exemptions for people in the sporting industry for a whole range of codes because it is important that we start that work. But they all go into quarantine.

I’ve given exemptions to people in entertainment and film because that’s bringing a lot of money into this state.

I can I say we need every single dollar in our state, um, we need to make sure our economy is going ahead as much as it can – as long as its safe.

So my first, um, the first thing I do before I make a decision about anything – is it safe to the Queensland population. And if it’s safe than I look at how it can be done.

And whether that’s the AFL, the NRL, whether its swimming, tennis, all of the sports – cricket. I’ve recently, because we’re coming into that season. Whether it’s any of those, whether it’s entertainment industry, film industry. Whether it’s agriculture, whether it’s resources and mining, construction.

Anything that will benefit our community – because I actually believe that the economy has an enormous role in determinants of health – in the health outcomes for Queenslanders.

But, before I agree to anything it’s whether it’s safe”

Importantly Dr Young directly links Queenslanders’ health to the economy but we also say the mental health of Queenslanders, particularly those needing assistance, should play an important part in determining exemptions.

PREMIER AND CHIEF HEALTH OFFICER

A Premier is entitled and in fact obligated to seek the advice of experts when facing a difficult decision let alone an emergency. Yet the people of Queensland elected Anastacia Palaszczuk to lead the State and make the hard decisions. The advice of Dr Young is critical yet the responsibility for the ultimate decision must rest with the Premier. True leadership is shown when tough decisions are called for and a true leader does not obfuscate that obligation. Dr Young can offer the advice but the Premier must make the call.

WHO DECIDES WHO DIES

In the Submission, by COTA, dated 26th June 2020 they refer to a document titled *"Queensland Ethical Framework to Guide Clinical Decision Making in the COVID 19 Pandemic"*. COTA in their submission concerning COVID 19 questions if the document raises the point of whether being **"over 65 years of age"** should be a barrier to getting medical treatment;

"when those medical resources must be rationed due to an overwhelming demand for intensive clinical support generated by a pandemic"

COTA further quotes an earlier Queensland Health Document titled *"Queensland Health – End – of - Life Care; Guidelines for decision - making about withholding and withdrawing life sustaining measures from adult patients"* again citing a Queensland Health website which they say states

"--- that age by itself should not influence these decisions"

These documents are at odds.

The COTA submission, in referring to the COVID-19 document, quotes what is termed "the life-cycle" consideration which they say states;

"Feedback from the community, identified this consideration as appropriate in complex occasions. Such that, equivalent scores occur priority be given to children and adults <50, adults who have not yet "lived a full life", 50-69 years and followed by those older ---. The "life cycle" principal is also described by the Ethics Subcommittee, Ventilator Document Workgroup for CDC6. While the life-cycle principal grants each individual equal opportunity to live through phases of life there is a relative priority to younger individuals. Also understood by

arguments of a “fair innings” and ethical justification that this principal enables opportunity for younger individual to live through life stages.

COTA raised the point that there is within the document a threat of “rationing of access to urgently required health care to seriously ill people over 65 years of age” as a consideration.

The Human Rights Commission were asked about the COVID-19 document at the hearing on the 19th of August 2020. They made the following statement;

“ There is a very real danger that the unconscious bias and indirect discrimination would lead to older people , people with disabilities, or people with cognitive impairment actually having their life ended earlier than otherwise would”

It appears the Queensland Health document was not seen by the Human Rights Commission before it was released.

Whilst we have a copy of the COVID-19 document it appears no longer accessible on Queensland Health's website.

If the document was taken down it is of concern and questions touching on human rights may have been ignored.

THE PUBLIC ADVOCATE

The Public Advocate appeared at the hearing on the 19th of August 2020 and their submission is dated the 30th of June 2020.

The time allocated for the Public Advocate and the Human Rights Commission prohibited any lengthy questioning on the rights of the Disabled or the Human Rights and at the conclusion of the hearing the Chairman, to both the Commission and the Public Advocate made this comment;

“I do not know whether the commission or the Public Advocate would like to add anything else, but any additional commentary will have to be sent to us because of our tight time schedule. We have COTA standing by now and we are eating into their time. If the commission or the Public Advocate wants to provide any additional information we would welcome that. I apologise for the tight time frame but you have raised some very good points today and in your submissions and we thank you very much for your time”

Importantly the question of Human Rights is one that is uppermost in people's minds usually when their personal rights are affected.

This is clearly an important question given the extreme powers granted as a consequence of the Declaration and one that must be looked at closely for the future.



Mark McArdle MP

Deputy Chair

Health, Communities, Disability Services
and Domestic and Family

Violence Prevention Committee

Member for Caloundra

14th September 2020



Marty Hunt MP

Member

Health, Communities, Disability Services
and Domestic and Family

Violence Prevention Committee

Member for Nicklin

14th September 2020



Michael Berkman MP
For Maiwar ▲

14 September 2020

Statement of reservation

This inquiry has reinforced the broad agreement among stakeholders and the Queensland community that the Queensland Government's health response to the COVID-19 Pandemic has been effective, as is evident in the continuing low rates of infection compared to some other states and countries. That said, the health challenges remain and the economic consequences are likely to worsen yet, with the reductions and potential cessation of federal Government support payments, and may continue for many years.

This interim report provides a valuable opportunity to consider the government's response to the pandemic and recommend any improvements suggested by stakeholders that warrant consideration by this and any future government. While the health outcomes in Queensland are certainly a good news story, this report missed some opportunities to highlight these valuable suggestions from stakeholders and leaves unresolved and often unaddressed some important issues raised throughout the inquiry.

In addition to the specific issues raised below, attached at Annexure 1 of this Statement is a table of various recommendations made in submissions, many of which are not adequately addressed in the Committee's interim report or, in a number of cases, not addressed at all. The inclusion of this table should not be taken as an endorsement of each recommendation. Rather, it is included to highlight that the Committee's interim report is very selective in which stakeholder views are included and highlighted in the report.

Again, there is much to applaud in the health outcomes achieved in Queensland throughout this pandemic. That said, it is important that an interim report such as this captures the various concerns and feedback presented to the Committee, and doesn't become purely an exercise in self-congratulation.

Unresolved concerns about Police conduct at protests

In a recent hearing with the Chief Health Officer and officers from the Queensland Police Service, including the Police Commissioner, I asked questions about the conduct of police at recent protests at the immigration prison in Kangaroo Point. The questions relate to my serious concern that QPS officers had forced peaceful protesters into confined spaces, such that they were not able to maintain a physical distance of 1.5m to comply with requirements and to minimise the risk of viral transmission.¹

Commissioner Carroll was not aware of the specifics or able to answer the questions at that time, so I offered to provide footage of the practices my question referred to and she took this question on notice.

¹ The exchange with Commissioner Carrol is at pages 27-28 of the transcript of the public hearing on 19 August 2020, available online:

<https://www.parliament.qld.gov.au/documents/committees/HCDSDVPC/2020/COVID-19/trns-19Aug2020.pdf>

Contact Us

Tel: (07) 37374100

maiwar@parliament.qld.gov.au

www.michaelberkman.com.au

Visit Us

1/49 Station Road, Indooroopilly

Open: Monday to Friday 9am - 5pm

The full QPS answer to this question on notice is Annexure 2 to this Statement,² and I have grave concerns that this answer is deliberately misleading.

The answer begins by stating "The footage referred to in the question shows Brisbane City Councillor Jonathon Sri claiming that police used a practice known as 'kettling' when dealing with protesters at Kangaroo Point on 21 June 2020. The footage does not show the so called 'kettling' occurring, or protesters being forcibly dealt with by officers in any way. It merely shows Councillor Sri making the accusation of officers using this tactic." (emphasis added)

The footage I provided for the Commissioner to review comprised 9 individual short videos,³ and Cr Sri **does not feature in any of these videos**, contrary to the claim made in the Commissioner's answer. Additionally, the footage was taken on two different occasions, at protests on 21 June 2020 and 15 August 2020, contrary to the assertion that this footage is from only 21 June 2020.

At best, this response from QPS is lazy, ill-informed and prepared without having reviewed the footage provided - instead, it appears the response is a direct reference to other footage posted by Cr Sri on social media.⁴ At worst, the response may be construed as a deliberate attempt to mislead the Committee, and distract from the issues raised in the question about police practices that are clearly evident in the footage provided.

In addition to concern that the QPS may have deliberately misled the Committee in this respect, the Committee has no useful response to the important question of whether QPS has taken any steps to prevent these practices being used again in the future.

Misleading a committee is a serious matter, which constitutes a contempt of Parliament and a criminal offence. I intend to write to the Chair to raise these issues and seek to have them considered by the Committee.

Separation of health and economic response to COVID-19

The establishment of two different inquiries to separately inquire and report back to the Assembly on the health response and the economic response to COVID-19 is a questionable one. There is no dispute that there are severe economic impacts as a direct result of the health response, and so the health response has direct consequences for any economic response. The Deputy Premier and Minister for Health and Minister for Ambulance Services made this interrelationship abundantly clear in his Ministerial Statement on the last sitting day of the 56th Parliament:

Our strong health response is the only reason we are in a position now to get on with our plan for economic recovery. The foundation of our plan to get people back to work and businesses open again is our health response.

It's increasingly clear that the Government's economic response and general economic conditions in this pandemic have very real health impacts, not least of all on people's mental health. The arbitrary separation of the Government's response to the pandemic, as though the health response and the

² The Commissioner's answer is also available online:

<https://www.parliament.qld.gov.au/documents/committees/HCDSDVPC/2020/COVID-19/qton2-19Aug2020.pdf>

³ This footage was made available for the Commissioner through a link to files on a Google drive:

https://drive.google.com/drive/folders/1opJHBWQlcNwqgf1_A6cWTi9JKqkC4hji

⁴ See, for example this facebook post: <https://www.facebook.com/ionno.sri/videos/981269075641486>

economic response are distinct and separate, limits a fulsome investigation of the many inextricable links between the health and economic responses and consequences of the pandemic.

Rather than tasking the respective committees with separate inquiries into the health and economic responses, my view is that it would have been preferable to establish a dedicated standing committee to inquire into the Government's response to COVID-19 as a whole. This would have allowed a more coherent investigation of the many overlapping health and economic issues, by a committee that was not otherwise busy working on other legislative inquiries.

These inquiries, like all other work of the portfolio Committees, will lapse on the dissolution of the 56th Parliament. While the newly formed Committees of the next Parliament could recommence these separate inquiries under their own initiative, it would be more sensible for the Assembly to establish a standing committee to undertake a comprehensive inquiry into all aspects of the Government's response to COVID-19.

Kind regards,



Michael Berkman MP

Recommendations to the committee – Inquiry into the Queensland Government's health response to COVID-19 – in issue order

Sub	Submitter	Topic	Detail	
36	Royal Australian College of General Practitioners	Communications	Messaging system for GPs	[That] the Queensland Government develops and implements a secure digital messaging system between QLD HHS and general practice.
9	Cairns Regional Council	Communications	Protocols and data management	That Queensland Health strengthen its communication protocols both to and as a conduit from Local Disaster Management Groups and/or Coordinators. This includes a review of data management systems to improve access to disaggregated data relevant to local decision making for LDMG's and other lead agencies.
14	Pharmacy Guild of Australia Queensland Branch	Delivery of health services	Access to medicines Make expanded access arrangements permanent	PGAQ calls on the Queensland Government to permanently extend and expand these initiatives during the recovery and beyond the pandemic, to support Queenslanders in better access to medicines and primary healthcare through the Queensland community pharmacy network
37	Pharmaceutical Society of Australia	Delivery of health services	Access to medicines - emergency supply arrangements	The Queensland Government should consider enabling contemporary legislation to permanently adopt emergency medicine supply arrangements (including the Drug Therapy Protocol – Communicable Diseases Program) enabled during the COVID-19 pandemic under a declared public health emergency.
36	Royal Australian College of General Practitioners	Delivery of health services	Access to medicines - flu vaccines	[That] adequate supply of influenza vaccinations (NIP and Private) be prioritised for general practice before supplied to pharmacies.
36	Royal Australian College of General Practitioners	Delivery of health services	Access to medicines - flu vaccines	[That] the annual supply for influenza vaccinations be calculated using Standardised Whole Patient Equivalent values.
23	Queensland Nurses and Midwives' Union	Delivery of health services	aged care - Collaboration	Improve communication and collaboration with health services – particularly in the aged care sector;

Sub	Submitter	Topic	Detail	
45	Aged & Community Services Australia	Delivery of health services	Aged care Protocols for residential aged care facilities	That protocols be established to manage further outbreaks in residential aged care including the transfer of COVID-19 positive cases to hospital.
23	Queensland Nurses and Midwives' Union	Delivery of health services	ATSI	Funding to address inequitable health outcomes for Aboriginal and Torres Strait Islander peoples (particular focus on culturally appropriate preventative health initiatives, addressing the social determinants of health and closing the health inequities gap);
26	Australian Medical Association Queensland	Delivery of health services	ATSI	...a dedicated pool of funding for Aboriginal and Torres Strait Islander communities and organisations to draw on for specified purposes including the procurement of personal protective equipment, point-of-care tests, staffing and consumables, capital expenditure, isolation and quarantine facilities, and satellite and outreach services to address current service gaps. Importantly, the amount of funds allocated for this funding pool should be considered on a needs-basis.
32	Queensland Aboriginal and Islander Health Council	Delivery of health services	ATSI	That the Queensland Government increase funding for Aboriginal community-controlled health services to employ staff to deliver mental health and social and emotional wellbeing services.
33	Australian Association of Social Workers	Delivery of health services	ATSI	That the Queensland Government increases funding for Aboriginal community-controlled health services to employ staff to deliver mental health and social and emotional wellbeing services.
44	Queensland Human Rights Commission	Delivery of health services	ATSI	Continue to work closely with Aboriginal and Torres Strait Islander community-controlled health services and local disaster management committees and where possible provide decision-making autonomy to regional and remote Indigenous communities regarding restrictions. Further consult with Aboriginal

Sub	Submitter	Topic	Detail	
				and Torres Strait Islander communities to address the underlying drivers of high pricing in remote areas.
33	Australian Association of Social Workers	Delivery of health services	ATSI	That the Queensland Government implement the recommendations made by the National Aboriginal Community Controlled Health Organisation (NACCHO) and other peak bodies.
20	Stroke Foundation	Delivery of health services	Clinical pathways for stroke victims	The State Government to emphasise the need for QLD hospitals to: Implement clinical pathways for rapid access to stroke reperfusion treatments which maintain the safety of staff and provide the best outcome for patients.
32	Queensland Aboriginal and Islander Health Council	Delivery of health services	Domestic family violence psychological support	That the Queensland Government advocate for the immediate introduction of a Medicare item number for family violence psychological support, so that survivors can access support without needing a mental health plan.
27	Public Health Association of Australia	Delivery of health services	Education - National agency to provide advice and public education	...the Government establish an Australian independent designated public agency to provide scientific advice and education, and coordination assistance on communicable disease control, including all diseases of public health importance.
9	Cairns Regional Council	Delivery of health services	Establishment of coordination group for ATSI	A recommendation for future events is the immediate establishment of an overarching coordination group specific to assess and manage localised responses for First Nations peoples. This includes the requisite authority to influence cross-agency responses and associated resourcing.
23	Queensland Nurses and Midwives' Union	Delivery of health services	Innovation	<ul style="list-style-type: none"> • Support innovative nursing and midwifery-led models of care that have emerged to respond to the COVID-19 pandemic; • Utilise nurse and midwifery-led models of care to respond to non-COVID-19 related health care

Sub	Submitter	Topic	Detail	
				demands that are predicted to surge during the recovery phase; <ul style="list-style-type: none"> • Support midwifery-led community models of care to provide alternative care out of hospital settings;
23	Queensland Nurses and Midwives' Union	Delivery of health services	Innovation	Expansion of the Hospital in the Home (HiTH) model to midwifery services on an ongoing basis;
23	Queensland Nurses and Midwives' Union	Delivery of health services	Innovation	That the QLD Government's continued health response to COVID-19 include: <ul style="list-style-type: none"> • Funding for innovative models of care for nurse and midwifery-led services (i.e. telehealth, hospital in the home etc).
23	Queensland Nurses and Midwives' Union	Delivery of health services	Integration of health services	That the QLD Government considers the need to integrate health systems to support the delivery of services to ensure that the right care is provided in a timely manner and in the right place (WHO, 2018).
23	Queensland Nurses and Midwives' Union	Delivery of health services	Integration of health services	Integrate health systems to support the delivery of services to ensure that the right care is provided at the right time and in the right place;
23	Queensland Nurses and Midwives' Union	Delivery of health services	Integration of health services	Utilise nursing and midwifery-led models of care to improve health system integration
23	Queensland Nurses and Midwives' Union	Delivery of health services	Integration of health services	Increase funding to incentivise health sector partnerships as part of a health system integration strategy.
9	Cairns Regional Council	Delivery of health services	Integration of services and outreach in regions	It is anticipated that there will be unprecedented demands on regional health and wellbeing services as the lag effects of COVID-19 are realised. In addition to recommendations for increased resources, strategies must focus on coordination capacity for improved service integration across the continuum of health and care services, from acute to therapeutic. This includes clinical, non-clinical and therapeutic services meaningfully integrated with case support across

Sub	Submitter	Topic	Detail	
				domestic violence, housing and homelessness, and youth services among others. In particular, responses must include an increased emphasis on outreach-based preventative support, to meet the needs of consumers before their mental health escalates to chronic levels, when acute care is the only option.
20	Stroke Foundation	Delivery of health services	Maintain regional stroke units	The State Government to emphasise the need for QLD hospitals to: Maintain geographically defined stroke units staffed by specialised medical, nursing and allied health professionals to provide evidence-based stroke care.
37	Pharmaceutical Society of Australia	Delivery of health services	medicine supply arrangements	Provisions should be in place to cease the issuing of prescriptions for medicines with directions to dispense multiple repeats at one time during a public health emergency, particularly when restrictions have been enforced for international and/or local travel.
33	Australian Association of Social Workers	Delivery of health services	Mental health	That the Queensland Government advocates for the immediate introduction of a Medicare item number for family violence psychological support, so that survivors can access support without needing a mental health plan.
23	Queensland Nurses and Midwives' Union	Delivery of health services	mental health impacts of COVID-19	Increase funding to support nurses and midwives responding to the long-term impacts of COVID-19, mental health and vulnerable populations (DV, homelessness, poverty);
22	yourtown	Delivery of health services	Mental health National strategy for services for young people	That the Queensland Government work with its National Cabinet colleagues to develop national strategies to ensure that no child or young person is unable to access appropriate digital devices, or access free unlimited internet access if they do not have the resources to afford them.
22	yourtown	Delivery of health services	Mental health needs of children and young people	That the Queensland Government work with its National Cabinet colleagues to develop a specific

Sub	Submitter	Topic	Detail	
				strategy to address the mental health needs of children and young people, designed to support them through the pandemic and the economic downturn, in future disasters and into the future.
22	yourtown	Delivery of health services	Mental health services for children and young people	That the Queensland Government prioritise its mental health response and service development in relation to the needs of children and young people, including those under 12 years old.
32	Queensland Aboriginal and Islander Health Council	Delivery of health services	Mental health support	That the Queensland government advocate for the immediate increase of Medicare Better Access mental health support sessions to 20 per calendar year.
32	Queensland Aboriginal and Islander Health Council	Delivery of health services	Mental health support	That the Queensland government provide mental health screening support for COVID-19 patients, including follow-up support for those at risk of developing post-traumatic stress disorder and depression
33	Australian Association of Social Workers	Delivery of health services	Mental health support	That the Queensland government advocates for the immediate increase of Medicare Better Access mental health support sessions to 20 per calendar year.
33	Australian Association of Social Workers	Delivery of health services	Mental health support	That the Queensland government provides mental health screening support for COVID-19 patients, including follow-up support for those at risk of developing post-traumatic stress disorder and depression
43	Asthma Australia	Delivery of health services	Mental health support	[That] resources and tools be developed for mainstream health providers and multidisciplinary teams to assess and support mental health needs at the point of interaction, as well as appropriate training to support skill development in this area.
22	yourtown	Delivery of health services	Mental health support for children and young people	That the Queensland Government maintain and advocate at National Cabinet for an adequate funding base dedicated to digital mental health supports, such

Sub	Submitter	Topic	Detail	
				as Kids Helpline and Circles, and prioritisation of investment into strategies to support increasing digital access and literacy of vulnerable cohorts of children, young people and their families.
38	Palliative Care Queensland	Delivery of health services	Palliative care	Ensure Palliative Care is included in the whole of government planning, preparedness and response to the COVID-19 health emergency.
38	Palliative Care Queensland	Delivery of health services	Palliative care	Include palliative care specialist teams in future planning across portfolios, to map the patient journey and the changing needs of the dying person and their loved ones at each stage and the training required for generalist health professional to ‘break bad news compassionately’, discuss ceilings of care, understand the palliative supports they can provide and practice self-care.
38	Palliative Care Queensland	Delivery of health services	Palliative care	Review funding and its demarcation for specialist palliative care as there is a lack of transparency and accountability in palliative care funding, where allocated funding is often diverted to other directorates that fund general end of life care, terminal care, care of the aged and frail. This is in line with recommendations made by Queensland Parliament’s Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee Report No. 33 on Aged Care, End-of-Life and Palliative Care ¹⁰ tabled to the Queensland Parliament on 31 March 2020.
38	Palliative Care Queensland	Delivery of health services	Palliative care	Commission of the analysis of palliative care learnings from international countries where COVID-19 death rates were high to ensure these are integrated into future pandemic disaster management plans.
38	Palliative Care Queensland	Delivery of health services	Palliative care	Consider the role that community can play in providing assistance. The response to the Care Army

Sub	Submitter	Topic	Detail	
				initiative identifies there is an appetite to care, however most charities and NGOs do not have the capability or capacity to activate these volunteers in a serge-style response. We recommend a consideration of a statewide palliative care volunteer village. With volunteer roles and appropriate training which can be scaled up in times of disaster to support people experiencing loss, dying and grief – for example bereavement care volunteers; spiritual care volunteers and compassionate connectors (volunteers for aged care disability facilities who can connect the residents with their families).
38	Palliative Care Queensland	Delivery of health services	Palliative care	Review the recommendations within the Queensland Parliament's Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee Report No. 33 on Aged Care, End-of-Life and Palliative Care tabled to the Queensland Parliament on 31 March 2020, to consider if these recommendations were in place prior to the pandemic, how this may have improved the Queensland response to the pandemic.
36	Royal Australian College of General Practitioners	Delivery of health services	Patient care - Discharge information for patients shared with GPs	[That] information regarding patient admission or discharge from hospital or other services be promptly shared with the patients regular GP.
45	Aged & Community Services Australia	Delivery of health services	Patient care - Elective surgery	ACSA recommends increasing the capacity of elective surgery in all Queensland Health Hospitals, to allow for the backlog of surgery to be addressed, including for older Australians.
36	Royal Australian College of General Practitioners	Delivery of health services	Patient care - Priority referrals	[That] the Queensland Government provide additional resources to ensure existing category-3 referrals are fast tracked and that new category-3 referral that have been withheld until after 1 August 2020 are seen as soon as it is possible.

Sub	Submitter	Topic	Detail	
44	Queensland Human Rights Commission	Delivery of health services	Patient care - Triage without bias	Ensure triage frameworks for scarce health resources include a discussion of human rights obligations, do not entrench unconscious bias, and are publicly available.
36	Royal Australian College of General Practitioners	Delivery of health services	Patient care guidelines - clinical care	Ensure clear, concise, consistent and accessible evidence-based information on clinical care for different population groups, especially those vulnerable and at higher risk.
36	Royal Australian College of General Practitioners	Delivery of health services	prescriptions	[That] the Queensland Government seeks to extend the temporary digital prescribing legislation introduced during the COVID-19 pandemic and moves to a full e-Prescriptions system.
14	Pharmacy Guild of Australia Queensland Branch	Delivery of health services	Recognise community pharmacists & support staff	That community pharmacists and pharmacy support staff be recognised as frontline and essential primary healthcare providers providing a critical role and value to the health system.
23	Queensland Nurses and Midwives' Union	Delivery of health services	research	That the QLD Government continue to encourage models of care research and funding, to continue to improve midwifery services and continuity of care. ...the funding of research into the value of these models of care in improving health outcomes for rural and remote populations as well as Aboriginal and Torres Strait Islander's health. These models can be utilised for a range of preparedness and responses during and post-pandemic.
23	Queensland Nurses and Midwives' Union	Delivery of health services	Research	That the QLD Government fund research that evaluates the long-term sequelae of COVID-19, as this will directly inform health care delivery.
12	Lung Foundation Australia	Delivery of health services	Research - Support for respiratory research	We believe that this inquiry is well placed to support/recommend the establishment of dedicated respiratory research mission of \$300M per year over 10 years under the MRFF.

Sub	Submitter	Topic	Detail	
23	Queensland Nurses and Midwives' Union	Delivery of health services	Scope of practice	That the QLD Government seek a National Federation Reform Council partnership agreement and other means in order to provide: <ul style="list-style-type: none"> • Expand primary health services to include midwives as a fundamental component of primary maternity health; • Provide options for midwives to have rights to private practice similar to Medical doctors; • Provide an exemption for persons with a Medicare provider number from section 19(2) as part of a strategy to incentivise hospitals to shift models of care that are supported by evidence to improve outcomes; • Ensure indemnity Insurance provision for employed midwives includes their private practice 23work in public hospitals like arrangements well established within Memorandum of Understandings.
28	Exercise & Sports Science Australia	Delivery of health services	Scope of practice	That Queensland Health maps COVID-19 related hospital activities against the scope of practice of allied health professionals (both Apha [AHPRA] and self-regulated professions) to determine the highest value use of qualified allied health staff.
23	Queensland Nurses and Midwives' Union	Delivery of health services	Scope of practice – nurses and midwives	Remove barriers for nurses and midwives to work to their full scope of practice; <p>...expanding the Council of Australian Governments s19(2) exemptions Initiative (Department of Health, 2020) to include all geographical areas in Australia, not just in rural and remote localities. This expansion would enable midwives and nurses to work to their full scope of practice within community-based services, reducing the need for intervention from general practice clinics or hospital care (Department of Health, 2020).</p>
32	Queensland Aboriginal and	Delivery of health services	Social workers in aged care	That the important role of social workers in residential aged care facilities be recognised by including the

Sub	Submitter	Topic	Detail	
	Islander Health Council			employment of qualified social workers as part of the core staffing allocation.
23	Queensland Nurses and Midwives' Union	Delivery of health services	Staffing	That nursing and midwifery workforces should be adequately staffed to ensure there is enough capacity to cope with health care demands, attributed to COVID-19 and its consequences.
28	Exercise & Sports Science Australia	Delivery of health services	Staffing - surge workforce	That Queensland Health considers utilising Accredited Exercise Scientists to work as allied health assistants in any future surge workforces.
23	Queensland Nurses and Midwives' Union	Delivery of health services	Strategy	That the QLD Government consider nursing and midwifery-led models of care that target disadvantaged populations and high risk locations.
23	Queensland Nurses and Midwives' Union	Delivery of health services	Strategy Target social determinants of health	Engage policy strategies and funding models that target social determinants of health (particularly for high-risk populations including those in aged care and Aboriginal and Torres Strait Islander populations to work towards closing the health inequity gap);
23	Queensland Nurses and Midwives' Union	Delivery of health services	Strategy	That the QLD Government invest in strategies and funding that support the delivery of midwifery-led services in communities and homes.
28	Exercise & Sports Science Australia	Delivery of health services	Strategy	That the Queensland Government via the National Cabinet and/or the NFRC requests the Australian Government task and resource Australian Allied Health Leadership Forum to facilitate the collection and dissemination of allied health service improvements made during COVID-19.
28	Exercise & Sports Science Australia	Delivery of health services	Strategy	That the Queensland Government via the National Cabinet and/or the NFRC requests the Australian Government fund an incorporated entity (possibly Allied Health Professions Australia) to support a Secretariat for the Australian Allied Health Leadership Forum to the same levels as the equivalent medical

Sub	Submitter	Topic	Detail	
				and nursing national networks and consider increasing funding to Allied Health Professions Australia.
28	Exercise & Sports Science Australia	Delivery of health services	Strategy	That the Queensland Government, the Australian Government and other state and territory jurisdiction works to harmonise requirements for COVID-19 Plans.
32	Queensland Aboriginal and Islander Health Council	Delivery of health services	Strategy	QAIHC recommends the Committee consider NACCHO's submission when deliberating the Australian Government's health response to COVID-19 and its impacts on the Queensland Government's response as part of this Inquiry.
32	Queensland Aboriginal and Islander Health Council	Delivery of health services	Strategy	Recognise QAIHC and the ATSIICHO Sector's extensive and vital role in the health response to COVID-19, and the valuable contribution the Sector made, and can continue to make, to the state's wellbeing.
32	Queensland Aboriginal and Islander Health Council	Delivery of health services	Strategy	Accept the shortcomings of the Queensland Government's health response, in particular in relation to partnerships and funding, and work with the Sector to prevent them from occurring again (Section 4 – problems)
32	Queensland Aboriginal and Islander Health Council	Delivery of health services	Strategy	Work with QAIHC to ensure short- and longer-term opportunities are realised and actioned, and reform of the relationship between the Sector and HHSs takes place (Section 5 – opportunities). This includes progressing the Hospital and Health Board Amendment Bill 2019 and the accompanying Regulation, as well as wider reform and support from across Government for prevention-based treatment and coordinated service delivery.
32	Queensland Aboriginal and Islander Health Council	Delivery of health services	Strategy	Recognise the realistic possibility of a second wave and / or another serious global health crisis, along with the immediate threat that a lack of access to health care presents for Closing the Health Gap, and work with the Sector to prioritise meaningful change.

Sub	Submitter	Topic	Detail	
32	Queensland Aboriginal and Islander Health Council	Delivery of health services	Strategy	Reform the elective surgery wait-list process: Embed COVID-19 system improvement as business as usual: Respect the ATSI/CHO Sector
32	Queensland Aboriginal and Islander Health Council	Delivery of health services	Strategy	Partnerships - an Aboriginal and Torres Strait Islander health voice: Partnerships - Regional Network Funding Agreements Increase efficiency and fix the funding model: Accountability: Apply pandemic-best practice principles to other health crises: Improve clinical capability: Provide healthcare closer to home:
32	Queensland Aboriginal and Islander Health Council	Delivery of health services	Strategy	That the Queensland Government implement the recommendations proposed by the National Aboriginal Community Controlled Health Organisation (NACCHO) and other peak bodies ¹ .
39	Health Consumers Queensland	Delivery of health services	Strategy	Capitalise on this major disruption and transform health care by working in strong partnerships with consumers.
39	Health Consumers Queensland	Delivery of health services	Strategy	Monitor and measure the impact COVID-19 is having on the people most at risk of being left behind. Involve these consumers in co-design to ensure the health response meets their needs.
23	Queensland Nurses and Midwives' Union	Delivery of health services	Support for staff - education programs	That the QLD Government's health response continue to provide education programs for nurses and midwives to deliver high-quality care to COVID-19 patients. We also emphasise that providing further education pathways are only as effective as a well-staffed workforce.
32	Queensland Aboriginal and	Delivery of health services	Support for staff - health workers	That the Queensland Government strengthen mental health support systems for health care workers, including an ongoing program of mental health

Sub	Submitter	Topic	Detail	
	Islander Health Council			monitoring and support for impacted healthcare workers.
33	Australian Association of Social Workers	Delivery of health services	Support for staff - health workers	That the Queensland Government strengthens mental health support systems for health care workers, including an ongoing program of mental health monitoring and support for impacted healthcare workers.
33	Australian Association of Social Workers	Delivery of health services	Support for staff- health workers	That the important role of social workers in residential aged care facilities be recognized including the employment of qualified social workers as part of the core staffing allocation.
23	Queensland Nurses and Midwives' Union	Delivery of health services	Support for staff - nurses and midwives	[That] increased funding and resources be provided to support nurses and midwives to respond to the predicted increase in mental health issues, domestic violence and poverty as a result of the pandemic.
28	Exercise & Sports Science Australia	Delivery of health services	Support for staff - Training resources	That the Queensland Government collaborates with the Australian Government to produce resources for service providers to educate staff (including plan managers and personal care workers) about the need to maintain the continuity of care for vulnerable target populations in times of pandemics and other disasters.
23	Queensland Nurses and Midwives' Union	Delivery of health services	Support for staff - Training resources for health professionals	That appropriate funding is provided to QLD HHSs to ensure all health professionals have access to training and education resources. ...the continued training, skill development and upskilling of the nurses and midwifery workforce beyond the COVID-19 recovery phase. We recognise that future preparedness plans require both nursing and midwifery workforces to be appropriately trained, staffed and supported to respond to future emergencies.
18	Women's Health Queensland	Delivery of health services	Support for women	Increase availability of free women-centred health information

Sub	Submitter	Topic	Detail	
18	Women's Health Queensland	Delivery of health services	Support for women	Increase funding for women-centred free to access counselling services to support women across Queensland.
18	Women's Health Queensland	Delivery of health services	Telehealth	Continuity of care support services accessible via telephone and video platforms for all women, particularly those who are isolated, at risk of chronic disease or show low engagement with current health services.
18	Women's Health Queensland	Delivery of health services	Telehealth	Increase funding for the provision of free interactive online and telephone based antenatal and postnatal services for all women across Queensland.
20	Stroke Foundation	Delivery of health services	Telehealth	The QLD Government to continue to recognise the benefits of telehealth, expanding its use for stroke in emergency and rehabilitation services, now and after this pandemic is over.
23	Queensland Nurses and Midwives' Union	Delivery of health services	Telehealth	Expand the MBS items available for nurses and midwives working in private practice and primary care settings, as well as nurses and midwives utilising telehealth models; <ul style="list-style-type: none"> • Expand MBS telehealth items for mental health services;
23	Queensland Nurses and Midwives' Union	Delivery of health services	Telehealth	Continue to utilise MBS telehealth services that provide non-COVID-19 related maternity services; <ul style="list-style-type: none"> • Provide funding for research into the efficiency of telehealth models and nursing and midwifery-led models of care that can be utilised for a range of preparedness and emergency responses; that the QLD Government fund research to evaluate the efficacy and effectiveness of telehealth nurse and midwifery-led models of care.
23	Queensland Nurses and Midwives' Union	Delivery of health services	Telehealth	...the QLD Government to invest in expanding telehealth models, infrastructure, equity of access,

Sub	Submitter	Topic	Detail	
				capacity and education, to implement telehealth services as part of standard practice where appropriate. That the QLD Government support innovative telehealth models of care to provide access to broader community needs. For instance, disability support and mental health. This means people can receive the care they need from the comfort of their own home with enormous benefits for them.
23	Queensland Nurses and Midwives' Union	Delivery of health services	Telehealth	Continued funding for access to Medicare-funded telehealth services beyond the scheduled expiry date in September 2020
28	Exercise & Sports Science Australia	Delivery of health services	Telehealth	That the Queensland Government via the National Cabinet and/or the NFRC supports the retention of all temporary telehealth items for allied health and other health care and reinvestigate funding models that focus on a long-term, whole person and population health perspective.
45	Aged & Community Services Australia	Delivery of health services	Telehealth	ACSA recommends that telehealth initiatives continue in the post-COVID era, this is an opportunity to reset the health/aged care interface.
43	Asthma Australia	Delivery of health services	Telehealth research	Funding for telehealth, which is due to expire in September, become permanent to expand options for continuity of care for people with asthma, with evaluation of services occurring alongside implementation to assure quality of care and outcomes.
23	Queensland Nurses and Midwives' Union	Delivery of health services	Testing guidelines	That the QLD Government consider implementing guidelines for fit testing and fit checking that are standardised across all HHSs.
36	Royal Australian College of General Practitioners	Delivery of health services	Vaccinations	The provision of NIP vaccinations be contingent on the ability to upload relevant information to the Australian Immunisation Register.

Sub	Submitter	Topic	Detail	
14	Pharmacy Guild of Australia Queensland Branch	Delivery of health services	Vaccinations - Allow pharmacists to access the NIP	Enact immediate policy change to allow community pharmacist-vaccinators access to the National Immunisation Program (NIP)
14	Pharmacy Guild of Australia Queensland Branch	Delivery of health services	Vaccinations - Implement travel medicine recs	Implement the travel medicine recommendation from the 2018 Inquiry into the establishment of a pharmacy council and transfer of pharmacy ownership in Queensland, as a timely measure which will support a return to safe travel as Queensland’s borders re-open
37	Pharmaceutical Society of Australia	Delivery of health services	Vaccinations through pharmacists	To provide greater protection against vaccine-preventable diseases, Queenslanders eligible to receive NIP- and state-funded vaccines should have the same equitable access arrangements to those vaccines if they choose to utilise a pharmacist-administered vaccination service.
37	Pharmaceutical Society of Australia	Delivery of health services	Vaccinations through pharmacists	Pharmacist immunisers should be able to administer vaccines in any location as long as they adhere to the vaccination standards and not be constrained to a community or hospital pharmacy setting.
28	Exercise & Sports Science Australia	Delivery of health services	Vulnerable groups	That the Queensland Government considers establishing an emergency healthcare services fund for vulnerable target populations unable to afford healthcare or unable to access additional Australian Government funding in times of pandemics and other disasters.
32	Queensland Aboriginal and Islander Health Council	Delivery of health services	Vulnerable groups - Care for refugees and asylum seekers	That the Queensland Government implement the recommendations provided by the Refugee Advice and Casework Services and introduces procedures and services for people seeking asylum and refugees which meet our international obligations on human rights, protect and promote the human rights of people seeking asylum and refugees; and which ensure humane, effective care while they await a decision.

Sub	Submitter	Topic	Detail	
33	Australian Association of Social Workers	Delivery of health services	Vulnerable groups - Care for refugees and asylum seekers	<p>The AASW refers the Queensland Government to the recommendations from the submission to this inquiry by the Refugee Advice and Casework Service. We want to highlight the following:</p> <ul style="list-style-type: none"> • Provision of adequate financial, medical, and housing support for temporary protection visa holders and asylum seekers. • Ensure clear access to health care to temporary migrants including asylum seekers on bridging visas and other visas. • Provide funded telephone interpreting to people seeking advice about how their immigration status is affected by COVID-19 and for those who have been affected by this pandemic. • Establish a just, clear policy during the pandemic to guide visa processing and to ensure that COVID-19 does not negatively impact the legal rights of people seeking asylum including priority processing of Bridging visa applications and granting Protection Visas without waiting for interview where possible • The Australian Government follow the recommendations of leading experts and reduce the current population of immigration detention facilities. • The Australian Government must follow its own Department of Health Guidelines, in reducing the risk of an outbreak in immigration detention facilities. • Provide a clear pathway for resumption of family reunion and humanitarian resettlement

Sub	Submitter	Topic	Detail	
				and allow temporary protection visa holders currently overseas to return to Australia
44	Queensland Human Rights Commission	Delivery of health services	Vulnerable groups - Support for people with disability	Further consider and prepare for the adverse impact on people with a disability should restrictions return, particularly in relation to those who rely on services for care and social contact. Consider infection control training for all disability service and accommodation providers and guidelines for the screening and testing of people with disability and their carers.
44	Queensland Human Rights Commission	Delivery of health services	Vulnerable groups - Support for young people exiting transitional support	Ensure adequate transitional support for young people exiting out-of-home care.
33	Australian Association of Social Workers	Delivery of health services	Vulnerable groups- Care for refugees and asylum seekers	That the Queensland Government implement the recommendations provided by the Refugee Advice and Casework Services and introduces procedures and services for people seeking asylum and refugees which meet our international obligations on human rights, protect and promote the human rights of people seeking asylum and refugees; and which ensure humane, effective care while they await a decision.
32	Queensland Aboriginal and Islander Health Council	Engagement		That the Queensland Government engage in greater consultation for all mental health service delivery policy decisions.
33	Australian Association of Social Workers	Engagement		That the Queensland Government engages in greater consultation for all mental health service delivery policy decisions.
37	Pharmaceutical Society of Australia	Engagement		[That] the Queensland Government should have a clear, regular and timely mechanism to consult with the Pharmaceutical Society of Australia, the peak professional body for pharmacists, on all matters relating to the supply of therapeutic goods and/or impacting on pharmacist practice.

Sub	Submitter	Topic	Detail	
39	Health Consumers Queensland	Engagement		Collaborate with consumers more.
41	Queensland Law Society	Engagement		Proactive ongoing consultation with relevant stakeholders, particularly with the Queensland Human Rights Commission and Aboriginal and Torres Strait Islander communities, amongst others. There are a number of groups within our community who will need targeted economic and health services to protect their human rights and to ensure that they receive appropriate and high level health services which are accessible and commensurate to the quality and access experienced by others in the community (such as those in metropolitan areas).
41	Queensland Law Society	Engagement		Proactive ongoing consultation with a range of organisations to ensure the Queensland Government's health response reflects its commitment to human rights. QLS particularly encourages engagement with the Queensland Human Rights Commission.
45	Aged & Community Services Australia	Engagement		ACSA recommends that the Queensland Health COVID-19 Working Group – Residential Aged Care continues to meet at regular intervals after the conclusion of the COVID-19 era, to address issues facing residential aged care in Queensland. This will ensure that the expertise and advice provided by the members of the Working Group is not lost and continues.
13	Qld Primary Health Networks	Engagement	Need for cross government forum	[That] the Qld Government establish a cross government forum to include the PHNs with responsibility to address the interface of primary health with other sectors, including aged care, disability, social services and communities.
1	Daniel Lavery	Health monitoring	Air quality - monitoring stations in Ayr Home Hill and Clare	Instead, as a minimum position, could the Committee recommend, firstly and as a matter of urgency, that air

Sub	Submitter	Topic	Detail	
				quality monitors be placed in the three major population centres in the Burdekin, that is Ayr, Home Hill and Clare, by the Department of Environment.
28	Exercise & Sports Science Australia	Legislation - National	Appointment of Australian Chief Allied Health Officer	That the Queensland Government via the National Cabinet and/or the NFRC asks the Australian Government to expedite the appointment a permanent Australian Chief Allied Health Officer as a matter of urgency.
37	Pharmaceutical Society of Australia	Legislation - National	Appointment of Chief Allied Health Officer	[That] a Queensland Chief Pharmacist must be appointed urgently to enable the design and coordination of consistent and rapid implementation of relevant measures during public health emergencies and to provide ongoing strategic leadership in improving an overall medicine safety and quality use of medicines agenda for Queensland.
44	Queensland Human Rights Commission	Legislation - Queensland	<i>Corrective Services Act 2006</i>	Impose a legal obligation on the Queensland Corrective Services Commissioner to regularly review emergency declarations made under the <i>Corrective Services Act 2006</i> and to publish them online.
44	Queensland Human Rights Commission	Legislation - Queensland	Domestic violence	Provide permanent legislative protections for people experiencing domestic violence during their residential tenancy.
37	Pharmaceutical Society of Australia	Legislation - Queensland	Support for workers – Protection of health workers from abuse	[That] contemporary and permanent legislation must be enacted in Queensland to protect pharmacists and other healthcare workers from physical violence and verbal abuse.
37	Pharmaceutical Society of Australia	Legislation - Queensland	Therapeutic goods legislation	[That] in consultation and partnership with other states and territories, the Queensland Government should provide leadership to consider the adoption of uniform therapeutic goods legislation across all jurisdictions as far as practicable.

Sub	Submitter	Topic	Detail	
24	Firearm Dealers Association Queensland	Legislation - Queensland	<i>Weapons Act 1990</i>	Amendment to the definition of a Primary Producer in the <i>Weapons Act 1990</i>
28	Exercise & Sports Science Australia	Legislation – Queensland	Definitions in health legislation	That the Queensland Government reviews all its health legislation to <ul style="list-style-type: none"> • ensure that the default definition of health practitioners reflects COAG policy and recognises health professions not registered with AHPRA and • consider defaulting to the Private Health Insurance (Accreditation) Rules 2011 (Cth).
28	Exercise & Sports Science Australia	Other issues	Care Army	That the Queensland Government provides health professionals with pathways and processes to support referrals to the Care Army.
32	Queensland Aboriginal and Islander Health Council	Other issues	Economic recovery	That the Queensland Government commit to ACOSS's proposal for economic recovery, and work with all stakeholders on implementation to achieve fair and equitable outcomes.
27	Public Health Association of Australia	Other issues	Economic recovery	PHAA strongly recommends that: <ul style="list-style-type: none"> • the stated purpose and terms of reference of the existing Commission are amended to reduce the focus to economic issues, and to provide clear and transparent processes and guidelines. • a reduced emphasis on fossil fuels and a greater emphasis on economic stimulus that reflects the urgent need for action in relation to the climate crisis. This will require additional members with that expertise and interest. • another Commission be established to provide advice on non-economic issues. This new Commission should be comprised of members with a diverse range of backgrounds in social policy and programs, to provide advice on impacts on particular sectors of society, and how to “build back better”.

Sub	Submitter	Topic	Detail	
32	Queensland Aboriginal and Islander Health Council	Other issues	Emergency housing	That the Queensland [Government] develop an emergency housing response plan in consultation with local stakeholders for future major events requiring a joint housing and health response to ensure a safer, more sustainable and cost-effective response that accounts for the complex needs of those experiencing homelessness.
33	Australian Association of Social Workers	Other issues	Emergency housing	[That]...relevant state government departments such as the Department of Housing and Public Works and Queensland Health engage with local stakeholders to develop an emergency housing response to prepare for future events requiring a joint health and housing response.
33	Australian Association of Social Workers	Other issues	Emergency housing	That the Queensland [Government] develops an emergency housing response plan in consultation with local stakeholders for future major events requiring a joint housing and health response to ensure a safer, more sustainable and cost-effective response that accounts for the complex needs of those experiencing homelessness.
35	Queenslanders with Disability Network	Other issues	Emergency housing	That the Queensland Government continues to undertake transition and outbreak planning on how to best identify and locate short-term housing options across social housing, private rentals, specialist disability accommodation, respite facilities and supported accommodation facilities to accommodate people with disability during a public health emergency.
44	Queensland Human Rights Commission	Other issues	Homelessness	Continue efforts to address homelessness during the pandemic while investigating and implementing long-term solutions to address housing instability.
32	Queensland Aboriginal and	Other issues	JobKeeper	That the Queensland Government advocate for JobKeeper payment to be extended to cover casual

Sub	Submitter	Topic	Detail	
	Islander Health Council			staff who have been employed for less than a year, and temporary visa holders.
33	Australian Association of Social Workers	Other issues	JobKeeper	That the Queensland Government advocate for JobKeeper payment be extended to cover casual staff who have been employed for less than a year, and temporary visa holders.
32	Queensland Aboriginal and Islander Health Council	Other issues	JobSeeker	That the Queensland Government advocate for permanently increasing Jobseeker and other allowances.
33	Australian Association of Social Workers	Other issues	JobSeeker	That the Queensland Government advocates for permanently increasing Jobseeker and other allowances.
41	Queensland Law Society	Other issues	Legal aid funding	Additional funding is required for the legal assistance sector to manage the increased demands arising from COVID-19. QLS members indicate an increased need for legal assistance from people seeking advice in relation to domestic and family violence; credit matters; insurance matters; superannuation claims; hardship applications; insolvency matters; tenancy disputes; and employment disputes - all of which have been impacted by the pandemic generally, and will be particularly challenging for groups experiencing impacts to regular health services due to disruption caused by COVID-19.
28	Exercise & Sports Science Australia	Other issues	NBN	That the Queensland Government through the National Cabinet and/or the NFRC reviews Australia's overall broadband network strategy to invest in better technology i.e. fibre to the premises (FTTP) to homes and businesses; and fibre to the basement (FTTB) for apartment blocks and other large buildings.
32	Queensland Aboriginal and	Other issues	Social housing	That the Queensland Government lead a substantial investment in social and affordable housing and a

Sub	Submitter	Topic	Detail	
	Islander Health Council			strategy to ensure that everyone in Australia has access to safe, affordable housing, and increase funding to specialist homelessness services to assist those experiencing homelessness to access and sustain housing.
33	Australian Association of Social Workers	Other issues	Social housing	That the Queensland Government leads a substantial investment in social and affordable housing and a strategy to ensure that everyone in Australia has access to safe, affordable housing, and increase funding to specialist homelessness services to assist those experiencing homelessness to access and sustain housing.
42	Tenants Queensland Inc	Other issues	Tenancy reform	<p>[That]... in the current pandemic as well as any similar future events, the Queensland Government:</p> <ul style="list-style-type: none"> • Continues to work productively with and through the National Cabinet structure to ensure no one is left behind during this health, economic and social crisis and the period of recovery leading out of it. • Work to extend the existing evictions moratorium to ensure: <ul style="list-style-type: none"> ○ That all renters are supported to stay safe in their homes through the crisis, and as our communities enter into a recovery period. ○ The removal of the additional grounds for eviction by lessors provided in the Residential Tenancies and Rooming Accommodation (COVID-19 Emergency Response) Regulation 2020 • Consider what measures or relief are required to support renters with debts accrued while

Sub	Submitter	Topic	Detail	
				<p>waiting for rent negotiations to complete, or because of failed rent negotiations to ensure they do not come out of the crisis burdened with unmanageable debt as a result of deferred and/or unaffordable rents.</p> <ul style="list-style-type: none"> • Provide timely, appropriate monitoring of COVID-19 impacts in relation to renting households and consideration of what further response/s will be required after the moratoriums lift. • Work with the Federal Government to ensure significantly increased public investment in social and affordable housing to assist in Australia's economic and social recovery from the COVID-19 pandemic.
44	Queensland Human Rights Commission	Other issues	Vulnerable groups - Access to tech for remote learning	Ensure access to the technology needed to support social connection as well as remote learning for children and young people in out-of-home care, and students unable to attend boarding school due to the restrictions.
22	yourtown	Other issues	Vulnerable groups - Digital learning for vulnerable students	That the Queensland Government advocate for a review of the school curriculum in relation to digital learning at school to ensure that it accommodates the needs of vulnerable students.
35	Queenslanders with Disability Network	Other issues	Vulnerable groups - Support for people with disability	that the Queensland Government works in collaboration with the Commonwealth Government, major retailers and people with disability to develop plans to ensure people with disability have priority access to essential, affordable food items and PPE in a crisis environment. Developing these plans will give people with disability greater certainty and reduce confusion in the event of a future health emergency event.

Sub	Submitter	Topic	Detail	
13	Qld Primary Health Networks	Pandemic/disaster planning	Acknowledge role of PHNs	The role and scope of PHNS should be clarified and embedded into state disaster planning and response processes.
13	Qld Primary Health Networks	Pandemic/disaster planning	Cooperation with PHNs	The Qld Government consider working collaboratively with QPHNs to identify and embed COVID innovations that should be transitioned into the new business as usual.
13	Qld Primary Health Networks	Pandemic/disaster planning	Data and information	Processes to aggregate data and intelligence from primary health care as part of state disaster planning processes need to be formalised.
36	Royal Australian College of General Practitioners	Pandemic/disaster planning	Engagement with GPs	General practice should be firmly embedded in the Queensland State Health Emergency Coordination Committee and other key state-wide and local planning and response groups responsible for pandemic and other emergencies.
37	Pharmaceutical Society of Australia	Pandemic/disaster planning	Engagement with pharmacists	As essential health workers during a pandemic or other public health emergency, any future pandemic planning must provide for adequate support for pharmacists and pharmacy staff in all settings to ensure pharmacist-delivered clinical services can continue during all stages of a pandemic and at every level of care.
43	Asthma Australia	Pandemic/disaster planning	National steering committee	...to establish a National Steering Committee to review existing pandemic plans, investigate areas for improvement, and build on the existing plans to create a comprehensive National Pandemic Preparedness Plan.
43	Asthma Australia	Pandemic/disaster planning	National steering committee	[That] the proposed National Steering Committee establish a working group to investigate issues relating to medication supply during the COVID-19 pandemic, including representatives from respiratory consumer health groups, pharmaceutical companies, wholesalers, retail banner groups and peak bodies.

Sub	Submitter	Topic	Detail	
				We also recommend the proposed National Pandemic Preparedness Plan address potential medication shortages.
43	Asthma Australia	Pandemic/disaster planning	National steering committee	[That] the proposed National Steering Committee investigate mental health needs, including of people with chronic respiratory illness, and address these needs in the proposed National Pandemic Preparedness Plan.
13	Qld Primary Health Networks	Pandemic/disaster planning	Need for primary care disaster plan	A primary care disaster management response plan, that complements state and federal disaster response plans should be developed for Queensland.
23	Queensland Nurses and Midwives' Union	Pandemic/disaster planning	Strategy	That the state review its capacity to respond and has the regulatory capacity and machinery in place to rapidly respond to future events.
44	Queensland Human Rights Commission	Pandemic/disaster planning	Update plans for Human Rights Act	The Commission suggests the government prioritise the updating of pandemic planning documents and processes, based on the experience of this pandemic, including expressly promoting the need to give proper consideration to human rights in decision-making, as well as acting and making decisions that are compatible with human rights.
44	Queensland Human Rights Commission	Pandemic/disaster planning	Update plans for Human Rights Act	Embed proper consideration of human rights and the obligation to act and make decisions that are compatible with human rights in all planning documents concerning pandemic and other emergencies.
44	Queensland Human Rights Commission	Pandemic/disaster planning	Update plans for Human Rights Act	Clarify decision-making lines of authority, ensure at least minimum standards requiring access to fresh air and exercise, and provide clear and transparent exemption and hardship application processes for those in mandatory quarantine in hotels.
44	Queensland Human Rights Commission	Parliamentary scrutiny		Maintain parliamentary scrutiny processes wherever possible along with stakeholder engagement prior to

Sub	Submitter	Topic	Detail	
				passing legislation and subordinate legislation. Consider whether legislation that has been passed without proper scrutiny should be referred to the relevant committee for retrospective scrutiny.
9	Cairns Regional Council	PHDs (public health directions)	Briefings of key personnel before PHDs issued	Council recommends Queensland Health consider identifying a key lead agency, support agencies, and role definitions to coordinate implementation of PHDs. This includes briefing key senior personnel at all levels of Government and regions prior to public announcements and provide coinciding templates and information for streamlined implementation. A key recommendation is the allowance for standing powers and delegations for relevant officers activated by emergency declarations.
44	Queensland Human Rights Commission	PHDs	Clear information	Provide clear, accessible information to the community about review and exemption processes in relation to the Public Health Directions.
24	Firearm Dealers Association Queensland	PHDs	Compensation	[That] compensation to be paid to all armourers, firearm dealers and sellers of ammunition or propellant powders in Queensland to bring their income for the period of the restrictions to that of the same period in the previous year.
24	Firearm Dealers Association Queensland	PHDs	Compensation	Compensation to ALL employees in those businesses commensurate with their normal income.
28	Exercise & Sports Science Australia	PHDs	Definitions for key terms in PHDs	That the Queensland Government through the National Cabinet and/or the National Federation Reform Council (NFRC) prioritises harmonising definitions of essential services in existing legislation or in any new essential services legislation, including a consistent definition for essential health and allied health services.

Sub	Submitter	Topic	Detail	
28	Exercise & Sports Science Australia	PHDs	Definitions for terms used in PHDs	That the Queensland Government ceases defaulting to the Health Practitioner Regulation National Law as the default definition of health practitioners in any COVID-19 exemptions and public health orders.
35	Queenslanders with Disability Network	PHDs	Issues in group housing	That the Queensland Government look at specific and detailed scenario outbreak planning to better inform how public health directives should be implemented in congregate housing settings and what services are considered 'essential'. It is vital that the development of these plans includes people with disability and their families.
44	Queensland Human Rights Commission	PHDs	Limitation of powers	Amend the Public Health Act to allow the exercise of powers under Chapter Part 7A only as part of a declared public health emergency.
45	Aged & Community Services Australia	PHDs	National approach	ACSA recommends that directions prescribed under COVID-19 Directives be uniform across all Australian states and territories wherever possible unless local circumstances warrant specific directives.
15	Shooters Union Queensland	PHDs	Need for focus on health matters and review legality of health directions issued	(a) That any future Health responses remain focused solely on matters relevant to Health and not allow the influence of party politics or other motivations. (b) That an inquiry be undertaken into the legality of the Health Direction with a view to compensating those affected by the closure of gunshops, firearms dealers and armourers.
44	Queensland Human Rights Commission	PHDs	People in closed environments	Ensure those in closed environments have reasonable access to fresh air and exercise and can engage in meaningful contact with family, others in their community and their lawyers.
44	Queensland Human Rights Commission	PHDs	People in closed environments Notify public of visits	Release public information about when visits will resume to all closed environments, and in particular youth detention centres.

Sub	Submitter	Topic	Detail	
44	Queensland Human Rights Commission	PHDs	People in closed environments Independent oversight	Maintain and improve independent oversight of closed environments, such as by creating an independent inspector of prisons.
44	Queensland Human Rights Commission	PHDs	Publish infringement data	Publicly release de-identified demographic data about recipients of Public Health Infringement Notices in order to evaluate whether particular communities are being disproportionately impacted by the enforcement of the Public Health Directions.
23	Queensland Nurses and Midwives' Union	PPE (personal protective equipment)	Availability, local supply, guidelines for laundering etc	That the QLD Government continue to focus on: <ul style="list-style-type: none"> • Improve access and use of PPE through local supply chains; • Mandate PPE supply contracts with locally sourced manufacturers; • Provide further guidelines for PPE (laundering of uniforms, PPE use etc) in line with emerging evidence-based research;
45	Aged & Community Services Australia	PPE	Emergency supplies	Work should occur to ensure that we are well prepared ahead of another pandemic. The full range of PPE needs to be stockpiled to a level able to cope with the current and future pandemics and define what constitutes essential equipment, supplies and medicines required for national emergencies and health pandemics ensuring secure national manufacturing and supply chain capabilities.
37	Pharmaceutical Society of Australia	PPE	Emergency supplies available to essential health workers	In any public health emergency planning process for distribution of personal protective equipment (PPE) from the National Medical Stockpile, the Queensland Government must negotiate for adequate supplies to be allocated to protect essential health workers in Queensland without the risk of facing shortages of PPE.
28	Exercise & Sports Science Australia	PPE	Emergency supply	That the Queensland Government via the National Cabinet and/or the NFRC ensures the Australian

Sub	Submitter	Topic	Detail	
				Government continues to maintain adequate supplies of PPE in the National Stockpile to ensure all health and allied health professionals have access to PPE in the event of another pandemic.
36	Royal Australian College of General Practitioners	PPE	Emergency supply	The Queensland Government should urgently address the supply shortages of PPE (P2/N95 masks, gloves, gowns and eyewear) to GPs and general practices when normal supplies and stockpiles are depleted.
36	Royal Australian College of General Practitioners	PPE	Emergency supply	That planning for future pandemics include the establishment of distribution channels for appropriate PPE that are able to respond to local requirements, not which Government funds or supplies the items.
9	Cairns Regional Council	PPE	Emergency supply - provision of access to state and federal reserves to sustain community – based health and social services for vulnerable cohorts	Future event contingencies should consider access to state and federal reserves of emergency PPE to sustain community-based human and social services for extremely vulnerable cohorts during times of significant disruption.
9	Cairns Regional Council	PPE	Guidelines on PPE required	It is also recommended that Queensland Health ensure clear and timely guidelines on the type and level of PPE required relevant to the Australian context, the nature of the event, and referring to the CDC guidelines as the international standard.
36	Royal Australian College of General Practitioners	PPE	Guidelines on PPE use	[That] clearer advice on the appropriate use of PPE should be based on agreed national guidance.
23	Queensland Nurses and Midwives' Union	PPE	Research – PPE care	That the QLD Government invest in research into best practice evidence for using gowns, laundering of uniforms and donning and doffing of PPE.
36	Royal Australian College of General Practitioners	Public education	About visiting GPs	[That] the Queensland Government invest in a range of public media and communications campaigns which highlight the importance of not delaying seeing a GP and accessing essential treatment, whether for existing health conditions or new symptoms.

Sub	Submitter	Topic	Detail	
36	Royal Australian College of General Practitioners	Public education	ATSI	Additional resources be provided to support QAIHC with a particular focus on delivering culturally appropriate preventive health activities, and addressing social determinants of health to ensure community preparedness for future pandemics.
36	Royal Australian College of General Practitioners	Public education	Different languages	Targeted education to be provided in different languages, tailored to carrying health literacy levels, around COVID-19 testing, public health management strategies, and the implications of a positive test and the need for self-isolation.
20	Stroke Foundation	Public education	Encourage people not to avoid hospitals	The QLD Chief Health Officer to continue to urge people not to avoid hospital if they are unwell, and reassure the public that hospitals will not be overburdened by patients seeking emergency medical treatment.
28	Exercise & Sports Science Australia	Public education	Exercise information	That the Queensland Government includes information on the value of exercise during a pandemic on the Healthier Queensland website.
28	Exercise & Sports Science Australia	Public education	Exercise information	That the Queensland Government provides Care Army volunteers with information to pass onto vulnerable Queenslanders about the need to exercise to maintain their mobility, independence, confidence.
24	Firearm Dealers Association Queensland	Public education	Firearms offences	That the QLD Cabinet approves a public education campaign advising of Hotline and discrete reporting mechanisms. Note 1: The licensed dealer network has volunteered to receive and securely store any firearms from homes for at risk people, ensuring at risk people do not walk into police shop fronts with their firearms. Note 2: This also addresses issues where police stations do not have adequate storage arrangements particularly where a large collection is involved.
20	Stroke Foundation	Public education	Guidelines –stroke	The QLD Government to support the continued development of living guidelines for stroke

Sub	Submitter	Topic	Detail	
				management and COVID-19 and the expansion of this innovation to benefit a range of other conditions.
36	Royal Australian College of General Practitioners	Public education	Immunisation	Queensland Government launch a public awareness campaign to educate Queenslanders about the importance of immunisation, and heading the advice of medical experts rather than celebrities who promote views contrary to scientific evidence.
28	Exercise & Sports Science Australia	Public education	Messaging to enforcement officers	That in the event of the further COVID-19 outbreaks and lock downs, the Queensland Government through the National Cabinet and/or the NFRC asks the Australian Government develop consistent, co-ordinated and clear messaging to educate law enforcement agencies about the range of essential health and allied health services.
37	Pharmaceutical Society of Australia	Public education	Pharmacists' role	Relevant Queensland Government agencies should facilitate the coordination and dissemination of key public health and medicine-related messages through pharmacists to patients and communities, and support pharmacists to reinforce those messages. Pharmacists must be appropriately recognised and remunerated by Government for this important role.
1	Daniel Lavery	Public education	Public health messaging about air quality	that Queensland Fire & Emergency Services (perhaps best advised by the Health Department) put in place relevant public health messaging in the Burdekin during the five months of the cane-burning season in 2020, in particular messaging that when the air quality monitors signal 'poor' air quality of above AQI 150 and ascending into the dangerous levels (which, in the Burdekin where burning occurs so close to residences, may go into the thousands and perhaps even above 10,000) appropriate health precautions need to be taken and where to get treatment or protective equipment if affected.

Sub	Submitter	Topic	Detail	
32	Queensland Aboriginal and Islander Health Council	Public education	Racism	Acknowledge and raise public awareness of institutional racism: Retain the focus on culturally safe communications:
28	Exercise & Sports Science Australia	Public education	Rehabilitation strategy	That the Queensland Government via the National Cabinet and/or the NFRC requests the Australian Government implement a rehabilitation strategy for patients of all ages requiring rehabilitation with strategic priorities for allied health and exercise physiologists
20	Stroke Foundation	Public education	Stroke signs	Increased investment in F.A.S.T. (Face. Arms. Speech. Time) signs of stroke education, empowering Queenslanders to seek help at the first sign of stroke.
39	Health Consumers Queensland	Public education	targeting	Recognise the social capital and connections available from the consumer-world and tap into these to inform communication, particularly communication aimed at those who require focused health attention and are likely to be impacted most by these decisions.
39	Health Consumers Queensland	Public education	targeting	Create communication campaigns with consumers playing a leading and active role.
28	Exercise & Sports Science Australia	Public education	Vulnerable target groups	That in the event of the further COVID-19 outbreaks and lock downs, the Queensland Government through the National Cabinet and/or the NFRC develops a public information campaign reassuring vulnerable target populations including older people (both in the community and in residential care), people with a disability and people with chronic conditions that health and allied health care is essential and should continue to be accessed; and that they be supported to stay active and remain mobile during COVID-19.
43	Asthma Australia	Research	Epidemiology of COVID-19	Funding for research into the epidemiology of COVID-19 and chronic respiratory illnesses including asthma.

Sub	Submitter	Topic	Detail	
23	Queensland Nurses and Midwives' Union	Testing, screening, contact tracing		that the QLD Government continue to prioritise testing, screening and contact tracing as a high priority for health professionals as restrictions are relaxed and workplaces re-open.
32	Queensland Aboriginal and Islander Health Council	Testing, screening, contact tracing	Data	Improve testing and screening data (pathology):
45	Aged & Community Services Australia	Testing, screening, contact tracing	Mobile fever clinics	ACSA recommends that mobile fever clinics be operational within aged care facilities and aged care community care centres during the pandemic, particularly where there are suspected or confirmed cases of COVID-19, ensuring residents do not have to leave a facility for testing. This strategy aligns with the Government's announcement on 13 March 2020 to fund COVID-19 pathology testing of residents within residential aged care facilities.
36	Royal Australian College of General Practitioners	Testing, screening, contact tracing	Test results - sharing	Timely reporting to GPs of information regarding patient COVID-19 test results, including via My Health Record.



OFFICIAL

Question Taken on Notice

Asked on 19 August 2020

Health, Communities, Disability Services and

Domestic and Family Violence Prevention Committee's public hearing

for its inquiry into the Queensland Government's health response to COVID-19

MR BERKMAN ASKED COMMISSIONER CARROLL, DEPUTY COMMISSIONER GOLLSCHESKI AND ASSISTANT COMMISSIONER CHELEPY

QUESTION:

Have you heard of any of the practices (referred that footage was available) where Police officers have forcibly, whether by direction or force, pushed protestors into a space where they are confined and can't practicably maintain that physical distance. Obviously, what we know will increase the risk of transmissions. The question is are you aware of that happening. Have any steps been taken to prevent it happening again.

ANSWER:

The footage referred to in the question shows Brisbane City Councillor Jonathon Sri claiming that police used a practice known as 'kettling' when dealing with protestors at Kangaroo Point on 21 June 2020. The footage does not show the so called 'kettling' occurring, or protestors being forcibly dealt with by officers in any way. It merely shows Councillor Sri making the accusation of officers using this tactic.

The Queensland Police Service (QPS) does not practice 'kettling' as a means of crowd control. On the day in question, officers were dealing with an unauthorised public assembly in Main Street Kangaroo Point, when they directed several hundred protestors to leave the roadway they had blocked. The advised protestors were directed to the footpath and off the roadways, where they were able to move freely, north and south along both sides of Main Street and into Walmsley Street.

Any concerns around social distancing, however brief, were appropriately mitigated by using face masks and hand sanitiser supplied to the protestors by the organisers. The footage clearly shows protestors, including Councillor Sri moving about freely, and protestors wearing face masks.

The QPS is committed to keeping our community safe, and in supporting an individual's democratic right to protest, works collaboratively with protest organisers, wherever possible, to ensure these activities are conducted peacefully, lawfully, and safely. The QPS also asks protest organisers to consider the impact to community safety when conducting protest activity during the current health pandemic.

OFFICIAL