All-Party Group on Coronavirus - Oral Evidence Session 17

Transcript by Communique Communications Ltd.

23 February 2021

Layla Moran MP

Well, good morning or good evening, depending on where our various panellists are, we are delighted to be able to have a special, and extra-special I should say, evidence hearing today of the All-Party Group on Coronavirus. Today on the day where the aftermath of the Government's latest road map out of the latest lockdown is being scrutinised. We are hoping to learn a lot from professionals who understand what went right in Australia and New Zealand and indeed elsewhere in the world. So to help us do that today I'd like to introduce an illustrious panel and I don't think that's an under-statement at all, we've got with us a good friend to the All-Party Group, Professor Martin McKee, welcome again Martin. Professor of European Public Health at the London School of Hygiene and Tropical Medicine.

We also have with us Professor Michael Baker, Professor of Public Health and Epidemiologist within the University of Otago, Baker is a member of the New Zealand Food Safety Authorities Academy and the New Zealand Ministry of Health Pandemic Influenza Technical Advisory Group, welcome Michael. Another Michael, you do not need to be called Michael to give us evidence today but we have another Michael, Professor Michael Moore, Adjunct Professor at the University of Canberra, and visiting Professor at the University of Technology Sydney, is the former CEO of the Public Health Association of Australia, so welcome Professor Moore.

And finally and certainly not least is Professor Catherine Bennet, Founding Chair and President of the Council of Academic Public Health Institutions Australia. Catherine is a leading researcher and teacher in public health with a specific interest in infectious disease epidemiology and community transmission.

Well, thank you all for joining us, just to give us a sense of where you are and what time is it, so Martin you're not far away and in our time zone, but Professor Baker where are you and what time is it there? Oh, you're on mute.

Professor Michael Baker

It's 10pm in Wellington.

Layla Moran MP

10pm, well thank you so much for staying up late to be with us. Professor Moore where are you and what time is it?

Professor Michael Moore

It's just 8pm and I'm in Canberra, the heart of our nation.

Layla Moran MP

Thank you so much, and Professor Bennett.

Professor Catherine Bennet

Same, 8pm, I'm in Melbourne the heart of lockdown in Australia.

Layla Moran MP

Yes, of course well I've no doubt that will come up. Well thank you all for joining us. My first question is you know what we all want to know in this country, what has been the special source over there that we can learn from here, so what in your view are the main drivers of success in suppressing the virus and perhaps I'll start with Professor Bennet given that you're right in the middle of an intervention at the moment. We'll go around the whole panel for your reflections, what's gone right where you are?

Professor Catherine Bennet

Yes, we've just actually come out of a short circuit breaker lockdown. I think what happened Australia-wide was that early action and decisive action when it came to the first lockdown in the first wave. The second wave is actually a different story for us and if we've got time later I've just got some slides that capture some of that, but it had a different dynamic, you know we had wider spread community transmission but we were also measuring it. But, most importantly we had the virus get into workplaces, significant workplaces and then age care and that all happened very quickly. It changed the dynamic. And so the interventions we put in place the first time which were very strict lockdown, similar to what you have put in place in the UK, though this is pre-masks, we weren't doing masks for the first wave but we had more strict lockdown in many respects and that where it worked for the first wave didn't seem to hold the second wave and we introduced masks, that probably did not only flatten the curve but bring our numbers down but before that really had chance to have a full effect we went into an even more strict lockdown.

So, we actually had a change in dynamic in our second wave in every respect. It was a different epidemiological dynamic, it was a different community participation dynamic and what I think we had found in the first wave Australia-wide was good community buy-in even though I think Michael would agree we didn't quite have our public health messaging coordinated across States and with Commonwealth and there was confusion as there always is in a pandemic. We did get good public buy-in. But the second wave played out a bit differently and there's some lessons to learn from that as well as, you know we still managed to struggle through and it was much more split into some fear messaging, so people reacted to that and we did have people who sort of knuckled down and really stuck with lockdown, but to the point where it was difficult for some people to come out of lockdown in Victoria and that of course was a very long lockdown.

So, what was successful was getting back to zero community transmission, though arguably taking 112 days to get there in strict lockdown, perhaps wasn't what we would call success and there's a lot in there that we need to unpack and learn from. But we did look at elements of that towards the end, particularly schools which I have mentioned as one of the areas of interest, was something we were able to look at our data and learn from what was happening locally. But, yeah it's been quite interesting to pull apart the pandemic in Victoria, this second wave, and look at where it actually moved through the community and if you take out age care and healthcare that explained that the

second half of the second wave, it explained two thirds of cases are either the workers themselves or their household contacts.

So, I guess that's an important question when we're thinking about not just the interventions you put in place but also the rules we have around stepping away from lockdown and how that looks and how you communicate it and the public health messaging around that as well. But I do think we had good buy-in, we did have trust in Government and we had weather on our side probably too as we were coming out of it, as we were heading into our Spring, so that no doubt helped a bit as well.

Layla Moran MP

Thank you very much, Professor Moore do you want to add from the Australian perspective before we move to New Zealand.

Professor Michael Moore

Yeah I do, and I'm going to add also a political perspective for you because I am formerly a Health Minister in the Australian Capital Territory as well as having a Masters in Public Health and a PhD and things, so the really interesting part to me was that in marked contrast to previous pandemics we saw after a hiccup in the start, a really interesting coordination. I should say I was an Independent member by the way, Australia's first Independent Minister, so I'm not particularly partisan in my comments at all and in fact different Governments right across Australia worked together extraordinarily well to achieve the results and it actually took me I have to say really by surprise because they decided that first of all they would all follow the health advice of their Chief Health, Chief Medical Officers and that is one of the things that really built trust in Government and Australia has seen trust in Government really diving very, very considerably over the last 15 years and we've just seen this curve go right up and I think it was we're working on the evidence, we're working on the advice of our Chief Health, Chief Medical Officer, so the Commonwealth is the Chief Medical Officer, the States have the Health Officers. And either the Premiers or the Chief Ministers or the Prime Minister would almost always stand next to their Chief Health, Chief Medical Officer and I think that helped build trust and that coordination they did between them also helped.

So, the Prime Minister established what he called the Australian Cabinet and it was a sort of, I think there was almost a compensation happening from our previous pandemics, you know that hadn't really got underway but when we look at swine flu and SARS and so on, the Public Health Association of Australia had been pushing very strongly for a Centre for Disease Control, because of the conflict that happens between the different levels of Government and Governments had been resisting that, they would come and Chief Medical Officers or the Secretary of the Department of Health would speak at our conferences and go 'we don't need it, because now we're doing this and this and this'. And so they had actually built up their coordinating capacity, not perfectly by any means, I suppose Catherine I might say 80% if I was gonna pick a figure out of the blue, but we did see a much better coordination.

So, the two really important messages, much better coordination, much more respectful of science and the health and medical advice that was coming with the politics. By the way, for people interested in politics and I know none of you probably are but, the jurisdictions of different colours that were firm that went for the lockdown that did this process, everyone that has been to an election have been returned, quite comfortably. And particularly when it looked previously like they would not be returned and so standing there evidence based, health has actually been a significant political advantage.

Layla Moran MP

That's really very interesting, thank you. Professor Baker.

Professor Michael Baker

Yeah, look I think many of the success factors described by Australia are very similar to New Zealand. I think informed scientific input right at the beginning was a very clear strategy. I mean we actually did give the strategy a label of elimination right at the beginning and the goal of zero tolerance of cases in the community and we were just following the successful models of China. And I remember looking at the success in Wuhan and the Joint Mission Report at the end of February laid out the success that had been achieved there and obviously there was uncertainties about the quality of some of the information and I became a major advocate for the elimination approach. I just assumed the entire world would do this because this was a WHO report, they had actually actively developed with their own staff and anyone who knows basic infectious disease, epidemiology, knows you've got a fork in the road, you either control things or you eliminate them and obviously it's not quite as simple as that but it's a very stark choice and it seemed that elimination or containment, I mean the Chinese didn't give this a name and I've talked to them about this that translates but it just seemed like the obvious approach.

So, I think the science input, the next central element is obviously good political leadership that listens to the scientists and then makes a decisive choice that I think is prioritising public health and of course as the year has gone on it's become very clear that protecting public health also protects economies, so you're not having to make a choice. So, that's one of the great lessons I think from a year of data.

The other elements are you obviously need to have public engagement and trust and a fourth element is enough public health infrastructure to deliver what you need to do and most, all high income countries have that infrastructure. You are just using the same basic tools that are available across the globe, I mean these are the non-pharmaceutical interventions or public health interventions and that is just managing borders, being able to dampen down transmission with movement controls and so on. I mean circuit breakers or stay at home orders and then obviously mass masking use and thirdly testing and contact tracing, that infrastructure.

And it helps of course if you are an island State, as the UK is, as New Zealand is, but you know you have this staggering success of places like Vietnam that don't have those natural advantages. So, it's not essential, you just have to have the will to pursue those interventions. And the last essential element is you obviously need a safety net to support groups who are disproportionately affected by those interventions. So, I think those five elements are really what is required and they are available to all high income countries and I think the timing is obviously important, making the decision early on based on the evidence and then committing to that. And it's actually much easier I think if you have a decisive target and I mean there's nothing more definitive than saying we will have no cases in the community because actually saying we're going to have suppression or I mean mitigation obviously was the flu model which most countries across the Western world happily rolled out without question seemingly, but then reverted you know to a suppression approach.

But actually it is problematic because having residual cases in the community obviously creates a starting point for further outbreaks and then epidemic spread, so I think we've found the goal of having no cases has been very helpful and it is, we still find it a bit … or people arriving to New Zealand find it a bit astounding that the entire country cares about a single case and a border worker just realises what's happening in the rest of the world, but that's the focus you have to have. And one of the effects is New Zealand has had less time under lockdown than virtually every country in the OECD just by having this huge focus on stamping out cases when they occur and being very decisive.

Layla Moran MP

Thank you, that's very helpful. And I don't think I had quite appreciated that last point because in this country the narrative is that by driving down, shooting for an elimination strategy means more lockdown, but actually in New Zealand it's been the opposite so I think that's really important. Martin, if I could ask you to perhaps answer the question of what have they done right but also invite you to consider the points that the Prime Minister made yesterday in his speech where he basically said that going after such an elimination strategy which he characterised as the 'zero Covid strategy' that wouldn't work in this country and there are those who are saying that we can't compare what Australia and New Zealand have done to the UK. Is that fair comment, can we not compare or could we have done it?

Professor Martin McKee

Well, I'm always puzzled by this because it's not just Australia and New Zealand and Taiwan which are islands albeit in Australia's case a very big island, but it's also as Michael said Vietnam and there are other parts of the world that have been very successful, even if they do have challenges, like Uruguay or Rwanda or Finland or Norway. So there are plenty of places that are trying to do this and it's this sort of strange, well they're different in some way which I find quite puzzling, particularly for New Zealand, a country I know reasonably well which has an awful lot of historical connections and in many ways culturally is very similar in fact so quite why people will respond differently there from here I don't know. I mean every time I go there I'm always meeting people who were at University with me in Northern Ireland and so on, so there's an awful lot of similarities.

But yeah, the Prime Minister's approach, I suppose I would turn it round a little bit and say I can understand how you can drive cases down and keep them down at a very low level, you know you need to have all the measures in place with lockdowns to get them down and then have a really good testing and tracing and isolating and support system in place, that's fine. What I cannot work out with a disease which spreads exponentially, in other words if it's not absolutely level it's either going up and if it goes up it will go up rapidly and after a while it will get to very high levels, or it will be going down. The idea that you can sort of somehow calibrate your policy responses to keep it at a level which is other than zero, particularly when you're trying to respond to data which are at the minimum about ten days out of date with when people got infected, so you know you're picking them up seven to ten days after they got infected, then you're having to analyse them and synthesise the data, then you're having to decide what to do and then you're having to do it. So, you're always two or three weeks behind the curve.

And to calibrate perfectly this level of infections at 1,000, 10,000, whatever cases and just keep it absolutely right without it either going up or as I would argue we want to get it down, I just don't know how you do that. And I think people need certainty. At the minute we have a situation where we're yo-yoing up and down, we have been, and that means that nobody can plan holidays, nobody can plan weddings, nobody can plan anything and that's the real issue. You know we're always told that markets hate uncertainty and we're just creating a massive dose of uncertainty by doing anything other than trying to drive it down.

Now, of course I recognise that there are major challenges, particularly I was going to say when you're a trading nation with a short sea route and so on but of course that situation is changing too, but we'll leave that for one minute, but I just don't get it, I don't get what the alternative is and that's my problem.

Layla Moran MP

No, thank you very much, that's very helpful. So to dive into all of these issues much further we've got our Parliamentarians with us who've got a plethora of questions, I'm going to start with Lord Strasburger.

Lord Strasburger

Good morning and good evening to our panel. I think we'd all join in congratulating Australia and New Zealand for their success in suppressing the virus and saving lives and of course here in the UK as we've been discussing our outcome has been the polar opposite and we've got the highest death rate in the world. I'd like to ask you two questions about that, why do you think the UK's outcome has been so inferior to Australia and New Zealand and are there any reasons why the UK could not have replicated what you've managed to achieve in Australia and New Zealand. Shall we start with Professor Bennet please?

Professor Catherine Bennet

Thank you Lord Strasburger, great questions. I think in the first instance when we looked at what happened around the world it was the UK going late and perhaps Sweden going softer that made a difference to the way the first wave played out. But right across the Northern Hemisphere I think it was the fact as has already been touched on, that there were always those low levels of community transmission but you know 300 or 400 cases a day in France right through Summer and not that different across other settings. And that was what you were detecting, not necessarily what was actually out there and so you had the potential for multiple sealing events, we use bushfire analogies here in Australia and we talk about smouldering logs and you just had thousands of them potentially out there to take off as soon as your winter months started to bring people indoors and so on.

So, in Australia and New Zealand I think that whole point about suppressing here or eliminating in New Zealand was, the idea was as you say equilibrium would take you down to zero if you had that aggressive strategy. So, you would find a new spot fire and you would try and contain it. We discovered how difficult that could be in Victoria, it had got away from us and it was like a microcosm of what you're experiencing in the North, in trying to actually manage multiple fires at the same time and make epidemiological sense of what was going on and knowing what strategies to put in place.

So, could other countries do what Australia has done? Yes. But, when the lockdown talk happened over the last few months it was always still a level where people in Australia would comment on the UK and just say, you know but the pubs are still open or they're closing them earlier whereas we had decided to go all-out when we did close down. I do think that we could have learnt more from what we did in Australia and New Zealand about what really matters, so that we pare back and we know exactly which bits of lockdown are the bits we should focus on. Particularly now we're using safety nets for small outbreaks for example. And that might have been something we could have shared and it would have helped put the focus on those areas where I think you're most vulnerable to those chains of transmission still occurring at a sufficient rate that it undermines what you're trying to achieve and then you get into that oscillating cases, but also that sort of public buy-in and cynicism that can happen around lockdowns not really working or lockdowns not actually really stopping some of the very activity that people are worried about.

Lord Strasburger

You mentioned our lateness and also you implied that we weren't thorough enough in our lockdowns. Does that in your mind mean that we missed the boat, by the time the prevalence was that high as it became, by the time we had the first lockdown, was it too late to go for this zero tolerance of community transmission or could we have got it back together, or could we still get it back together?

Professor Catherine Bennet

Look, I maintain that if you go into lockdown it actually doesn't matter whether you've got the virus in 0.01% of the households in your country or 25% of the households. The whole point of locking down is the virus dies out within households and so you can have widespread transmission but it means you have to have widespread and very strict lockdowns and you have to have them in place long enough to work. We didn't measure our community transmission in the first wave, we weren't testing people even if they had symptoms outside of our return travellers and known linked cases, but we successfully shut down and eliminated the virus in the first wave, in Victoria we've got the genomic tests to show that. And so, without even knowing how far spread it was.

If you look at the data for our second wave again it's probably six to eight weeks but that's when you see the shutdown happen in community transmission. It was the receding into the community through workplaces and these long outbreaks that happened particularly in age care, that kept things going. So, you've always got that balance with your essential workers and those things you need to keep open but if you can keep the virus out of your healthcare, your age care, your distribution centres and so on then you do have a chance, no matter how widespread the virus is in the community, if you can cover that with a sufficient lockdown for long enough to actually close down community transmission, if you're also snuffing out those seeding outbreaks which are bringing the virus in, or you close your borders so you're also not seeding from outside.

Lord Strasburger

Thank you, Professor Moore please?

Professor Michael Moore

So, Catherine of course is in Victoria and where the most difficult challenges were for that second wave and the rest of Australia basically had a series of shorter but also strident lockdowns. They have actually really built on the learning from Victoria, I have to say. I think it is worth going back to the very beginning though, the goal at the very beginning was not elimination, at the very beginning the rhetoric at least politically was to protect our hospital systems, our intensive care units and so on. And I think the early success then may have been part of why we went actually, maybe as I perceive it, maybe we can achieve a zero result in terms of the spread of the virus, zero cases. Whereas I think New Zealand and Michael will elaborate on this but I think New Zealand actually went straight away for the zero community transmission.

So, I think there was a difference in there and you know Michael's five elements I think are really though the key elements in answering your question and when you look back at the UK response I think it was basically weak on almost all of them and whereas our contact tracing, our … it improved, it wasn't perfect but it was certainly seemed to be better than what happened in the UK. Along with these other tactics or techniques if you like, the five elements that Michael was using. And look, I concur with Catherine, I think all of us have people we know very well, my niece has just had a baby

in Birmingham, you know we know people very well in the UK and it has been challenging for us to … and frustrating for us to watch and go why doesn't the Government just … and I suppose I could leave it there, in some ways it's an easy thing for an outsider always to say but in some ways it's been quite frustrating. I hope that's helpful.

Lord Strasburger

Thank you. Professor Baker?

Professor Michael Baker

Yes, well look I absolutely concur with the previous speakers. It's hard as others have said as an outsider to comment on what happened in the UK but at a distance and through conversations with people like Martin and also Neil Pearce and other epidemiologists I know in London and the UK, and Scotland and Ireland, it did seem that a key factor was how the problem was conceptualised early on and a lot of people talked about how this was perceived to be like influenza and I think even sort of thinking about herd immunity for a period. And of course if you look at an influenza wave it comes through, it's very abrupt, you know in New Zealand in 1918 the influenza came through in six weeks and killed 9,000 people, you know 1% of the population in six weeks. And then it was gone, I mean it was brutal but I think many people thought that Covid-19 would behave just like influenza. So you had a herd immunity and I know it was sort of talked about in the UK and the Netherlands and Sweden and possibly only Sweden really stuck with that as really almost the official strategy for a while.

But I think there were shades of that thinking persisted maybe, well possibly not till now but for a long time and I think that did affect, there wasn't the scientific unanimity about pursuing more the SARS model which was very much that you had chains of transmission and you would stamp them out and that was the way to interrupt the disease.

And of course, in New Zealand we realised we did not have anything like the testing and the tracing capability early on, so we went back to the basic, very Mediaeval approach of just shutting the country down and saying to everyone stay at home, and for seven weeks everyone did that. Partly because they were so terrified looking at images coming from Northern Italy and basically that extinguished chains of transmission. I mean it's the crudest possible way, whereas testing and contact tracing of course just does exactly the same thing but it does it in a surgical way, it's very precise, you identify the cases and you quarantine and isolate.

But, if you don't have those resources you know that the circuit breaker or the lockdown or the stay at home order just achieves the same thing but just at a very crude population level, it will stop anything or any respiratory virus probably.

Lord Strasburger

So, you seem to be saying that we didn't take it seriously enough early enough, that would seem to be a summary of what you've said.

Professor Michael Baker

I think perhaps that it was conceived as a different, I mean the whole Western world had spent 20 years rehearsing the influenza pandemic plans and dutifully rolled them out. And New Zealand was going to do the same until really last minute interventions by a few of us to say actually we should

follow the Chinese model because it actually seems to have worked. And we had, you know enlightened politicians and New Zealand is a bit of a village so you can just talk to the politicians directly and they listened.

Lord Strasburger

Right, thank you, and Professor McKee.

Professor Martin McKee

Well, I'd concur with everything that's been said so I won't repeat it, but I think one additional factor that we didn't fully appreciate here which was the extent to which areas with high levels of deprivation were going to be breeding grounds for the infection and particularly if multi-generational households and with people with an informal economy, the gig economy, so that people were unable to isolate where there were powerful incentives not to get tested, not to take time off work and so on. And I think that in the first wave while the level of infection came down in the country as a whole it never really got suppressed up in the North-West in particular, Blackburn and places like that. And that was where it sort of spread out from again.

And I think it's very worrying at the minute as we're seeing a big gap in the uptake of vaccination even within some of the Northern cities. So, I think we need to be cautious to not make the same mistakes and to not focus on the aggregate numbers but also to look at the distribution on all of these things. But otherwise I agree completely with what's been said.

Lord Strasburger

So, I note that none of you has picked up my second question which is why couldn't we have done the same and had the same results in the UK, is that fair comment, I'll give you a second chance to volunteer something in that area?

Layla Moran MP

Martin, do you want to have a crack and then we'll move on.

Professor Martin McKee

Yeah, I think we could have done the same actually and I think this point about not having the right plan which I've said before, you know I've used this analogy of a ship in a storm and you need to have a Captain at the bridge who's paying attention but they also need to have the right chart and we had a chart that was marked pandemic influenza whereas other countries had a chart that was marked SARS and that made a huge difference. And of course some of the other countries, not so much Australia and New Zealand but the ones in South-East Asia have had since 2003 to prepare for that. Which of course helped a great deal, that's more in Taiwan and Singapore. So, I think it was entirely possible.

And you know, at the end of the day there's now a growing literature on the political determinants, to go back to Michael Moore's point, on the way that politics played out in all of this, I won't rehearse it again, but I think you saw very clear political leadership, you saw very clear messaging with Jacinta

Ardern and Ashley Bloomfield the Chief Medical Officer there working very closely together. I think also in the States and Territories and very much at that more local level as well as the Federal Government.

And also, I think a big advantage there was that as you said too, Michael Moore, you know everybody was working together and that's so different … I mean we had a bit of an issue here, but of course it was much worse in Italy and Spain, Spain in particular where there were huge problems, but I think that cohesiveness is really important. Politics really does matter.

Lord Strasburger

Thank you, back to you Chair.

Layla Moran MP

Barbara Keeley.

Barbara Keeley MP

Thanks Chair, I'll come onto talking about exit strategy. What do you see as being the key tests or pillars that must be met or be in place before lockdown can be lifted? If we start with Professor Bennet, I think you were indicating then anyway.

Professor Catherine Bennet

Thank you, I have a fascination with exit strategies. I think it was a struggle for us in Victoria. The first wave was quite clear cut, our State went later than others to be sure, you know to be extra safe but most pulled out … eased out … and we could see there was a legacy, you know in terms of people keeping their distance and so on, even after we eased out of lockdown. But the second lockdown was very different for us and I just wanted to touch briefly on a point relating to Lord Strasburger's question and Martin's response around where the virus lands and the second wave for us it landed in casual workers, it landed in lower socio-economic belts, it landed amongst migrant workers and it landed in public housing towers, and so that's where things changed very dramatically. But we introduced … it took a little while, but we did get things in place that were hardship payments so if people had to go into quarantine it meant, you know they couldn't go into work, they had some money in pocket. Not means tested, it was just handed out, no cost in administration it was really designed to try and support people and make it happen quickly. I guess the challenge with that though is of course if you're a casual worker it doesn't mean the work will be there next week when you do go back even if you've had money to tide you over, so there were a lot of issues around that.

We as epidemiologists, when we looked across the problem that we had in Victoria and were coming out, I think every epidemiologist said it's about getting your numbers down, you know the public wanted to know, everyone was dying to get out of this lockdown so we all talked about getting into double digits. But what was most important were what was called 'mystery cases' here in Victoria and that was a signal that you actually weren't on top of the outbreak, you didn't know how all cases were linked. You had people not coming in for testing or you had silent transmission in asymptomatic people in the community or your contact tracing wasn't just connecting all the dots and that wasn't up to speed. So, in fact mystery cases were an indication of the health of the public health response in a way.

So, it was those two things that were used to evaluation readiness to come out of lockdown. We had a road map in Victoria, it wasn't formed by some modelling but it was interesting because the modelling used actually didn't, wasn't modelling the exact precautions we had in place and it didn't actually model the mapped road map to come out of lockdown either. So, it was a strange use of modelling, I actually think it's one of those areas where we could have done a lot more in terms of the data and science informing policy and taken the public with us if we'd been much clearer on that.

The one exception where I think modelling was particularly useful from a public health perspective was in schools and that work actually changed policy, they changed the road map to open up schools a bit earlier for younger children when they realised, from the modelling, they were confident and they had good data behind that, that that wasn't going to pose an unacceptable risk, given where we were in terms of the epidemic.

So, I do think it was about formulating a road map but taking people with you in terms of the evidence behind the road map, but then I think it's about sticking to the road map, so there were a lot of people that thought the road map, myself included, was particularly harsh. You had to get to 28 days with zero cases on a 14-day rolling average which meant you know a long time with no cases to actually open up to a level that other States were managing even if they were managing local outbreaks with contact tracing and so on.

But in fact we didn't actually even stick with that, so they introduced additional rules, we had a rule about not moving more than 5km from home, then they would carry that forward into the next step, they shifted dates and so I do think if you have a path and you are basing it on evidence you should stick to it, because otherwise you know you don't have people then knowing what … not a 'reward' is, but what is now safe or what you said was safe should be safe, if it's been well thought through and laid out.

So, I do think there were a couple of issues with the way we stepped out. By the time we came out of lockdown we had no cases in the community and I'm not convinced that you have to stay in lockdown till you have 28 days of zero cases because you know as we've all said you've got that ten day lag time to see what's happening, if you're monitoring it really closely we have early warning systems in place and you can mop up outbreaks then our data show that the last six weeks were really quite contained outbreaks that could have been managed without the rest of the population in lockdown.

So, it's actually when you bring the lockdown in and we introduced not only contact tracing but also going to secondary contacts at the same time, that's about … you can only do that when your case numbers come down but that does bring lockdown to the actual areas of exposure and gives you more freedom to open up. It took us a long time to get that in place, we had it in place for weeks before we opened up but that was seen by the Premier in particular who is by this stage very, very cautious, to actually be the key to coming out of lockdown, was knowing that you had contact tracing in place, that extra step in the contact tracing that not only helped contain the outbreaks but told you when you'd come to the edge of it. When you'd found that ring of contacts, all who were negative, you knew the virus hadn't gone beyond those close contacts. So, that in itself was reassuring plus some of the early warning systems like waste water and so on which come into their own once your case numbers come down.

So, it was having those strategies to maintain but the vigilance then built around that to have the confidence to be able to open up safely. But yeah, getting the balance right I think we erred on the side of caution which cost us dearly financially and I think in terms of public morale.

Barbara Keeley MP

Thank you, Professor Moore do you want to add anything to that?

Professor Michael Moore

I just have a brief addition because it's really Catherine's area of expertise. I think one of the other issues we haven't really touched on was the communications that were going on. You know the Victorian Premier every day for, Catherine correct me, 120 days or something straight was on television answering questions, taking whatever questions and going through a press conference, quite long press conferences and saying no, it's my responsibility and this is what we're doing, this is the road map, as you say it was adjusted, but this is the road map, this is how we're gonna get out of it and this is what we're doing about the economy. So, and I'll come back later to the issues around the economy but I think that was quite important.

Barbara Keeley MP

Thank you, Professor Baker from the New Zealand perspective.

Professor Michael Baker

Yeah, we've got two different experiences coming out of lockdown, the first one was in the first wave when we really didn't know what we were dealing with and how effective these measures would go and so we were very conservative and a bit like what Catherine was saying, we were using a mixture of observational data, very high volume testing and then at a certain point not seeing any evidence of the virus and then the modelling was starting to say that the probability of the virus still being circulating was very low. But still there was this real conservatism about coming out of lockdown too soon and it was, we started right away with a four level system and so we went to the highest level and then we were stepping down that but very cautiously, I'm sure we could have gone faster.

Now, we've had one moderate sized outbreak a few months after, three months of no cases and we decided to use the lockdown in a far more targeted way because we had better modelling and more extensive testing and contact tracing and now we're just having a few, we have the odd border failure and a few cases in the community and so we're now using the sort of lockdown methods in a very geographically targeted way and not barely going into a stay at home order and combined with very high volume testing and contact tracing that seems to work very well.

And the modelling is, you know with these very small numbers is not very precise and we often are relying on looking at the results of testing contacts and their contacts and looking at a certain point when you stop to see, where you're not seeing anymore cases in the people you're testing, that's quite reassuring that you can relax at that point. So I think it's moving from the blunt instruments to the very targeted instruments as you get more comfortable with using them. And I think the public also understands better the process.

I did have a question of course, the other huge change now is that we have vaccines combined with public health measures, so the rules are going to change dramatically in terms of what elimination means because this is another thing that surprises me is there are numerous elimination strategies rolling out around the globe and have been for several decades and they generally require vaccines but they're not vaccines on their own, they're always combined with public health measures as well. So, I'm just interested in this what will be a combined assault on the virus with both of these tools and all it means is that elimination is that much easier and it does seem sometimes with the terminology people think it's vaccination or elimination, but actually they are a combined approach and so I'm sure with vaccination we'll have to rewrite the rules or our experience of how it'll be much easier to achieve zero transmission.

Barbara Keeley MP

Thank you. Do you have anything to add Professor McKee?

Professor Martin McKee

Well, just to add to what has been said, I'm very much involved in a lot of discussions around this in my role advising the European region of WHO and we are trying to look at what the long term prospects are and by that we're trying to pull together the best expertise on the evolution of the virus and in particular talking to virologists and mathematicians about whether it will be evolving in what we call convergent evolution towards some perfect fit or very good fit with the receptors. Or will it be like influenza which we think it probably won't be, where you've got eight sub units that are constantly mixing and getting in bits from pigs and from birds and so on. And if we do get the convergent evolution then we will probably need one or two new re-engineered vaccines, but it won't be an annual one so that will be good news, but we need to understand that better.

We are a bit concerned at the minute about the evidence that the new variants are infectious for longer and Michael Baker, I'd be interested to talk to you later about this as to whether that's accounting for some of the escapes you're getting in people who are infectious after coming out of quarantine as to whether that may be something we need to be concerned about. And we also need to know more of the very encouraging signs coming out actually from Scotland, from Israel about the role of the vaccine in preventing transmission. And also looking at ways in which we can use innovative measures, not innovative but established measures of surveillance in waste water sewage and so on.

So, we're trying to pull this together to look at perhaps the longer term, not just getting out of lockdown but how we actually get to a real long term control, elimination, whatever and we're still, this is work in progress at the minute because there are so many uncertainties. But there is quite a bit of evidence that we can draw on which we're doing at the minute.

Barbara Keeley MP

Thank you.

Layla Moran MP

Thank you very much. Just before we quickly move onto Philippa Whitford, the Government does seem to be relying, and this is for Martin very briefly, relying very heavily on mass testing, so it's mass testing and vaccination that seems to be the main thrust of their approach right now. Can you just quickly comment on what evidence we have that this is going to work?

Professor Martin McKee

Yeah, so we published a paper in the British Medical Journal recently, I was working with colleagues including Iain Buchan in Liverpool where we looked in some detail at the different strategies, the different ways in which you can use mass testing. In brief, there are advantages of PCR and advantages of mass testing and disadvantages of both so they're different. The rapid testing does seem to be better at picking up people who are actually infectious, you do get some false positives in people who had been infectious and now no longer are. And essentially to cut a long story short, what we argued

was for a really carefully thought through strategy about when these tests are appropriate and when they can be used and the big message that comes out of Liverpool is work with the local communities to find the ways in which they can work.

So, for example they were using them for daily testing with the Fire Service because they were having a problem in that once one person was infected the whole Fire Crew was unable to function and that was a real danger. So, they have I think a lot of very good experience that we can draw on, but you have to work with communities on the frontline to find out how they can be used, where they can be used. They have an important role but it's not as simple as the Government is portraying I think.

Layla Moran MP

Thank you, Philippa Whitford.

Philippa Whitford MP

Thanks very much Layla. If I could start with Professor Bennet and then I'll come to the two Michaels. How concerned are you about new variants, particularly ones that might be more vaccine resistant like the Brazilian or the South African, or more infectious like the UK variant. And do you think that means that we really need to maintain tight border control or border quarantine for a long time, possibly throughout this year. I mean last Summer Scotland managed to eliminate almost all of the 300 strains that we'd had in the first wave, we got right down to elimination levels and then everyone felt they'd a God-given right to go on holiday and off we went again. So, are we stuck for 2021, do you think with tight border controls?

Professor Catherine Bennet

That's been the big question, you know because of our border closure strategy being one of our main tools. What I can imagine is … we're mainly focused on using AstraZeneca vaccine, so we do have a concern about the variants and a clear and present danger with the variant we associate with South Africa, so I do think it's going to play out on borders. I do think the way these variants behave, including potentially longer infectious periods is something that's been on our minds a lot of late. We've introduced testing to everyone leaving our hotel quarantine at the end of testing, we only did that if they hadn't tested positive previously as part of their exit strategy. Now, if they do test positive they are still screened and then reviewed by a panel if they're still shedding virus. And we've introduced day 16 testing so we keep ours in quarantine for 14 days, even if they have an infection, it used to be ten days or three days after symptoms. So, we've tightened all of that up because of this uncertainty about the new variants.

We do have to have the big conversations about when and if we let the virus into the country, if we think the vaccines cover us enough to protect our elderly, our vulnerable, our health systems from that impact of serious illness and deaths then it might be that we are in a position to relax the borders, but not if we still have this clear and present danger that we're watching out for which are these variants, particularly given the vaccine profile in the country.

So, I can imagine a scenario where we continue to have quarantine but maybe it's actually screening for variants and if you come in and you're positive and it's a garden variant, and I know we have got evidence of co-infection, but I think that's very rare, that you might say OK you can go through because it's not a variant we're worried about. If you don't, if you're not positive then you might have to stay in quarantine till we know whether you're gonna become positive and if you've got the variant they're

the people that we hold in special quarantine to be sure of. So, I do think we have to think about that as we're in that process of understanding whether we do need to then move to the next generation of vaccine and what that means for how we manage the virus at our borders and within the country.

Philippa Whitford MP

What are your thoughts about the fact that in the UK having finally introduced border quarantine after a year it's so limited, it's only the 33 red list countries, even though we know the South African variant is in at least 35 other countries and of course there could be a new variant none of us know about yet?

Dr Catherine Bennet

I think that's very interesting. We could have the length of the Victoria lockdown spent just discussing contact tracing alone, let alone hotel quarantine. It's a hot issue because of course all our virus in the country has been, apart from the initial travellers, failure at our borders to contain it. And I have talked to the BBC about your hotel quarantine as well and the fact that it is ten days, the fact that people are allowed out for exercise, a range of things that to us just come back to how I think we perceived lockdowns initially is that there's too many holes in this sieve and you know we keep talking about the Swiss cheese and how you have to have layers and layers, we test our hotel quarantine staff daily in Victoria, it's one of the things I really pushed for when we reset our quarantine in Victoria, that's what we put in place. We now test our hotel quarantine workers daily on their days off, that's been introduced because we had where it was crossing over from the borders, it was someone who'd gone home, tested negative on their last day and was positive by the time they came back to work and the exposure had already happened in the community.

So, you can … you know we didn't actually look at our hotel quarantine end to end in a sufficient way as it turned out, we weren't really managing our airline crews very well, particularly the ones who were Australians and were allowed to go home between shifts. So, I do think there's a real challenge for us in having meaningful border control, I mean we're always taught in microbiology it's your weakest link and if you're going to let, you know you have too many holes in the sieve then why bother with the sieve. And I think that's what you need to look at, it's having a really credible, hard commitment to something to make it work, or pull back and then have your surveillance systems in place, your early warning, your testing, your sentinel worker surveillance, that sort of thing.

Philippa Whitford MP

Thanks very much, Professor Moore if I come to you before we look at New Zealand. Do you have anything to add?

Professor Michael Moore

Well, I was going to say it's great having Catherine here because she covers the areas so methodically, but there is an elephant in the room. We had a very conservative national Government who had spent years talking about national debt and bringing national debt down and they basically immediately turned that completely on its head and said no, we have an emergency we are going to spend and we're going to spent big and we're gonna put the safety nets in place to allow all of these other things to happen and they did. And they've borrowed to do it. It did sort of put a lie to the way they've been campaigning for 15 years, however I think it actually helped build the trust and you know we've touched on trust quite a number of times because they said no, this is a serious emergency.

In terms of the new variants I don't have that much to add to Catherine other than it's really our community is very, very conscious of it and we're conscious of the fact that our quarantine systems have by and large worked and we want them to be held very firmly and so I think that if there's any risk around the variants that is perceived to increase chances of spread then we'll see things tightening up. And we're all of course hoping that the vaccines are going to cover those variances as well. But we've got to see.

Philippa Whitford MP

Yeah, I mean we look from here obviously in the UK there is still this battle between public health and economy and it's almost like a pinball between we have a surge, we have a lockdown, then we push people back out, then we have another surge. Whereas we look at you, we look at the Australian Tennis Open and see that if you control your borders you get your domestic economy and society back, whereas we're a bit stuck in the worst of both worlds at the moment. If I can come to yourself Professor Baker to finish off obviously from the New Zealand point of view.

Professor Michael Baker

Yeah, I think it's pretty similar to the Australian perspective. I mean one of the huge benefits of eliminating transmission is you don't have to worry about the variants anymore and it is a good insurance policy if that's your goal and also it reduces obviously viral evolution, you know the selective pressure favouring both a more infectious variant and variants that escape vaccine, is if we can get the numbers down to zero and then obviously deal with the R at outbreak. You've got another key tool which means you're not dependent on vaccine. I mean obviously vaccines are a key method for getting there and you're still going to do it, but that is one of the other benefits of it.

I'd also agree with the points Catherine makes very well, that if you're going to invest in border biosecurity to stop the entry of the virus you really have to do it properly or not at all, I just don't see the point of dabbling with it. And that's what … I've done one or two interviews with the UK on the subject and when they described what they were doing it was very hard for me not to express real scepticism and like everything you have to have a purpose for doing it and probably repeating myself to say that aiming for no transmission in the community is a very powerful unifying force for pulling all your strategies together and for also communicating to the public what you're trying to achieve. Because people have got right behind that and I think certainly Australia and New Zealand and other countries, Vietnam I gather it's such a unifying focus for the whole community to actually have no transmission and if they have cases to stamp it out. It's a very relatable goal.

Philippa Whitford MP

Thanks very much. Professor McKee, obviously we have the Kent variant which is a home-grown domestic one, how much do you think the opportunity for that to evolve came because there wasn't early enough action in the Autumn. Obviously SAGE called for a fire break lockdown in the UK on the 21st of September, but that lockdown didn't happen for another six weeks. Do you think those high levels contributed to developing that variant?

Professor Martin McKee

Well, as you well know viruses that don't replicate don't mutate and so therefore it clearly did and we looked to the example of SARS from 2003 that is no longer circulating, it hasn't mutated, so then it's

really not surprising. And this is I think another strong argument for suppressing the levels because as long as we continue to let them circulate then we will just accumulate mutations.

The big question as I mentioned in one of the earlier answers is whether we're getting this convergent mutation to a perfect fit and then any further mutations will be a less good fit and it will have an evolutionary disadvantage and of course that could change with vaccination as well. But I think we don't know, there are some interesting papers using in silico modelling looking at the potential variants that could arise that we're trying to understand. I mean Catherine may know more about this than I do, but I'm struggling to try to get my head around all of this at the minute, but as long as if we can suppress it it's not going to mutate at anything like the same rate.

Philippa Whitford MP

And do you think the vaccine resistant versions such as South Africa could undermine the vaccine programme here on which we seem to be kind of betting all of our money?

Professor Martin McKee

It's really difficult to know and the other thing is of course looking ahead, we already are looking at the potential for inhaled vaccines like we do with children with influenza which may have a greater role in preventing transmission, so there's a whole lot of things that are quite uncertain but I would defer to people who have more expertise than me here.

Philippa Whitford MP

Thanks very much, back to you Chair.

Layla Moran MP

Thank you so much. Caroline Lucas.

Caroline Lucas MP

Thanks Layla. And you've all mentioned test and trace at least once or twice so far in what you've been telling us and what I would love to understand better is how critical a functioning test and trace system has been to your outcomes and in particular what's been done in New Zealand and Australia to ensure that when cases are traced that the chains of transmission are actually broken and you'll know we've probably got some quite big issues here around the amount of support that's been given to people isolating. So, I don't know maybe to change the order maybe start with Professor Baker if you could give us your view on that.

Professor Michael Baker

Yeah, look there's great questions and again it's like the borders, you just … if you're going to do it you have to do it well. There's no point, I mean it's got all these elements of testing, isolating cases, quarantining contacts, all those elements have to be in place and quite early on we realised that when you found someone who is positive you couldn't rely on them isolating at home, you basically had to

put them into one of the managed isolation quarantine hotels that are used for people arriving into the country and then we realised you had to also put their family members in there as well because they'd been often heavily exposed. So, they then had the same experience as people who are arriving into the country because essentially your country is split into two groups, those in the country who are virus free and those who've been exposed either through arriving from overseas or from contact with a case and found to be exposed as a result of contact tracing.

So, you had to apply the same level of rigour to this populous of population and that took a little while, I mean that took a few weeks of experience to realise that. I don't know what you do in the UK but, then the other thing is you also look at huge professionalisation is needed of that approach, you need very good information system trained staff, very tight performance indicators on the speed of identifying contacts, you really need to take a very business-like approach to this. Of course like most things in New Zealand we have done this within the State sector rather than contracting it out and that has resulted I think in high quality, very high quality State-run service throughout. So a lot of learning along the way, somethings we did use contractors, we found they were not generally up to the task and it's been pulled back more into the Government sector over time.

Caroline Lucas MP

Wow, I mean can I just understand that you're saying that anyone who was self-isolating and their families where they required legally to go into a quarantine hotel or how did that actually work in terms of enforcing it?

Professor Michael Baker

Well they were strongly encouraged to go and occasionally some people wouldn't, I mean some household contacts said actually I'm going to stay at home and they were managed in their homes and they had the same testing and so on regime. And in many cases they weren't of course infected. But over time people actually found it was easier to go into these facilities and be cared for, because they were quite worried about the risks to family members getting infected. So, that became the norm after a while and I think, actually I don't have data on how often people rejected it, I think it was very unusual that people rejected that kind offer from the State.

Caroline Lucas MP

And what kind of financial support was given to them as well, because one of the problems we have in the UK is that only three in ten people who should be self-isolating are self-isolating because it's so difficult to get financial support and even if you do get it it's at a pitiful level.

Professor Michael Baker

Initially there wasn't support then that was phased in, so there's a special allowance for people to cover this period of being in quarantine or isolation.

Caroline Lucas MP

Is it enough, do people get a sense that it's … I don't know how you would compare it for example to your minimum wage, your living wage, your average wage.

Professor Michael Baker

It's a good question, it is a subsistence level, it's probably approaching the minimum wage level. The other thing is that sick leave has also been, there's a special entitlement you can get now if you need to stay off work as part of a contact tracing process while you're awaiting the results of your testing. So once someone's tested they have to stay at home until that result is available and they may be required to stay home longer and be re-tested if they're a high risk contact in the community, this isn't household contacts. So, it has been a moving process and adding lots of refinements along the way to make it really work.

Caroline Lucas MP

And so those people that were staying at home waiting for their tests would get again the equivalent to roughly like a minimum wage type amount, is that what you mean?

Professor Michael Baker

They can, yes.

Caroline Lucas PM

Thank you, Professor Moore, maybe I could come to you next.

Professor Michael Moore

Mostly Catherine has much more expertise than I do on this, so I'll be very brief. And she has lived through it, in my jurisdiction we've had minimal lockdown actually and that has been through a series of things that have been mentioned before. For me one of the interesting things was using Police to check when people are in self-isolation and they were both phoning and visiting as well. I often wondered why they weren't using Police for the normal contact tracing because these are skills that Police Officers actually have and I would have thought that this was a fairly obvious use in a set of circumstances that we had. I'm interested in Catherine being critical of that comment. But, she has much more expertise than I do on this.

Caroline Lucas MP

OK, pressure's on. Professor Bennet.

Professor Catherine Bennet

Thanks, we do have some differences to New Zealand and we have some differences in my State to the rest of Australia as Michael said, we bore the brunt of it, we had at our peak 725 new cases in a day, when you think about you know the households that you'd have to manage we couldn't put them into quarantine if we'd wanted to. They always had an allowance, if someone was vulnerable and not infected and someone in their house became a case then there was the opportunity to separate the household and try and protect the vulnerable. Also larger households of course you could potentially

have them in isolation for a very long time if there was a slow serial transmission from person to person, particularly if they had children for example.

So, there were different circumstances where managed isolation was an option, but in the main the vast majority of our people and I think when you had at our peak, I'm just going to have a peek at our spreadsheet here for our active number of cases, but we probably peaked at … where were we up to … we had something like up to 7,500 active cases at any one time, so they would have to home isolate and we would have these spot checks, they didn't check on them all the time initially there were reports that you know 25% of the people weren't where they were meant to be when the Police went there, but that was actually a communication issue and it turned out the percentage of people who failed that random check was incredibly low, it was incredibly low, so people were actually in the main compliant.

Caroline Lucas MP

Was there a sanction if they weren't not found to be where they should be?

Professor Catherine Bennet

Yes, our State had moved down the punary [ph 1:17:59.2] path which I think was unfortunate given that people were so compliant and working so well with Government but very serious fines that got up into the thousands of dollars for breaches of particular kinds in the end, mask wearing, not being in isolation and so on, but they you know, people were actually amazingly good. The risk is always that you don't know if they're having people over to their homes or you know and other ways that it might not work, but of course it did work for us, we managed to get to our zero cases and so it was clearly sufficient even if there was the odd breach within that, the majority it was managed well.

Contact tracing as Michael alluded to earlier got better over time but nowhere more than Victoria, you know the contact tracing we now realise was a miracle that we actually managed that first wave as we did with lockdown because it didn't, the risk, the downside was it didn't test our contact tracing and we didn't realise how undercooked our contact tracing system was. So we came out of that first wave not even being aware at the time that we were actually approaching elimination as the second wave took off, you know actually the seeding of the second wave actually was in the tail of the first wave. And that took off very quickly because as I said earlier it got into those very extensive households in very well networked parts of the community and people with multiple jobs. And we found that very quickly the contact tracing wasn't working.

And this was perhaps the big area of contrast to what Michael's presented in terms of trusting Government and the communication from Government but there was this combination of the concern about how direct the Government was being about owning this problem, that this seeding had happened out of a hotel breach, but also about how good the contact tracing was and so they were talking it up, they were saying it's fine, it's fine and yet we were hearing more and more stories from the community about you know businesses had waited a month to hear from the Government when they've had an outbreak in their restaurant or something. So, there was this disconnect between the Government messaging and clearly what was going on.

The other disconnect was we didn't use, build off our outbreak management teams, we actually built something in a big tent over here that's outside our health department, so we weren't building on that expertise as well as we might. And then we did what you didn't do Michael in New Zealand, we outsourced contact tracing and we also had other States contributing and we lost some of those precious things that make for a really good contact tracing system and that is local knowledge, local relationship with community leaders, particularly as we had the second wave in areas where it wasn't

just about having someone who could speak the language, but understood what those people in the community understood about Government and how they wanted to interact with Government and how they networked, you know what contact tracing looks like in some of these communities is very different to what someone sitting in an office in another State might envisage.

Caroline Lucas MP

Can I just interrupt you, I'm really sorry, I'm just very aware that we're beginning to run out of time and there's just one more thing I wanted to ask you about the financial support that people got in your State.

Professor Catherine Bennet

So, we did have I think it was about $750 if you had to go and get a test because you might have to wait for two days or so to get your result back and then we had another payment which I can't remember now, it's 1500 or 1750 which was for the people that needed to isolate.

Caroline Lucas MP

Did you ever have a problem saying that they couldn't afford to self-isolate?

Professor Catherine Bennet

So, that was the concern and that happened in the second wave when we had this community impacted and particularly the casual workers who didn't have sick leave. So, if you didn't have access to sick leave this hardship payment was put in place, but as I said you really only had to ask for it and to demonstrate where you worked that didn't have sick leave, particularly if you were a casual worker and so a lot of people did tap into that. But, as I said it wasn't always just the money though, I think some people's views about their own job security could mean that that wasn't necessarily the answer for those people. So I'm sure we had problems with people coming forward for testing but at the same time I thought that was a great move, particularly knowing the parts of the community that were impacted at the time.

Caroline Lucas MP

Thank you, sorry to rush you.

Professor Michael Moore

There were also some financial problems around foreign students who haven't been able, yeah, yeah.

Professor Catherine Bennet

Yes, they were stuck here and couldn't work, couldn't do anything, yeah.

Caroline Lucas MP

Did Professor McKee want to add any last word on that one?

Professor Martin McKee

No, I've nothing to add.

Caroline Lucas MP

Thank you and sorry to rush you, it's only because I know that there's more questions.

Layla Moran MP

No, thank you very much. Yes indeed, we've got about 15 minutes left and so my plea to Parliamentarians and panellists is keep it short, I'm also very aware that Professor Baker it's approaching midnight for you. We are very grateful and I just wanted to restate that. Baroness Masham.

Baroness Brinton

Oh, I thought it was me.

Layla Moran MP

Oh sorry, Baroness Brinton. My fault. Apologies.

Baroness Brinton

Sorry. Thank you very much. My question originally was about deprivation and ethnicity but I think we've covered deprivation quite a lot already, so my question is were there specific issues about ethnic or indigenous communities and what are the risks and have you had the same experiences as us or perhaps your experience has been different. Can I start with Professor Baker please?

Professor Michael Baker

Thanks, that's a hugely important issue. I would say in New Zealand because we've such a huge focus on ethnic inequalities and also treaty relationship with the indigenous Mauri population that all strategies have equity as a key driving force and we know, we knew that if there was widespread Covid-19 transmission in New Zealand based on the pattern of previous pandemics and inequalities with other infectious diseases that there would be a very disproportionate effect on Mauri and also Pacific migrants in New Zealand.

In the end we didn't see that because we didn't have enough transmission in New Zealand. We had 25 deaths and we had you know I think probably only about 1200 actually introduced cases at most, or circulating cases in New Zealand, the rest were cases detected at the border which still added to our total of course. So, we never saw ethnic inequalities manifest just because the most pro-equity

thing you can do is not have the virus in your population and that policy was very strongly supported by all Mauri and Pacific groups and they were very … we worked very hard on looking at inequalities.

In the end the main problem is actually the response has been harsher on low income people, unemployment has risen slightly and housing problems have been exacerbated, so there are ethnic inequalities but from the response more than the disease.

Baroness Brinton

Thank you, Professor Moore.

Professor Michael Moore

The vulnerability of indigenous people I think is really demonstrated by the fact they have very high priority in terms of receiving the vaccine, so we certainly recognised that that is a vulnerability. One of the elements we haven't touched on of course is luck, I think there has been an element of luck that we have not seen widespread disease within the Aboriginal and [inaudible 1:26:06.9] community, I'm sure Catherine has a broader … but you know everybody has touched on equity, boy if we ever needed to understand the social determinants of health this was a very clear demonstrator of it and for those of us who probably everybody here who's very familiar with Sir Michael Marmot's work, if people had been paying attention to that a bit earlier I think we would have been also taking a much more targeted approach.

Baroness Brinton

Just before we move to Professor Bennet, do you have the same problem that we have with much lower uptake on the vaccine within ethnic communities?

Professor Michael Moore

Let me start with indigenous communities because actually we have a very high compliance on all vaccines in our indigenous communities, it's sort of the only area that's back to front for what we would normally expect. I don't think we can lump all our ethnic communities together because different ones have different approaches and that was one of the things that Catherine mentioned earlier was targeting those particular groups and that was I think one of the keys to avoiding the outbreaks and making sure that their community leaders were engaged and understood.

Baroness Brinton

Thank you and Professor Bennet.

Professor Catherine Bennet

Yeah, look just to add in some ways our indigenous community in urban areas was a bit of a model in Victoria because of their own networking and community support has really helped people who were in isolation, so people were holding up some of those as really good examples of ways we should think about supporting people in community. And with our contact tracing, I mean that was one of the big

shifts in my State, it was a centralised health system, was moving to community based and that was also you know very much a partnership with local community health services that already had established relationships with community leaders. And I think we've still got a long way to go down that path, when you've been very centralised but at the same time that makes an enormous difference both to the quality of information you actually get into the health department and the way you can work with community to manage those outbreaks and to learn about what's really happening in the community as well. So de-centralising, community based and learning from some of those community support models.

Baroness Brinton

Thank you and did you want to add anything Professor McKee.

Professor Martin McKee

Well, not really except to say that of course there are quite important differences in between the Aboriginal population in Australia and the Mauri and Pacific Islanders in New Zealand and particularly the treaty rights under the Treaty of Waitangi and that does shape all sorts of things, but we have the experts here, so I'll just add that comment from afar.

Baroness Brinton

Thank you. Back to you Chair.

Layla Moran MP

Thank you very much, now Baroness Masham.

Baroness Masham

How many vaccines have been administered and what extent is the roll out of vaccines part of overall Covid strategy and can you comment on the UK's approach to increasing the interval between vaccines. I have a personal interest in this as I had the first Pfizer and suddenly from three weeks it was changed to three months, so I haven't had my second. Could we have Professor Martin first please?

Professor Martin McKee

Well, we looked, in Independent SAGE we looked at this issue of extending the interval with the vaccine. In an ideal world we wouldn't have to of course but we believe that if we take say a theoretical 100 people and you have 100 doses of vaccine it is better to give all 100 75-80% protection rather than give 50% of them 85-90% protection and leave 50% of them unvaccinated. So we came to the reluctant conclusion that what the Government in the UK is doing is actually the right thing to do here. But clearly we need to make sure that then the second dose does get administered without too much of a further delay.

Baroness Brinton

What about New Zealand, Professor Baker.

Professor Michael Baker

Yes, well there's very little vaccines been administered in New Zealand at this point, we've got some Pfizer vaccine that has been given to the border workers, it's quite interesting the prioritisation is very different in countries pursuing elimination, where you start with your border workers and then you work through healthcare workers and then start to work through the vulnerable populations but that's going to take us to the end of the year because the vaccine arrival was at much smaller levels because it's not a matter of life or death in New Zealand. But the border workers have been a key priority and they're being vaccinated now.

Baroness Masham

And anybody else want to comment?

Professor Michael Moore

Actually similar in Australia but the Prime Minister and the Leader of the Opposition got theirs today but we've really only just received the vaccine and it's starting to roll out now but a similar situation to New Zealand. We will have more of the AstraZeneca vaccine because it's going to be manufactured in Australia.

Baroness Masham

Thank you.

Professor Catherine Bennet

I was just going to say, they're hoping for coverage in nine months' time, that's the aim. I think we are going for our most vulnerable at the same time we're going to our border workers in our first phase of our vaccination roll out in Australia, but how far down the vaccination pathway we need to be before we start to integrate other policy shifts that's yet to be seen. So we will continue with our precautions in place until we're at least some way along that path.

Baroness Masham

Well thank you very much indeed.

Layla Moran MP

Indeed, thank you all. And to round us off, Lord Russell.

Lord Russell

Are we not going to go to Lady Finlay?

Layla Moran MP

Oh, my goodness, I'm so sorry, I can't read my own writing today, yes.

Baroness Finlay

Thank you so much, I'll try and be very brief and perhaps the answers could be brief too, but we are quite worried I think about the reopening of schools and universities and the potential mixing and so on. I just wondered from Australia and New Zealand how you have viewed the reopening of schools and universities as well. So, possibly should we start again with Professor Bennet?

Professor Catherine Bennet

Thank you, so as I said we had a big focus on schools, we did a study in New South Wales early on and found very low evidence of transmission amongst children, if we had cases in school aged children they didn't find other cases in the schools and they only found one instance of a child who appeared to have been an index case in their household and that was actually a 17 year old who passed it onto his father. So, that actually gave us some confidence around particularly the lower classes in schools and as I said in Victoria our own modelling based on our own Australian data showed a very low percentage of our cases were children, of course we were testing in symptomatic people preferentially, children are more like to be asymptomatic but the only cases we had school outbreaks was where we had a lot of community transmission and it followed community transmission. It was, I think, the children taking the virus into the schools rather than schools being a significant incubator or accelerator in that community spread.

Our universities have kind of taken a very cautious path in Australia as well, you know of course we've lost our international students but we basically moved them completely online and we only started to open up campuses this year, but we're all going in for blended learning, you know and so it'll be a different approach to education for sometime yet and the focus was really trying to get people back in essential classes like prac [ph 1:34:33.1] classes but then thinking about density limits, wearing masks and so on. So, it's been a measured approach to try and make it a safe option to go back but equally we looked at pre-school young children and the sort of primary school age here in Australia up to 11 and then our secondary school age is a separate group and so we had staged return after lockdown that actually broke the school groups up into those different age levels and then the universities came later.

Baroness Finlay

Thank you, just can I just ask very briefly whether the other two, New Zealand whether you have anything to add to that and then I do want to just take Martin for a quick comment.

Professor Michael Baker

Well, I think in New Zealand we just had a four level system and we treated schools and universities pretty much like other workplaces and we regarded them as places where people met and the parents would meet so, generally they were a level four, they were completely shut, that was our circuit breaker level and level three largely shut.

Baroness Finlay

Martin, have you got a comment?

Professor Martin McKee

Yeah, look we know that this is a virus that is transmitted in situations where people meet together indoors for prolonged periods of time and it doesn't differentiate between schools, bars, restaurants and anything else. There are certainly children are at lower risk but as we're opening, as we're seeing the experience in Israel, children are becoming more affected as the society is opening up a bit, so we just need to be very cautious. We've put out a lot of detailed advice on making schools much safer, investing in ventilation and spacing and larger spaces for teaching and so on and it's just unfortunate that not enough has been done.

Baroness Finlay

Our schools are quite crowded places though often with really poor ventilation here and there is a pressure to vaccinate teachers as well, whether they should actually be vaccinated to cut down that pool now that the kids are going back.

Professor Martin McKee

Yeah, so the guidance from the JCVI is very much based on vaccinating people to reduce the risk of serious illness and of death which is essentially related to age and underlying health conditions. I think that's a good principle. There is evidence that the vaccine is reducing transmission but I don't think that's enough to change it at this stage personally, but I realise that there are differing views on this.

Baroness Finlay

Thank you, thank you Layla.

Layla Moran MP

No, thank you and sorry I missed you. And now finally, Lord Russell.

Lord Russell

Yes, very quickly, so the question is a very brief one to each of you which is if you had a single key message to give to the Government here what would it be, could I start with Professor Moore because

the comments you made about the way in which the Commonwealth and the different States were working together is very prescient here because we have had our problems with the UK Government which is actually comprised of four different national governments not always agreeing with one another, so what advice would you give for the UK Government Professor Moore?

Professor Michael Moore

Number one is health and economics are integrally connected, they are the same, they are the same thing. Decent health and the economy follows, and vice versa. So, that's element one. Element two and you touched on it Lord Russell, it's coordination because when you've got that coordination and agreement and compromise made then people can, it increases trust. They weren't always in absolute agreement and so the Governments would then identify that we're going to do things slightly differently in Queensland because we haven't got the outbreaks that are happening in Victoria or whatever and this is why we're doing it. And so, it was still a coordinated effort but allowing the exception if you like and so they were seen to be working together for the benefit of the community as a whole.

Lord Russell

Thank you very much. Professor Bennet?

Professor Catherine Bennet

I think it's interesting that over time our governments have probably started to take quite different views in terms of State border closures and so on, so I think actually to the UK Government is about leadership and I do think, you know we had strong leadership, we had the national cabinet, but we could always have stronger leadership. You know when you're looking at having a national approach to your border control and the way you manage your quarantine. We have very strong national leadership here around the vaccination programme. That's the first part of this whole effort where they've actually brought together a forum where they've brought all the key scientists, the commentators, everybody together in the room and we're just about to have our third forum, but it's really important to actually think about that, to actually think about having that coordinated approach, getting the best advice, putting your heads together about who should be vaccinated, who should be in each phase and so on and also just bringing your communication strategy together.

So, national leadership really matters, it doesn't stifle what's happening at local level or across your different contributing leadership groups but it's critical that you do have that consensus and coordination over the big issues.

Lord Russell

Thank you, it clearly does help if your leadership is not selectively deaf which our appears to be. Professor Baker.

Professor Michael Baker

Well, I am a convert to the elimination approach. I think the evidence base is compelling and I think it does provide a unifying goal which coordinates strategies and motivates people and so I would say give it a go.

Lord Russell

Yeah and lastly Professor McKee.

Professor Martin McKee

I would ask the Government to tell us what your objectives are and how you hope to achieve them, it's as simple as that. I'm still confused, there are far too many vagaries in the road map that we have.

Lord Russell

I think the problem is they're confused too Professor, thank you very much.

Layla Moran MP

And on that bombshell, yes indeed. Thank you so much all for taking the time to be with us our morning, your evening, especially those who have stayed up well past bedtime. I hope that many people who are watching will take heed and take on the advice and we're very, very grateful. I think this session has proved to provide a lot of clarity to the thinking that's going on in the UK, so I thank you all very, very much. Thank you to our Parliamentarians, thank you all for watching and stay … stay safe everybody that's all we can really say at this point isn't it. Take care, bye.